STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 08/16, 08/17, 08/20, 08/21, 08/22, and 08/23 with an exit conference via telephone on 08/24/18.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on interviews, record reviews, and observations, the facility failed to assure 3 0f 6 exit doors accessible for residents' usehad an alarm that activated for the safety for 1 of 1 sampled residents (Resident #3) with dementia who wandered from the facility without the staff's knowledge. The findings are: Observation made during tour of facility on 8/16/18 revealed: -At 10:45am, the door alarm to the front door of the main entrance did not sound upon entering the facility.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 1	D 067		

- At 12:15pm the exit door at the end of the 200 hall was not locked and the exit door alarm was not turned on and did not sound when the exit door was opened.
-At 1:00pm the exit door in the TV room which opened to the outside smoking area was not locked and the alarm was not turned on and did not sound when the door was opened.
-The exit door alarms at the end of the 200 hall and the activity room sounded when door was opened.

Review of Resident #4's current FL-2 dated 05/19/18 revealed:
-Resident #3 had diagnoses that included vascular dementia.

Resident #3 resided on the 100 hall.

Review of psychiatric evaluation visit dated 04/30/18 revealed:
-Resident #3 was in her wheel chair and wandering the hall aimlessly.
-She was being witnessed on several occasions trying to exit the facility front door.

Interview with a medication aide on 08/16/18 at 11:10am revealed Resident #3 wanders around the halls in her wheel chair and sometimes goes out the front door of the building.

Interview with a medication aide/supervisor-in-charge on 08/17/18 at 10:40am revealed:
-She did 30 minute checks on resident #3 because she would go out the front door of the facility and go around the side of the building near the activity room door.

Interview with primary care provider (PCP) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 2	D 067		

08/21/18 at 5:30pm revealed:
-She was not aware that Resident #3 was wondering outside of the facility in her wheel chair without staff with her.
-The PCP was concerned about Resident #3's safety and going outside in her wheel chair unsupervised.
-She thought Resident #3 may not be appropriate for the facility and may need to be in a locked unit to keep her safe due to her wondering.

Interview with the resident care coordinator (RCC) on 8/17/18 at 3:55pm revealed:
-There are alarms on all the facility exit doors.
-The exit door alarms (front door, hall exit doors, exit door to smoking area and activity door) should be kept on to alert the staff if exit doors were opened.
-The alarm on the TV room exit door, to the smoking area, has been broken and until it can be fixed there is a box alarm on the door that alarms when the door is opened.
-Resident #3 liked to go outside and ambulate herself around the building in her wheelchair, but she had started to go to the ditch near the facility.
-If the staff did not see her go outside, they would go outside to get her and bring her back inside.
-All of the exit doors were alarmed and the alarms should be on at all times.
-She would check the door alarms to assure the alarms were on.

Observation of exit door alarms on the front entrance and the exit door to the smoking area revealed the exit door alarms sounded when the doors where opened.

Telephone interview with the Administrator on 08/22/18 at 4:15pm revealed:
-She was not aware all exit door alarms were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 067	Continued From page 3 sounded (turned on) at all times. -She was aware Resident #3 wandered in and out of the facility.	D 067		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 6 of 10 water fixtures including sinks, tub and shower in the residents' bathrooms on the 100 and 200 Hall and the common tub room on the 100 Hall. The findings are: Observations during the initial tour on 08/16/18 between 10:45am and 12:21pm of the water temperatures at fixtures used by the residents on the 100 hall revealed: -At 11:37am the hot water temperature at the 100 hall shared hall bath #1 tub was 126 degrees	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 113	Continued From page 4	D 113		

Fahrenheit (F) and the sink hot water temperature was 120 F.
-At 11:55am recheck of the hot water temperature at the shared hall bath #1 tub was 120 degrees F and the sink hot water temperature was 122 degrees F.
-At 12:21pm the hot water temperature at the sink in the shared bathroom between rooms 107 and 109 was 120 degrees F.
-At 12:10pm, the hot water temperature at the sink in the bathroom in room 213 was 118 degrees F.

The facility thermometer and the surveyor's thermometer were calibrated in an ice water bath at 1:15pm. The facility's thermometer calibrated at 32.6 degrees F. The surveyor's thermometer calibrated at 32 degrees F.

Observation of the of 100 hall shared bath #1 with the residential care coordinator (RCC) on 08/16/18 at 1:27pm revealed hot water temperature at the tub was 130 degrees F and the hot water temperature of the sink was 130 degrees F.

Interview with the RCC on 08/16/18 at 1:45pm revealed, she was going to put up warning hot water signs immediatly on all the rooms and the bathing areas on 100 hall.

Interview with the maintenance/floor technician on 08/16/18 at 3:05pm revealed:
-He was not the one assigned to check the water temperatures daily.
-The persoanal care aides (PCA) or medication aides (MA) were assigned to check the water temperatures.
-The water temperature was reported as too hot on the last county environmental health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 113	Continued From page 5	D 113		

inspection done in July 2018.
-He had adjusted the thermostat on the water heater to lower the water temperature.
-He could not specify how much he had adjusted the thermostat or the date of the initial temperature adjustment.
-He did not know what normal temperature ranges for the water were needed to be maintained in the facility.

Observation of the hot water temperatures on 08/16/18 between 4:53pm and 5:05pm revealed:
-At 4:53pm, the hot water temperature of the shared bath #1 tub was 128 degrees F and the hot water temperature of the sink was 122 degrees F. Steam was observed coming from the hot water in the sink and the tub.
-At 4:58pm, the hot water temperature in the shared bathroom sink between rooms 111-113 was 122 degrees F. Steam was observed coming from the hot water.
-At 5:05pm, the hot water temperature in the shared bathroom sink between rooms 110-112 was 124 degrees F. There was steam coming from the hot water.

Confidential interview with a resident revealed:
-The water temperature in the tub/shower room "got hot enough to take your skin off".
-The resident had to get the PCA to adjust the water temperature several times when using the shower because the water was hot.
-The resident had not complained to the RCC about the water being to hot.

Confidential interview with a staff member revealed:
-The water temperature on the 100 hall "gets pretty hot because you can see steam when adjusting the water temperature in the tub and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 113	Continued From page 6	D 113		

showers".
-The water temperature "got hot pretty fast at the sinks in the residents' bathrooms too on the 100 hall".
-The staff member identified one resident who needed to be monitored using the tub and shower room on the 100 Hall to make sure the resident did not get burned by the hot water.
-"The RCC instructed the staff to monitor the resident because the resident may forget how to adjust the water temperature or only turn on the hot water."
-The staff member was not sure what the process was for checking the water temperatures.
-The water temperatures were elevated once on the 100 Hall once in July and the supervisor reported it to maintenance.
-The staff did not know if the thermostat on the hot water heater had been adjusted since July 2018.

Recheck of the hot water temperaturesof the 100 hall shared bath #1 on 08/17/18 at 9:05am revealed:
-The hot water temperature of the tub was 105.6 degrees F.
-The hot water temperature of the sink was 103 degrees F.

Interview with the RCC on 08/17/18 at 12:45pm revealed:
-The hot water temperatures had been up and down recently.
-The environmental inspector on 07/07/18 saw higher hot water temperatures.
-Maintenance lowered the hot water tank temperature on the 100 hall after the 07/07/18 environmental inspection.
- When staff got hot water temperature readings above 116 degrees F they are supposed to report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 113	Continued From page 7	D 113		

it to RCC or SIC.
-There have been no complaints of hot water from the staff or residents.

Review of the water temperature log documentation provided by the RCC revealed:
-For 07/01/18-07/31/18 the water temperature logs for the first, second and third shift for the shared bath #1 on the 100 hall ranged from 97.3 to 116 degrees F
-Except on 07/02/18 the temperature was 148.3 degrees F.
-For 08/01/18-08/15/18 the water temperature logs for the first, second and third shift for the shared bath #1 on the 100 hall ranged from 98.1-112 degrees.

Interview with the RCC on 08/20/18 at 9:15am revealed:
-The water temperatures readings on the 100 Hall were still greater than 116 degrees F.
-She was going to call a plumber on 08/20/18 to have the hot water heater checked on the 100 Hall.

Interview with the plumber on 08/20/18 at 10:00am revealed:
-The RCC had called him to check the water heater on the 100 Hall because of the high water temperature readings.
-He had adjusted the "mixing valve" on the hot water heater setting from 120 degrees F to 114 degrees F.
-He "was not sure why the water temperature had been elevated since the hot water heater was only about 4 years old."
-The water temperature could be rechecked in 1 hour.

Telephone interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 113	Continued From page 8 08/22/18 at 4:15pm revealed: -Hot water temperatures were reported to the RCC and the RCC informed maintenance of the hot water temperatures. -Maintenance was responsible for adjusting hot water temperatures. ._____ The facility failed to maintain the hot water temperature between 100-116 degrees F resulting in hot water temperatures between 118-130 degrees F which placed the residents on at substantial risk for harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/17/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2018. .	D 113		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by:	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 9 TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 5 of 6 sampled residents (Residents #1, 2, 4, 5, and 6) for a resident who had left-sided paralysis and not provided bathing/showers or nail care (#5); not provided adequate personal hygiene and bathing/showers to a resident with pressure ulcers (#4); not provided transfer and toileting assistance resulting in falls (#1); not provided personal care of bathing/showering, shaving and nail care (#6 and #2). The findings are: 1.Review of Resident #5's current FL-2 dated 12/11/17 revealed: - Diagnoses included cerebrovascular disease, muscle weakness, anxiety disorder and human immunodeficiency virus (HIV). -The resident was non-ambulatory and require assistance with bathing and dressing. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 01/03/18. Review of an admission skin assessment dated 01/03/18 revealed Resident #5's skin was without wounds, only a healed surgical scar on his left knee. Review of Resident #5's care plan dated 01/05/18 revealed: -The resident was sometimes disoriented, had limited range of motion, limited strength and only ambulated with a wheelchair. -The resident required extensive assistance with	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 10	D 269		

toileting, transfers and grooming.
-The resident required total assistance with bathing and dressing.

Review of Resident # 5's personal care log for the months of July 2018 and August 2018 revealed:
-There was documentation the resident was assisted with repositioning every day/night on 2nd and 3rd shifts (only one staff initial per shift).
-There was no documentation of the resident being turned or repositioned on 1st shift except for one day in July (07/05/18) and one day in August (08/11/18).

Review of Bath and Skin reports for July 2018 and August 2018 revealed:
-From 07/03/18 - 07/31/18, 13 reports had documentation of Resident #5's bedsore on his buttock and an ulcer on his left leg.
- From 08/02/18 - 08/14/18, 13 reports had documentation of Resident #5's bedsore on his buttock and an ulcer on his left leg.
-There were no Bath and Skin reports available from January 2018 through June 2018.

Review of Resident #5's wound clinic report dated 07/19/18 revealed:
-Resident #5 was diagnosed with a pressure ulcer of the left ischium (lower buttock) which was open, had a foul odor and unstageable and an ulcer of left lower leg.
-The pressure ulcers measurements were 1.7cm (length) 1.9cm (width) 2.2cm (depth) with slough/fibrin.
-The wound was debrided of slough, but the procedure was terminated because Resident #5 did not tolerate the procedure well.
-The wound of the resident's left buttock was classified as a stage III pressure ulcer after debridement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 11	D 269		

-The resident reported a sharp pain of wound areas rated at 7 before debridement and did not know how long the wound was on his buttock.
-The resident reported he sat in a wheelchair all day long.
-There were orders for daily wound care (clean with normal saline, apply Santyl ointment to wound bed and cover with foam dressing. Change every day and as needed). Referral to home health for skilled nursing care (wound care) and turn/reposition the resident every 2 hours.

Review of Resident #5's emergency room report dated 07/30/18 revealed:
-The resident's chief complaint was left buttock decubitus ulcer.
-The resident was diagnosed with an acute left buttock decubitus ulcer and ordered Clindamycin 300mg (an antibiotic used to treat infections) every 6 hours (80 capsules).
-He was to follow-up with primary care or specialist in 1 day if possible.

Review of a hospital wound care report from the wound clinic dated 08/02/18 revealed:
-The Stage III decubitus of Resident #5's left lower buttock measured at 1.5cm (length) 2cm (width), 3cm (depth) 2.356cm (tunneling) and 7.069 cm(undermining).
-Daily wound care continued (clean with normal saline, apply Santyl ointment to wound bed and cover with foam dressing. Change every day and as needed) and turn/reposition every 2 hours.

a. Interview with a Medication Aide (MA) on 08/21/18 at 8:40am revealed:
-Resident #5 required total assistance with transfers and repositioning.
-The resident was incontinent of bowel and bladder and required total assistance with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 12	D 269		

incontinent care.
-The resident had wounds (decubitus) on his lower left buttock and left leg which started about 2 months ago.
-The personal care aides (PCA) was suppose to reposition/turn the resident at least every 2 hours.
-The MA was not sure how often the resident was turned/repositioned.

Interview with Resident #5's Home Health Nurse (HHN) on 08/21/18 a 10:20am revealed:
-Resident #5 developed a decubitus on his left lower buttock (ischium area) and left posterior leg a few weeks ago (did not know the exact date).
-The resident was treated at the wound clinic on 07/19/18 and orders were received for daily wound care by the HHN.
-The buttock wound was necrotic and draining with a small hole in the center.
-The leg wound was beefy red with yellowish slough (tissue).
-The wound on the buttock was infected and the resident was transported to the local emergency room and treated with antibiotics at the end of July 2018.
-The facility staff was instructed by the HHN to turn/reposition the resident every 2 hours, but he did not know how often the staff was repositioning the resident.
-The resident should never be up in his wheelchair longer than 2 hours to keep pressure off the resident's buttocks/wounds to promote healing.
-He was not sure how long the resident sat up in his wheelchair befored he was transferred back to bed.

Observation on 08/21/18 at 11:00am revealed:
-Two PCAs were pulling up the resident's incontinent brief in the facility's community's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 13	D 269		

bathroom.
-The PCAs assisted the resident from a shower chair to a standing position.
-An open wound was on Resident #5's left lower buttock near back of his thigh.
-The wound was approximately the size of a quarter with depth. There was no drainage.
-The resident complained of pain of the area as the PCAs were changing his incontinent brief ans requested to go back to bed.
-The wound on the back of the resident's lower leg had pink granulation tissue and was not open or draining.
-The resident was assisted back into the wheelchair.

Interview with a PCA on 8/21/18 at 11:00am revealed:
-She only turned or repositioned Resident #5 if he asked.
-He sat up in his wheel chair for several hours in the morning and was usually in bed before lunch.
-The PCA did not turn the resident every 2 hours, but knew the resident was paralyzed and could not turn himself or transfer without assistance.
-She had never been instructed to reposition Resident #5 every 2 hours.
-The resident had developed a bedsore on his lower buttock and left leg about 2 months ago.

Interview with Resident #5 on 08/22/18 at 9:15am revealed:
-The resident was unable to transfer or reposition without assistance from staff.
-The third shift staff assisted the resident into his wheelchair at 5:00am.
-He usually sat up in the wheel chair until late morning, 10-11:00am, until it was unbearable.
-The resident complained of pain in his buttocks and his buttocks always hurt when he sat up in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 14	D 269		

the wheelchair over 30 minutes.
-He usually required pain medication to relieve the pain after he was assisted to bed.
-The resident was unable to reposition himself due to left-sided paralysis.
-The personal care aides (PCA) never repositioned him when he was in the wheelchair and only occasionally repositioned him when he was in bed, about one time during the shift, but not always.
-He usually sat or laid in the same position for hours.
-He did not have wounds when admitted to the facility but developed "sores" about 2 months ago on his left buttock near his upper thigh and on the back of his left leg.
-The HHN provided wound care every day and he went to the wound clinic at times.

Interview with second PCA on 08/22/18 at 9:35am revealed:
-Resident #5 was assisted out of bed before breakfast and sat in his wheel chair until late morning.
-When the resident was in bed, the PCA let him rest. The resident would let the PCA know if he needed anything.
-The PCA checked on the resident every hour but did not reposition him.
-The PCA repositioned the resident when the resident requested repositioning.
-The PCA was never instructed to reposition the resident every 2 hours.
-The resident developed wounds on his lower left buttock and back of the left leg about 3 months ago and she noticed the wounds when doing incontinent care.
-The wounds were documented on the skin assessment sheets.
-The HHN provided daily wound care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 15 Observation made on 08/22/18 at 11:10am revealed a third PCA assisted the resident in bed and positioned him on his right side. Interview with Resident #5's primary care provider (PCP) on 08/22/18 at 12:50pm revealed: -Resident #5 had a stage III decubitus on his lower left buttock and a stage II or III decubitus on his left posterior leg and wound care was initiated in July 2018. -The resident was paralyzed on his left side and he required assistance with turning and transfers. -The resident should be repositioned every 2 hours to promote healing of the decubitus and to prevent further skin breakdown. b. Interview with Resident #5 on 08/20/18 at 11:50am revealed: -He was scheduled to receive a shower 3 days a week on Tuesday, Thursday and Saturday. -The staff did not bath him often, only on Saturdays occasionally when the staff "feels like it". -The resident only received bed baths if he needed it (after incontinent episodes of bowels). -If the resident "smelled" himself or needed to be shaved, he would ask the male PCA to bath or shave him. -The resident did not remember when his nails had been trimmed. The home health nurse had trimmed his nails in the past, but did not remember when. Observation made on 08/20/18 at 11:55am revealed: -Resident #5's finger nails were long and dirty with a dark substance under his nails. -The resident's toenails were long and curved downward.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 16 Interview with a MA on 08/21/18 at 8:40am revealed: -The PCAs were responsible for completing the residents baths (as scheduled) and providing nail care (cleaning nails if the resident was a diabetic) -The PCAs document all personal care, including baths and nail care on the personal care sheet. -The PCAs document skin care assessment and nail care on bath and skin report. Review of Resident #5's Bath and Skin reports for July 2018 and August 2018 revealed the resident did not receive nail care. Interview with a PCA on 08/21/18 at 10:40am revealed: -Resident #5 was scheduled to receive a shower on Tuesday, Thursday and Saturday. -The resident was to receive a bed bath on all other days. -The PCA did not know if the resident received baths every day, but all baths were recorded on the personal care sheet. -The staff initialed the date and the shift the resident was assisted with a bath/personal care. -The Home Health nurse trimmed the resident's nails because the resident was diabtic, but did not know when they were last trimmed. He would trim the resident's nails when staff asked him. Observation on 08/21/18 at 11:00am revealed the Resident #5 was in the community bathroom, sitting on a shower chair and the PCA was putting on clothes. Interview with another PCA on 8/22/18 at 9:40am revealed: -The bath schedule was not followed most of the time.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 17	D 269		

-If a resident did not want a shower it was not given, but refusals were not documented.
-Resident #5 usually received a shower on Saturday because he liked showers on Saturday and received bed baths if he did not want a shower.

Review of Resident #5's daily Personal Care sheets for July and August 2018 revealed no documentation of showers on Tuesday, Thursday or Saturday and no documentation of bed baths on all other days.

Interview with the RCC on 8/21/18 at 4:10pm revealed:
-Staff was expected to follow bath schedules and document resident refusals on the personal care sheet.
-All skin issues should be documented on the skin assessment sheets and reported to the supervisor.
-The RCC and the supervisor were responsible for reviewing these sheets to assure care was done but they have not checked the sheets in several months.

Refer to interview with the Administrator on 08/22/18 at 4:15pm.

2. Review of Resident #4's current FL-2 dated 01/11/18 revealed:
-Diagnosis included healthcare acquired pneumonia (HCAP), acute on chronic diastolic heart failure, obstructive sleep apnea (OSA), morbid obesity, hypertension, and decubitus ulcer of the left foot.
-The resident was non-ambulatory.
-The resident was total care.
-The resident was incontinent of bowel and bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 18 Review of the Resident Register for Resident #4 revealed: -The resident was admitted to the facility on 01/10/17. Review of Resident #4's care plan dated 01/30/18 revealed: -Ambulation/Locomotion was marked as wheelchair with a performance code of three indicating extensive assistance was needed. -The bowel section was marked as daily incontinence. -The bladder section was marked as daily incontinence. -Self-care was not marked as yes or no in the bladder or bowel section. -The skin section was left blank. -Under the skin section the headings of normal, pressure areas, decubiti, other, and skin care needs were left blank. -Toileting was marked as being totally dependent. -Bathing was marked as being totally dependent. -Transferring was marked as being totally dependent. -Grooming and personal hygiene was marked as needing extensive assistance. Observation of Resident #4 on 08/20/18 at 11:55am revealed: -She was in her room supine on her bed wearing a shirt and an incontinence brief, and was covered with a blanket. -A medication aide (MA) and a Personal Care Aide (PCA) was providing incontinence care. -Her incontinence brief was wet with urine. -The MA and PCA rolled Resident #4 on her left side and removed the incontinence brief. -The MA and PCA did not perform toileting hygiene to Resident #4.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 19 -There was a light red colored area approximately six inches long by one and a half inches wide to her right inner buttock area with scattered areas of small blisters approximately the size of an ink pen tip. -There was a wound on the back of her left inner upper thigh area, just below her left buttock that was circular and approximately two inches in diameter, light red to dark pink in color, towards the inner part of the wound it was scabbed with an open area in the center that was approximately one centimeter and was bright red in color with clear colored drainage. -There was an area to her left lower abdominal fold where her stomach skin laid on her left upper leg and groin area that was bright red to light pink in color with small scattered red intact blisters approximately four (4) inches long. -The MA applied a barrier cream to her buttocks, the open wound, and left abdominal fold area. -Her buttocks area and open wound was not cleaned prior to applying the barrier cream. -The MA and the PCA applied a clean incontinent brief. -Her buttocks area was not cleaned or wiped by staff prior to applying a clean incontinence brief. Interview with a PCA on 08/20/18 at 11:55am and 4:05pm revealed: -Resident #4 had the open wound to the back of her left inner thigh area for two months. -Resident #4 had the reddened area to the left lower stomach and left groin fold for 1 week. -Both areas were being treated at the wound care center. -She thought there was an order for barrier cream to both areas. -Skin assessments were performed and documented by the PCAs when Resident #4 had her baths.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 20 -Resident #4 was bathed on Mondays, Wednesdays, and Fridays during second shift. Review of Resident #4's personal care sheet for 08/01/18 - 08/20/18 revealed: -There were the letters "LA" indicating "limited assist" that Resident #4 was bathed five out of twenty days. -There was the letter "R" indicating that Resident #4 refused a bath four out of nine attempts. -There was no documentation of the provider being notified of Resident #4 refusing a bath for any of the dates documented. Review of the Resident #4's personal care sheet for July 2018 revealed: -There were the letters "LA" indicating Resident #4 was bathed two out of thirty-one days. -There was the letter "R" indicating on 07/18/18 Resident #4 refused a bath. -There was no documentation of the provider being notified of Resident #4 refusing a bath. Review of Resident #4's personal care sheet for June 2018 revealed: -There were the letters "LA" indicating that Resident #4 was bathed four out of thirty days. -There was the letter "R" on 06/15/18 indicating that Resident #4 refused a bath. -There was no documentation of the provider being notified of Resident #4 refusing a bath. Review of Resident #4's bath and skin assessment sheets for 08/01/18 - 08/17/18 revealed: -There were nine reports completed for Resident #4. -There were five of Resident #4's reports with documentation of "OK" beside head, ears, shoulders, arms/hands, hips, coccyx (tailbone),	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 21	D 269		

knees/legs, feet, and heels.
-There were four of the nine reports with documentation beside head, ears, shoulders, arms/hands, hips, coccyx (tailbone), knees/legs, feet, and heels indicating that Resident #4 had refused.
-There was no documentation on any of the reports for 08/01/18 - 08/17/18 that the provider was notified of Resident #4's bath refusal.

Review of the Resident #4's bath and skin assessment sheets for July 2018 revealed:
-There were ten reports completed for Resident #4.
-There were five of ten reports with documentation of "OK" beside head, ears, shoulders, arms/hands, hips, coccyx (tailbone), knees/legs, feet, and heels.
-There were five of ten reports with documentation beside head, ears, shoulders, arms/hands, hips, coccyx (tailbone), knees/legs, feet, and heels indicating that Resident #4 had refused.
-There was no documentation in any of the reports that the provider was notified of Resident #4's bath refusal.

Review of the Resident #4's bath and skin assessment sheets for June 2018 revealed:
-There were thirteen reports completed for Resident #4.
-There were six of thirteen reports that had documentation of "OK" beside head, ears, shoulders, arms/hands, hips, coccyx (tailbone), knees/legs, feet, and heels.
-There was one report on 06/13/18 with documentation beside coccyx (tailbone) of "breakdown on buttocks."
-There was no documentation indicating the provider was notified of the skin breakdown.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 22 -There were 4 out of twelve reports with documentation beside head, ears, shoulders, arms/hands, hips, coccyx (tailbone), knees/legs, feet, and heels indicating that Resident #4 had refused. -There was 1 of twelve reports with documentation "refused maybe 6-9-18." -There was 1 of twelve reports with documentation "hair was washed" and "was not able to today need hoyer lift." -There was no documentation in any of the reports that the provider was notified of Resident #4's bath refusal. Interview with a second PCA on 08/23/18 at 4:43pm revealed: -She had cared for Resident #4 on 06/13/18. -She completed Resident #4's skin assessment sheet on bathing for 06/13/18. -The skin assessment sheets were completed with each bath. -She thought the buttocks skin break down documented on the 06/13/18 skin assessment for Resident #4 was on the right buttock area. -She could not remember if there was skin breakdown on the left buttock or back of the left inner thigh. -If a new wound or other significant finding was discovered during the bath assessment they were to inform the supervisor of skin breakdown and the supervisor would inform the provider. -She would not be responsible for informing the provider of skin break down. -She completed the 06/13/18 skin assessment sheet and gave it to the supervisor with a verbal report. -The skin assessment sheets are filed in the RCC's office. Interview with Resident #4 on 08/21/18 at 8:30	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 23	D 269		

am revealed:
-She thought the staff was "afraid to bathe me because of having to use the hoyer lift."
-Staff did not know how to use the hoyer lift.
-Staff told each other that the other was "hooking it up wrong."
-"I'm kinda afraid for them to bathe me because of them having to use the hoyer lift."
-She was afraid staff may drop her.
-She would not use the shower because the shower chair was "too small."
-She had mostly bed baths.

Interview with a Medication Aide (MA) on 08/21/18 at 9:00 am revealed:
-Resident #4 was bathed on second shift.
-Resident #4 would sometimes refuse a bath.

Interview with a second MA on 08/21/18 at 1:15pm revealed:
-Resident #4 could not turn herself when in bed.
-Resident #4's bed was to small for her.
-Resident #4 was not being turned when she was in bed.
-The only sore Resident #4 had when she entered the facility was on her "left foot and that's all."

Interview with a second MA on 08/21/18 at 5:40pm revealed:
-Resident #4 had a bed bath most of the time.
-She had used the hoyer lift with Resident #4 but it was a "struggle" for Resident #4.
-Resident #4 complained that the hoyer lift "confines" her.
-The PCAs gave Resident #4 a shower or a bed bath.
-The provider was to be notified when any resident refused a bath or shower for three consecutive times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 24 Interview with a third MA on 08/21/18 at 5:50pm revealed: -She had been employed at the facility for six years. -She had provided care for Resident #4 on second shift. -She had provided care for Resident #4 on second shift on 08/20/18. -Resident #4 was dependent on staff for hygiene. -She would perform toileting hygiene to Resident #4's buttocks area only with incontinence brief changes. -Resident #4 was dependent on staff for bathing. -She would give Resident #4 a bed bath or a shower. -Resident #4 would wash the front of her upper body. -She would wash Resident #4's back upper and lower body. -She did not know of a wound to the back of Resident #4's inner thigh. -She did not know of any wounds to Resident #4's left lower stomach/groin area. Interview with a third PCA on 08/23/18 at 5:10pm revealed: -He did not provide personal care for Resident #'4s buttock/backside area before applying a new incontinence brief on 08/20/18. -He only provided personal care for Resident #4's buttocks/backside before applying a new incontinence brief if she "wets herself a lot, like up to her back" and with bowel movements. -He followed the same process with Resident #4 for every incontinence brief change. Interview with the RCC on 08/21/18 at 4:45pm revealed: -Skin assessments should be performed and	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 25	D 269		

documented on bath assessments sheets.
-Any markings, bruises, discolorations, that were not previously there should be documented.
-The findings were to be reported to the supervisor then the supervisor would inform the MA/SIC on first shift or to the facility provider.
-The supervisor would address the new discovery, attempt to obtain orders from the provider, or follow standing orders if appropriate.
-There was no policy for repositioning residents with skin break down.
-Significant change was communicated to staff by verbal notification and handed down to each oncoming shift.
-Residents could have a shower on any shift the resident desired.
-If a resident refused a bath the staff documented the refusal on the personal care sheet and should document on the skin assessment sheet.
-She expected staff to document the residents' refusal for a bath on at least one of them.

Refer to interview with the Administrator on 08/22/18 at 4:15pm.
3. Review of Resident #1's current FL-2 dated 05/10/18 revealed diagnoses included morbid obesity, chronic obstructive pulmonary disease, diabetes mellitus, acute encephalopathy, history of deep vein thrombosis, alcohol abuse, and congestive heart failure.

Review of the Care Plan assessment dated 11/02/17 for Resident #1 revealed:
-The resident required supervision with transfers.
-The resident required limited assistance with toileting and ambulation.
-The resident required extensive assistance with bathing, dressing, and grooming.

Review of Resident Notes for Resident #1 from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 26	D 269		

01/03/18 to present revealed there were five falls documented when the resident was toileting and transferring without assistance as follows:
-On 01/03/18, the resident fell off the toilet, and got himself back in the wheelchair.
-On 02/20/18, the resident fell on third shift.
-On 03/17/18, the resident was trying to go to the bathroom, slipped and fell. Staff helped the resident back into the wheelchair.
-On 05/04/18 at 1:55pm, the resident was found on the floor in the bathroom.
-On 05/04/18 at 10:00pm, the resident was found on the floor in the doorway of the bathroom and stated he was trying to get to the toilet.

Review of an incident report for Resident #1 dated 08/01/18 revealed:
-Date and time of incident was documented for 08/01/18 at 3:20am.
-Description of event was documented as "resident stated his knees gave out while trying to get into wheelchair to go to bathroom."
-Description of injury was documented as "small scrape along left side."

Interview with Resident #1 on 08/16/18 at 5:10pm revealed:
-He transferred himself from the bed to the wheelchair.
-He toileted without staff assistance.
-Sometimes his "knees buckle" when he got up from the bed.
-He was able to tell, once he stood up, if his knees were weak.
-His knees buckled about 3 weeks ago and he fell and hurt his side.

Interview with Resident #1 on 08/20/18 at 12:00pm revealed:
-He denied having staff assist with transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 27	D 269		

-He did not need help getting out of the bed.
-His knees bothered him "on and off, not constant."
-He would sit back down on the bed, then try again in a few seconds to stand up, if his knees were weak and he could not stand up. He would then have enough strength and could get in his wheelchair.
-He did not ask anybody for help.
-He only asked for help if his legs gave out on him and he "ended up on the floor".

Review of August 2018 Personal Care Record for Resident #1 revealed:
-Staff documented Resident #1 was independent with transferring.
-Staff documented Resident #1 was independent with bathing.
-Staff documented Resident #1 was independent with toileting.

Interview with a Medication Aide/Personal Care Aide (MA/PCA) on 08/17/18 at 8:55am revealed:
-Resident #1 was assisted with showering on Tuesdays, Thursdays, and Saturdays, by the second shift staff.
-Resident #1 toileted and dressed himself.
-He would let staff know if he needed assistance.
-Unless he needed help and asked staff, he did for himself.
-He could stand but not for long.
-When the resident stood up, he stayed in a "squatting position."
-She was not aware of any falls for Resident #1.

Interview with a Personal Care Aide (PCA) on 08/17/18 at 3:15pm revealed:
-Resident #1 provided his own personal care.
-She went by what the MA told her with regards to level of assistance to provide to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 28 -She did not know Resident #1 was assessed to need assistance with transferring, bathing, or dressing. -She had not seen Resident #1's care plan. Interview with a second PCA on 08/17/18 at 3:25pm revealed: -When she worked with Resident #1, she would go in the resident's room and ask him if he needed anything and the resident might say yes or no. -She provided assistance to Resident #1 based on what the resident said. Interview with a MA on 08/17/18 at 3:55pm revealed: -Resident #1 provided his own care unless he was feeling bad. -She did not know Resident #1 was assessed as needing assistance with transfers and ambulation. -She went by what she saw Resident #1 do and what she knew the resident could and could not do. -Staff saw Resident #1 go to the bathroom and get out of bed without assistance. -There was not a lot Resident #1 could not do for himself. Interview with a PCA on 08/20/18 at 12:55pm revealed: -Resident #1 was included in her assignment for today. -She did not have to do anything for the resident. -She checked on him every two hours. -He went to the bathroom by himself. -He wheeled himself to the bathroom in the wheelchair, stood up and pivoted, and transferred to the toilet. -She determined the amount of assistance to	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 29	D 269		

provide to residents just based on what she saw the resident do.
-She did not know Resident #1 was supposed to have assistance with transfers, bathing, or dressing, according to his care plan assessment.

Interview with another PCA on 08/21/18 at 9:00am revealed:
-Resident #1 would ask "just like anybody else" if he needed assistance.
-She hardly provided any assistance to the resident.
-Sometimes Resident #1 looked like he needed assistance, maybe getting up, but unless he asked, he would do it independently.
-She had not been "trained" that Resident #1 needed assistance with activities of daily living.
-She was not aware of any falls for Resident #1.
-She very seldom got a report on the residents from the MAs when she came in to work.
-Usually the PCA getting off work would say "watch so and so."
-She walked through the halls and helped whoever she saw needed to be helped.

Observation of the PCA on 08/21/18 at 9:05am revealed:
-She moved Resident #1's wheelchair close to the bathroom door where the resident was.
-She asked Resident #1 if he was okay and left the resident's room.

Observation of Resident #1 on 08/20/18 at 12:00pm revealed the resident was in his room sitting in his wheelchair.

Interview with a MA on 08/21/18 at 11:15am revealed:
-She was responsible for completing resident care plan assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 30 -Once the care plan was signed by the primary care provider, she put the signed care plan in the resident record. -She asked the PCAs if residents needed assistance with transferring and other activities of daily living (ADLs). -Once the care plan was completed, only the MAs had access to the care plan. -The PCAs knew what ADLs the resident needed assistance with because the PCAs were "trained" with other PCAs. -Resident #1 needed assistance "sometimes". -Resident #1 was constantly asked to request assistance and would not. -Resident #1 refused to ask staff for assistance with ADLs. Interview with the Resident Care Coordinator (RCC) on 08/21/18 at 4:15pm revealed: -Resident #1 did not really walk a lot. -He might stand and pivot. -He might walk from his bed to his wheelchair. -He tried to be independent. -She thought he could be a two person assist with transfers because he could stand and pivot. -When staff were trained, they were told who needed assistance. -Staff were told verbally which residents needed assistance. Refer to interview with the Administrator on 08/22/18 at 4:15pm. 4. Review of Resident #6's current FL-2 dated 01/09/18 revealed: -Diagnoses included dementia, urge incontinence, hypertensive heart disease, cerebral atherosclerosis, dysphagia, mixed hyperlipidemia, and vitamin B deficiency. -Resident #6 was intermittently confused.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 31 -Resident #6 was incontinent of bladder and required personal care assistance with bathing and dressing. Review of the Resident Register revealed Resident #6 was admitted on 01/24/17. Review of Resident #6's care plan dated 01/24/18 revealed: -Resident #6 was sometimes disoriented and forgetful (needed reminders). -Resident #6 required extensive assistance daily with bathing, dressing, and grooming. -He was occasionally incontinent of bladder and required limited assistance with toileting (i.e., remove and pull up pants, and hygiene after toileting). -Resident #6 was independent with ambulation and transferring. Observation of Resident #6 on 08/16/18 at 11:24am revealed: -Resident #6 was sitting in his wheelchair in his room and he was unshaven. -Resident #6's fingernails were approximately ½ inch long with black dirt caked under the nails of both hands. -Resident #6 was wearing a gray t-shirt with several dark circular stains on the front and blue pants. -The heel areas of Resident #6's socks were twisted to the topside of his feet and had large gray stained areas. Interview with Resident #6 on 08/16/18 at 11:25am revealed: -He was not able to say the last time he had a shave or nail care. -Staff did not offer to assist him with bathing and dressing unless he asked them.-"I do the best I	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 32	D 269		

can by myself".
-He dressed himself on 08/16/18.

Observation of Resident #6 on 08/17/18 at 9:55am revealed:
-Resident #6 was lying in bed asleep with the same clothes on from 08/16/18.
-Resident #6 was still unshaven and his fingernails were still dirty and long.
-Resident #6 had a noticeable body odor.

Confidential interview with staff revealed:
-Resident #6 was independent with his personal care.
-Staff only assisted Resident #6 if he asked for help.
-Resident #6 was able to bath and dress himself.
-The staff member was not sure if Resident #6 needed any help with nail care or with shaving.
-Staff was not sure what type of personal care assistance Resident #6 needed because the staff member had never seen Resident #6's care plan.
-Shower days were Tuesdays, Thursdays, and Saturdays for the men in the facility.
-The staff member was not sure the last time Resident #6 had taken a shower.
-All personal care for residents was documented on the resident's personal care record at the nurse's station.

Review of the facility shower and bath schedule revealed:
-Resident #6 was on the shower schedule for Tuesdays, Thursdays, and Saturdays during the second shift.
-Nail care was to be provided on shower days and all men were to be shaved.

Review of Resident #6's August 2018 personal care record from 08/01/18 through 08/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 33 revealed: -It was documented Resident #6 independently performed his own tub bath or shower on 08/02/18, 08/03/18, 08/04/18, 08/09/18, and 08/14/18 during second shift. -No tub bath or shower was documented as provided for Resident #6 on any other days during first, second, or third shift. -It was documented Resident #6 independently bathed his upper body and lower body on 08/02/18, 08/03/18, 08/04/18, 08/09/18, 08/10/18, 08/11/18, 08/12/18, 08/14/18, 08/16/18, 08/18/18, and 08/1918 during second shift. -There was no other documentation od any bathing assistance provided to Resident #6 on any other days during first, second, or third shift. -There was no documentation of any nail care or shaves provided for Resident #6 or staff assistance with nail care or shaves for Resident #6 from 08/01/18 through 08/21/18. -It was documented that Resident #6 was independent with toileting and dressing from 08/01/18 through 08/21/18. Interview with a personal care aide (PCA) on 08/21/18 at 9:00am revealed: -She was trained by another PCA that Resident #6 "was basically independently". -She did not assist Resident #6 with any of his personal care unless he asked her to because that was the way she was trained to do. -Resident #6 could bathe and dress himself. -She "helped" Resident #6 "if he had an accident like urinating on himself and he needed help cleaning up". -She had not seen Resident #6's care plan and she did not know if he needed help with any activities of daily living. -She had not been told that Resident #6 needed staff assistance with his personal care needs.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 34 -She "checked on" Resident #6 "about once every 2 hours to see if he may need help with anything". -Resident #6 "usually did not ask for any help with his personal care needs". -She had not noticed any problems with Resident #6 having dirty fingernails, needing to be shaved, or wearing dirty clothes. Interview with a medication aide (MA) on 08/21/18 at 11:45am revealed: -Resident #6 required assistance with bathing and the men in the facility were scheduled for showers on Tuesdays, Thursdays, and Saturdays on either first or third shifts. -Resident #6 was incontinent of bladder sometimes and needed staff assistance occasionally then. -She had not noticed any problems with Resident #6's personal care or hygiene. -The MA "was not sure what other type of personal care assistance" Resident #6 "needed without reviewing his care plan." -The MAs and supervisors had access to Resident #6's care plan, but the PCAs did not have access to Resident #6's care plan. -The PCAs reported to the supervisors in the facility. -She had not communicated Resident #6's personal care needs to the PCAs because "there was too many other responsibilities that she had to do when she was the supervisor". -The PCAs were taught by other PCAs how to provide for Resident #6's personal care needs. Interview with the MA/Supervisor on 08/21/18 at 11:15am revealed: -She completed all of the care plans and FL-2s for the residents. -She was not aware any issues with Resident #6	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 269	Continued From page 35	D 269		

not receiving assistance from the PCAs with bathing, grooming, dressing, shaving, or nail care.
-The PCAs should follow the bath schedule for all residents as it was assigned in the facility.
-The PCAs did not have access to the Resident #6's plan of care regarding the type of assistance needed for Resident #6's activities of daily living.
-She did not know how it was communicated to the PCAs what type of staff assistance was needed for Resident #6's personal care.

Interview with the Resident Care Coordinator on 08/21/18 at 4:12pm revealed:
-She did know of any problems with Resident #6 receiving assistance with his personal care from the staff at the facility.
-The PCAs should be offering to assist Resident #6 with his personal care according to his care plan.
-Resident #6 did need staff assistance with bathing, dressing, and grooming.
-She was not aware of any problems with Resident #6 not being shaved or not having nail care.
-She would have to review Resident #6's personal care record to see why it was being documented Resident #6 was independent with his personal care needs and if his personal care was not provided.

5. Review of Resident #2's current FL-2 dated 12/27/17 revealed:
-Diagnoses included acute encephalopathy, gastrointestinal bleed, history of cerebrovascular accident, seizure disorder.
-Resident #2 was incontinent of bladder and bowel.
-He required personal care assistance with bathing and dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 36 Review of the Resident Register revealed Resident #2 was admitted on 01/04/17. Review of Resident #2's care plan dated 01/22/18 revealed: -Resident #2 was sometimes disoriented and forgetful (needed reminders). -Resident #2 was ambulatory with a wheelchair and had limited strength to his upper extremities. -Resident #2 required extensive assistance daily with bathing and limited assistance daily with ambulation, dressing, and grooming. -He had occasional incontinence of bowel and daily incontinence of bladder and required limited assistance with toileting (i.e., remove and pull up pants, and hygiene after toileting). -Resident #2 required supervision with transferring. Observation of Resident #2 on 08/16/18 at 12:20pm revealed: -Resident #2 was sitting in his wheelchair in his room and he was unshaven with his mustache overgrown over his mouth. -Resident #2's fingernails were approximately ¼ inch long, yellowed, with black dirt caked under the nails of both hands. -Resident #2's left hand was contracted. -Resident #2 was wearing a red pajama top with blue pajama pants. Interview with Resident #2 on 08/16/18 at 12:22pm revealed: -He would like to get a shave because "my mustache gets in the way when I eat my food". -Staff did assist him sometimes with bathing but only using the wash pan in his room. -Staff last assisted him with bathing using the wash pan two weeks ago and he had not had a	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 37	D 269		

shower for at least a month.
-He never refused his showers.
-"Staff waited too late at night to offer my shower at almost 11:00pm."
-He had not complained about his shower times to anyone at the facility.
-Staff did not trim his nails, assist him with getting dressed, or getting to the bathroom unless he asked for help.
-Staff did not offer any assistance to him.
-He did the best he could "bathing using the wash pan in his room when staff wouldn't help" and using his right arm.

Review of the facility shower and bath schedule revealed:
-Resident #2 was on the shower schedule for Tuesdays, Thursdays, and Saturdays during the second shift.
-Nail care was to be provided on shower days and all men were to be shaved.

Attempted review of the June 2018 facility bath and skin reports for Resident #2 were not available for review.

Review of Resident #2's June 2018 personal care record revealed:
-It was documented Resident #2 refused his shower on 06/12/18 and 06/16/18 on second shift.
-There was no other documentation of any bathing or showering provided by staff for Resident #2 for any other days in June.
-There was no documentation that Resident #2 received nail care, mouth care, or was shaved from 06/01/18 through 06/30/18.
-Resident #2 received limited assistance from staff for transferring, dressing, and toileting.

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 38 Review of the July 2018 facility bath and skin sheets for Resident #2 revealed: -Skin assessments and bathing were performed by staff on Resident #2 on 07/19/18 and 07/26/18; but no nail care was provided by the staff. -On 7/12/18, Resident #2 did not receive a shower because there were no more towels. -On 7/31/18, Resident #2 did not receive a shower because there were no more wash cloths. -It was documented Resident #2 refused his shower on 07/05/18, 07/07/18, 07/17/18, 07/24/18, and 07/28/18. -There was no documentation of staff assisting Resident #2 to shower on 07/03/18, 07/10/18, 07/14/18, or 07/21/18 which were scheduled shower days. Review of Resident #2's July 2018 personal care sheet revealed: -There was no documentation that Resident #2 received any bathing/showering, nail care, mouth care, or was shaved from 07/01/18 through 07/31/18. -There was no documentation of any refusal of personal care by Resident #2. -Resident #2 received limited assistance from staff for transferring, dressing, and toileting. Review of the August 2018 facility bath and skin sheets for Resident #2 from 08/01/18 through 08/19/18 revealed: -Skin assessments and bathing were performed by staff on Resident #2 on 08/04/18, 08/11/18, and 08/18/18; but no nail care was provided by the staff. -It was documented Resident #2 refused his shower on 08/02/18, 08/07/18, and 08/09/18. -There was no documentation of staff assisting Resident #2 to shower on 08/14/18 or 08/16/18.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 39 Review of Resident #2's August 2018 personal care sheet from 08/01/18 through 08/19/18 revealed: -It was documented Resident #2 refused to bathe on 08/02/18 and 08/07/18 on second shift. -There was no documentation of Resident #2 receiving a bath or shower from 08/01/18 through 08/19/18. -There was no documentation that Resident #2 received any nail care, mouth care, or was shaved from 08/01/18 through 08/19/18. -Resident #2 received limited assistance from staff for transferring, dressing, and toileting from 08/01/18 through 08/19/18. Interview with a personal care aide (PCA) on 08/20/18 at 4:40pm revealed: -She worked on second shift and provided assistance to Resident #2. -She helped Resident #2 with toileting, "getting his pants up and down, cleaning him up after he used bathroom". -She "assisted him [Resident #2] with transferring him to and from the toilet because he was in a wheelchair." -Resident #2 could independentlyly transfer himself sometimes. -"Because he was so unsteady, it was just more comfortable for him [Resident #2]to be transferred with the assistance of one staff person." -Resident #2 was scheduled for showers on second shift on Tuesdays, Thursdays, and Saturdays. -Resident #2 was sometimes uncooperative with taking his showers; would complain about not feeling well and refuse to shower. -"If he refused to go to the shower on his scheduled days, she washed him [Resident #2]	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 40	D 269		

off in his room."
-Resident #2 "last refused a shower when she worked on 08/11/18 and she washed him off in his room."
-She provided skin and nail care for Resident #2 on 08/11/18.
-Resident #2 refused to be shaved on 08/11/18.
-She documented on Resident #2's shower and shave refusals on 08/11/18 on his personal care sheet and reported she gave a pan bath instead.
-She "reported when Resident #2 refused his showers and personal care to the medication aide and the MA reported to the supervisor."
-Resident #2 had never complained about his showers being offered too late on second shift.
-"Most residents' showers were done after dinner finished at 6pm."
-She had not noticed any problems with Resident #2 having dirty fingernails or needing to be shaved.

Interview with a second PCA on 08/20/18 at 4:50pm revealed:
-Resident #2 "refused to take a shower at least once or twice a week."
-"When he [Resident #2] refused his shower, he refused everything else like his shave and cleaning his nails."
-Resident #2 "needed staff to help with his personal care, but he only wanted certain staff to take care of him."
-She offered to assist him [Resident #2] with his personal care and if he refused; she let the MA know and documented on his personal care sheet.
-"You can't help someone if they don't want to be helped."

Interview with a third PCA on 08/21/18 at 9:00am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 41	D 269		

-She was trained by another PCA that Resident #2 was basically independently.
-She did not assist Resident #2 with any of his personal care unless he asked her to.
-Resident #2 "was usually up and dressed" when she came to work.
-She had not seen Resident #2's care plan and she did not know if he needed help with any activities of daily living.
-She had not been told that Resident #2 needed staff assistance with his any of personal care needs.
-She "checked on" Resident #2 "about once every 2 hours to see if he may need help with anything".
-She had not noticed any problems with Resident #2 having dirty fingernails or needing to be shaved.

Interview with the MA/Supervisor on 08/21/18 at 11:15am revealed:
-She completed all of the care plans and FL-2s for the residents.
-She did not know of any issues with Resident #2 not receiving assistance from the PCAs with bathing, grooming, dressing, shaving, or nail care.
-The PCAs should follow the bath schedule for all residents as it is assigned in the facility.
-The PCAs did not have access to the Resident #2's plan of care regarding the type of assistance needed for Resident #2's activities of daily living.
-She did not know how it was communicated to the PCAs what type of staff assistance was needed for Resident #2's personal care.
-She knew Resident #2 "occasionally refused his showers and his shaves but she did not know how often he refused."

Interview with the Resident Care Coordinator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 42 08/21/18 at 4:12pm revealed: -She did not know of any problems with Resident #2 receiving assistance with his personal care from the staff at the facility. -The PCAs should be offering to assist Resident #2 with his personal care according to his care plan. -Resident #2 needed assistance with bathing, dressing, and grooming. -She did not know Resident #2 refused showers or other personal care. -Resident #2 liked certain staff to assist with his showers and personal care. Refer to interview with the Administrator on 08/22/18 at 4:15pm. _____ Interview with the Administrator on 08/22/18 at 4:15pm revealed: -The RCC and the supervisor are responsible for updating care plans and bath schedules. -The RCC and the supervisor are responsible for assuring all residents recieve adequate personal care. -She was not aware all residents were not recieving adequate personal care since she was only at the facility 1 to 2 times a week. _____ The facility failed to provide personal care assistance for 5 of 6 sampled residents, resulting in Resident #5 not being turned and repositioned and sustaining a pressure ulcer; Resident #4, who had a pressure ulcer and not being provided personal care; and Resident #1 not being provided with assistance with transferring and toileting resulting in falls with injury. The facility's failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 269	Continued From page 43 The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/21/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2018.	D 269		
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 A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for 6 of 9 sampled residents (#1, #3, #5, #7, #8 and #9), related to residents fighting in the smoking area and sustained injuries; a resident with known history of aggressive behaviors resulitng in two altercations with other residents resulting in a head injury (#8); a resident hitting another resident (#5) in the head causing injury; a resident locked his legs around another resident's abdomen in the smoking area until he could not breathe (#7); a resident smoking in the facility (#9); a resident with known agitation, who was verbally and physically abusive to other residents, caused injuries to another	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 44	D 270		

resident (#1); and a resident with dementia wandering outside the facility unsupervised (#3).

The findings are:

1. Review of Resident #8's current FL-2 dated 12/29/17 revealed:
-Diagnoses included chronic memory loss, cerebral infarction, chronic obstructive pulmonary disease, anxiety, hyperlipidemia, and hypertension.
-Resident #8 was intermittently confused and ambulatory.

Review of the Resident Register revealed Resident #8 was admitted on 01/03/18.

Review of Resident #8's care plan dated 01/24/18 revealed Resident #8 was sometimes disoriented and forgetful (needed reminders).

Review of a Resident #8's progress note dated 05/21/18 revealed:
-Resident #8 was very agitated and claimed another resident stole his stuff.
-Resident #8 threatened to hurt the other resident.

Review of Resident #8's psychiatric evaluation note for 05/31/18 revealed:
-Resident #8 was seen for a routine follow-up regarding stabilization of depressed, anxious mood with poor sleep and adjustment issues.
-Resident #8 was referred in January 2018 with some complaints of short-term memory loss, anxiety, adjustment issues, and disturbing nightmares.
-He frequently dreamed of people being killed.
-Resident #8 was anxious in the evening due to a distrust of the evening staff at the facility

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 270	Continued From page 45 -He had problem resting because he feared staff or other residents would come in his room if they thought he was asleep. -His diagnoses included major depressive disorder, insomnia, and anxiety. -Resident #8 would be followed by psychiatry as needed. Confidential interview with staff revealed: -"Sometime in May or June, he (Resident #8) went off because he thought someone had stolen his belt and he was pacing back and forth from his room to the nurse's station." -Resident #8 "would not listen when staff tried to calm him down but another resident at the facility was able to get him calm after about 15 or 20 minutes." -Resident #8 was usually "easy going until he got mad and then he would explode." -Staff was not given any instructions on how to manage Resident #8 when Resident #8 would not calm down. Review of Resident #8's emergency room report dated 06/12/18 revealed: -Resident #8 was brought in for medical evaluation following a physical altercation with another resident at the facility. -Resident #8 was complaining of head and neck pain due his head being hit on the concrete. -Resident #8 presented with bilateral skin tears to both hands and right elbow. -Resident had a history of a brain aneurysm. Attempted review of the facility incident/accident report for Resident #8 that correlated to 06/12/18 revealed it was not available for review. Confidential interview with staff revealed: -There was another incident "about 2 months ago	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 270	Continued From page 46 when he (Resident #8) got into a fist fight with another male resident in the smoking area. -Resident #8 "reportedly bruised up the face of the other male resident badly and the other male resident complained of being sore." -Staff was not given any instructions to increase supervision of Resident #8 after this altercation. Interview with the RCC on 08/22/18 at 10:45am revealed: -She could not recall Resident #8 getting into an altercation with another male resident on 06/12/18. -She would have to review Resident #8's record for more information. Interview on 08/22/18 at 2:53pm with a PCA who worked on first shift on 06/12/18 revealed: -He was unable to recall any altercation between Resident #8 and a male resident. -Resident #8 "does not bother anyone unless he is provoked like if you call him 'ugly names'." Interview with Resident #8 on 08/22/18 at 2:15pm revealed: -He really could not remember much about 06/12/18. -He and another male resident were in the smoking area and they started arguing. -"The male resident grabbed him by his shirt and they started fighting." -"He hit me in the back of my head; I hit him; somehow I tripped and hit my head on the ground." -"We apologized to each other later." -Resident #8 did not remember going to the hospital or any cuts to his hands. -He could not remember if any staff were in the smoking area during the altercation on 06/12/18.	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 47 Review of Resident #8's psychiatric evaluation note for 07/31/18 revealed: -Resident #8 requested to be seen regarding his depressed mood with insomnia. -He was still having "terrible nightmares". -Diagnoses included unspecified mood disorder, unspecified post-traumatic stress disorder, nightmare disorder, and unspecified anxiety state. Review of the facility incident/accident report for Resident #8 for 08/14/18 at 9:00pm revealed: -Resident #8 was standing out back (in smoking area) when another resident in an electric wheelchair threw open the back door and almost knocked him down. -Resident #8 got into a verbal altercation with the other resident. -Resident #8 threw a small ashtray bucket and struck the other resident on the back left side of the head. -Resident #8 reported his left ankle was hit by the other resident's electric wheelchair. Confidential interview with a staff member revealed: -Resident #8 "had a history of hitting other residents." -The staff member "saw soot stains on the back of the other resident's neck and head after Resident #8 had thrown the ashtray on 08/14/18. -"Ashes and soot stains were on the other resident's electric wheelchair headrest too". -Staff was not instructed to increase supervision of Resident #8 after the altercation on 08/14/18. Interview with Resident #8 on 08/22/18 at 2:15pm revealed: -Resident #8 admitted he was angry with the other resident on the evening of 08/14/18 because she ran over his left ankle with her	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 270	Continued From page 48	D 270		

electric wheelchair earlier that afternoon.
-He did not report when the other resident ran over his ankle because he "had complained several times about it before to the Resident Care Coordinator (RCC) and it did not do any good."
-"I was going to fix her so I unplugged the battery pack of her electric wheelchair" when we were in the smoking area.
-"She called me some vulgar names and I got mad and I wanted to hit; but I didn't."
-He "picked up the ashtray and threw it at the fan and the ashtray bounced off the fan and ended up hitting the headrest" of the other resident's electric wheelchair and the ash got into her hair.
-"She got mad because the other residents in the smoking area started laughing at her."
-He couldn't remember if any staff was outside when he threw the ashtray.
-"Staff took an incident report and that was all."

Interview with the RCC on 08/17/18 at 12:45pm revealed:
-She knew of the altercation between Resident #8 and the other resident on 08/14/18.
-"It was hard to keep up with the residents when they went out to smoke because staff didn't realize they are fussing until it is too late (fighting)."
-"We try to keep him (Resident #8) away from the other female resident so they don't argue."
-She told staff to watch Resident #8 and the other female resident when they were in the smoking area together to make sure they did not fight after 08/14/18.
-She could not specify how often Resident #8 and the other female resident were monitored while in the smoking area since 08/14/18.
-"When these types of situations happen between residents, staff contacts the doctor, contacts psych, and documents in the resident's record."

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 49 -She could not recall if she had contacted Resident #8's psychiatrist regarding the 08/14/18. -When Resident #8 "gets mad staff tries to calm him down and give him a chance to cool down." Attempted interview with Resident #8's psychiatrist on 08/23/18 at 9:00am was unsuccessful. Refer to telephone interview with the Administrator on 08/22/18 at 4:55pm. 2. Review of Resident #5's FL-2 dated 12/11/17 revealed diagnoses of cerebrovascular disease, muscle weakness, anxiety disorder and a communicable disease. Review of an Incident Report dated 07/11/18 revealed: -At 7:30am two residents (Resident #5 and Resident#1) were trying to go out the door at the same time. Resident #5 punched Resident #1 and Resident #1 hit him back. -Resident #1 had a knot on the right side of his head and emergency medical service was called and Resident #5 was transported to the local emergency room (ER) and came back without complaints. Review of Resident #5's Acute Monitoring Reports revealed: -On 07/12/18, Resident #5 had no complaints at this time. The resident's eye was swollen shut and a bruise was on the top of his head. -On 07/13/18, Resident #5 eye was swollen but no complaints at this time. -On 07/14/18, Resident #5 had no complaints and his eye was swollen shut. Review of Resident #5's emergency room (ER)	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 270	Continued From page 50	D 270		

report dated7/11/18 revealed:
-Resident #5 arrived with a head injury from a facility after being punched by another resident.
-The resident had a 5cm hematoma to the right side of his forehead.
-A Computerized Axial Tomography (CAT) scan of the head of the resident was ordered and no acute intracranial process was found and the resident was discharged back to the facility.

Interview with Resident #5 on 08/17/18 at 10:05am revealed:
-He had an altercation with another resident when they were coming in side from smoking.
-They were both trying to come through the door at the same time.
-Both residents started throwing punches and Resident #5 hit the other resident in his face.
-The other resident hit Resident #5 on his forehead multiple times and he had big hematoma on his forehead and a swollen eye.
-Staff came to the door and stopped the fight and Resident #5 was transported to the local ER for evaluation.
-There were no staff in the smoking area when the fight started.
-No one talked to Resident #5 about fighting.

Interview with a PCA on 08/17/18 at 9:45am revealed:
-Resident #5 had an altercation with another male resident last month.
-They were just 2 grown men who had a disagreement.
-Resident #5 was hit on his head and had a knot on his head for a while.
-The staff did not supervise the residents in the smoking area, even though there have been several fights between residents in the smoking area.

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D 270	Continued From page 51 -Residents were checked on every 1 to 2 hours and there were no change in supervision after resident fights. Interview with the Supervisor on 08/17/18 at 10:15am revealed: -Last month (July 2018) Resident #5 and Resident #1 were coming inside from smoking. Resident #1 told Resident #5 he was moving too slow. Resident #1 pushed Resident #5's wheelchair and Resident #5 hit the other resident. -The other resident hit Resident #5 on his head and eye and he had a knot the size of an apple on his head and his eye was swollen shut. -Resident #5 was taken to the ER and was ok. -The residents were not supervised in the smoking area even though there have been multiple fights between residents. -If the residents start fighting, the staff would stop them as soon as they could and separate the residents. Interview with the Resident Care Coordinator (RCC) on 08/17/18 at 11:00am revealed: -She knew the residents were fighting causing injuries in the smoking area. She knew Resident #5 and another resident had a fight recently. -There were no change in supervision after the fight. -All residents were checked every 2 hours and staff did not monitor/supervise the residents when they were in the smoking area. -There was not an increase or change in supervision for residents who were fighting since the staff were checking on them throughout their shifts. Refer to telephone interview with the Administrator on 08/22/18 at 4:55pm.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 52 3. Review of Resident #7's FL-2 dated 07/14/18 revealed diagnoses included chronic anxiety disorder, chronic stage 3 kidney disease, and history of alcohol abuse. Interview with Resident #7 on 08/23/18 at 9:20am revealed; -He and another resident started arguing last month (July 2018) while in the smoking area. -A resident who could not defend herself was being hit by a female resident and Resident #7 asked another female resident to go get staff to stop her. -They started arguing and she slapped him. A male resident came over and they started fighting and fell to the pavement. -Resident #7 locked his legs around the other resident's abdomen until the other resident could not breath and said he would quit. -The other resident was bleeding from his head and had to go to the ER. -At the time of the fight I "though I may had to kill him to stop him". -There were no staff monitoring the smoking area when the fights occurred. Interview with the supervisor on 08/17/18 at 10:15pm revealed: -She knew Resident #7 and another resident had a fight last month (July 2018) in the smoking area and the other resident was injured and had to go to the ER for evaluation. -She did not know what happened but the other resident had a black eye and had to go to the ER. -Staff did not monitor the smoking area while the residents were smoking but all residents were checked evert 2 hours. Interview with the Resident Care Coordinator (RCC) on 08/17/18 at 11:00am revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 53	D 270		

-She was knew of the fight between Resident #7 and another resident.
-There had not been any change in their supervision; staff continued to check on the residents every 2 hours.

Refer to telephone interview with the Administrator on 08/22/18 at 4:55pm.

4. Review of Resident #3's current FL-2 dated 05/19/18 revealed, diagnoses that included vascular dementia, hypertension, history of cerebral vascular accident (CVA), and acute bronchitis.

Review of Resident #3's care plan dated 01/30/18 revealed:
-Resident #3 was always disoriented and was forgetful and needs reminders.
-Resident #3's speech and communication was weak.

Review of Resident #3's psychiatric evaluation visit dated 04/30/18 revealed:
-Resident #3 was in her wheelchair and wandering the hall aimlessly.
-She was being witnessed on several occasions trying to exit the facility front door.

Observation of the facility front door upon entering the facility on 08/16/18 at 10:45am the door alarm was not on and did not sound.

Interview with a medication aide (MA) on 08/16/18 at 11:10am revealed, Resident #3 wandered around the halls in her wheelchair and sometimes went out the front door of the building.

Observation of the door going onto the smoking patio from the TV room on 08/16/18 revealed,

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 54 there was no alarm on the door when it was opened. Interview with a MA/supervisor on 08/17/18 at 10:40am revealed, she did 30 minute checks on resident #3 because she would go out the front door of the facility and go around the side of the building near the activity room door. Interview with the residential care coordinator (RCC) on 08/17/18 at 12:45pm revealed: -The general supervision of the residents was to know where they were and what they were doing every two hours and document. -Resident #3 could only answer questions at times. -Resident #3 only followed directions at times. -Resident #3 would not tell staff when she went outside. -Resident #3 liked to go outside and wheel around the building. -Sometimes Resident #3 went outside around the building by the kitchen door near the ditch on the side of the building. -Staff watched out for Resident #3 and if they did not see her they went to look for her. -There had been no concerns reported by staff to the RCC about Resident #3 going outside by herself. Observation on 08/17/18 at 3:24pm revealed, Resident #3 was on the smoking patio sitting in her wheelchair and then she was brought back into the building by the RCC. Interview with a PCA/MA on 08/22/18 at 9:25am revealed: -When Resident #3 went outside I "keep an eye on her". -All the staff watched out for Resident #3.	D 270		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 55 -The PCA working on the 100 hall was responsible for knowing where Resident #3 was. -In the past Resident #3 would go outside by herself and the staff would check on her. -On 08/17/18 the RCC instructed staff that when Resident #3 went outside a staff had to be with her. Interview with Resident #3's primary care provider (PCP) on 08/21/18 at 5:30pm revealed: -She did not know that Resident #3 was wandering outside of the facility in her wheelchair without staff with her. -The PCP was concerned about Resident #3's safety and going outside in her wheelchair unsupervised. -She thought Resident #3 may not be appropriate for the facility and may need to be in a locked unit to keep her safe due to her wandering. Attempted interview with Resident #3's psychiatrist on 08/23/18 at 9:00am was unsuccessful Telephone interview with the Administrator on 08/22/18 at 4:55pm revealed: -The RCC and BOM were her contacts most of the time. -When she was at the facility (1 - 2 times a week), she looked at things and discussed them. -She had not discussed ResidenT #3 wandering outside of the building and was not aware the resident wandered. -The RCC and BOM were her "eyes and ears when I'm not there." -If there was something she had talked about with the RCC and BOM, she tried to be sure to follow up with the RCC and BOM either when on the telephone or in the facility.	D 270		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 270	Continued From page 56 5. Review of Resident #9's current FL-2 dated 04/09/18 revealed diagnoses included chronic renal insufficiency, bipolar disorder, and dementia. Review of a psychiatric inpatient history and physical for Resident #9 dated 02/28/18 revealed: -He was confused. -He was not oriented to place and time. -His thoughts were disorganized. -His judgment was impaired. -He had poor insight. Review of the Care Plan assessment for Resident #9 dated 05/08/18 revealed: -He was sometimes disoriented. -He was forgetful and needed reminders. Observations of the facility at the intersection of the 100 and 200 hall close to the front entrance on 08/21/18 at 2:11pm revealed: -There was a smell of smoke in the air. -There was loud talking coming from room 200. Observation of room 200 on 08/21/18 at 2:11pm revealed: -The Supervisor, Medication Aide (MA), and a Personal Care Aide (PCA) were standing inside the room, and another resident was standing in the doorway of room 200. -Resident #9 was seated in a chair beside the door. -There was a trashcan sitting next to the chair that had a white plastic liner inside. -There was a grayish-black flaky substance scattered over the left side of the trashcan liner. -There was a small cigarette butt on top of two dark purplish colored gloves in the trashcan. -There was a smell of smoke in the room.	D 270		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 57 Interview with the Supervisor on 08/21/18 at 2:15pm revealed: -Resident #9 was putting out a cigarette and putting it in the trashcan when she walked in the room. -She could smell smoke in the room. -This was not the first time Resident #9 had smoked in the room. Interview and observation with the PCA on 08/21/18 at 2:20pm revealed: -He was going to do his 2:00pm checks when he saw the MA and Supervisor in Resident #9's room addressing the resident about smoking in the room. -He could smell smoke in the room. -He could see the smoke in the air in the room. -There was an empty cigarette box in the seat of the residents' walker with a cigarette lighter inside the box. -He went to the window in the room and opened the window. Interview with the Resident Care Coordinator (RCC) on 08/21/18 at 2:25pm revealed: -She could smell smoke in the residents' room. -The smell of smoke in the room was "bothering" her. -Resident #9 had never smoked in the room before. -Resident #9's cigarettes and lighter were kept behind the staff desk. Interview with the RCC on 08/22/18 at 3:05pm revealed: -She found out that another resident gave Resident #9 the cigarette and a second resident gave Resident #9 the cigarette lighter. -The residents were not allowed to keep	D 270		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 270	Continued From page 58 cigarettes and lighters in their rooms. Interview with the RCC on 08/22/18 at 4:23pm revealed residents had never smoked inside the facility before and that was the facility policy. Interview with Resident #9 on 08/21/18 at 2:28pm with the RCC present revealed he had smoked in his room because he did not have anything else to do. Interview with the PCA on 08/21/18 at 2:41pm revealed: -Everybody knew there was no smoking in the facility. -He had not seen a written smoking policy. -This was the first time he had caught Resident #9 smoking. -He could not say that all the residents' lighters and cigarettes were kept at the staff desk. Review of the facility House Rules for Tobacco Use included: -Residents who smoke must use designated smoking areas. -No smoking was allowed in residents bedrooms. -Staff would supervise residents who smoked as needed. -The facility reserved the right to confiscate all smoking materials if a resident failed to abide by smoking policies to ensure fire safety for themselves and other residents and staff. Interview with a MA/Supervisor on 08/22/18 at 3:00pm revealed: -Week before last, a PCA [named] on second shift came to her. She went to Resident #9's room. It smelled like Resident #9 had been smoking in the room. -She checked the room with the PCA and found	D 270		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 270	Continued From page 59	D 270		

the resident had part of a cigarette in his hand. The cigarette was not lit.
-She removed the cigarettes and lighter from Resident #9's room.
-She let the oncoming shift know what had been found and left a note posted at the desk to make sure if Resident #9 was given a cigarette that he took it outside with him.
-She did not know where Resident #9 had gotten the cigarette from because she had not given him a cigarette that night.
-She had not documented in Resident #9's record about the smoking because it slipped her mind.

Observation of Resident #9 on 08/23/18 at 9:28am revealed there was a small circular area with brown edges noted on the side of the left pants legs close to the knee.

Interview with Resident #9 on 08/23/18 at 9:30am revealed:
-He burned his pants with a cigarette.
-He was smoking in his room.
-About one week ago, staff took his lighter and cigarettes.
-He knew he was not supposed to smoke in his room.
-He did not have anything else to do.

Telephone interview with Resident #9's Power of Attorney (POA) on 08/23/18 at 4:45pm revealed:
-It was reported to another family member from facility staff about a week ago that Resident #9 was smoking in the room.
-The cigarette lighter had been removed from the resident.
-The facility staff had not reported the smoking incident on 08/22/18 to the POA.
-The family had talked to the resident about smoking when it was reported to them.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 60 6. Review of Resident #1's current FL-2 dated 05/10/18 revealed: -Diagnoses included morbid obesity, chronic obstructive pulmonary disease, diabetes mellitus, acute encephalopathy, history of deep vein thrombosis, alcohol abuse, and congestive heart failure. -Medication orders included mood stabilizers, antidepressants, and anti-anxiety medications. Review of the Care Plan assessment for Resident #1 dated 11/02/17 revealed he "can become agitated and verbally abusive to staff and other residents." a. Review of Resident Notes for Resident #1 dated 11/01/17 revealed the resident grabbed another resident pulled her down, and hit her in the back of the head multiple times. There was no documentation of any interventions implemented. Review of an Incident/Accident Report for Resident #1 dated 07/11/18 revealed he "punched" another resident, who punched him, and left a knot on the side of the resident's head. The resident was administered Ativan (used for anxiety and agitation) 0.5mg per instruction of the mental health provider. There was no documentation of any additional interventions implemented. Interview with a Personal Care Aide/Medication Aide (PCA/MA) on 08/17/18 at 8:55am revealed: -Resident #1 "fuss" with other residents and "picks" with other residents. -He was "not ugly just picking." -There were "not really" any aggressive residents at the facility.	D 270		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 61 -She had not heard any other residents say they were afraid of another resident. -She thought two other residents (#7 and #8) had gotten into a fight either 2 weeks or a month ago. -If there was an altercation between residents, the MA was supposed to complete an incident report, call the resident's family member, let the oncoming shift know to keep an eye out and try to keep the residents separated, and document a progress note in the residents' record about the incident. -If someone got hurt, the staff called 911 (emergency medical service) after the resident was assessed. -The PCAs could complete an incident report if the PCA witnessed the incident. -The Resident Care Coordinator and her assistant kept the incident reports. Interview with a PCA/MA on 08/17/18 at 9:30am revealed incident reports were completed for falls, resident to resident fighting, or injury of known or unknown origin. Interview with a second MA/Supervisor on 08/17/18 at 9:50am revealed: -Resident #1 would "cut up, what comes up come out." -He was good as long as things went his way. -He could get harsh with words and were not directed at any particular person. -She had never seen Resident #1 physically aggressive with a resident or staff. -She could not recall who Resident #1 was reported to have been aggressive with, and could not remember when it had occurred. -She could not recall the last time there had been training for staff on managing aggressive behavior, but thought there had been training in the last couple of months.	D 270		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 270	Continued From page 62 Interview with the Resident Care Coordinator (RCC) on 08/17/18 at 12:50pm revealed: -Staff were supposed to check on each resident every two hours. -If a resident exhibited behaviors, the mental health provider would be called. -If staff called a mental health provider, it would be documented in the resident's progress notes. -Every staff did not always document in the resident progress notes. -She knew of Resident #1's behaviors. -Most of Resident #1's behaviors was exhibited verbally. -When he exhibited behaviors, staff talked to him. Telephone interview with the Administrator on 08/22/18 at 4:55pm revealed: -She was aware of a "few" incidents involving resident altercations. -One of the incidents she was aware of involved a resident who got mad when going out to smoke. -The RCC and BOM were her contacts most of the time. -When she was at the facility, she looked at things and discussed them. -The RCC and BOM were her "eyes and ears when I'm not there." -If there was something she had talked about with the RCC and BOM, she tried to be sure to follow up with the RCC and BOM either when on the telephone or in the facility. -Staff called her "most time" to make her aware. b. Review of the Care Plan assessment dated 11/02/17 for Resident #1 revealed: -The resident required supervision with transfers. -The resident required limited assistance with toileting and ambulation.	D 270		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 270	Continued From page 63 Review of Resident Notes for Resident #1 from 01/03/18 to present revealed there were five falls documented when the resident was toileting and transferring without assistance as follows: -On 01/03/18, the resident fell off the toilet, and got himself back in the wheelchair. -On 02/20/18, the resident fell on third shift. -On 03/17/18, the resident was trying to go to the bathroom, slipped and fell. Staff helped the resident back into the wheelchair. -On 05/04/18 at 1:55pm, the resident was found on the floor in the bathroom. -On 05/04/18 at 10:00pm, the resident was found on the floor in the doorway of the bathroom and stated he was trying to get to the toilet. Review of an incident report for Resident #1 dated 08/01/18 revealed: -Date and time of incident was documented for 08/01/18 at 3:20am. -Description of event was documented as "resident stated his knees gave out while trying to get into wheelchair to go to bathroom." -Description of injury was documented as "small scrape along left side." Interview with a Medication Aide/Personal Care Aide (MA/PCA) on 08/17/18 at 8:55am revealed: -Resident #1 could stand but not for long. -When the resident stood up, he stayed in a "squatting position." -She was not aware of any falls for Resident #1. Interview with another PCA on 08/21/18 at 9:00am revealed: -She was not aware of any falls for Resident #1. -She very seldom got a report on the residents from the MAs when she came in to work. -Usually the PCA getting off work would say "watch so and so."	D 270		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 270	Continued From page 64 -She walked through the halls and helped whoever she saw needed to be helped. _____ Telephone interview with the Administrator on 08/22/18 at 4:55pm revealed: -She was aware of a "few" incidents involving resident altercations. -The RCC and BOM were her contacts most of the time. -When she was at the facility, she looked at things and discussed them. -The RCC and BOM were her "eyes and ears when I'm not there." -If there was something she had talked about with the RCC and BOM, she tried to be sure to follow up with the RCC and BOM either when on the telephone or in the facility. -Staff called her "most time" to make her aware. _____ The facility failed to provide supervision in the smoking area for 6 of 9 sampled residents resulted in Residents #5 and #8, who were involved in fights sustaining head injuries, and Resident #9 smoking inside the facility. The facility's failure resulted in serious neglect and physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/17/2018 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2018.	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 273	Continued From page 65	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: A1 VIOLATION Based on observations, record reviews and interviews, the facility failed to assure physician notification for 4 of 7 sampled residents resulting in multiple areas of skin breakdown (Resident #4), The development of an infected stage III decubitus (Resident #5), a delay in receiving treatment for an abdominal injury after a fall (Resident #1) who fell, and refusal of personal care and baths (Resident #3). The findings are: 1. Review of Resident 4's current FL-2 dated 01/11/18 revealed: -Diagnoses of healthcare acquired pneumonia, acute on chronic diastolic heart failure, obstructive sleep apnea, morbid obesity, hypertension, and decubitus ulcer of left foot. -Respiration was marked Oxygen (O2) 3 liters per minute (L/min) nasal cannula (NC) continuous. -Personal Care Assistance was marked for total care. -Bladder was marked incontinent. -Bowel was marked incontinent. Review of the Resident Register for Resident #4 revealed the resident was admitted to the facility	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 66 on 01/10/17. Review of a care plan dated 01/30/18 revealed: -Ambulation/Locomotion was marked as wheelchair. -Oxygen was marked in the respiration section. -The device needed in respiratory section was left blank. -The bowel section was marked as daily incontinence. -The bladder section was marked as daily incontinence. -Self-care was not marked as yes or no in the bladder or bowel section. -The skin section was left blank. -Under the skin section the headings of normal, pressure areas, decubiti, other, and skin care needs were left blank. -Toileting was marked as being totally dependent. -Bathing was marked as being totally dependent. -Transferring was marked as being totally dependent. -Grooming and personal hygiene was marked as needing extensive assistance. a. Observation and Interview with Resident #4 on 08/16/18 at 1:20pm revealed: -She was in her room and was sitting in an electric high back wheelchair. -She was shifting with facial grimace and reported buttocks pain while sitting in the electric wheelchair. -She wanted to return to bed due to buttocks pain. -She had been at the facility for one and a half years. -She had pressure sores on her bottom for six months. -The "staff" put "medicine on it and let it go." -She had a home health nurse (HHN) performing	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 67	D 273		

wound care to her left foot wound every other morning.
-She had told the HHN about the sores on her buttocks.
-The HHN had not assessed her buttocks.

Interview with the HHN on 08/17/18 at 8:35am revealed:
-He was treating Resident #4's left foot wound.
-He last completed a head to toe assessment on Resident #4 1 week ago.
-Resident #4 did not have any wounds on her buttocks.
-He was also the Licensed Health Professional Support (LHPS) nurse for the facility.

Observation of Resident #4 on 08/20/18 at 11:55am revealed:
-She was in her room supine on her bed wearing a shirt and incontinence brief and was covered with a blanket.
-A medication aide (MA) and a Personal Care Aide (PCA) unfastened Resident 4's incontinence brief.
-Her incontinence brief was wet with urine.
-The MA and PCA rolled Resident #4 on her left side and removed the incontinence brief.
-There was a light red colored area approximately six inches long by one and a half inches wide to her right inner buttock area with scattered areas of small blisters approximately the size of an ink pen tip.
-There was a wound to the back of her left inner upper thigh area, just below her left buttock that was circular in diameter approximately two inches in diameter, light red to dark pink in color, towards the inner part of the wound was scabbed with an open area in the center that was approximately one centimeter in size and was bright red with clear colored drainage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 68 -There was an area to her left lower abdominal fold where her stomach skin laid on her left upper leg and groin area that was bright red to light pink in color with small scattered red intact blisters approximately four inches long. Interview with a MA on 08/20/18 at 11:55am revealed: -She knew of the wound to the left inner upper thigh area. -She knew of the wound to the right buttock area. -There were orders for a barrier cream to the left inner upper thigh and right buttock area that was to be applied with each brief change. -She did not know of the skin irritation to Resident #4's left lower stomach and left groin where the two meet. -The wound care center knew of the open wound to the back of Resident #4's left inner upper thigh area. Interview with a PCA on 08/20/18 at 11:55am and 4:05pm revealed: -Resident #4 had the open wound to the back of her left inner thigh area for two months. -Resident #4 had the reddened area to left lower stomach and left groin fold for 1 week. -Both areas were being addressed at the wound care center. -There was an order for barrier cream to both areas. -Skin assessments were performed and documented by the PCAs when Resident #4 had her baths. Interview with the LHPS/HHN on 08/20/18 at 5:05pm revealed: -Resident #4 had a chronic wound to the bottom of her left foot. -Resident #4 was being followed by podiatry for	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 69	D 273		

the wound to her left foot.
-Home health (HH) was performing wound care to the left foot three (3) times a week.
-There were no other wounds documented.

Interview with Resident #4 on 08/21/18 at 8:30am revealed:
-On 08/20/18, she reported a "sore on my bottom" to the LHPS/HHN.
-On 08/20/18, the wounds on her buttocks and backside were inspected by the LHPS/HHN.
-08/20/18 was the first time the wounds on her buttocks and backside were inspected by the LHPS/HHN.
-She reported the wounds on her buttocks and backside to the wound care center a "few months ago."
-She could not specify how long a "few months" were.

Interview with LHPS/HHN on 08/21/18 at 09:30am revealed:
-On 08/20/18, Resident #4 informed him of a sore on her buttocks area.
-On inspection of Resident #4 there were "denuded" areas to her ischium's.
-He defined "denuded" as meaning "reddened areas, no open areas."
-There were no open areas to her buttocks/backside.
-The last wound to Resident #4's buttocks area was "approximately" eight months ago.
-He did not currently have orders for wound care to Resident #4's buttocks area.
-The process for new wound discovery on residents who were under the care of the wound care center would be to report findings to the facility provider and the wound care center.
-On Resident #4's 08/20/18 inspection he did not see a wound to the back of Resident #4's left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 70	D 273		

inner upper thigh area, just below her left buttock.
-On the 08/20/18 inspection he did not see a reddened area with intact blisters to Resident #4's left lower stomach/groin area.
-He had not informed anyone of Resident #4's 08/20/18 wound assessment findings to her ischium's.
-Resident #4 had orders for "cream" to her buttocks area.
-Resident #4 was being followed by the wound care center once a week for her left foot and they were addressing the buttock wounds.

Review of an order dated 08/16/18 from the wound care center revealed:
-Barrier cream to left breast inferior fold and right buttock/thigh skin breakdown daily.
-Wound #1 left lateral plantar foot other: apply calcium alginate to wound bed-be sure to tuck into wound bed cover with optilock, wrap with gauze, change every other day or more frequently to control drainage.
-There was nothing documented regarding the wound to the back of Resident #4's left inner thigh area.

Review of Resident #4's resident progress notes on 08/21/18 at 9:30 am with the LHPS/HHN revealed:
-He had not documented notes on Resident #4 since 09/18/17.
-On 09/18/17, there was documentation regarding a dressing change to Resident #4's left foot wound.

Review of a HH skilled nursing clinical note on 08/21/18 for date of service of 08/20/18 revealed:
-The skin assessment section was documented as no wounds identified.
-There was a wound assessment documented on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 71	D 273		

Resident #4's bottom left foot.
-Additional assessment findings documented on Resident #4 were "denuded areas to bilateral ischiums, no drainage or induration"
-Resident #4 denied any new problems.

Observation of Resident #4 and interview with LHPS/HHN on 08/21/18 at 9:58am revealed:
-She was in her room supine on her bed.
-The LHPS/HHN revealed Resident #4's right buttocks crease.
-He assessed Resident #4's right buttock crease area on 08/20/18.
-The LHPS/HHN revealed Resident #4's left buttock/thigh area.
-He did not see the left buttock/thigh area wound, or the "crater in the wound" on 08/20/18.
-The left buttock/thigh wound was being treated at the wound care center.
-The left back of Resident #4's left inner thigh wound was being treated with barrier cream.
-He did not see Resident #4's left lower stomach/groin wound on 08/20/18.

Interview with a MA supervisor on 08/21/18 at 10:50am and 11:15am revealed:
-She completed Resident #4's care plan that was signed and dated 01/25/18.
-She did not know why the skin assessment section was left blank.
-The provider was supposed to look at the care plans and complete the skin assessments.
-Care plans were completed within 30 days after admission, yearly, and with significant change.
-Development of a wound would be considered a significant change.
-She knew of a wound between Resident #4's thighs.
-She did not know anything about the wound, how long it had been there, or what type of wound it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 72	D 273		

was.
-The process for reporting new resident findings would be for whoever discovered (either MA or PCA) would be responsible for contacting the provider and informing of the new finding, then either the MA or PCA would notify herself or the Resident Care Coordinator (RCC).

Review of Resident #4's record on 08/21/2018 revealed there was no indication that a provider had been informed of an open wound to Resident #'4's back left inner thigh area or left abdominal fold and left groin area where the two meet.

Interview with the RCC on 08/21/18 at 4:45pm revealed:
-Skin assessments should be performed and documented on bath assessments sheets.
-Any markings, bruises, discolorations, anything that was not previously there should be documented.
-The findings were to be reported to the supervisor then the supervisor would inform the MA/supervisor on first shift or to the facility provider.
-The supervisor should address the new discovery, attempt to obtain orders from the provider, or follow standing orders if appropriate.
-Significant change was communicated to staff by verbal notification and handed down to each oncoming shift.

Interview with a second MA supervisor on 08/21/18 at 5:40pm revealed:
-Resident #4 had "two or three" sores on her bottom.
-There was a round open area with exposed skin on Resident #4's bottom that had been present for greater than one month.
-Resident #4 was being treated at the wound care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 73	D 273		

center for the wound to her bottom.
-She did not know of any wound to Resident #4's left lower stomach and groin area.
-She did not know of a wound to the back of her inner left thigh.

Interview with a second MA on 08/21/18 at 5:50pm revealed:
-She did not know of a wound to the back of Resident #4's inner thigh.
-She did not know of any wounds to Resident #4's left lower stomach/groin area.

Telephone interview with the nurse at the wound care center on 08/22/18 at 8:45am revealed:
-She did not know Resident #4 had open wounds to her buttocks, back side, or back of her left inner thigh.
-The open wound to Resident #4's buttocks, backside, and back of left inner thigh had not been reported to the wound care center.
-She thought Resident #4 had "reddened areas only" that "looked like she had been sitting in her wheelchair too long" to her buttocks.
-There was an order written on 06/21/18 for a barrier cream to Resident #4's left breast and right buttock thigh area.
-Resident #4 was last seen at the wound care center on 08/16/18.
-There was an order on 08/16/18 to continue barrier cream to the left breast and right buttock thigh area.
-The barrier cream was ordered as a skin protectant, not to treat a wound.
-Her expectation was that the facility or HH nurse would call the wound care center to report any new findings.
-There had not been any notification to the wound care center from the facility or HH nurse regarding any new findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 74 Interview with the RCC on 08/22/18 at 4:16pm revealed: -The process for referrals and follow up was that the supervisor would inform (named staff) who would notify her. -(named staff) is responsible for making the residents medical appointments. -She and (named staff) were responsible for notifying physicians of significant changes or findings. Interview with the LHPS/HHN on 08/23/18 at 10:53am revealed: -Both of Resident #4's ishiums were "endurated." -Both of Resident #4's ishiums were red. -There were no open areas to Resident #4's buttocks or back of left inner thigh. -His 08/20/18 morning assessment of Resident #4 did not reveal an open wound to the back of her left inner thigh area. -He did not see an open wound to the back of Resident #4's left inner thigh until it was pointed out to him by surveyors during his 08/21/18 9:58am examination. -He thought there were orders for the wound to Resident #4's left back inner thigh, but there were no orders. -There were orders for a barrier cream to Resident #4's right buttock instead. -He called the wound care center on 08/20/18 after his assessment of Resident #4 to obtain orders for a barrier cream to Resident #4's left buttock and back of left inner thigh wound,. -He did not document Resident #4 had a wound to the back of her left inner thigh. Interview with the RCC on 08/23/18 at 12:20pm revealed: -She expected the provider to be notified for any	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 75	D 273		

new skin break down for Resident #4.
-She expected who ever discovered the new skin break down to notify the supervisor and the supervisor should inform the RCC or MA/supervisor on day shift.

Interview with another PCA on 08/23/18 at 4:43pm revealed:
-She had provided care to Resident #4 on 06/13/18.
-She completed Resident #4's skin assessment sheet on bathing for 06/13/18.
-The skin assessment sheets were completed with each bath.
-She thought the buttock skin break down documented on the 06/13/18 skin assessment for Resident #4 was on the right buttock area.
-She could not remember if there was skin breakdown on the left buttock or back of left inner thigh.
-The process for new wound or findings discovered during the bath assessment would be to inform the supervisor of skin breakdown and the supervisor would inform the provider.
-She would not be responsible for informing the provider of skin break down.
-She completed the 06/13/18 skin assessment sheet and gave it to the supervisor with a verbal report.
-The skin assessment sheets were filed in the RCC's office.

Interview with the supervisor on 08/23/18 at 1:55pm revealed:
-She was the supervisor working on 06/13/18.
-The PCA reported Resident #4's skin break down on the buttock to her.
-She could not remember where on and to what extent the skin break down was to Resident #4's buttock.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 76	D 273		

-She would report new findings to the LHPS nurse or the provider.
-Any skin breakdown noted on second shift would be reported to the LHPS nurse.
-She thought she reported Resident #4's skin breakdown on the buttocks to the LHPS nurse, but was not certain.
-If she did not report Resident #4's skin breakdown she would have verbally informed the next shift staff coming on to relieve her.
-She did not document notifying the LHPS nurse and/or oncoming shift of Resident #4's skin breakdown.

b. Review of Resident #4's physician's order dated 08/02/18 revealed:
-There was an order documented as "Patient needs ambulatory training!!!!!.".
-There was no fax confirmation sheet attached.

Review of Resident #4's physician's order dated 08/16/18 revealed:
-There was an order documented as "Patient desperately needs access to a GYM in order to receive proper physical therapy for ambulation training."
-There was a fax confirmation sheet attached showing it was faxed on 08/16/18

Telephone interview with a manager of a Home Health agency on 08/22/18 at 9:30am revealed:
-Resident #4 was receiving wound care services from their home health agency.
-They had not received an August 2018 order for physical therapy on Resident #4.
-The last physical therapy order they received on Resident #4 was 01/11/18.
-Physical Therapy last saw Resident #4 on 01/26/18.
-The physical therapy evaluation would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 77 performed if they had received the order. Telephone interview with Resident #4's physician at the wound care center on 08/22/18 at 12:45pm revealed: -Resident #4 had been receiving treatment at the wound care center for approximately 1 year. -Resident #4 had been non-ambulatory since she had been going to the wound care center. -Resident #4 used her wheelchair for mobility. -Resident #4 was deconditioned. -Based on Resident #4's report Resident #4 needed weekly physical therapy at a gym facility. -She did not see a reason why Resident #4 could not walk with ambulation training. -Her expectation was that physical therapy would start two weeks after the physical therapy referral. Interview with the Resident Care Coordinator (RCC) on 08/22/18 at 5:05pm revealed: -There was an order for "PT gym" that was faxed to the Home Health agency. -There was an attached fax confirmation sheet. -The LHPS/HHN told the RCC he had received the physical therapy orders. -The resident "talks about wanting to walk but when it comes down to it she won't do it." -Physical Therapy had previously treated Resident #4. Interview with a medication aide supervisor (MA/supervisor) on 08/23/18 at 09:35am revealed: -Resident #4 could not walk. -Resident #4 had not walked since she had been at the facility. -Physical Therapy orders were to be faxed the order to the "PT place", review the fax confirmation sheet, if it was documented the transmission was "OK" attach the confirmation	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 78	D 273		

sheet to the order and file in the chart.
-The 08/12/18 PT order was faxed to the Home Health agency.
-There was no fax confirmation sheet attached to the 08/02/18 PT order.
-She could not confirm the 08/02/18 PT order was received by the Home Health agency because she did not have a fax confirmation.
-She verified the 08/16/18 physical therapy order had been faxed to the Home Health agency by looking at the attached fax confirmation sheet.
-There was no process to follow up on faxing orders.
-She did not know why the 08/02/18 order for physical therapy was not forwarded to home health.
-She could not verify the 08/16/18 physical therapy order that was faxed to the home health agency was followed up to be certain they had received the order.
-She did not know who had faxed the 08/16/18 physical therapy order, but she would follow-up.

Interview with the LHPS/HHN on 08/23/18 at 11:15am revealed:
-He reviewed the 08/02/18 PT order in Resident #4's facility record on 08/23/18.
-He reviewed the 08/16/18 PT order in Resident #4's facility record on 08/23/18.
-He did not know Resident #4 had aPT order dated 08/02/18, and 08/16/18.
-Any orders received by the Home Health agency would be filed in Resident #4's HH electronic record.
-He reviewed Resident #4's HH electronic record on 08/22/18 and there were no orders for PT.
-He did not tell the RCC that he had Resident #4's PT order.

c. Review of the Resident #4's FL-2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 79 01/11/18 revealed an order for Oxygen (O2) 3 liters per minute (L/min) nasal cannula (NC) continuous. Review of an order dated 01/16/18 revealed an order to continue Oxygen at 3 L/min by NC continuous as ordered by the hospital. Review of Resident #4's electronic Medication Administration Record (eMAR) for June, July, and August 2018 revealed there was not an entry for Oxygen. Observation of Resident #4 on 08/16/18 at 11:55am revealed: -She was in her room and was being transferred from an Emergency Medical Services (EMS) stretcher to her bed. -She was not wearing oxygen. Observation of Resident #4's room on 08/16/18 at 11:55am revealed: -There was an oxygen in use sign on her room door. -There was a portable oxygen tank that was not on. -There was an oxygen concentrator that was not on. -There was a Continuous Positive Airway Pressure (CPAP) machine that was not on. -There was oxygen tubing laying on the floor beside her bed. Observation of Resident #4 on 08/16/18 at 1:35pm revealed: -She was sitting in her electric wheelchair in her room. -She was not wearing oxygen. -A Personal Care Aide (PCA) and a Medication Aide (MA) entered her room to assist her to bed.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 273	Continued From page 80 Interview with Resident #4 on 08/16/18 at 5:51pm revealed she only needed the oxygen when she was sleeping due to "I stop breathing when I sleep." Observation of Resident #4 on 08/17/18 at 8:10am revealed: -She was in her electric high back wheelchair in the dining room. -She was not wearing oxygen. -There was no oxygen device present. Observation of Resident #4 on 08/20/18 at 11:55am revealed: -She was in her room supine on her bed. -She was not wearing oxygen. -A portable oxygen tank and an oxygen concentrator were in her room and were not on. Interview with a MA on 08/20/18 at 11:55am and 4:05pm revealed: -She did not know Resident #4 needed oxygen continuous. -She had never been told Resident #4 needed oxygen continuous. -Resident #4 only used oxygen at night through her CPAP. Interview with a PCA on 08/20/18 at 1:30pm revealed: -Resident #4 had an order for continuous oxygen. -Resident #4 did not wear her oxygen continuously. -He had not reported to the physician that Resident #4 did not wear her oxygen continuously. Interview with a second MA on 08/21/18 at 9:00am revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 81	D 273		

-Resident #4 was supposed to use oxygen.
-Resident #4 did not use oxygen because "she is a smoker."
-Resident #4 was supposed to use her CPAP at night.
-She had not reported to the provider that Resident #4 did not use her oxygen.
-She did not know if the provider was aware Resident #4 did not use her oxygen.

Interview with MA/Supervisor on 08/17/18 at 9:49am revealed:
-She had been employed at the facility for 10 years.
-She worked Monday - Friday, on first shift, and some Saturdays when the Nurse Practitioner saw the residents in the facility.

Interview with MA/Supervisor on 08/21/18 at 10:50am revealed:
-She did not provide direct resident care.
-Resident #4 did not have an order for Oxygen 3 L/min NC continuously.
-Providers were to be notified of residents who did not follow orders.

Interview with a second MA/Supervisor on 08/21/18 at 5:40pm revealed:
-She knew Resident #4 had refused to wear oxygen.
-She thought the Oxygen 3 L/min by NC continuous order had been discontinued.
-She was unable to locate the order to discontinue continuous Oxygen.

Interview with a third MA on 08/21/18 at 5:50pm revealed:
-She had provided care for Resident #4 on second shift.
-She did not know of an order for oxygen

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 82	D 273		

continuous for Resident #4, and thought Resident #4 received Oxygen through her CPAP at night.

Telephone interview with Resident #4's primary care provider on 08/22/18 at 1:10pm revealed:
-She did not know of an order for continuous Oxygen.
-She thought the order for continuous Oxygen had been discontinued.
-She did not know who would have written the order to discontinue Oxygen continuously.
-She didn't not write the order for continuous Oxygen.
-Resident #4 had sleep apnea.

d. Review of a physicians order dated 01/16/18 for Resident #4 revealed an order to check finger stick blood sugars every day and notify the doctor if blood sugar is greater than (>) 200 or less than (<) 80. If blood sugar is <80 give juice and a snack and notify doctor.

Review of Resident #4's electronic Medication Administration Record (EMAR) for 08/01/18 - 08/16/18 revealed:
-There was an entry to check the blood glucose every day and notify doctor if blood glucose is > 200 or < 80. If < 80 give juice and a snack and notify doctor.
-On 08/12/18 Resident #4's blood sugar was documented as 258.
-There was no documentation Resident #4' s primary care provider (PCP) was notified of a blood sugar > 200.

Review of Resident #4's July 2018 eMAR revealed:
-There was an entry to check the blood glucose every day and notify doctor if blood glucose is > 200 or < 80. If < 80 give juice and a snack and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 83 notify doctor. -There were 7 out of 31 days Resident #4's blood sugars were > 200. -For example, on 07/01/18 Resident #4's blood sugar was documented as 271. -On 07/14/18 Resident #4's blood sugar was documented as 272. -On 07/15/18 Resident #4's blood sugar was documented as 254. - There was no documentation Resident #4's PCP was notified of any of the blood sugars > 200. Review of Resident #4's June 2018 eMAR revealed: -There was an entry to check the blood glucose every day and notify doctor if blood glucose is > 200 or < 80. If < 80 give juice and a snack and notify doctor. -There were 23 out of 30 days Resident #4's blood sugars were documented > 200. -For example, on 06/27/18 Resident #4's blood sugar was documented as 331. -On 06/28/18 Resident #4's blood sugar was documented as 291. -On 06/23/18 Resident #4's blood sugar was documented as 295. -On 06/19/18 Resident #4's blood sugar was documented as 258. -On 06/29/18 Resident #4's blood sugar was documented as 255. -On 06/08/18 Resident #4's blood sugar was documented as 245. -There was no documentation Resident #4's PCP was notified of any of the blood sugars > 200. Interview with MA/Supervisor on 08/23/18 at 12:05pm revealed: -Provider notification of blood sugars > 200 would be documented on the back of each month's	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 84	D 273		

blood sugar sheet for Resident #4.
-She did not call the PCP to report blood sugars > 200.
-She did not see the part of the order that read to "notify provider for blood sugars > 200 and < 80."
-She had "messed up" by not notifying the provider.
-The provider would not know to look at Resident #4's blood sugar results if she was not notified they were > 200.
-There was no other area that physician notification of blood sugars > 200 would be documented.

Review of Resident #4's June, July, and August 2018 blood sugar sheet revealed no documentation the physician was notified of blood sugars > 200.

Interview with the Resident Care Coordinator (RCC) on 08/23/18 at 12:20 pm revealed:
-She expected the provider to be notified for any blood sugars that were out of parameters for Resident #4.

Telephone interview with Resident #4's PCP on 08/22/18 at 1:10pm revealed:
-She remembered one incident in June 2018 where Resident #4's blood sugar was greater than 200.
-She did not have the reading of the June 2018 blood sugar.
-She expected blood sugars that were > 200 to be recorded and the resident to be added to the schedule to be seen on the next facility visit.
-She did not expect to be called for blood sugars > 200.

Refer to the interview with the Administrator on 08/22/18 at 4:15pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 85 2. Review of Resident #5's current FL-2 dated 12/11/17 revealed: - Diagnoses of cerebrovascular disease, muscle weakness, anxiety disorder and a communicable disease. -The resident was non-ambulatory and required assistance with bathing and dressing. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 01/03/18. Review of an admission skin assessment dated 01/03/18 revealed Resident #5's skin was without wounds, only a healed surgical scar on his left knee. Review of Resident #5's care plan dated 01/05/18 revealed: -The resident was sometimes disoriented, had limited range of motion, limited strength and only ambulated with wheelchair. -The resident required extensive assistance with toileting, transfers and grooming. -The resident required total assistance with bathing and dressing. Review of Bath and Skin Assessment sheets for July 2018 and August 2018 revealed: -From 07/03/18 - 07/31/18, 13 reports had documentation of Resident #5's bedsore on his buttock and an ulcer on his left leg. - From 08/02/18 - 08/14/18, 13 reports had documentation of Resident #5's bedsore on his buttock and an ulcer on his left leg. -The Bath and Skin care Assessment sheets from January 2018 through June 2018 were not available for review. Review of Resident #5's wound care clinic from	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 273	Continued From page 86	D 273		

the wound clinic dated 07/19/18 revealed:
-Resident #5 was diagnosed with a pressure ulcer of the left ischium (lower buttock) which was open, had a foul odor and unstageable and ulcer of the left lower leg.
-The pressure ulcers measurements were 1.7cm (length) 1.9cm (width) 2.2cm (depth) with slough/fibrin.
-The wound was debrided of slough, but the procedure was terminated because Resident #5 did not tolerate procedure well.
-The wound of the resident's left buttock was classified as stage III pressure ulcer after debridement.
-The resident reported sharp pain of wound areas rated at 7 before debridement and did not know how long the wound was on his buttock.
-There were orders for daily wound care and referral to home health for skilled nursing care (wound care) and turn/reposition the resident every 2 hours.

Review of Resident #5's emergency room report dated 07/30/18 revealed:
-The resident's chief complaint was left buttock decubitus ulcer.
-The resident was diagnose with an acute left buttock decubitus ulcer.
-He was ordered Clindamycin 300mg (an antibiotic used to treat infections) every 6 hours (80 capsules). Follow-up with primary care or specialist in 1 day if possible.

Review of Resident #5's wound care report from the wound clinic dated 8/02/18 revealed:
-The Stage III decubitus of Resident #5's left lower buttock measured at 1.5cm (length) 2cm (width), 3cm (depth) 2.356cm (tunneling) and 7.069 cm(undermining).
-Daily wound care continued and turn/reposition

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

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KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 273	Continued From page 87 every 2 hours. Interview with Resident #5's primary care provider (PCP) on 8/22/18 at 12:50pm revealed: -The PCP became aware of the Stage III wound on Resident #5's buttock on 8/11/18. -Resident #5 was diagnosed with a stage III decubitus on his lower left buttock and a stage II or III decubitus on his left posterior leg after an ER visit in July 2018 and wound care was started by home health in July 2018. -The resident was being followed by the hospital wound clinic. -The resident was started on an antibiotic in the ER on 7/31/18 for infection of the buttock wound. -The skin breakdown should have been reported earlier when the facility became aware of the wound and treatment could have been started earlier. -The facility did not informed the PCP of the wounds before 8/11/18. Interview with a Medication Aide (MA) on 8/21/18 at 8:40am revealed: -Resident #5 required total assistance with transfers and repositioning. -The resident was incontinent of bowel and bladder and required total assistance with incontinent care. -The resident had wounds (decubitus) on his lower left buttock and left leg which started about 2 months ago and should have been repositioned/turned at least every 2 hours. -The MA was not sure how often the resident was turned/repositioned. Interview with Resident #5's Home Health Nurse (HHN) on 08/21/18 a 10:20am revealed: -The resident was treated at the wound clinic on 07/19/18 and orders were received for daily	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 88 wound for the Stage III decubitus care by the home health nurse. -The buttock wound was necrotic and draining with a small hole in the center. The leg wound was beefy red with yellowish slough (tissue). -The wound on the buttock was infected and the resident was transported to the local emergency room and treated with antibiotics at the end of July 2018. Interview with Resident #5 on 08/22/18 at 9:15am revealed: -The resident was unable to transfer or reposition without assistance from staff. -The 3rd shift staff assisted the resident into his wheelchair at 5:00am. -He would usually sit up in the wheelchair until late morning, 10-11:00am, until it was unbearable. -The resident complained of pain of his buttocks and stated his buttocks always hurt when he sat up in the wheelchair over 30 minutes. He usually required pain medication to relieve the pain after he was assisted to bed. -The resident was unable to reposition himself due to left-sided paralysis. -The personal care aides (PCA) never repositioned him when he was in the wheelchair and only occasionally repositioned him when he was in bed, about one time during the shift, but not always. -He usually sat or laid in the same position for hours. -The resident did not have wounds when admitted to the facility but developed "sores" about 2 months ago on his left buttock near his upper thigh and on the back of his left leg. -His left buttock and left leg was painful a few weeks before he was seen at the wound clinic and his buttock continued to be painful.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 89 -He informed the staff (PCAs and MAs) of the pain when it started. -The home nurse provided wound care every day and he went to the wound clinic at times. -There was no wound care performed on the wounds before going to the wound clinic. Interview with a PCA on 8/21/18 at 11:00am revealed: -She only turned or repositioned Resident #5 if he asked and when he needed incontinent care. -The skin assessment sheets were completed on days the resident received a shower and his bedsores were documented on the assessment sheets. -The resident had developed a bedsore on his lower buttock and left leg about 2 months ago. -The PCA was sure the MA knew of the bedsores because the skin assessment sheets were given to the MAs and the RCC. -The PCA did not know when the HHN started wound care, but the resident had developed the wounds at least 2-3 weeks before wound care was started. Interview with another PCA on 08/22/18 at 9:35am revealed: -The resident developed wounds on his lower left buttock and back of the left leg about 2-3 months ago. -The wounds were documented on the skin assessment sheets. -The HHN provided daily wound care which started in July 2018. -The Resident Care Coordinator reviewed the skin assessment sheets and should have known about Resident #5's wounds. Interview with the supervisor on 08/22/18 at 3:05pm revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 90 -A PCA reported the wounds on Resident #5's left buttock and left leg to her about 2 months ago. -The supervisor reported the wounds to Resident #5's PCP but she did not remember the date the wounds were reported, and did not document the report. -She did not remember if she called or faxed the report to the PCP. Interview the RCC on 08/21/18 at 4:10pm revealed: -She did not know how long Resident #5 had wounds on his left buttock and left leg, maybe 1and one-half to 2 months. -She did not know when the wounds were reported to the resident's PCP, but the RCC did not report the wounds. -The PCAs performed skin assessments during baths and reported any skin problems to the supervisor and the supervisor reported to the resident's PCP. -Resident #5's PCP visited the facility every other Saturday and should have known about the wounds before the buttock wound developed into a stage III decubitus. -She did not know if staff reported the wounds to the PCP. Refer to the interview with the Administrator on 08/22/18 at 4:15pm. 3. Review of Resident #1's current hospital generated FL-2 dated 05/10/18 revealed diagnoses included morbid obesity, chronic obstructive pulmonary disease, diabetes mellitus, acute encephalopathy, history of deep vein thrombosis, alcohol abuse, and congestive heart failure.	D 273		

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
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D 273	Continued From page 91 Review of an incident report for Resident #1 dated 08/01/18 revealed: -The time of incident was documented for 3:20am. -The description of the event was documented as "resident stated his knees gave out while trying to get into wheelchair to go to bathroom." -The description of the injury was documented as "small scrape along left side." -The staff action taken was documented as "checked vitals, checked for injury, contacted family, refused to be sent out. -The section of the incident report for "doctor notified" had no information indicating the physician was contacted about the fall. -There was a signature of the Medication Aide/Supervisor (MA/Supervisor) identified as the Resident Care Coordinator's (RCC) assistant in the area designated as "Administrator" with the date of 08/01/18. Interview with the Licensed Health Professional Support Nurse/Home Health Nurse (LHPS/HHN) on 08/17/18 at 8:00am revealed: -He saw the injury on Resident #1's left side "the first of the week." -He thought he saw it either the "first of this week or maybe last week." -There was a large bruised area with a scab in the center. The area was dry and there was no drainage. -He did not know how the injury occurred. -He did not note it in his home health notes when he saw the area on the resident's left side. -He "just" told staff to "watch it." Interview with a Personal Care Aide/Medication Aide (PCA/MA) on 08/17/18 at 9:15am revealed: -She saw the area on Resident #1's left side last Thursday (08/09/18).	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

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D 273	Continued From page 92 -There was a bruised, reddish colored area with a knot in the middle, with a scab. The area was swollen. -The resident said it was sore. -She did not know what happened. -The resident said he bumped it on the side of a chair but did not say when it occurred. -She told the Supervisor (named), and the RCC's assistant, when the resident told her about the area on his left side. -She did not write anything anywhere because she told the RCC's assistant about it so the resident could be seen by the Nurse Practitioner (NP). Interview with the MA/Supervisor, identified as the assistant to the RCC, on 08/17/18 at 9:50am revealed: -She was a MA/Supervisor but did whatever she was asked to do. -Her job duties included getting everything ready for the NP to go over when she made facility visits every other Saturday to see residents with acute symptoms and routine visits. -She compiled a list of residents to be seen by the NP when the NP came to the facility. -She saw an incident report dated 08/01/18 where the resident was trying to get from his wheelchair to the commode and slipped and hit his side. The incident did not indicate what the resident hit his left side on. -Resident #1 was seen by the NP on 08/11/18 because he had a bruise and hematoma on his left side. -He came to her last Thursday (08/09/18) and said he had a bruise on his left side and wanted to see the doctor. -She (MA/Supervisor) looked at the bruise on 08/09/18. There was a "regular sized bruise, bigger than a 50 cent piece."	D 273		

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D 273	Continued From page 93 -He kept saying "my ribs are coming through." -Resident #1 was seen by the NP on 08/11/18 and the NP ordered an ultrasound and xray. Interview with a MA on 08/17/18 at 3:55pm revealed: -Resident #1 told her about the injury to his left side about 2 weeks ago. -She called the primary care provider but did not remember if she documented the call. -She left a note for the LHPS/HHN to take a look at the area on the resident's left side. -The area was "oozing yellowish liquid" and she kept it covered up until the doctor could come. Review of resident notes and physician progress notes for Resident #1 revealed: -There was no documentation found in Resident #1's record for interventions from 08/09/18, when the resident requested to be seen by the doctor with complaints of rib pain. -There was no documentation found in Resident #1's record indicating the resident had been examined by the NP on 08/11/18 when she came to the facility to see residents. Review of a physician's order for Resident #1 dated 08/13/18 revealed there was a printed order from the Nurse Practitioner (NP) documenting "contusion of back. Contusion of left back wall of thorax, initial encounter. Apply a warm compress or warm rag to bruise located on left side every 4 hours for 15 minutes until bruise resolves." Review of a physician's order for Resident #1 dated 08/14/18 revealed there was an order for x-rays of the hips and ribs, and an ultrasound on the hip with a diagnosis of left lower quadrant pain.	D 273		

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D 273	Continued From page 94 Review of an x-ray report for Resident #1 dated 08/14/18 revealed: -The left ribs and left hip were x-rayed post fall/bruise. -The impression of the left ribs x-ray documented there were sclerotic changes left anterolateral sixth rib consistent with a fracture indeterminate in dating. Review of an ultrasound report for Resident #1 dated 08/15/18 revealed: -A left lateral soft tissue ultrasound was performed. -The clinical indication for the ultrasound was documented as "soft tissue hematoma over the left hip." -The impression was documented as "there is a 6.7cm by 3.3cm by 7.3cm complex fluid collection in the subcutaneous tissue over the left hip. This collection is compatible with an organized hematoma. The presence of infection cannot be excluded by this examination. Clinical follow-up is recommended." Telephone interview with the NP on 08/22/18 at 12:40pm revealed: -She saw Resident #1 on 08/11/18 at the facility because of a fall. -She thought he went to the hospital emergency room when he fell in August 2018. -The resident fell between 07/28/18 and 08/11/18. The NP did not know the exact date for the August 2018 fall. -She came to the facility every two weeks and the facility added all emergency room follow ups to her schedule to be seen. -Resident #1 had a couple falls from his wheelchair transferring to the commode.	D 273		

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D 273	Continued From page 95 Review of hospital records from 05/01/18 to 08/20/18 received from the local hospital for Resident #1 revealed there were no reports of hospital emergency room visits for August 2018. Refer to the interview with the Administrator on 08/22/18 at 4:15pm. 4. Review of Resident #3's current FL-2 dated 05/19/18 revealed: -Diagnoses that included vascular dementia, hypertension, history of cerebral vascular accident (CVA), and acute bronchitis. -Resident #3 was incontinent of bowel and bladder. -Resident #3 needed personal care assistance with bathing and dressing. -Resident #3 was intermittently disoriented and was non-ambulatory and used a wheelchair. Review of Resident #3's care plan dated 01/30/18 revealed: -Resident #3 was totally dependent for bathing, dressing, grooming/personal hygiene and toileting. -Resident #3 refuses personal care at times and was verbally and physically abusive to staff and became easily agitated. Observation of Resident #3 on 08/16/18 at 5:00pm revealed: -Resident #3 was sitting in her wheelchair in the hall by the dining room. -Resident #3's hair was greasy. -Resident #3"s clothing was large for her and her shirt was hanging off her shoulders. Review of the facility's shower and bath schedule for the day shift revealed, Resident #3 was on the schedule for a shower or bath on Monday, Wednesday and Friday.	D 273		

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D 273	Continued From page 96 Review of the facility's August 2018 Personal Care sheet for Resident #3 revealed: -The tub bath/shower section of the Personal Care sheet for Resident #3 was blank for all dates on the first shift (7am-3pm) from 08/01/18 to 08/20/18 except on 08/09/18 there was a slash line. -The help with getting in tub/shower section was blank on the first shift (7am-3pm) from 08/01/18 to 08/20/18 except for 08/09/18 and 08/13/18 there was a slash line. -The bed bath section was blank on the first shift (7am-3pm) from 08/01/18 to 08/20/18 except on 08/09/18 and 08/13/18 there was a slash line. -The sponge bath section was blank on the first shift (7am-3pm) from 08/01/18-08/20/18 except on 08/09/18 and 08/13/18 there was a slash line. -The shampoo/haircare section on the first shift (7am-3pm) from 08/01/18-08/20/18 was blank except on 08/09/13 and 08/13/18 there was a slash line. Review of the assistance codes on the Personal Care Record for Resident #3 revealed, there was not a slash line listed in the codes. Interview with a personal care aide/medication aide (PCA/MA) on 08/17/18 at 10:27am revealed: -The slash lines for August 2018 meant the task was not done. -The blanks on the August 2018 dates means the tub bath or shower, bed bath, sponge bath and shampoo/hair care was not completed. -Resident #3 would become combative when staff tried to give her a shower or change her when she was incontinent. -She was not sure the last time that Resident #3 had a shower and had her hair washed. -If Resident #3 refused personal care they just	D 273		

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D 273	Continued From page 97	D 273		

kept trying and let the next shift know.
-They did not have shift to shift written documentation about what has gone on during the shift, it was all done verbally.
-She was not sure if her refusals of personal care had been reported to Resident #3's primary care provider (PCP) or her psychiatrist.
-If a resident was refusing personal care the PCP and psychiatrist should be notified after three consecutive refusals.
-They did not always send a fax or call to let the PCP or psychiatrist to let them know of a resident's refusal of personal care.
-Sometimes they waited until the PCP or psychiatrist came to the facility to tell them about refusals of personal care.
-They did not usually document that they told the PCP or psychiatrist about refusals of care.

Review of the bath and skin sheets for 08/01/18, 08/03/18, 08/06/18, 08/10/18, 08/13/18, 08/15/18, 08/17/18 and 08/20/18 revealed Resident #3's showers were documented as refused and signed by the supervisor or resident care coordinator (RCC).

Based on observation, interviews and record reviews it was determined that Resident #3 was not interviewable.

Interview with the RCC on 08/17/18 at 12:45pm revealed:
-She had instructed PCAs when Resident #3 was combative with personal care, not force her because she would scratch, hit and fight staff.
-She was not sure the last time Resident #3 had a shower.
-If Resident #3's PCP was notified of personal care and bathing refusals there would be documentation in her medical record.

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D 273	Continued From page 98 There was no documentation of PCP or psychiatrist being notified of personal care and bathing refusals in Resident #3's medical record. Attempted interview with Resident #3's psychiatrist on 08/23/18 at 9:00am was unsuccessful. Interview with Resident #3's PCP on 08/23/18 at 1:30pm revealed: -She had not been notified of any personal care and bathing refusals for Resident #3. -She would expect the facility to notify her of the frequent refusals of personal care so she could reassess the Resident #3's needs. -If she or the psychiatrist had been notified about the personal care and bathing refusals they could have made some medication adjustments for Resident #3. Refer to the interview with the Administrator on 08/22/18 at 4:15pm. _____ Interview with the Administrator on 08/22/18 at 4:15pm revealed: -The RCC and the supervisor were responsible for contacting the residents' health care providers to report any resident changes. -The RCC and the business office manager (BOM) were her contacts most of the time. -When she was at the facility, she looked at things and discussed them. -The RCC and BOM were her "eyes and ears when I'm not there." _____ The facility failed to assure health care follow-up for 4 of 7 sampled residents (#1, #3, #4, #5) resulting in multiple areas of skin breakdown for	D 273		

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D 273	Continued From page 99 Resident #4; and the development of a stage III decubitus ulcer, a delay in follow up treatment resulting in infection and treatment with antibiotics for Resident #5; and a delay in Resident #1 receiving treatment of an abdominal injury after a fall. The facility's failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation.. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/22/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2018.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews, observations and record review, the facility failed to implement physician's orders for 2 of 6 sampled residents (Residents #5 and #6) regarding blood sugar with perimeters (Resident #5) and applying thrombo-embolic	D 276		

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
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D 276	Continued From page 100	D 276		

deterrent (TED) hose (Resident #6). The findings are:

1. Review of Resident #5's FL-2 dated 12/11/17 revealed diagnoses of cerebrovascular disease, muscle weakness, anxiety disorder and a communicable disease.

Review of a physician's order dated 01/17/18 revealed an order to check fingerstick blood sugars (FSBS) two times a day. Notify physician if blood sugar (BS) is greater than 200. If BS is less than 80, give juice, give a snack, recheck in 10 minutes and notify the primary care provider (PCP).

Review of Resident #5's electronic Medication Administration Records (eMARS) for June 2018 revealed:
-In June 2018, the resident's FSBS were documented 2 times a day, every day, from 06/1/18 - 06/30/18 at 8:00am and 8:00pm with 7 FSBS ranged from 207 to 242 (there was no documentation of the FSBS reported to the physician).
-There were 10 FSBS from 68 to 78 (there was no documentation of juice or snack given or reported to the PCP).

Review of Resident #5's electronic Medication Administration Records (eMARS) for July 2018 revealed:
-In July 2018 the resident's FSBS were documented 2 times a day, from 07/1/18 - 07/31/18 at 8:00am and 8:00pm with 4 FSBS from 207 to 315 (there were no documentation of the FSBS reported to the physician).
-There were 9 FSBS from 68 to 77 (there was no documentation of juice or snack given or reported to the PCP).

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D 276	Continued From page 101 Review of Resident #5's electronic Medication Administration Records (eMARS) for August 2018 revealed: -In August 2018 the resident's FSBS were documented 2 times a day, from 08/1/18 - 08/21/18 at 8:00am and 8:00pm with 3 FSBS from 235 to 280 (there were no documentation of the FSBS reported to the physician). -There were 5 FSBS from 72 to 78 (there was no documentation of juice or snack given or reported to the PCP). Interview with Resident #5 on 08/22/18 at 9:15am revealed: -The Medication Aides (MA) checked his BS 2 times a day (in the morning and at bedtime). -Sometimes his BS was low but the staff did not give him juice or a snack. -If the resident's BS was low, he would get a piece of candy out of his bedside table drawer and eat the candy. The staff never rechecked his BS. -The resident did not know if his FSBS were greater than 200 or if the staff called his PCP to report high or low BS. Interview with Resident #5's PCP on 08/22/18 at 12:50pm revealed: -The resident was diabetic but did not require medication to control blood sugars. His diabetes were diet control only. -The facility should be monitoring the resident's BS two times a day and reporting FSBS less than 80 or greater than 200. -All FSBS which were less than 80 should have been treated as ordered with juice and a snack administered by the facility. -FSBS less than 80 could have been dangerous for the resident and if there were no interventions	D 276		

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
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 276	Continued From page 102	D 276		

as ordered, the resident could have gone into a life threatening hypoglycemic episode.
-The facility had never reported any FSBS less than 80 and reported only 1 BS greater than 200 about 2 months ago.

Interview with the supervisor on 08/22/18 at 3:05pm revealed:
-The MAs were responsible for checking and documenting Resident #5's BS two times a day (am and pm).
-If the MAs did not document their intervention, the supervisor did not know if they reported the resident's high or low FSBS or administered juice or gave the resident a snack for low FSBS.
-The supervisor had never reported FSBS to the PCP and had never given the resident juice or snacks for low FSBS.
-The MAs or the supervisor were responsible for reporting the BSs to the PCP.

Interview with a MA on 08/23/18 at 4:40pm revealed:
-The MA checked Resident #5's BS at 8:00pm and documented the FSBS.
-The MA knew of the order to give the resident juice and a snack and recheck the BS if less than 80 and to call the PCP if BS greater than 200 or less than 80.
-The MA had checked the resident's FSBS which were less than 80.
-The MA had never given the resident a snack or juice for BS less than 80 or rechecked BS.
-The MA did not know if the FSBS were reported to the PCP, she had never reported the FSBS.

Interview with the Resident Care Coordinator (RCC) on 08/22/18 revealed:
-The MAs who checked Resident #5's BS should follow the order exactly as written.

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D 276	Continued From page 103 -The resident's PCP should have been notified of the FSBS and the resident should be given juice and a snack for FSBS less than 80 and BS rechecked as ordered. 2. Review of Resident #6's current FL-2 dated 01/09/18 revealed: -Diagnoses included dementia, urge incontinence, hypertensive heart disease, cerebral atherosclerosis, dysphagia, mixed hyperlipidemia, and vitamin B deficiency. -Resident #6 was intermittently confused. -There was a physician's order to apply TED hose every morning and remove every evening. Review of Resident #6's physician orders dated 07/14/18 revealed the application of the TED hose every morning and removed at bedtime. Review of Resident #6's June 2018, July 2018, and August 2018 electronic Medication Administration Record (eMAR) revealed: -An computerized entry to apply TED hose at 6:00am daily to Resident #6's legs. -An computerized entry to remove TED hose at 8:00pm daily to Resident #6's legs. -Resident #6's TED hose were documented as applied and removed daily from 06/01/18 through 08/15/18. Review of Resident #6's August 2018 personal care record from 08/01/18 through 08/21/18 revealed there was no documentation of staff applying Resident #6's TED hose on first, second, or third shift. Observations of Resident #6 from 08/16/18	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 276	Continued From page 104 through 08/22/18 revealed: -On 08/16/18 at 11:24am, Resident #6 was sitting in his wheelchair in his room; he was not wearing any TED hose, but had on a pair of white socks with gray stains at the heel. -On 08/17/18 at 9:55am, Resident #6 was asleep in his bed and he was not wearing any TED hose (Resident #6 was still wearing the stained white socks from 08/16/18). -On 08/20/18 at 10:45am, Resident #6 was rolling himself backwards down the 100 Hall and was not wearing any TED hose. -On 08/21/18 at 11:10am, Resident #6 was not wearing any TED hose while sitting in the front living area; Resident #6 with bilateral lower leg edema observed. -A new pair of TED hose for Resident #6 were being dried in the laundry but were never applied during the first shift on 08/21/18. -On 08/22/18 at 9:33am, Resident #6 was lying in bed without his TED hose on wearing a pair of the stained white socks with a hole in the big toe of the right sock -TED hose were in a chair in Resident #6's room on 08/22/18. -On 08/22/18 at 1:15pm, Resident #6 was still not wearing his TED hose as he returned back from lunch. -On 08/22/18 at 2:15pm, Resident #6 was not wearing his TED hose as he wheeled himself backwards down the 100 Hall. -On 08/22/18 at 2:45pm, Resident #6 was not wearing his TED hose as he sat in the front living room area and he continued to have bilateral swelling to both lower extremities. Interview with Resident #8 on 08/21/18 at 11:10am revealed: -He denied having any leg pain. -He did not know what TED hose were.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 105 -He did not know if staff put TED hose on him. -He just wore regular socks when he got up to dress. Interview with a personal care aide (PCA) on 08/21/18 at 11:12am revealed: -She did not know if Resident #6 was supposed to wear TED hose. -"Normally, third shift staff put on TED hose for residents if TED hose were ordered." -She could not recall if she had ever seen Resident #6 wearing TED hose and she had not checked to see if Resident #6 was wearing TED hose. -Resident #6's TED hose were supposed to be on put by third shift and she did not have to do it. -Resident #6's TED were taking off by the second shift staff. Interview with the first medication aide (MA) on 08/21/18 at 1:30pm revealed: -Resident #6 was supposed to wear TED hose during the day that were put on by third shift staff. -She thought Resident #6 was wearing his TED hose earlier on 08/21/18. -She would have to check to see if Resident #6 was still wearing his TED hose. -Resident #6 may have taken the TED hose off after the third shift put them on. Interview with the Resident Care Coordinator (RCC) on 08/21/18 at 2:05 revealed: -Resident #6 was supposed to have TED hose on. -TED hose were put on by the third shift staff. -Sometimes, Resident #6 took off his TED hose after the third shift staff had put them on. -She was not sure if the first shift staff checked Resident #6 to make he was wearing his TED hose.	D 276		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

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D 276	Continued From page 106	D 276		

-She did not know why Resident #6 was not wearing his TED hose.
-Resident #6 may have gotten his TED hose dirty and staff had put them in the laundry.
-She would have to follow-up with the first shift staff.

Interview with a third shift MA on 08/21/18 at 4:00pm revealed:
-Resident #6 was supposed to wear TED hose.
-The third shift PCA put the TED hose on at 6:00am and TED hose were supposed to be removed at 8:00pm.
-She checked behind the PCA to make sure Resident #6's TED hose were on and then the MA documented on his eMAR.
-She did not know anything about documenting TED hose application on the residents' personal care sheet.
-Resident #6 "was probably taking off his TED hose after we left."

Interview with a PCA/MA on 08/22/18 at 9:37am revealed:
-Resident #6 was supposed to have on his TED hose because the third shift PCA put them on before she left.
-She did not check to see if Resident #6 was wearing his TED hose when she came on the floor.
-She did not check to see if Resident #6 took his TED hose off during the course of the day.
-She had not every put Resident #6's TED hose.

Interview with the Nurse Practitioner from the Resident #6's physician's office on 08/23/18 at 1:40pm revealed:
-She had seen Resident #6 on 08/11/18 for a routine check-up at the facility.
-She could not recall if Resident #6 was wearing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 276	Continued From page 107 his TED hose or if staff reported anything Resident #6 had not been wearing his TED hose during that visit. -It was her expectation for Resident #6 to wear his TED hose as ordered. -She did not think Resident #6 had the strength or coordination to put on or take off his TED with assistance. -If Resident #6 took off his TED hose, it was her expectation for staff to reapply the TED hose as soon possible.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the kitchen area was free of contamination including the dried food particles and black marks on the walls behind the dish washer, dark stains on the top and second shelf of the utility cart, dark stains on dish washer racks, dark stains on the floors and dark baked on material on the top of stove around the burners and inside of the all ovens including the oven hood switch area. The findings are: Observation of the facility kitchen area on 08/17/18 at 9:50am revealed: -The utility cart used to carry food and dishes had	D 282		

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
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 282	Continued From page 108	D 282		

brown and black stains on the upper and lower shelf.
-The dish and cups racks of the dishwasher had brown stains on all sides.
-The walls behind the dishwasher had dried food drips and many black marks on the walls.
-The doorway into the dining room had dark stains in the corners.
-The window sill over the sink had crumbs and white material on it.
-There was dried food drips on the window blind over the kitchen sink.
-The stove had dried black baked on material around three burners.
-The knobs on the stove and oven were sticky.
-The hood switch had brown sticky material on it.
-The inside of both ovens had black baked on material.
-The floor in front to the left of the oven had black sticky marks on the floor.
-The inside of the convection oven door had brown baked on material.
- The door sill between the walk-in refrigerator and freezer had black sticky material on it.
-The fan in the walk-in refrigerator had dust on it.

Interview with the cook on 08/17/18 at 10:00am revealed:
-There was a weekly cleaning schedule.
-There was no check off list for the weekly cleaning schedule.
-The dietary aide was supposed to wipe everything down in the kitchen daily and follow the cleaning schedule.
-The cook was responsible to ensure the cleaning schedule was followed.
-The floors in the kitchen were mopped daily.
-The floors are pressure washed every 1-2 months.
-He did not remember the date that the floors

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 282	Continued From page 109	D 282		

were pressure washed.
-The last time the kitchen was deep cleaned was 4 months ago but he did not remember the date.
-The stains on the utility cart will not come off.
-The convection oven has not been thoroughly cleaned for 6 months.

Interview with a second cook/dietary aide on 08/17/18 at 10:25am revealed:
-She was usually the cook, but today they needed her to be the dietary aide.
-She knew about the daily cleaning schedule.
-There was no check off for the cleaning schedule.
-"We just know what needs to be done, but not sure all the cleaning is done according to the schedule."
-She was not sure the last time the kitchen was deep cleaned.
-It was the cook's responsibility to be sure the cleaning schedule was followed.

Interview with the business office manager on 08/17/18 at 4:15pm revealed, the kitchen had the floors and baseboards pressure washed a few months ago but she did not remember the date.

Interview with the residential care coordinator (RCC) on 08/22/18 at 9:20am revealed:
-She supervised the kitchen staff.
-The cook should be sure the cleaning schedule was followed by the dietary staff.
-She went into the kitchen on 08/16/18 in the morning to address the cleaning schedule with the dietary aide and the dietary aide quit.
-She expected the kitchen staff to keep the kitchen clean and to follow the cleaning schedule.
-She tried to go into the kitchen 2 times a week to follow-up and check to see if the kitchen was clean.

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 282	Continued From page 110 -She could not remember the last date before 08/16/18 that she went into the kitchen to be sure the cleaning schedule was being followed.	D 282		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure that each resident had the opportunity to participate in activities that promoted and encouraged active involvement, socialization, and mental stimulation. The findings are: Observation during the initial tour of the facility on 08/16/18 revealed an activity calendar was posted on the wall across the hall from the activity room. Review of the posted activity calendar on 08/16/18 revealed: -There were 13 to 15.5 hours of weekly activity planned. -There was an arts and craft activity scheduled	D 315		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 315	Continued From page 111 for 1:30pm-3:00pm for 08/16/18. -There was a scheduled activity for 4:00pm on Tuesday of each week that did not include a stop time. -There was a birthday party scheduled for 2:30pm on 08/17/18 that did not include a stop time. -There was a movie day scheduled for 08/21/18 that did not include a start or stop time. Interview with the Resident Care Coordinator (RCC) on 08/16/18 at 10:53am revealed: -The facility had been without an activity director for about two months. -Everybody at the facility was "pretty much all pitching in" with activities. Interview with a resident on 08/16/18 at 12:15pm revealed: -The facility did not have an Activity Director. -He sat around and talked to friends. -Activities offered at the facility were bingo and crafts. -He did not remember going on an outing with the facility. -He went on outings with his family. Observation in the activity room on 08/16/18 at 1:30pm revealed: -There was one resident participating in a chess game with a visitor. -There were three residents sitting watching television. -There was no staff present in the activity room. -There were no arts and craft activity being provided. Confidential interview with a staff revealed: -The residents really did not have activities. -The residents played bingo maybe once or twice a month.	D 315		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 315	Continued From page 112 -Somebody came to the facility on Monday and Wednesday for church and someone came to the facility on Saturday to sing. -There was not an Activity Director at the facility since the last one left. -The facility had been without an Activity Director for three months. -There was nobody assigned to do activities. -Residents were aggressive because there was nothing to do. -A staff person (named) made out the activity calendar. -Residents only left the facility for doctor visits or when their family would take them out of the facility. -Staff did the shopping for the residents. -The residents did not ask about activities because they had gotten used to not doing anything. -Staff had to "beg" residents to participate in birthday parties because they had been without activities. -There were residents (two named) who used to participate in activities. Observation on 08/20/18 at 10:45am revealed: -The scheduled activity for 10:30am - 11:30am was stretching. -The activity room was empty. -There were no activities being provided. Observation of the activity room on 08/21/18 at 4:30pm revealed: -There were two people named on the activity calendar scheduled to come to the facility to provide an activity. -The activity room was empty. -There were no activities being offered. -There was one resident was sitting in the chair by the telephone outside the activity room.	D 315		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 315	Continued From page 113 -There was another resident was walking in the hallway where the activity room was located. Interview with the Business Office Manager (BOM) on 08/21/18 at 4:30pm revealed: -The scheduled activity for 08/21/18 at 4:00pm did not occur. -The persons (named) scheduled to conduct the activity did not come. -She did not know why they did not come to conduct the activity and they usually called. -She could not remember the last time the named persons (named) did not come to conduct the scheduled activity. Interview with Resident #8 on 08/21/18 at 4:35pm revealed he thought the two (2) people scheduled were residents who had birthdays. Interview with a second resident on 08/21/18 at 5:30pm revealed: -A [named] medication aide/supervisor (MA/Supervisor) did the activities. -There were arm exercises and leg exercises activities. -There was bingo activity at the facility "about every other week." -She could not remember the last time she had been on an outing. Interview with a third resident on 08/21/18 at 5:45pm revealed: -His activities consisted of visiting with others, playing cards, and "whatever we can think of, we keep ourselves occupied." -He sometimes went in the activity room and played games and colored, but did not do that too very often because there was no Activity Director. -He liked to go out back and have a smoke. -His family took him on outings.	D 315		

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	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 5 of 9 sampled residents were free from resident to resident altercations resulting in physical injuries (Residents #1, #4, #5, #7 and #8). The findings are: 1. Review of Resident #8's current FL-2 dated 12/29/17 revealed: -Diagnoses included chronic memory loss, cerebral infarction, chronic obstructive pulmonary disease, anxiety, hyperlipidemia, and hypertension. -Resident #8 was intermittently confused and ambulatory. Review of Resident #8's care plan dated 01/24/18 revealed Resident #8 was sometimes disoriented and forgetful (needed reminders). Review of Resident #8's emergency summary visit form dated 03/02/18 revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 115 -Resident #8 was brought by private vehicle for complaints of left shoulder and left hip pain. -Resident #8 reported that he was hit by another resident with her electric wheelchair. Interview with Resident #8 on 08/22/18 at 2:15pm revealed: -"It really upset" him that Resident #4 "had hit him several times with her electric wheelchair or the door of the smoking door." -Resident #4 had run over his left ankle at least two times. -Staff at the facility had warned Resident #4 to "be more careful with her wheelchair but it did not do any good." Interview with the Resident Care Coordinator (RCC) on 08/17/18 at 12:45pm revealed: -Resident #8 "had a right to be mad about Resident #4 hitting him with the smoking area door and wheelchair." -Staff had told Resident #4 several times not to kick the door open to avoid hitting other residents in the smoking area. Interview with Resident #4 on 08/20/18 at 10:55am revealed: -She did not kick open the door to the smoking area. -She had not used her wheelchair to intentional hurt any resident. -When she hit Resident #8 with the smoking area door, it was an accident because he was standing too close to the door when she came through it. Review of Resident #8's emergency summary visit form dated 06/12/18 revealed: -Resident #8 was brought in for medical evaluation following a physical altercation with another resident at the facility.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D 338	Continued From page 116	D 338		

-Resident #8 was complaining of head and neck pain due his head being hit on the concrete.
-Resident #8 presented with bilateral skin tears to both hands and right elbow.
-Resident had a history of a brain aneurysm.

Interview with Resident #8 on 08/22/18 at 2:15pm revealed:
-He really could not remember much about 06/12/18.
-He and Resident #7 were in the smoking area and they started arguing.
-Resident #7 "grabbed him by his shirt and they started fighting."
- Resident #7 "hit me in the back of my head; I hit him; somehow I tripped and hit my head on the ground."
-"We apologized to each other later."

Interview with Resident #7 on 08/23/18 at 10:40am revealed:
-A few weeks ago (the resident did not know the exact date) he and Resident #8 were involved in an argument and fight in the smoking area.
-Resident #8 walked over and hit Resident #7 because he was arguing with a female resident.
-He and Resident #8 started fighting and fell on the pavement.
-Resident #8 would not stop fighting so he (Resident #7) had to lock his legs around Resident #8's stomach so he could not breathe.
-Resident #8 finally gave up and quit fighting after about 30 seconds.
-He thought killing Resident #8 was the only way to stop him from fighting.
-Resident #8 was bleeding from his head and had to be transported to the ER.
-There were no staff in the smoking area during the fight.

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KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 117 Interview with the RCC on 08/22/18 at 10:45am revealed: -She could not recall the Resident #8 getting into an altercation with Resident #7 on 06/12/18. -She would have to review Resident #8's record for more information. Interview on 08/22/18 at 2:53pm with a personal care aide (PCA) who worked on first shift on 06/12/18 revealed: -He was unable to recall any altercation between Resident #8 and Resident #7 on 06/12/18. -Resident #8 "does not bother anyone unless he is provoked like if you call him 'ugly names'." Review of the facility incident/accident report for Resident #8 for 08/14/18 at 9:00pm revealed: -Resident #8 was standing out back (in the smoking area) when Resident #4 in an electric wheelchair threw open the back door and almost knocked him down. -Resident #8 got into a verbal altercation with Resident #4. -Resident #8 threw a small ashtray bucket and struck the Resident #4 on the back left side of the head. -Resident #8 reported his left ankle was hit by the Resident #4's electric wheelchair. Interview with Resident #8 on 08/22/18 at 2:15pm revealed: -Resident #8 admitted he was angry with Resident #4 on the evening of 08/14/18 because she ran over his left ankle with her electric wheelchair earlier that afternoon. -He did not report when Resident #4 ran over his ankle because he "had complained several times about it before to the RCC and it did not do any good." -"I was going to fix her so I unplugged the battery	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 118	D 338		

pack of her electric wheelchair" when we were in the smoking area.
- Resident #4 "called me some vulgar names and I got mad and I wanted to hit her; but I didn't."
-He "picked up the ashtray and threw it at the fan and the ashtray bounced off the fan and ended up hitting the headrest" of the Resident #4's electric wheelchair and the ash got into her hair.

Interview with Resident #4 on 08/20/18 at 10:55am revealed:
-She and Resident #8 were arguing in the smoking area when she was hit with the ash tray Resident #8 threw at her on 08/14/18.
-She could not remember what they were arguing about.
-She was upset because Resident #8 threw an ashtray and hit her in the back of head.
-The cigarette ashes got into her hair and clothes and that made her more upset.
-No staff was in the smoking area when Resident #8 threw the ashtray.

Interview with the RCC on 08/17/18 at 12:45pm revealed:
-She was aware of the altercation between Resident #8 and Resident #4 on 08/14/18.
-"It was hard to keep up with the residents when they went out to smoke because staff doesn't realize they are fussing until it is too late (fighting)."
-"We try to keep him (Resident #8) away from Resident #4 so they don't argue."
-When Resident #8 "gets mad staff tries to calm him down and give him a chance to cool down."

Refer to telephone interview with the Administrator on 08/22/18 at 4:55pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 119	D 338		

2. Review of Resident #4's current FL-2 dated 01/11/18 revealed diagnosis of healthcare acquired pneumonia (HCAP), acute on chronic diastolic heart failure, obstructive sleep apnea (OSA), morbid obesity, hypertension, decubitus ulcer left foot.

Interview with Resident #4 on 08/16/18 at 1:35pm revealed:
-She was hit in the head with an "ash tray" in the smoking area by a male resident (Resident #8) "the day before yesterday."
-She requested the police be notified.
-The supervisor would not call the police.
-The supervisor told her she could not go to the police station to complete the warrant.
-The supervisor did not tell her why she could not go to the police station to take out the warrant.
-The supervisor told her Resident #8 was "crazy", and "wouldn't do any good anyway."
-Resident #8 had attacked her previously 1 week ago in the smoking area by "slinging lemonade and ice" in her face.
-She felt safe as long as she kept away from Resident #8.
-She avoided Resident #8.

Second interview with Resident #4 on 08/16/18 at 5:15pm revealed:
-She and Resident #8 were arguing in the smoking area when she was hit with the ash tray.
-She did not remember what the argument was about.
-The ash tray was a metal pan used for cigarette butts.
-The bottom of the metal pan busted out when she was struck.
-There was no staff present when she was attacked.
-Resident # 8 was " ...sneaky. He don't let you

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 120	D 338		

know what he's gonna do he just does it."
-Three days ago Resident #8 kicked her left foot when walking by her.
-She did not report this incident to staff because "everytime I say anything to them about him they throw it back on me" and she interpreted that as the staff blamed her for the incidents.

Review of an incident report dated 08/14/18 for 9:00pm revealed:
-Resident #4 was going through a back door in her electric wheelchair when she almost knocked over Resident #8.
-At that time Resident #4 struck Resident #8 on the left ankle with her electric wheelchair.
-There was a verbal altercation and Resident #8 threw a small bucket used for an ashtray at Resident #4 striking her on the left side of her face by her ear.
-The incident report was signed by the shift SIC on 08/14/18.
-The incident report was signed by the medication aide (MA) supervisor on 08/15/18.

Interview with a MA/Supervisor on 08/20/18 at 4:05pm revealed:
-She did not witness the assault on Resident #4.
-The assault was not witnessed by staff.
-Resident #4 reported the assault to her on 08/14/18.
-She completed the incident report.
-Resident #4 told her she was going to call the police.
-She told Resident #4 "if that's what you feel like you need to do."
-Police were not notified.
-She did not know of a second assault on Resident #4 by Resident #8..

Interview with a second MA/Supervisor on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 121 08/17/18 at 9:49am revealed: -She worked Monday - Friday, on day shift, and some Saturdays when the Nurse Practitioner saw the residents at the facility. -She reviewed and signed the 08/14/18 incident report for Resident #4. -She did not know of any other altercations between Resident #4 and Resident #8. -The MA or MA/Supervisor on shift would complete the incident report if they witnessed it and make the contacts. -If the Personal Care Aide (PCA) witnessed the incident they would complete the incident report. -If the aggression or incident was not witnessed by staff the MA would complete the incident report. -She had training but could not remember the last time she had training on incidents and/or aggressive behaviors. -She could not "recall" what training "they" had. -Resident #8 was aggressive "at times, not every week." -Resident #4 may have "pushed him to the limit that day." -Resident #4 could be "very ugly and very rude, share some harsh words." Confidential interview with a staff member revealed: -The staff member "saw soot stains on the back of Resident #4's neck and head after Resident #8 had thrown the ash tray on 08/14/18. -"Ashes and soot stains were on Resident #4's electric wheelchair headrest too." -Resident #4 "complained" Resident #8 "had hit her in the back of the head with the ashtray." Interview with Resident #4 on 08/17/18 at 9:20am revealed: -Two hours before she was attacked on 08/14/18	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 122	D 338		

she went out the door to the smoking area in her electric wheelchair.
-The door opened on Resident #8 when she went outside.
-Resident #8 never told her why he threw the bucket at her.
-When she and Resident # 8 got in their "fights" he called her a "(expletive), bag lady, drug addict."
-She defended herself by "running my mouth."

Interview with a MA on 08/21/18 at 1:15pm revealed:
-Resident fighting was something that had recently started.
-There was nothing for the residents to do here.

Interview with a Personal Care Aide (PCA) on 08/22/18 at 2:45pm revealed:
-He had been instructed to "keep an eye" on Resident #4 and Resident #8.
-He had been instructed to use "coping skills" with Resident #4 and Resident #8.
-He had been instructed to "walk and talk with them."
-He had been instructed to contact the supervisor on his shift or the RCC to resolve any resident aggression.
-He had reported to the supervisor on his shift that Resident #4 may hurt someone while maneuvering in her wheelchair.
-He had reported to the RCC that Resident #4 may hurt someone while maneuvering in her wheelchair.
-He did not witness the incident between Resident #4 and Resident #8.

Interview with the RCC on 08/17/18 at 12:45pm revealed:
-She followed up on any resident incidents if they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 123	D 338		

were reported.
-She talked to the involved residents.
-If the involved resident was established with the psychiatrist she made certain that resident followed-up with the psychiatrist.
-There was one resident who kept causing "a lot of incidents by running her mouth."
-She would not say who the resident was that kept causing "a lot of incidents by running her mouth."
-Staff did not realize residents argued until it was too late.
-She knew of the incident between Resident #4 and Resident #8.
-Most of the issues were verbal.
-Resident #4 "goes out the smoking door wide open" in her electric wheelchair.
-She had spoken with Resident #4 that if she continued to go out of the smoking door wide open she may not be able to keep her electric wheelchair.

Telephone interview with the Administrator on 08/22/18 at 4:16pm revealed:
-She knew of an incident regarding a resident hurting another resident with the door while going in the smoking area.
-The "issue was addressed" by the RCC speaking with the involved residents.
-She took notes and re-evaluated a problem either on the phone or in the building when a problem was discussed.

Refer to telephone interview with the Administrator on 08/22/18 at 4:55pm.
3. Review of Resident #5's current FL-2 dated 12/11/17 revealed diagnoses of cerebrovascular disease, muscle weakness, anxiety disorder and a communicable disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 124 Review of Resident #5's care plan dated 01/05/18 revealed: -The resident was sometimes disoriented, had limited range of motion, limited strength and only ambulated with wheelchair. -The resident required extensive assistance with transfers and was wheelchair bound. Review of an Incident/Accident Report dated 07/11/18 revealed: -Resident #5 and another resident were trying to go out of the door at the same time. -Resident #5 punched the other resident and the other resident hit him back. -Resident #5 sustained "a knot" on the right side of his head. -Staff called emergency medical service (EMS) and was transported to the hospital and came back with no complaints. Review of an Resident #5's emergency room (ER) report from the local ER dated 07/11/18 revealed: -Resident #5 arrived by EMS with complaint of head injury after being punched by another resident. -The resident and another resident were trying to go through a doorway at the same time and Resident #5 punched the other resident. The other resident punched him back. -Resident #5 had visible swelling to mid forehead (5cm hematoma) and complained of headache. -A CT scan of the resident's head was completed and there was no acute intracranial hemorrhage. -The resident was discharged back to the facility. Interview with Resident #5 on 8/17/18 at 10:05 revealed: -He was involved in a confrontation with Resident #1 about a month ago.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 125	D 338		

-Both residents were trying to go out the door to the smoking area at the same time and they started "throwing punches".
-Resident #1 hit Resident #5 on his forehead and continued to hit him very hard several times on the same spot until the area was swollen and painful. The staff eventually stopped him from hitting Resident #5..
-Staff called EMS and Resident #5 was transported to the local ER and evaluated for head injuries.
-The painful hematoma on Resident #5's head remained for several days.
-Resident #5 blamed himself for the incident because he hit Resident #1 first.
-The Administrator has never talked to Resident #5 about the incident.

Interview with a personal care aide (PCA) on 08/17/18 at 9:45am revealed:
-Resident #5 had a fight with Resident #1 about a month ago.
-Resident #5 had a "knot" on his forehead that remained for several days.
-The PCA was not concerned about the altercation because both of them were "grown men" and they settled their differences.

Interview with the supervisor on 08/17/18 at 10:15am revealed:
-Resident #5 and Resident #1 were coming inside from smoking area and both were trying to come through the door at the same time.
-Resident #1 told Resident #5 he was moving too slow and pushed his wheelchair.
-Resident #5 hit Resident #1 and Resident #1 hit Resident #5 repeatedly on his forehead and caused a big hematoma the size of an apple on his forehead.
-Staff separated the residents and Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 126	D 338		

went to his room. Resident #5 was transported to the ER for evaluation.

Interview with the Resident Care Coordinator (RCC) on 08/21/18 at 4:10pm revealed:
-She knew of the fight Residents' #5 and #1 had about a month ago while both were trying to roll their wheelchairs through the door from the smoking area at the same time.
-She did not follow-up with the residents about the fight because they had worked out their differences and Resident #5 had apologized to Resident #1.

Interview with Resident #5's primary care provider (PCP) on 8/22/18 at 12:50pm revealed:
-She knew Resident #5 had a dispute with another resident about a month ago.
-She talked with Resident #5 about fighting not appropriate in the facility.

Refer to telephone interview with the Administrator on 08/22/18 at 4:55pm.

4. Review of Resident #7's FL-2 dated 07/14/18 revealed diagnoses included anxiety disorder and history of alcohol abuse.

Review of Resident #7's Psychiatric Evaluation report dated 7/31/18 revealed a diagnosis of bipolar affective with mania.

Interview with the supervisor on 08/17/18 at 10:15 am revealed:
-Resident #7 and #8 got into a confrontation last month (July 2018).
-She did not know what happened but Resident #7 had a black eye and Resident #8 was transported to the emergency room (ER) for evaluation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 127 -She did not know what they were fighting about but Resident #7 apologized to Resident #8. Interview with a personal care aide (PCA) on 08/17/18 at 9:45am revealed: -Last month Residents' #7 and #8 were in the smoking area and got into a "scuffle". -Resident #7 was cussing at a female resident and Resident #8 was defending the female resident. Interview with Resident #7 on 08/23/18 at 9:20am revealed: -A few weeks ago (the resident did not know the exact date) he and Resident #8 were involved in an argument and fight in the smoking area that could have been avoided. -Resident #7 and a female resident were arguing and the female resident slapped him. Resident #8 walked over and hit Resident #7. -The two residents started fighting and both of them fell to the pavement. Resident #7 locked his legs around Resident #8's abdomen and squeezed him until he could hardly breathe. -Resident #7 kept squeezing him (20-30 seconds) until he said he was going to quit. -He would have kept him in that leg lock until he died if he not stated he would quit because at that time he thought killing Resident #8 was the only way to stop him from fighting. -At the time of the fight Resident #7 wanted to kill Resident #8. -Resident #8 was bleeding from his head and had to be transported to the ER. -He felt bad about the fight and Resident #8's head injury because Resident #8 had an aneurysm in the past. -There were no staff in the smoking area during the fight.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 128	D 338		

Refer to telephone interview with the Administrator on 08/22/18 at 4:55pm.
5. Review of Resident #1's current FL-2 dated 05/10/18 revealed:
-Diagnoses included morbid obesity, chronic obstructive pulmonary disease, diabetes mellitus, acute encephalopathy, history of deep vein thrombosis, alcohol abuse, and congestive heart failure.
-He was semi-ambulatory.

Review of the Resident #1's Care Plan dated 11/21/17 revealed:
-He used a wheelchair for mobility.
-He could "become agitated and verbally abusive to staff and other residents."

Review of an incident report dated 07/11/18 at 7:30pm revealed:
-Resident #1 was punched by Resident #5 when he was trying to get out a door.
-The resident got a busted lip on the left side.

Interview with a Medication Aide (MA) on 08/17/18 at 8:55am revealed:
-She had never heard any residents say they were afraid of another resident.
-There were some residents at the facility that argued with each other.

Interview with a Personal Care Aide (PCA) on 08/17/18 at 9:45am revealed:
-Resident #1 and Resident #5 had a fight about a month ago.
-Resident #5 had a "knot" on his forehead that remained for several days.
-The PCA was not concerned about the altercation because both of them were "grown men" and they settled their differences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 129 Interview with the Supervisor on 08/17/18 at 10:15am revealed: -Resident #1 and Resident #5 were coming inside from the smoking area and both were trying to come through the door at the same time. -Resident #1 told Resident #5 he was moving too slow and pushed his wheelchair. -Resident #5 hit Resident #1 and Resident #1 hit Resident #5 repeatedly on his forehead and caused a big hematoma the size of an apple. -Staff separated the residents and Resident #1 went to his room. Resident #5 was transported to the emergency room for evaluation. Interview with the Resident Care Coordinator (RCC) on 08/17/18 at 1:00pm revealed: -She knew Resident #1 had exhibited aggressive behaviors. -Most of Resident #1's behaviors were exhibited verbally. -She tried to talk to the resident when behaviors were displayed. Interview with the RCC on 08/21/18 at 4:10pm revealed: -She knew of the fight between Resident #1 and Resident #5 that happened about a month ago when both residents were trying to roll their wheelchairs through the door from the smoking area at the same time. -She did not follow-up with the residents about the fight because they had worked out their differences and Resident #5 had apologized to Resident #1. Refer to telephone interview with the Administrator on 08/22/18 at 4:55pm. Attempted interview with Resident #1 on 08/24/18 at 10:18am revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 130 -Resident #1 did not want to talk about the 07/11/18 incident. -He declined to be interviewed. _____ Telephone interview with the Administrator on 08/22/18 at 4:55pm revealed: -She was aware of a "few" incidents involving resident altercations. -One of the incidents she was aware of involved a resident who got mad when going out to smoke. -The RCC and BOM were her contacts most of the time. -When she was at the facility, she looked at things and discussed them. -The RCC and BOM were her "eyes and ears when I'm not there." -If there was something she had talked about with the RCC and BOM, she tried to be sure to follow up with the RCC and BOM either when on the telephone or in the facility. -Staff called her "most time" to make her aware. _____ The facility failed to assure each resident was protected from resident to resident altercations resulting in Resident #5 who sustained a head injury and hematoma to his forehead; and Resident #8 (with a history of a brain aneurysm) who sustained a head injury, neck pain, and skin tears to his right elbow and bilateral hands. The facility's failure placed the residents at substantial physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/17/2018 for this violation. THE CORRECTION DATE FOR THIS TYPE A2	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 131 VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2018.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure insulin was administered as ordered to 1 of 1 resident (#1) sampled with an order for Novolog sliding scale insulin. The findings are: Review of Resident #1's current hospital generated FL-2 dated 05/10/18 revealed: -Diagnoses included chronic obstructive pulmonary disease, hypoxemic respiratory failure chronic, acute encephalopathy, diabetes mellitus, history of deep vein thrombosis, congestive heart failure, and morbid obesity. -There was a physician's order for Novolog 30 units three times daily before meals. -There was a physician's order for Novolog per sliding scale three times a day with meals. -There was no sliding scale parameters provided.	D 358		

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D 358	Continued From page 132 Review of medication clarification physician's order dated 05/10/18 for Resident #1 revealed: -There was a physician's order for finger stick blood sugar (FSBS) checks four times a day before meals and at bedtime. -There was a physician's order for Novolog Injection Flexpen, check blood glucose before meals, sliding scale parameters of 150-170=1 unit, 171-190=2 units, 191-210=3 units, 211-230=4 units, 231-250=5 units, 251-270=6 units, 271-290=7 units, 291-310=8 units, 311-330=9 units, 331-350=10 units, 351-370=11 units, 371-400=12 units and call doctor. Review of a subsequent physician's order dated 07/14/18 for Resident #1 revealed: -There was a physician's order for finger stick blood sugar checks before meals and at bedtime, and notify the doctor if greater than 500 or less than 80 with scheduled hours for the blood sugar checks of 7:30am, 11:30am, 5:30pm, and 8:00pm. -There was a physician's order continuing Novolog Injection Flexpen, check blood glucose before meals, sliding scale parameters of 150-170=1 unit, 171-190=2 units, 191-210=3 units, 211-230=4 units, 231-250=5 units, 251-270=6 units, 271-290=7 units, 291-310=8 units, 311-330=9 units, 331-350=10 units, 351-370=11 units, 371-400=12 units and call doctor. -There were scheduled hours of 7:30am, 11:30am, and 4:30pm for the blood glucose checks before meals. Interview with the Resident Care Coordinator (RCC) on 08/16/18 at 11:05am revealed resident meals were breakfast at 8:00am, lunch at 12:00noon, and supper at 6:00pm.	D 358		

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D 358	Continued From page 133	D 358		

Review of the June 2018 blood sugar flowsheet for Resident #1 revealed there were four times when the medication aides (MAs) documented administering the Novolog sliding scale insulin (SSI) at 8:00pm when the SSI was not ordered for administration according to the 05/10/18 physician's order as follows:
-On 06/02/18 at 8pm, Resident #1's FSBS reading was documented as 465. The MA documented administration of Novolog 12 units.
-On 06/03/18 at 8pm, Resident #1's FSBS reading was documented as 422. The MA documented administration of Novolog 12 units.
-On 06/08/18 at 8pm, Resident #1's FSBS reading was documented as 344. The MA documented administration of Novolog 10 units.
-On 06/17/18 at 8pm, Resident #1's FSBS reading was documented as 191. The MA documented administration of Novolog 2 units.

Continued review of the June 2018 blood sugar flowsheet for Resident #1 revealed there were four times when Resident #1's FSBS results required SSI administration and no SSI was administered as follows:
-On 06/09/18 at 11:30am, Resident #1's FSBS reading was documented as 240. Resident #1 should have been administered Novolog 5 units.
-On 06/11/18 at 7:30am, Resident #1's FSBS reading was documented as 150. Resident #1 should have been administered Novolog 1 unit.
-On 06/16/18 at 5:30pm, Resident #1's FSBS reading was documented as 155. Resident #1 should have been administered Novolog 1 unit.
-On 06/23/18 at 5:30pm, Resident #1's FSBS reading was documented as 160. Resident #1 should have been administered Novolog 1 unit.
-On 06/24/18 at 5:30pm, Resident #1's FSBS reading was documented as 170. Resident #1 should have been administered Novolog 1 unit.

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D 358	Continued From page 134 Review of the July 2018 blood sugar flowsheet for Resident #1 revealed there were seven times when the MAs documented administering the Novolog sliding scale insulin (SSI) at 8:00pm when the SSI was not ordered for administration according to the 05/10/18 physician's order as follows: -On 07/01/18 at 8pm, Resident #1's FSBS reading was documented as 140. The MA documented administration of Novolog 2 units. -On 07/07/18 at 8pm, Resident #1's FSBS reading was documented as 181. The MA documented administration of Novolog 2 units. -On 07/15/18 at 8pm, Resident #1's FSBS reading was documented as 225. The MA documented administration of Novolog 4 units. -On 07/20/18 at 8pm, Resident #1's FSBS reading was documented as 192. The MA documented administration of Novolog 3 units. -On 07/27/18 at 8pm, Resident #1's FSBS reading was documented as 328. The MA documented administration of Novolog 9 units. -On 07/28/18 at 8pm, Resident #1's FSBS reading was documented as 246. The MA documented administration of Novolog 5 units. -On 07/29/18 at 8pm, Resident #1's FSBS reading was documented as 222. The MA documented administration of Novolog 4 units. Continued review of the July 2018 blood sugar flow sheet for Resident #1 revealed there were five times when Resident #1's FSBS results required SSI administration and no Novolog insulin or an incorrect amount of Novolog insulin was administered as follows: -On 07/02/18 at 5:30pm, Resident #1's FSBS reading was documented as 164. Resident #1 should have been administered Novolog 1 unit. There was no documentation for administration of	D 358		

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D 358	Continued From page 135	D 358		

Novolog insulin.
-On 07/06/18 at 5:30pm, Resident #1's FSBS reading was documented as 205. The MA documented administration for Novolog insulin 2 units. Resident #1 should have been administered Novolog 3 units.
-On 07/11/18 at 5:30pm, Resident #1's FSBS reading was documented as 180. Resident #1 should have been administered Novolog 2 units. There was no documentation for administration of Novolog insulin.
-On 07/14/18 at 11:30am, Resident #1's FSBS reading was documented as 210. Resident #1 should have been administered Novolog 3 units. The MA documented administration for Novolog insulin 4 units.
-On 07/15/18 at 5:30pm, Resident #1's FSBS reading was documented as 234. Resident #1 should have been administered Novolog 5 units. The MA documented administration for Novolog insulin 4 units.

Review of the August 2018 blood sugar flow sheet for Resident #1 revealed there were four times when the MAs documented administering the Novolog sliding scale insulin (SSI) at 8:00pm when the SSI was not ordered for administration according to the 05/10/18 physician's order as follows:
-On 08/10/18 at 8pm, Resident #1's FSBS reading was documented as 215. The MA documented administration of Novolog 4 units.
-On 08/12/18 at 8pm, Resident #1's FSBS reading was documented as 228. The MA documented administration of Novolog 4 units.
-On 08/17/18 at 8pm, Resident #1's FSBS reading was documented as 172. The MA documented administration of Novolog 2 units.

Continued review of the August 2018 blood sugar

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D 358	Continued From page 136	D 358		

flow sheet for Resident #1 revealed there were four times when Resident #1's FSBS results required SSI administration and no Novolog insulin or an incorrect amount of Novolog insulin was documented as administered as follows:
-On 08/04/18 at 5:30pm, Resident #1's FSBS reading was documented as 172. Resident #1 should have been administered Novolog 2 units.
-On 08/05/18 at 11:30am, Resident #1's FSBS reading was documented as 279. Resident #1 should have been administered Novolog 7 units. The MA documented administration for Novolog 6 units.
-On 08/06/18 at 7:30am, Resident #1's FSBS reading was documented as 250. Resident #1 should have been administered Novolog 5 units.

Interview with a MA on 08/17/18 at 8:55am revealed:
-Resident #1's FSBS was checked four times a day.
-Resident #1 was on scheduled insulin and sliding scale insulin.
-Resident #1 was administered Novolog insulin per sliding scale before meals.
-She administered medications according to the electronic Medication Administration Records.

Interview with Resident #1 on 08/16/18 at 5:10pm revealed:
-He was administered medication three times a day.
-He was not told what all his medications were prescribed for.
-He was diabetic.
-He was administered insulin three times a day.
-His blood sugar ran "up and down, depends on how much sweets I eat, not supposed to have sweets, I get it when I can get it."

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D 358	Continued From page 137 Telephone interview with the Nurse Practitioner (NP) on 08/22/18 at 12:45pm revealed: -Resident #1 was being followed by an Endocrinologist for his diabetes. -She reviewed his blood sugar flow sheets when she saw him during her visits at the facility. -She had adjusted Resident #1's medication due to reported finger stick blood sugar results, but not recently. -Resident #1 was on a sliding scale insulin.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Hot water temperatures, personal care assistance, supervision of residents, health care referral and follow-up, and health care implementation of orders. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure the hot water	D912		

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D912	Continued From page 138 temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 6 of 10 water fixtures including sinks, tub and shower in the residents' bathrooms on the 100 and 200 Hall and the common tub room on the 100 Hall.[Tag 311, 10A NCAC 13F .0305 Physical Environment (Type A2 Violation)]. 2. Based on observations, record reviews and interviews, the facility failed to assure physician notification for 4 of 7 sampled residents resulting in multiple areas of skin breakdown (Resident #4), The development of an infected stage III decubitus (Resident #5), a delay in receiving treatment for an abdominal injury after a fall (Resident #1) who fell, and refusal of personal care and baths (Resident #3). [Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents are free of neglect and in compliance with federal and state laws and rules and regulations related to physical altercations, personal care and supervision. The findings are:	D914		

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D914	Continued From page 139 1. Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 5 of 6 sampled residents (Residents #1, 2, 4, 5, and 6) for a resident who had left-sided paralysis and not provided bathing/showers or nail care (#5); not provided adequate personal hygiene and bathing/showers to a resident with pressure ulcers (#4); not provided transfer and toileting assistance resulting in falls (#1); not provided personal care of bathing/showering, shaving and nail care (#2). [Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)]. 2.Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for 6 of 9 sampled residents (#1, #3, #5, #7, #8 and #9), related to residents fighting in the smoking area and sustained injuries; a resident with known history of aggressive behaviors resulitng in two altercations with other residents resulting in a head injury (#8); a resident hitting another resident (#5) in the head causing injury; a resident locked his legs around another resident's abdomen in the smoking area until he could not breathe (#7); a resident smoking in the facility (#9); a resident with known agitation, who was verbally and physically abusive to other residents, caused injuries to another resident (#1); and a resident with dementia wandering outside the facility unsupervised (#3). [Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 3.Based on observations, interviews, and record reviews, the facility failed to assure 5 of 9 sampled residents were free from resident to resident altercations resulting in physical injuries (Residents #1, #4, #5, #7 and #8). [Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A2	D914		

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D914	Continued From page 140 Violation)]. 4.Based on observations, interviews, and record reviews, the Administrator, who was responsible for the total operation of the facility, failed to assure policies and procedures were implemented and in substantial compliance with the rules and statutes governing adult care homes as related to other requirements, personal care and supervision, health care, and residents' rights. [Tag 980, G.S. 131D-25 Implementation (Type A1 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator, who was responsible for the total operation of the facility, failed to assure policies and procedures were implemented and in substantial compliance with the rules and statutes governing adult care homes as related to other requirements, personal care and supervision, health care, and residents' rights. The findings are:	D980		

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D980	Continued From page 141 Interview with the Business Office Manager (BOM) on 08/16/18 at 10:45am revealed: -The facility census was 38 residents. -The Administrator was not in the facility today (08/16/18). -The Administrator came to the facility once a week. -The facility staff communicated with the Administrator by telephone. -The Resident Care Coordinator (RCC) was in charge. -The facility did not have a dietary manager. Confidential interviews with three staff revealed: -Staff saw the Administrator in the facility every week. -Staff reported concerns to the RCC's assistant who then reported to the RCC. -Staff reported to the RCC who "more than likely makes final decision." -The Administrator was usually in the office with the BOM and RCC when she was at the facility. -Staff hardly saw the Administrator/Owner interacting with residents. -Staff did not know if the Administrator/Owner knew some of the staff by name. -The BOM was "normally" the only person that could be found. -The RCC may not be in the building all the time. -A staff did not really know who was in charge. Confidential resident interview revealed: -Staff were "lazy about things" sometimes. -The resident went to the medication aides if something was needed, and usually got it "if they got time." -Sometimes staff were talking on their cellular phones and would say "wait til I get through." -The resident could not talk to the RCC about the "establishment" because the RCC did not want to	D980		

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D980	Continued From page 142 listen. -The RCC might come in to the facility around "9, 10, or 11. She gets off usually 4. Out of here by 3:30pm." -The RCC stayed at the facility until 7pm when the Owner was in the facility. -The Owner/Administrator was at the facility until around 7pm. Telephone interview with the Administrator on 08/22/18 at 4:55pm revealed: -She was aware of a "few" incidents involving resident altercations. -One of the incidents she was aware of involved a resident who got mad when going out to smoke. -The RCC and BOM were her contacts most of the time. -When she was at the facility, she looked at things and discussed them. -The RCC and BOM were her "eyes and ears when I'm not there." -If there was something she had talked about with the RCC and BOM, she tried to be sure to follow up with the RCC and BOM either when on the telephone or in the facility. -Staff called her "most time" to make her aware. Interview with the RCC on 08/23/18 at 5:55pm revealed: -She was not aware residents were not being properly cleaned when incontinent care was provided. -The supervisors were responsible to make sure personal care aides (PCA) were performing the job duties. -The supervisors were supposed to watch and observe the PCAs. Non-compliance was identified at violation level in the following rule areas:	D980		

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D980	Continued From page 143 1. Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 5 of 6 sampled residents (Residents #1, 2, 4, 5, and 6) for a resident who had left-sided paralysis and not provided bathing/showers or nail care (#5); not provided adequate personal hygiene and bathing/showers to a resident with pressure ulcers (#4); not provided transfer and toileting assistance resulting in falls (#1); not provided personal care of bathing/showering, shavibg and nail care (#2). [Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)]. 2.Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for 6 of 9 sampled residents (#1, #3, #5, #7, #8 and #9), related to residents fighting in the smoking area and sustained injuries; a resident with known history of aggressive behaviors resulitng in two altercations with other residents resulting in a head injury (#8); a resident hitting another resident (#5) in the head causing injury; a resident locked his legs around another resident's abdomen in the smoking area until he could not breathe (#7); a resident smoking in the facility (#9); a resident with known agitation, who was verbally and physically abusive to other residents, caused injuries to another resident (#1); and a resident with dementia wandering outside the facility unsupervised (#3). [Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 3.Based on observations, interviews, and record reviews, the facility failed to assure 5 of 9 sampled residents were free from resident to resident altercations resulting in physical injuries (Residents #1, #4, #5, #7 and #8). [Tag 338, 10A	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINSTON ASSISTED LIVING	2130 ROSE VISTA ROAD KINSTON, NC 28504

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D980	Continued From page 144 NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 4.Based on observations, interviews and record reviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 6 of 10 water fixtures including sinks, tub and shower in the residents' bathrooms on the 100 and 200 Hall and the common tub room on the 100 Hall.[Tag 311, 10A NCAC 13F .0305 Physicial Environment (Type A2 Violation)]. 5. Based on observations, record reviews and interviews, the facility failed to assure physician notification for 4 of 7 sampled residents (Resident #4 who developed skin breakdown in multiple areas, Resident #5 who developed a pressure ulcer, Resident #1 who fell and substained an abdomen wound, and Resident #3 who refused personal care and baths). [Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. _____ The Administrator failed to assure hot water temperatures were maintained between 100-116 degrees Fahrenheit (F) in 6 of 10 water fixtures sampled resulting in hot water temperatures ranging from 118-130 degrees F at fixtures used by residentw; failed to assure supervision was provided resulting in altercations between residents in the smoking area, a resident with dementia (#3) wandering unsupervised outside of the facility, and Resident #9 smoking inside the facility; failed to protect 5 of 9 sampled residents (Residents #1, #4, #5, #7 and #8) from resident to resident altercations resulting in injuries and/or hospital evaluation; failed to assure personal care was provided for 4 of 6 sampled residents (Residents #1, 4, 5, and 6) resulting in Resident #5 not being turned and repositioned resulting in	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054062	A. BUILDING: _____ B. WING _____	08/24/2018

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D980	Continued From page 145 a pressure ulcer, Resident #4 developing a pressure ulcer after not being provided adequate personal care, and Resident #1 not being provided assistance with transfers and toileting resulting in falls with injury; and failed to assure 4 of 7 sampled residents (#4, #5, #1, and #3) received acute and routine health care services resulting in Resident #5 developing a stage III decubitus ulcer, infection, and a delay in treatment requiring antibiotic treatment and delay in Resident #1 receiving treatment for an abdominal wound. The Administrator's failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/22/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2018.	D980		