Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060077	A. BUILDING: _____ B. WING _____	R 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

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{D 000}	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow-up survey and a complaint investigaton 04/23/19-04/25/19.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 violation was not abated. Based on observations, interviews and record reviews, the facility failed to assure physician notification for 4 of 7 sampled residents related to a missed appointment to the orthopedic practice after sustaining a fall requiring a total left hip replacement (Resident #1), symptoms of a urinary tract infection and abdominal pain (Resident #2), not notifying the physician of missed neurological appointments resulting in a delay in treatment and a four day hospitalization (Resident #5), and regarding a delayed urology consult (Resident #6). The findings are:	{D 273}		

Reviewed and accepted. Jay Reynolds 7/1/19

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{D 273}	Continued From page 1 1. Review of Resident #2's current FL-2 dated 01/16/19 revealed diagnoses included a history of transient ischemic attack, low tension glaucoma, hypertension, diabetes mellitus, hiatal hernia, neurocognitive deficit, and depression. Review of Resident #2's facility computer generated progress notes from April 2019 revealed: -On 04/14/19, Resident #2 was unable to help with her activities of daily living. She showed signs of great confusion and was unable to answer simple questions. EMS was called for Resident #2 and stated they believed Resident #2 was dehydrated with a possible urinary tract infection. -On 04/15/19, the facility received a telephone call from a registered nurse from a local hospital that Resident #2 needed to return to the hospital to be treated for a staph infection and C-diff. The medic was called to transport resident back to the hospital. Interview with the lead supervisor on 04/24/19 at 1:35pm revealed: -She had Resident #2 sent out to the Emergency Room on 04/14/19 to be sent out for evaluation. -Resident #2 was "completely out of it" and could not respond to questions, and she did not know her name or where she was. -Resident #2 could not get up or move, she was "dead weight", it took herself and three additional staff members to get her up. -Resident #2 was screaming because she could not go to the bathroom, and she kept saying her stomach was hurting badly. -Resident #2 told staff not to touch her because her stomach hurt. -The supervisor thought Resident #2 had a	{D 273}		

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{D 273}	Continued From page 2 urinary tract infection because Resident #2 had a strong pungent musty urine odor while assisting other staff with changing her brief. -The supervisor was never informed by any staff Resident #2 had complained about vaginal itching or had a strong urine odor. -Resident #2 returned to the facility, but the hospital called on 04/15/19 requesting the resident return immediately to the hospital because she needed IV antibiotics for an infection. -As of 04/24/19, Resident #2 remained in the hospital. Review of hospital records for Resident #2 dated 04/15/19 revealed: -Resident #2 was seen in the hospital on 04/14/19 for altered mental status and generalized weakness and was diagnosed with a urinary tract infection. -On 04/14/19, Resident #2 was noted to be febrile (fever) to 100.6 rectally, she was normotensive (having a normal blood pressure) and not tachycardic (having a fast heart rate). -Resident #2 had a positive blood culture growing gram-positive cocci clusters which led the hospital to call the facility for Resident #2 to return to the hospital. -Resident #2 verbalized some abdominal pain, but she was unable to localize the pain. -A computed tomography (CT) scan of the abdomen and pelvis was and results completed showed rectal fecal distention. -Resident #2 was treated with Rocephin (used to treat infection), 1 dose of Diflucan (used to treat and prevent fungal infections) for funguria, IV fluids, and to relieve constipation. -Resident #2 was admitted to the hospital for observation until confirmation of medical contamination diagnoses of positive blood culture	{D 273}		

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{D 273}	Continued From page 3 for a blood infection. Review of hospital records for Resident #2 dated 04/20/19 revealed: -Resident #2 had a difficult urinary catheter placement. -Resident #2 had fecal impaction upon admission with a huge rectal distension. -She had a repeat x-ray of the abdomen that included the kidneys, ureters, and urinary that continued to show concerns of impaction. -Resident #2 had not urinated on 04/20/19 and had more than 500cc urine showing on the bladder scan. -Resident #2 appeared to have a bladder prolapse out of the urethra. -Resident #2's urine looked like purulent (consisting of, containing or discharging pus). -The nurse's note documented "her urine looks like milk." -The rectal exam documented soft stool with almost no rectal tone. -Resident #2 continued to have abdominal discomfort and was not eating much. -Resident #2 could not hold a suppository or enema due to her rectal tone. Review of hospital records for Resident #2 dated 04/22/19 revealed: -Resident #2 had funguria-candida albicans-frank (milky-urine) from her catheter and was started on fluconazole (used to treat and prevent fungal infections). -Resident #2 continued to have severe rectal distension/impactions on the scan. -Resident #2 was started on lactulose (a medication used to treat constipation). -Resident #2 was scheduled for gastrografin enema (x-ray of the large intestine that included the colon and rectum; and also used to relieve	{D 273}		

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{D 273}	Continued From page 4 constipation.) -Resident #2 may need gastroenterologist consult for manual removal of her impaction according to the general surgeon. Interview with a personal care aide (PCA) on 04/24/19 at 1:59pm revealed: -Resident #2 was described as "being out of it" on 04/14/19. -On 04/14/19, Resident #2 was in the hallway slumped over in her wheelchair, she kept repeating "my stomach was hurting really bad," she could not hold her head up or move her legs. -Resident #2 was barely eating or drinking for the last two weeks prior to hospitalization, staff had started feeding her. -Resident #2 was unable to pick up her spoon to feed herself. -Resident #2 could not stand up, and Resident #2 required 3 to 4 people to change her. -Resident #2 didn't have an odor, but she was always itching in the vaginal area. -She reported the vaginal itching to the previous Resident Care Coordinator (RCC) in March 2019, who stated she would check on Resident #2. -Resident #2 had complained about the vaginal itching for approximately 3 weeks or longer prior to being hospitalized. -When the previous RCC did not respond to concerns about Resident #2's vaginal itching, she reported the concerns to the Director of Resident Care (DRC). -The DRC stated that she would inform the PCP. -Resident #2 had some redness and was always scratching in the vaginal area. -She only observed a clear white discharge once during perineal care. -She had applied cream to Resident #2's vaginal area and used regular baby powder.	{D 273}		

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{D 273}	Continued From page 5 Interview with a second PCA on 04/24/19 at 2:20pm revealed: -Resident #2 became total care because she had stopped walking and could not do anything with her hands. -It took about 4 staff to get Resident #2 up, or she "would just fall." -She noticed when she showered Resident #2 she always had a "bad odor" that smelled like "old folks pee and poop." -Anytime Resident #2's brief was taken off, she would scratch herself so hard the resident would say "it burns." -Sometimes Resident #2 scratched so hard she bled. -Resident #2 would say "the water makes me feel better." -She never reported this itching to the RCC or the DRC. -She had never used a cream on Resident #2, but she had asked the medication aide (MA) about a cream to help with vaginal itching. -She was never given a cream to use on Resident #2. Interview with a MA on 04/24/19 at 2:45pm revealed: -Resident #2 required 2 or more people assistance to transfer. -She was incontinent of bowel and bladder. -The odor from Resident #2 was hard to describe. -She was never told by staff Resident #2 was scratching or itching in the vaginal area. -Resident #2 had a urinary tract infection "a couple months ago" and was treated with an antibiotic. -She was not sure why Resident #2 went to the hospital. -Resident #2 was still in the hospital.	{D 273}		

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{D 273}	Continued From page 6 Interview with another MA on 04/25/19 at 3:30pm revealed: -No staff had ever reported to her Resident #2 had vaginal itching. -Resident #2 had a urine odor like she needed to be changed. -She never reported to anyone Resident #2's condition. -She had observed Resident #2 required a lot of help prior to being admitted to the hospital. Interview with the DRC on 4/24/19 at 3:23pm revealed: -Resident #2 was a 2 person assist, and she required assistance with feeding. -Resident #2 had dementia. -Resident #2 was incontinent of bowel and bladder. -Resident #2 had become non-ambulatory. -She did not know Resident #2 had a urine odor. -Resident #2 was in and out of the hospital due to falls and a urinary tract infection "a couple months ago". -The DRC did not recall anyone reporting Resident #2 had vaginal itching or scratching so hard she would bleed. Telephone interview with the primary care provider on 04/24/19 at 4:00pm revealed: -He was aware Resident #2 had vaginal itching in March 2019 when he treated her with a one time dose of Diflucan. -He was never informed Resident #2 continued to have problems with vaginal itching or scratching. -He recently wrote an order for Resident #2 to be referred to Hospice. -He had noticed a change with Resident #2 over the last 2 months. -He was not aware that Resident #2 was currently in the hospital.	{D 273}		

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{D 273}	Continued From page 7 -When asked if he knew Resident #2 was being treated in the hospital for funguria-candida albicans-frank, "milky urine" and severe rectal impact, he responded, "Oh wow, that's not good." Telephone interview with the family member of Resident #2 on 04/24/19 at 4:30pm revealed: - Resident #2 was in the hospital because "something was in her system." -She was not able to clearly explain Resident #2's health issues. Further review of Resident #2's record revealed: -There was no documentation of Resident #2 having vaginal itching since March of 2019. -There was no documentation Resident #2 had problems with being constipated. Interview with the Administrator on 04/24/19 at 3:50pm revealed: -He had observed a slight change with Resident #2, but the change was not drastic. -Resident #2 did require some assistance with feeding. -He did know Resident #2 could sometimes be resistant to care and would take more than two people to assist her. -He did receive the call for Resident #2 to return to the hospital for a possible infection and c-diff, but that was all the information he knew. -He would expect the physician to be notified with any changes in the resident's care. Based on interview, observations, and record review Resident #2 was unable to be interviewed since the resident remained hospitalized as of 04/25/19. 2. Review of Resident #5's current FL2 dated 02/20/19 revealed:	{D 273}		

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{D 273}	Continued From page 8 -Diagnoses included multiple sclerosis (MS) and epilepsy. -Resident #5's ambulatory status was non-ambulatory. Review of Resident #5's record revealed a physician order dated 10/28/18 for a referral to a neurologist for ongoing evaluation and management. Review of Resident #5's Neurologist initial visit notes dated 11/06/18 revealed: -Resident #5 was being seen for her MS, seizures and epilepsy. -There was documentation Resident #5 was seen in the Emergency Room (ER) February 2018 for seizures. -The Neurologist ordered laboratory studies and radiology to perform a Magnetic Resonance Imagining (MRI) of the brain and spine. -The Neurologist requested Resident #5 return to the office in 4 weeks for further evaluation. -There was documentation Resident #5 would be a "good candidate" for aggressive infusion therapy. Interview with Resident #5 on 04/24/19 at 9:30am revealed: -She remembered going to a neurologist once, but it was awhile back. -She had 3 neurologist appointments canceled by the facility staff due to not having transportation. -She did not know if the facility staff had contacted the neurologist office when the appointments were missed. -She thought she needed to return to the neurologist because no one was following her medications and treatment for the MS and epilepsy. -She was sent out to the hospital in January 2019	{D 273}		

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{D 273}	Continued From page 9 because she had a seizure in the facility. -"If I have a flare up of MS I guess the staff would just send me to the ER." Observation of Resident #5 on 04/23/19 between 9:30am and 10:45am revealed Resident #5 used a motorized wheelchair for ambulation in the facility. Review of a discharge summary from a local hospital for Resident #5 dated 01/29/19 revealed: -Resident #5 was admitted to the hospital on 01/25/19 with diagnoses which included MS, epilepsy and a urinary tract infection. -Resident #5 was discharged back to the facility on 01/29/19. -There was an order for a follow up appointment with the Neurologist in 1 week. Telephone interview with Resident #5's neurologist's office medical assistant on 04/23/19 at 10:42am revealed: -The Neurologist had seen Resident #5 for an initial visit on 11/06/18. -Resident #5 had appointments for 12/13/18, 02/04/19 and on 03/13/19, but did not show up for the appointments. -The facility staff never called the office to reschedule the missed appointment. -The office medical assistant contacted the facility "60 times" to request Resident #5 return to the office. -The medical assistant had spoken to the nursing supervisor in the facility, informing her how important it was for Resident #5 to keep the appointment with the Neurologist office for treatment and medication management of her MS and epilepsy. -"It is highly important for [Resident #5] to keep her appointments with the Neurologist."	{D 273}		

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{D 273}	Continued From page 10 -"The longer she [Resident #5] goes without her treatments it is harder to control the symptoms of MS." -She did not know Resident #5 had been hospitalized from 01/25/19 to 01/29/19 for seizures and MS. -"I am not sure who is managing her medications, but it's not our office." Interview with the facility Nurse Practitioner for Resident #5 on 04/24/19 at 10:40am revealed: -She had written an order on 10/28/18 for a referral to the Neurologist due to Resident #5's diagnoses of MS and epilepsy. -She did not know Resident #5 had only seen the Neurologist once on 11/06/18. -She did not know Resident #5 was not being followed by the Neurologist since the initial appointment on 11/06/18. -It was very important Resident #5 be seen by the Neurologist for her ongoing MS treatment and medication management. -The facility staff never informed her Resident #5 missed the Neurologist appointments scheduled for 12/13/18, 02/04/19, and on 03/13/19. -She did not know Resident #5 was not seen by the Neurologist after the hospital visit on 01/29/19 as ordered by the hospital physician. -Her expectation for the facility staff were to follow her orders as well as the orders from the hospital discharge summary. Telephone interview with Resident #5's Neurologist on 04/23/19 at 2:00pm revealed: -Resident #5 was a new client seen in his office on 11/06/18. -He requested she return to the office in 4 weeks for further evaluation and treatment. -He ordered a MRI of the brain and spine for a baseline status due to lesions.	{D 273}		

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{D 273}	Continued From page 11 -Resident #5 had not kept her appointments for the follow-ups on 12/13/18, 02/04/19, and on 03/13/19. -It was very important for Resident #5 to keep her appointments due to treatment and monitoring MS and medication management of seizures and epilepsy. -"If MS is not managed the symptoms could increase and lead to difficulty with day to day activities." -"If epilepsy is not treated this could lead to seizures and possibly death." -He did not know Resident #5 had been hospitalized from 01/25/19 to 01/29/19 for seizures and MS. -"Evidently her MS and epilepsy are not being controlled or she would not be having seizures." -"If I would have known [Resident#5] had seizures, I would have adjusted her medications." Interview with the Director Resident Care (DRC) on 04/24/19 at 1:30pm revealed: -She started as the DRC in January 2019, and was responsible for overseeing the clinical staff. -She was responsible for reviewing all physician orders and the hospital discharges. -She had not reviewed Resident #5's referral order dated 10/28/18 or the hospital discharge summary dated 01/29/19. -She knew Resident #5 missed several Neurologist appointments. -Resident #5's insurance had "ran out" that was why the Neurologist appointments were never kept. -She never contacted the Neurologist office to cancel the appointments for Resident #5. -She had never spoken to the neurologist office medical assistant on the telephone. -She never informed the facility Nurse Practitioner Resident #5 missed the Neurologist	{D 273}		

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{D 273}	Continued From page 12 appointments on 12/13/18, 02/04/19, and on 03/13/19. -"I guess it got overlooked by staff that were here before me." Interview with the facility transportation person on 04/24/19 at 3:45pm revealed: -She was hired about a week ago for transportation. -She was the only one who transported residents to appointments. -She never transported Resident #5 to any physician appointments. -She was in charge of scheduling appointments for residents and providing transportation to the appointments. -She was not aware Resident #5 had missed Neurologist appointments. Interview with the Administrator on 04/25/19 at 3:30pm revealed: -He started as the Administrator on 12/17/19. -He did not know Resident #5 had missed multiple neurology appointments due to transportation not provided by the facility. -He relied on the nursing staff to review all physician's orders and the hospital discharge summary. -He relied on the DRC and Resident Care Coordinator (RCC)) to follow through on all the orders for referral and appointments. -He relied on the RCC and the DRC to contact the medical providers for any changes to the residents care or any missed appointments. -"I think it was a communication issue, it was not because transportation was not available." 3. Review of Resident #'1s current FL2 dated 1/17/19 revealed: -Diagnoses included Type 2 diabetes; Hepatitis C;	{D 273}		

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hypertension and chronic obstructive pulmonary disease (COPD).
-Resident #1 was semi ambulatory with a wheelchair, needing assistance at times with transfers, and assistance with bathing and dressing.

Review of Resident #1's hospital discharge summary dated 04/24/19 revealed a total left hip replacement on 07/16/18 after he sustained a fall.

Review of Resident #1's primary care physician's (PCP) order dated 01/31/19 revealed:
-There was an order to schedule an appointment at an orthopedic practice and transport Resident #1 to the appointment.
-The appointment date was 02/12/19 at 12:45pm.
-The Resident Care Coordinator (RCC) and Director of Resident Care (DRC) signed the referral order from the physician.
-There was a handwritten entry on the physician's order with the date of the appointment as 02/12/19 at 12:45pm.

Review of the appointment book for 2019 revealed there was no entry for Resident #1's appointment on 02/12/19.

Telephone interview with the scheduler at the orthopedist office on 02/24/19 at 2:15pm revealed:
-Resident #1 had an appointment at the hip and knee orthopedic office on 02/12/19 at 12:45pm.
-The resident was a "No Show".
-There was no follow up appointment made for Resident #1.

Review of Resident #1's Physician Summary Visit on 02/27/19 revealed:
-The resident was seen for significant pain in the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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left hip.
-Resident #1 requested to be seen by an orthopedist for chronic hip pain.
-There was no documentation an appointment with the orthopedist was scheduled.

Review of Resident #1's emergency department (ED) summary revealed:
-Resident #1 was seen at the ED on 03/01/19 for significant left hip pain shooting down his left leg.
-A follow up appointment with the orthopedist in 2-4 days was ordered by the ED physician.

Review of the appointment book for 2019 revealed there was no entry for an appointment for Resident #1 at the orthopedic office in March 2019.

Interview with Resident #1's PCP on 04/23/19 at 9:45am revealed:
-Resident #1 had complained of left hip pain for several months.
-She had left verbal orders and a written order dated 01/31/19 to make an appointment and transfer Resident #1 to the appointment as soon as possible.
-Resident #1 had an appointment at an orthopedic practice on 02/12/19.
-She did not know why he did not make the appointment.
-She felt it was very important to be seen by an orthopedic physician since the pain was radiating from the site of his hip surgery in July 2018.

Interview with the Director of Resident Care (DRC) on 04/25/19 at 4:35pm revealed:
-The former Resident Care Coordinator (RCC) was scheduling the resident's appointments and arranging the transportation with the facility's former driver.

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{D 273}	Continued From page 15 -She knew Resident #1 had an appointment on 02/12/19 at the orthopedic office. -She did not know he did not make the orthopedic appointment until recently. -She did not have a copy of the appointments when she first started in this position. -The current transportation driver gave the DRC a copy of the appointments for the week each Friday, along with her schedule, for approval. Interview with the Administrator on 04/25/19 at 4:35pm revealed: -The former RCC scheduled all resident appointments. -The facility van was in disrepair until mid-March 2019. -The sister facilities and the veteran's administration (VA) were providing transportation to appointments for the residents in the interim. -He did not know Resident #1 missed an orthopedic appointment. -He did not know Resident #1 had additional referral orders to be seen at the orthopedic group for hip pain. -He relied on the clinical staff to make appointments and provide transportation for the residents. 4. Review of Resident #6's current FL2 dated 01/17/19 revealed diagnoses included hypertension, insomnia, and diabetes mellitus type 2. Review of Resident #6's physician's order dated 01/11/19 revealed: -There was an order to schedule a urology appointment and transport patient. -There were handwritten notes written on the order stating "2nd request" and "urgent". -There was a handwritten note on the order	{D 273}		

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indicating an appointment had been scheduled on 01/24/19 at 1:00pm, with a note "rescheduled".
-There was a handwritten note indicating another appointment had been scheduled on 02/13/19 at 1:15pm.

Interview with Resident #6 on 04/25/19 at 11:00am revealed:
-He had been referred by his primary care physician (PCP) in January 2019 to see a Urologist because his urine was discolored.
-He had been administered antibiotics by the PCP, but the color of his urine had not improved so he needed to see the Urologist.
-He had appointments scheduled, but they had to be rescheduled, and he could not remember why the appointments were rescheduled.

Interview with the urology office appointment scheduler on 04/24/19 at 4:15pm revealed:
-Resident #6 had 2 appointments scheduled 01/24/19 and 02/14/19 but both were cancelled.
-Resident #6's appointments scheduled was for an inital visit.
-Resident #6 was seen on 03/13/19 by the urologist.

Interview with the Resident Care Coordinator (RCC) on 04/25/19 at 3:44pm:
-She had been the RCC for one week.
-The previous RCC would have been responsible for making sure the transportation coordinator scheduled appointments.
-She was not sure what happened with Resident #6's urology appointment.
-The transportation coordinator was responsible for scheduling appointments and transporting resident to appointments.

Interview with the Director of Resident Care

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(DRC) on 04/25/19 at 8:42am revealed:
-Orders from physicians were received by the RCC and any appointments ordered would be scheduled by the transportation coordinator.
-The previous transportation coordinator was responsible for scheduling and transporting residents to appointments.
-The transportation coordinator was cancelling several appointments, however she did not know why the appointment were cancelled.
-She did not know Resident #6 had an order for a urology consultation.
-The previous transportation coordinator no longer worked at the facility as of 04/01/19.

Interview with Resident #6's PCP on 04/25/19 at 9:50am revealed:
-Resident #6 was ordered a urology consult due to blood in his urine in January 2019.
-Resident #6 did not respond to antibiotics so she wanted him to see a Urologist promptly.
-She found out from Resident #6 appointments with the urology office were missed in January 2019 and February 2019.
-When she saw Resident #6 in February 2019 she wrote "urgent" on the order dated 01/11/19.

Interview with the Administrator on 04/25/19 at 4:25pm revealed:
-The previous transportation coordinator would have been responsible for scheduling appointments.
-He did not know Resident #6's scheduled urology appointments were cancelled.
-He did not know why Resident #6's appointments were cancelled.
-He expected residents with appointments to be transported as ordered by the PCP.

Attempted telephone interview with the Urologist

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{D 273}	Continued From page 18 on 04/24/19 at 4:15pm was unsuccessful. The facility failed to assure physician notification regarding symptoms of a urinary tract infection and abdominal pain for Resident #2 which led to an admission to the local hospital on 04/14/19 for altered mental status, generalized weakness, urinary tract infection; Resident#5 missed multiple neurologist appointments for treatment of MS and epilepsy as ordered and the Neurologist was never contacted, Resident #5 was hospitalized for seizures with discharge orders to follow-up with the neurologist in 1 week; Resident #1 sustained a fall resulting in a total left hip replacement with a referral made for an orthopedic consult due to severe pain resulting in an ER visit for significant left hip pain shooting down his left leg, and Resident #6 ordered a urology consult due to blood in his urine resulting in a delay of treatment for severe pain. This failure to assure physician notification resulted in serious physical harm and neglect and constitutes an unabated Type A1 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 04/24/19 for this violation.	{D 273}		
{D 282}	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by:	{D 282}		

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{D 282}	Continued From page 19 Based on observations, interviews, and record review the facility failed to assure the kitchen, dining and food storage areas including kitchen appliances, walls in the kitchen, floors in the dining room and kitchen, and table linens in the dining room were clean and protected from contamination. The findings are: Review of the local Food Establishment Inspection Report dated 04/16/19 revealed: -The kitchen sanitation score was 92. -The ceiling was observed to be peeling in front of the walk-in cooler. -There was wall damage observed in the dish machine area. -The ceiling and wall needed to be repaired. -One demerit was incurred as a result of this repeat violation. Observation of the dry food storage area in the kitchen on 04/23/19 at 10:47am revealed the floor was covered in food crumbs and dirt. Observation of the main kitchen area on 04/23/19 at 10:47am revealed: -The sides of the stove and oven were covered in a build up of grease. -The front of the oven and rack under the oven were covered in a dried brown substance. -The bottom shelf of a food prep table was covered in food crumbs and a dried red substance. -The floor underneath the food prep sink was covered in crumbs and dirt. -The inside of the ice machine had a black substance covering the area where the lid closed. -The floor of the walk-in cooler was covered in food crumbs.	{D 282}		

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{D 282}	Continued From page 20 -The ceiling was peeling in front of the walk-in cooler. -The wall was peeling and damaged near the dish wash machine area. Observation of the dining room on 04/23/19 at 12:02pm revealed: -There were no residents in the dining room. -The lunch meal service had not begun. -The tables were covered with table linens. -Food crumbs were on the table linens. -There were spots of a dried, pink, sticky substance on the floor throughout the dining room. -The food crumbs were not removed from the table linens nor was the pink, sticky substance on the floor removed prior to residents entering the dining room for the lunch meal service. Observation of the dining room on 04/24/19 at 7:29am revealed: -There were no residents in the dining room. -The breakfast meal service had not begun. -Many chairs had food crumbs on the seats. -The floor was covered in food crumbs and a dried, pink sticky substance. -The dining room was not cleaned prior to the residents entering for their breakfast meal. Observation of the dining room on 04/24/19 at 3:52pm revealed: -There were no residents in the dining room. -The tables were set with forks, knives, spoons and napkins for the dinner meal. -The table linens were covered in spots of a dried, pink liquid. -The floor was covered with spots of a dried, pink sticky substance. Interviews with three residents on 04/23/19 at	{D 282}		

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{D 282}	Continued From page 21 various times revealed: -One resident reported the cleanliness in the dining room had improved, but it was still dirty at some meals. -A second resident was bothered by the dining room floors being "dirty and sticky" and the table linens rarely being changed between meals. -A third resident reported the dining room was never cleaned after meals. "It's not right. It's humiliating." Interview with a cook on 04/23/19 at 2:51pm revealed: -Some days she worked as a cook and other days she worked as a dietary aide. -The cooks were responsible for keeping the kitchen clean. -The dietary aides were responsible for stripping the table linens from the dining room tables after every meal and replacing them with clean linens. -The housekeepers were responsible for sweeping and mopping the dining room floors after every meal. -A "deep clean" of the dining room had occurred in January 2019 with the purchase of new dining chairs and scrubbing of the dining tables. -The facility did not have a Dietary Manager (DM) and there was no set cleaning schedule. She "just cleaned when she had time." Interview with a housekeeper on 04/24/19 at 8:17am revealed: -The housekeepers were responsible for sweeping and mopping the floors in the dining room after breakfast and lunch. -She did not have any cleaning chemicals that would properly remove the dried, sticky substance from the dining room floors. -The housekeepers were responsible for "spot checking" the dining room chairs, wiping them off	{D 282}		

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{D 282}	Continued From page 22 if they were dirty, and cleaning the window ledges in the dining room. -The housekeepers did not clean in the kitchen. Interview with the Administrator on 04/24/19 at 2:48pm revealed: -The facility had been without a DM since 04/01/19. -He was serving as the DM in the interim until they could hire someone. -The housekeepers were responsible for sweeping and mopping the dining room floors after breakfast and lunch. -The personal care aides (PCA) and night shift staff were responsible for cleaning the dining room after the dinner meal including changing the table linens "if needed" and wiping down the chairs. -There was no set cleaning schedule, but the kitchen staff were responsible for daily "general cleaning" of the kitchen including washing dishes, sweeping, mopping, and wiping off counters and appliances. -The dining room floors should not be covered in a pink, sticky substance because housekeeping staff generally left the building at 3:00pm and should have already swept and mopped. -He and other members of the management team performed monthly audits of the kitchen and dining room an observed for cleanliness. He had last performed an audit of the kitchen and dining room on 04/23/19. -He had put in a request to maintenance to repair the ceiling and wall in the kitchen. They had not been repaired, and he had not followed up with maintenance.	{D 282}		
{D 296}	10A NCAC 13F .0904(c)(7) Nutrition And Food Service	{D 296}		

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{D 296}	Continued From page 23 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic menu for 2 of 2 sampled residents (Residents #8 and #9) with physician's orders for therapeutic diets as evidenced by no mechanical soft (MS) menu (#8) and no pureed menu (#9). The findings are: Observation of the food serving line in the kitchen on 04/23/19 and 04/24/19 revealed: -There was one menu ("weekly menu") posted for guidance of the food service staff, and it listed foods for residents on a regular diet. -The menu did not list what foods should be served to residents on a pureed diet or MS diet. 1. Review of Resident #8's current FL-2 dated 03/08/19 revealed: -Diagnoses included moderate intellectual disability. -The diet order was mechanical soft. Review of the therapeutic diet list posted in the kitchen on 04/23/19 revealed Resident #8 was to be served a mechanical soft diet. Review of the facility menus revealed there was no therapeutic menu for a mechanical soft diet.	{D 296}		

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{D 296}	Continued From page 24 Observation of the lunch meal service on 04/23/19 between 12:30pm and 1:15pm revealed: -Resident #8 was served beef stew with rice, steamed broccoli, and canned pears with whipped cream topping. -Resident #8 consumed 100% of the meal without difficulty. It could not be determined if Resident #8 was served the appropriate meal due to no therapeutic diet menu availabe for staff guidance. Observation of the breakfast meal service on 04/24/19 from 7:30am to 8:05am revealed Resident #8 did not come to the dining room for breakfast. Refer to interview with the cook on 04/23/19 at 2:51pm. Refer to interview with the Administrator on 04/23/19 at 2:48pm. 2. Review of Resident #9's current FL-2 dated 02/07/19 revealed: -Diagnoses included dementia. -There was a physician's order for a pureed diet. Review of the therapeutic diet list posted in the kitchen on 04/23/19 revealed Resident #9 was to be served a pureed diet. Review of the facility menus revealed there was no therapeutic menu for a pureed diet. Observation of the lunch meal service on 04/23/19 between 12:30pm and 1:15pm revealed: -Resident #9 was served pureed beef stew with rice, pureed broccoli and pureed pears with whipped topping.	{D 296}		

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{D 296}	Continued From page 25 -Resident #9 consumed 100% of the meal without difficulty. It could not be determined if Resident #9 was served the appropriate meal due to no therapeutic diet menu availabe for staff guidance. Observation of the breakfast meal service on 04/24/19 from 7:30am to 8:05am revealed: -Resident #9 was served pureed sausage, pureed eggs, and grits. -Resident #9 consumed 100% of the meal without difficulty. It could not be determined if Resident #9 was served the appropriate meal due to no therapeutic diet menu availabe for staff guidance. Refer to interview with the cook on 04/23/19 at 2:51pm. Refer to interview with the Administrator on 04/23/19 at 2:48pm. --- Interview with the cook on 04/23/19 at 2:51pm revealed: -The only menu she used to prepare and serve food was the "weekly menu" containing only menu items for residents on a regular diet. -Residents on a mechanical soft diet were served the same foods all residents were served, but the food was chopped up. -Residents on a pureed diet were served the same foods all residents were served, but the food was pureed in the food processor. -She did not know alterations needed to be made for residents on a mechanical soft diet such as adding sauce or gravy to meats, removing skins from potatoes, or omitting nuts and bacon from	{D 296}		

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{D 296}	Continued From page 26 recipes. Interview with the Administrator on 04/24/19 at 2:48pm revealed: -The facility had been without a Dietary Manager (DM) since 04/01/19. -He was serving as the DM in the interim until they could hire someone. -He printed the "weekly menu" from their online menu provider each week for guidance of food service staff. -He did not print the available therapeutic menus. -He thought the facility could provide a "liberalized diet" to all residents, meaning all residents could be served the same foods on the regular diet menu even if they had physicians' orders for therapeutic diets. -He had not requested the physician to change any residents' diet orders from a therapeutic diet to a regular or "liberalized" diet.	{D 296}		
{D 321}	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles.	{D 321}		

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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 321}	Continued From page 27	{D 321}		

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION

Based on these findings, the previous Type B violation was not abated.

Based on observations, interviews and record reviews, the facility failed to ensure 1 of 7 sampled residents (Resident #5) was provided transportation to scheduled physician's appointments related to missed Neurologist appointments, resulting in a delay of treatment and hospitalization for seizures.

The findings are:

Review of Resident #5's current FL2 dated 02/20/19 revealed:
-Diagnoses included multiple sclerosis (MS) and epilepsy.
-Resident #5's ambulatory status was non-ambulatory.

Observation of Resident #5 on 04/23/19 between 9:30am and 10:45am revealed Resident #5 used a motorized wheelchair for ambulation in the facility.

Review of Resident #5's record revealed a signed physician's order dated 10/28/18 for a referral to a Neurologist.

Review of Resident #5's Neurologist initial visit notes dated 11/06/18 revealed:
-Resident #5 was being seen on 11/06/18 for MS and epilepsy.
-The Neurologist ordered laboratory studies and radiology to perform a Magnetic Resonance Imagining (MRI) of the brain and spine.

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	HAL060077	A. BUILDING: _____ B. WING _____	R 04/25/2019

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{D 321}	Continued From page 28 -The Neurologist requested Resident #5 return to the office in 4 weeks for further evaluation which included aggressive infusion therapy. Review of a discharge summary from a local hospital for Resident #5 dated 01/29/19 revealed: -Resident #5 was admitted to the hospital on 01/25/19 with diagnoses which included MS, epilepsy and a urinary tract infection. -Resident #5 was discharged back to the facility on 01/29/19. -There was an order for a follow up appointment with the Neurologist in 1 week. Review of the facility appointment book calendar for January and February 2019 revealed there were no physician appointments documented for Resident #5. Interview with Resident #5 on 04/24/19 at 9:30am revealed: -She remembered going to a Neurologist once, but it was awhile back. -She had 3 Neurologist appointments canceled by the facility staff due to not having transportation to the appointments. -The former Resident Care Coordinator (RCC) had told her the van was broken and they could not transport her to the appointments. Telephone interview with Resident #5's Neurologist office medical assistant on 04/23/19 at 10:42am revealed: -Resident #5 had appointments with the Neurologist scheduled for 12/13/18, 02/04/19 and on 03/13/19. -Resident #5 did not show up for the appointments. -The facility staff never called the office to reschedule the missed appointments.	{D 321}		

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{D 321}	Continued From page 29 -The Neurologist was seeing Resident #5 for a follow-up from an initial visit on 11/06/18. -The office medical assistant contacted the facility "60 times" to request Resident #5 return to the office. -The medical assistant had spoken to the nursing supervisor in the facility, informing her how important it was for Resident #5 to keep the appointments with the Neurologist office for treatment and medication management of her MS and epilepsy. -"It is highly important for [Resident #5] to keep her appointments with the Neurologist." -"The longer [Resident #5] goes without her treatments, it is harder to control the symptoms of MS." Interview with Resident #5's Nurse Practitioner on 04/24/19 at 10:40am revealed: -She had written an order on 10/28/18 for a referral to the Neurologist due to Resident #5's diagnoses of MS, seizures and epilepsy. -She did not know Resident #5 had not seen by the Neurologist since 11/06/18. -She did not know Resident #5 was never transported to the Neurologist for the follow up appointment from the hospital discharge dated 01/29/19. -Resident #5 never told her the facility van was broken and the former Resident Care Coordinator (RCC) had told Resident #5 the facility could not get her to the Neurologist appointments. -The NP was told by other residents in the facility the van used for transportation was broken and could not transport them to appointments. -The facility staff were to follow her orders and transport Resident #5 to her Neurologist appointments as she had ordered. -The facility staff were responsible for providing transportation for Resident #5 to the	{D 321}		

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{D 321}	Continued From page 30 appointments. Interview with a medication aide (MA) on 04/23/19 at 12:45am revealed: -The transportation person was responsible for scheduling appointments for the residents. -The former transportation person had been terminated about a week ago, there was a new transportation person which made appointments and transported residents to their appointments. -She did not know Resident #5 had physician appointments with the Neurologist. -There was a facility van used for transportation for the residents to the physician appointments, but it had been broken for about 3 months between December 2018 and February 2019. -The facility used another facility's van until it was wrecked by the former transportation person. -Sometimes staff used their personal vehicles to transport residents to physician appointments. -She was not sure why the Neurologist appointments were missed for Resident #5. Interview with the Director of Resident Care (DRC) on 04/24/19 at 1:30pm revealed: -She had started as the DRC of the facility in January 2019, and was overseeing the clinical staff. -She knew Resident #5 had missed Neurologist appointments. -Resident #5's insurance had "ran out" and that was why the Neurologist appointments were never kept. -The facility van had "broken down" several months ago and they had used another facility's van for transportation. -She knew several residents had missed physician appointments due to the former transportation person. -The former transportation person would cancel	{D 321}		

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{D 321}	Continued From page 31	{D 321}		

appointments or just not take the residents to their appointments.
-The facility had a new transportation person which started about a week ago.
-The transportation person was responsible for scheduling residents' appointments and ensuring transportation to the appointments.
-She was responsible for maintaining a weekly schedule log for all the residents' appointments and to follow up with transportation to ensure the residents were getting to their appointments.

Interview with the facility transportation person on 04/24/19 at 3:45pm revealed:
-She was hired about a week ago for transportation.
-She was the only one who transported residents to appointments.
-She had never transported Resident #5 to any appointments.
-She was in charge of scheduling appointments for residents and providing transportation to the appointments.
-The facility van was currently working except "the air conditioner did not work."
-Management was aware the air conditioner was not working in the facility van.
-She was responsible for recording the residents' appointments in the transportation calendar book.
-She was not aware Resident #5 had missed Neurologist appointments.

Interview with the Administrator on 04/25/19 at 3:30pm revealed:
-He had started as the Administrator on 12/17/19.
-He knew the facility van was in the shop for about 3 months from December 2018 to February 2019 due to the transmission.
-The facility used another facility's transportation van and a private vehicle for transportation during

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{D 321}	Continued From page 32 the 3 months for residents' physician appointments. -He did not know Resident #5 had missed multiple neurological appointments due to transportation not provided by the facility. -He was not aware the former RCC had told Resident #5 the facility van was broken and the facility could not provide transportation to the Neurologist. -There was transportation available for transporting Resident #5 to her appointments, "I am not sure why she was told we could not transport her." -He knew there was a problem with the transportation person that was why "she was let go." -"I think it was a communication issue, it was not because transportation was not available." _____ The facility failed to assure coordination of the provision of transportation for Resident #5 to Neurologist appointments for treatment, laboratory studies, medication management, and to the radiologist for a MRI of the brain and spine, resulting in a delay in treatment for Resident #5 who was sent to the ER for seizures. The facility's failure to ensure transportation was in place resulted in potential risk for disease progression for Resident #5 and was detrimental to the health, safety, and welfare, constituting an Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/23/19 for this violation.	{D 321}		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	{D 338}		

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{D 338}	Continued From page 33 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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B violation was not abated. Based on observations, interviews and record reviews, the facility failed to assure residents were treated with dignity and respect in regards to failing to provide bath towels, washcloths, and linens for residents to use, not providing paper towels and toilet paper resident to use, not providing spoons to consume their meal when requested, and staff speaking to residents in a disrespectful manner. The findings are: 1. Confidential interview with a resident revealed: -The facility did not have towels and washcloths available for her to use on her shower days. -The resident did not keep towels or wash clothes in her room. -On 03/16/19 the resident wanted to take a shower but was told by the facility staff there were	{D 338}		

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{D 338}	Continued From page 35	{D 338}		

had torn a bath towel in half and gave her a half of the towel to dry off.
-The resident kept no towels or wash clothes in her room.
-If you ask staff for towels and wash clothes, "maybe you get one maybe you don't."

Confidential three staff interview revealed:
-There were not enough towels and washcloths in the facility for the residents.
-Sometimes they were unable to assist the residents with their scheduled showers because there were no bath towels to use.
-There were not enough pillow cases for the resident's pillows.
-The linen closet was not locked and the towels and pillow cases were always missing.
-They have brought this to the attention of the Administrator and the Director of Resident Care (DRC).

Confidential interview with 2 staff revealed:
-There were no towels or washcloths available for the residents to use on shower days.
-Some of the residents "hoard towels" and that was why there were none to use.
-"It is hard to do our job if we do not have the supplies we need."
-"I had to use a bed sheet to dry residents off before."
-The Administrator bought new towels and washcloths about 2 months ago, but we cannot find them now.
-Residents have skipped showers because we do not have towels and wash clothes for them to use.
-Sometimes the residents get upset, "but what can we do."
-Management knew there was a towel shortage.

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{D 338}	Continued From page 36 Interview with the laundry person on 04/25/19 at 1:30pm revealed: -She performed laundry duty on weekday first shift which included washing, drying and folding clothes for the residents as well as washing the linens, towels and washcloths. -She was unsure how many towels and washcloths the facility had for the residents to use. -The residents would ask her for towels and wash clothes and she would tell them they needed to get the towels and wash clothes from the PCAs. -The towels and wash clothes were the resident's responsibility and were kept in the resident's rooms. -She could not recall how many towels and washcloths she washed each day. -There was a staff on second shift that did the laundry also. -The residents never complained to her about not having towels or washcloths to use on shower days. -She was not aware residents were drying off with sheets due to not having towels available to use. Interview with the Administrator on 03/25/19 at 2:47pm revealed: -He did not know towels and washcloths were not in the facility for residents to use. -The staff never informed him of not having towels available to use. -He did not know residents were being dried off using bed sheets due to not having towels. -He did not know staff had torn towels in half to accommodate showers for residents. -He had supplied the facility with paper towels and toilet paper on 04/24/19 when staff informed him the facility was out of these products. -"If staff tell me I will get anything the resident's need, but if I do not know I cannot fix the	{D 338}		

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{D 338}	Continued From page 37 problem." 2. Observation of the breakfast meal service on 04/24/19 from 7:30am-8:05am revealed: -There were 102 place settings on the dining tables. -Each place setting contained a non-disposable fork and knife. -Twenty nine place settings contained a disposable spoon, and the remaining 73 contained a non-disposable spoon. Confidential interview with a resident revealed: -On 04/21/19, for dinner "we were served chicken noodle soup, and given a fork and knife". -The resident asked for a spoon and was told "I'm not your servant eat with your fingers". -"I just want to be treated fair". Confidential interview with another resident on revealed. -The kitchen served chicken noodle soup and grilled cheese sandwiches for Easter dinner. -The kitchen staff were angry when you "asked for a spoon to eat your soup." -When the resident told management about problems, nothing was done. Interview with a resident on 04/23/19 at 10:20am revealed: -The previous Sunday, chicken noodle soup was served for dinner. -Residents were not provided spoons for their soup. -When she requested a spoon, staff argued with her, asking "What am I supposed to do about it? It's not my responsibility." -She was not provided a spoon and had to "drink" her soup.	{D 338}		

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{D 338}	Continued From page 38 Interviews with 3 staff members on 04/25/19 at 11:42am revealed: -The facility ran out of spoons two weeks ago. -Residents and staff have taken the spoons and there were not always enough to give each resident. -There were times residents got "upset and disrespectful." -"We try to meet their needs, but sometimes we cannot diffuse the situation." -"I can't remember if I told management staff we were short of spoons." Interview with the Administrator on 4/25/19 at 3:30pm revealed: -He did not know residents did not have enough spoons available in the kitchen. -He would have expected staff to notify him so that additional spoons could be purchased. 3. Confidential interview with a resident revealed: -Several of the staff have "attitude problems" by talking down to residents and making residents feel bad about having to live at the facility and needing help. -The staff knew which residents to talk down to and belittle them. -"I wish I had somewhere else to go." Confidential interview with a second resident revealed: -"Some of the staff don't know how to speak to me, they come through the halls and yell that it's time for lunch." -"I feel like I'm in jail." -There were times staff became mean and rude, "beligerent," after an incontinence episode. -He did not always feel the staff were willing to help him because of their attitude.	{D 338}		

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{D 338}	Continued From page 39 Confidential interviews with 2 residents revealed: -She and her roommate did not get showers three times a week. -Her roommate was incontinent and some of the staff treated her rudely when they had to change her briefs. -Some of the staff could be "ugly" in the manner they spoke to the residents when providing care. Confidential interview with staff revealed: -Sometimes she heard staff speaking to the residents disrespectfully. -She would remind the staff not to speak to the residents that way. -She never reported this behavior to the management team. Interview with the Administrator on 04/25/19 at 3:30pm revealed: -He did not know residents were spoken to in a disrespectful manner. -He expected staff to treat residents with dignity and respect. -He would investigate the complaint and educate the staff. The facility failed to assure residents were treated with respect and dignity by failing to provide bath towels, washcloths and linens for residents to use, not providing spoons when requested, and failing to supply toilet paper and paper towels to residents, and staff speaking in a disrespectful manner. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type Unabated B violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 04/25/19.	{D 338}		

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{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: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 7 sampled residents (Residents #2, #7, #6 and #1) related to a resident not receiving her insulin (Resident #2), a resident not receiving the evening dose of long acting insulin (Resident #7), a resident diagnosed with pneumonia not receiving nebulizer treatments as ordered (Resident #1), and a resident experiencing muscle spasm and not administered pain medication (Resident #6).	{D 358}		

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{D 358}	Continued From page 41 The findings are: 1. Review of Resident #7's current FL2 dated 01/16/19 revealed: -Diagnoses included diabetes mellitus Type II, hyperglycemia, and encephalopathy. -There was a physician's order for fingerstick blood sugars (FSBS) before meals and at bedtime. -There was a physician's order for levemir touch pen 100 units/ml, a long acting insulin to treat high blood sugar, administer 60 units at bedtime. Review of Resident #7's subsequent physician's order dated 03/20/19 revealed an order for levemir 100 units/ml to be increased to 70 units at bedtime. Review of Resident #7's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for FSBS four times daily scheduled at 6:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for levemir touch pen, 60 units at bedtime, to be administered at 8:00pm. -There was documentation levemir 60 units was administered from 03/10/19-03/19/19. -There was no entry for levemir insulin to be administered at 8:00pm, from 03/20/19-03/31/19 -There was no documentation levemir was administered from 03/20/19-03/31/19. -The documented FSBS readings ranged from 105-436. Review of Resident #7's April 2019 eMAR from 04/01/19-04/25/19 revealed: -There was no entry for levemir 70 units to be administered at bedtime. -The documented FSBS readings ranged from	{D 358}		

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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 358}	Continued From page 42 77-429. Interview with the primary care physician (PCP) on 04/24/19 at 10:15am revealed: -Resident #7's blood sugar was very high. -He increased the levemir from 60 units to 70 units on 03/20/19. -Resident #7 needed the evening dose of insulin to keep his blood sugar at an acceptable range. -Resident #7 was not compliant with his diet. -Resident #7 was at risk for hyperglycemia if his blood sugar was not controlled. Review of Resident #7's laboratory results dated 01/18/19 revealed: -There was a hemoglobin A1C laboratory test, a measurement of the level of glucose in the blood over a 3 month period. -Diabetics with poor glucose control have an A1C level of 7% or higher. -Resident #7's A1C result was 9.8% (the normal reference range was below 6%) . Interview with a pharmacy staff on 04/24/19 at 1:20pm revealed: -The pharmacy staff had received an order dated 03/20/19 for levemir 70 units every evening for Resident #7. -A 26 day supply of twelve levemir touch pens, 70 units to be administered in the evening, were sent to the facility on 03/20/19. -Levemir 70 units continued as an active order to date on Resident #7's medication profile. -The pharmacy software did not interface with the facility software. -The pharmacy staff could not view the resident's eMAR entries. -The pharmacy discontinued medications only with an order from the physician. -The facility Director of Resident Care (DRC)	{D 358}		

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{D 358}	Continued From page 43 could enter or discontinue an order on the eMAR. Observation of the refrigerator in the medication room revealed: -There were six unopened levemir Flex touch pens for Resident #7. -The directions on the pharmacy label were to administer 70 units of levemir insulin, scheduled twice a day. -The fill date on the levemir pens was 03/20/19. Interview with the lead supervisor on 04/24/19 at 2:10pm revealed: -She performed cart audits weekly on Monday and Tuesday. -The cart audits were submitted to the DRC on Wednesday. -She printed the physician order summary (POS) report for all the residents and compared it to their eMAR. -She separated the POS by cart (A, B and C) and further separated by resident's in alphabetical order. -She included the refrigerator in the medication room which also housed medications. -The last cart audit had been completed 2 weeks ago. -She had been working on the medication cart and was not able to complete the cart audit last week. -She did not know the levemir insulin for Resident #7 had been discontinued in error. -The levemir insulin to be administered at 8:00pm was not on the April 2019 eMAR or the POS when she performed the cart audit. -She did not remember seeing the levemir pens in the refrigerator for Resident #7. -The medication aides (MAs) did not report Resident #7's levemir insulin was discontinued on the eMAR.	{D 358}		

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{D 358}	Continued From page 44 Interview with the DRC on 04/24/19 at 2:35pm revealed: -She did not know Resident #7's insulin had mistakenly been discontinued on the eMAR from 03/20/19 through 4/24/19. -She noticed when she reviewed the eMARs in mid-March, the entries for insulin orders did not have parameters. -She entered parameters (notify the PCP if blood sugar readings were <60 or >400) for the insulin orders as best practice. -It was her practice to put parameters on all insulin orders. -She did not know when she entered the parameters on the insulin order, the order would be discontinued. -The eMAR system she had previously worked with did not discontinue the order if parameters were added to an existing order. -She frequently checked with the medication aides (MAs) on the floor to determine if there were any problems with medications or orders. -The MAs on second shift did not mention Resident #7's levemir insulin was discontinued on the eMAR. -The cart audits submitted to her did not indicate there were 6 levemir insulin touch pens in the refrigerator that had not been opened. Refer to interview with the Administrator on 04/24/19 at 3:45pm. Telephone interview with the second shift MA on 04/25/19 at 2:40pm revealed: -She administered Resident #7's evening medications regularly. -She administered the levemir touch pen to Resident #7 nightly before bed. -She noticed the levemir order was not on the	{D 358}		

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{D 358}	Continued From page 45 eMAR around mid-March. -She reported it to the supervisor on her shift at their monthly meeting with the Regional Nurse in March. -She could not remember the exact date. -Nothing else was mentioned, so she thought the levemir order was changed. -The MAs were instructed to report to the supervisors on their shift any concerns with the residents' care or medications. -The supervisors were to report to the Resident Care Coordinator (RCC) or the DRC. Interview with Resident #7 on 04/25/19 at 4:05pm revealed: -He did not think the MAs were giving him the correct insulin. -He thought he received insulin before bedtime but was not sure if he received it every night. -He received insulin injections, but did not know what insulin was administered to him. Interview with the second shift supervisor on 04/25/19 at 4:30pm revealed: -She did not recall the second shift MA reporting Resident #7's evening insulin (levemir) was discontinued on the eMAR. -If it was reported to her, she would have called the pharmacy and checked the resident's record for an order. -She would report to the RCC and the DRC if she could not resolve the issue. -She did not know the levemir insulin was not on Resident #7's eMAR from 03/20/19-04/25/19. 2. Review of Resident #1's current FL2 dated 01/17/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD), Type II diabetes, Hepatitis C and hypertension.	{D 358}		

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{D 358}	Continued From page 46 Interview with Resident #1's primary care physician (PCP) on 04/23/19 at 9:35am revealed: -On 02/19/19 the home health nurse contacted the PCP to report Resident #1's lungs were congested and his appetite had decreased. -The PCP visited the resident the following day and ordered a chest x-ray. -Based on the results of the chest x-ray, the PCP began treatment for pneumonia on 02/20/19. -The PA ordered levaquin, an oral antibiotic, and albuterol sulfate nebulizer treatments, to open the airways in the lungs, for Resident #1. -Albuterol nebulizer treatments were to be administered every 4 hours for 48 hours, and continued as needed (PRN) every 4 hours for wheezing or shortness of breath. -On the follow up visit on 02/27/19, Resident #1 complained to the PCP of a continued cough and of congestion. -The PA reviewed the eMARs for Resident #1 and spoke with the lead supervisor and determined the albuterol nebulizer treatment had not been administered to Resident #1 as a scheduled dose for 48 hours or as a PRN dose as ordered the previous week. -She ordered the nebulizer treatments (to be administered every 4 hours for 48 hours, and PRN) for Resident #1 to start on 02/27/19. Review of the signed Physician Visit Summary report for Resident #1 dated 02/27/19 revealed an order for nebulizer treatments to be administered every 4 hours for 48 hours, and continued PRN. Review of Resident #1's February 2019 electronic Medication Administration Record (eMAR) from 02/20/19-02/28/19 revealed: -There was an entry dated 02/20/19 for albuterol sulfate nebulizer treatments scheduled every 4	{D 358}		

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{D 358}	Continued From page 47 hours for the following 48 hours. -The entry for the scheduled albuterol nebulizer treatment was discontinued on 02/22/19. -There was no documentation the albuterol nebulizer was administered from 02/20/19 through 02/22/19 as ordered. -The documented reason was the medication was not available to administer. -There was an entry dated 02/22/19 for albuterol nebulizer treatments every 4 hours as needed. -There was no documentation the PRN albuterol treatments were administered to Resident #1. Review of Resident #1's March 2019 eMAR from 03/01/19-03/06/19 revealed: -There was an entry for albuterol sulfate nebulizer treatments every 4 hours PRN. -There was no documentation the albuterol treatments were administered to Resident #1. Review of Resident #1's emergency room (ED) discharge summary on 03/01/19 revealed: -Resident #1 was seen in the ED for left hip pain. -During the examination, the physician noted Resident #1 was bronchospastic with wheezing and coughing. -Resident #1 told the physician his PCP had prescribed antibiotics and other medications for these symptoms, so no further action was taken. Review of Resident #1's hospital discharge summary dated 04/24/19 revealed Resident #1 was admitted to the hospital on 03/05/19 for acute respiratory failure and was on day 50 of his hospital stay. Telephone interview with the contracted pharmacy staff on 04/24/19 at 1:20pm revealed: -An order was received from the facility for albuterol sulfate nebulizer treatments every 4	{D 358}		

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{D 358}	Continued From page 48 hours for the next 48 hours, and every 4 hours thereafter as needed on 02/20/19. -The albuterol sulfate solution was sent to the facility on 02/20/19 in the evening tote. -There were 90 individual vials of albuterol sulfate solution sent to the facility on 02/20/19. -The pharmacy records showed albuterol sulfate solution was returned to the pharmacy, but the records did not indicate the amount returned. -Resident #1 was no longer an active resident with the pharmacy. Interview with the lead supervisor on 04/25/19 at 2:45pm revealed: -She knew Resident #1 had an order on 02/20/19 for scheduled albuterol nebulizer treatments. -The pharmacy never sent the albuterol sulfate. -She followed up with the pharmacy from 02/20/19-02/21/19 and finally went to the backup pharmacy and picked up the albuterol solution for the nebulizer treatments on the evening of 02/21/19. -She administered the albuterol nebulizer treatment to Resident #1 on 02/21/19 after 9:00pm and forgot to document. -She did not notify the physician the nebulizer treatments were not administered as ordered. -She did not notify the Director of Resident Care (DRC) the nebulizer treatments were not administered as ordered. Interview with the DRC on 04/24/19 at 2:35pm revealed: -She knew Resident #1 had orders for albuterol nebulizer treatments scheduled for 48 hours and PRN there after due to his diagnosis of pneumonia. -She had verified the entry on the eMAR. -She did not know Resident #1 had not received the treatments as ordered.	{D 358}		

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{D 358}	Continued From page 49 -The supervisor did not report there was any delay in receiving the medication from the pharmacy. -She did not know the PCP had ordered the albuterol treatments to be reinstated on 02/27/19. -She did not review the Physician Visit Summary notes for Resident #1 since the physician did not leave a copy of the electronic notes with the facility. -She expected the supervisors and the MAs to report to her when there were problems obtaining medications as ordered from the pharmacy. Telephone interview with the PCP on 04/25/19 at 11:05am revealed: -On 02/27/19 she had a follow up visit with Resident #1 as related to his diagnosis of pneumonia. -Upon review of the eMAR and an interview with the MA on Resident #1's medication cart, it was determined he had not received his scheduled albuterol nebulizer treatments or any PRN nebulizer treatments. -Resident #1 was still congested and complained of coughing. -In the Physician Visit Summary on 02/27/19, under the heading of The Plan, she ordered the nebulizer treatments to "start today." -If these nebulizer treatments had been administered they could have aided in his respiratory recovery. Refer to interview with the Administrator on 04/24/19 at 3:45pm. 3. Review of Resident #2's current FL2 dated 01/16/19 revealed: -Diagnoses included a history of transient ischemic attack, low tension glaucoma, hypertension, diabetes mellitus, hiatal hernia,	{D 358}		

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{D 358}	Continued From page 50 neurocognitive deficit, and depression. -There was a handwritten note on the FL2 medication orders documenting, "See attached orders 1/16/19." Review of Resident #2's physician's orders dated 01/16/19 revealed: -There was an order for fingerstick blood sugars (FSBS) to be administered once a day. -There was no order for insulin administration. a. Review of Resident #2's Physician Visit summary dated 02/08/19 revealed: -There was an order for FSBS in the morning and at bedtime. -There was an order for levemir, a long acting insulin used to control blood sugar, 15 units twice a day. Review of Resident #2's February 2019 electronic medication administration record (eMAR) from 02/08/19 through 02/18/19 revealed: -There was an entry for FSBS in the morning, to be obtained at 8:00am. -There was documentation the FSBS readings ranged from 167 to 309. -There was an entry for FSBS in the evening, to be obtained at 8:00pm. -There was documentation the FSBS readings ranged from 225 to 434. -There was no entry for levemir 15 units, to be administered twice a day. -There was no documentation levemir 15 units was administered to Resident #2 from 02/08/19 until 02/18/19 twice a day. Review of Resident #2's record revealed the pharmacy notified the facility on 02/18/19 that Resident #2's levemir was not covered by insurance and recommended lantus another type	{D 358}		

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{D 358}	Continued From page 51 of long acting insulin used to control blood sugar. Interview with the Director of Resident Care (DRC) on 04/24/19 at 2:35pm revealed: -She did not know the levemir insulin ordered for Resident #2 on 02/08/19 was not administered for 10 days. -She knew insurance would not cover the levemir insulin and the PCP had ordered lantus on 02/18/19. -She frequently checked with the MAs on the floor to determine if there were any problems with medications or orders. -The MAs on the first and second shift did not report Resident #2's lantus insulin was discontinued on the eMAR. Interview with the medication aide (MA) on 04/24/19 at 2:45pm revealed: -She only administered medications that populated on the computer screen for administration. -Resident #2's levemir did not populate to be administered. -She never reported to the lead supervisor or the DRC that Resident #2's blood sugars were high. -She was not responsible for entering the medication orders in the computer system. -The Resident Care Coordinator (RCC), the DRC and the pharmacy entered orders on the eMAR. -She only administered what appeared on the computer screen. b. Review of Resident #2's physician's orders dated 02/18/19 revealed an order for lantus insulin 15 units twice a day in the morning and the evening. Review of Resident #2's February 2019 eMAR revealed:	{D 358}		

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{D 358}	Continued From page 52 -There was no entry for lantus 15 units to be administered twice a day. -There was no documentation lantus 15 units a long acting insulin used to control blood sugar, was administered to Resident #2 twice a day from 02/18/19-02/28/19. Review of Resident #2's March 2019 eMAR from 03/01/19-03/21/19 revealed: -There was an entry for lantus 15 units twice a day, to be administered at 6:30am and 8:00pm. -There was documentation lantus 15 units was administered at 6:30am from 03/01/19 through 03/20/19. -There was documentation lantus 15 units was administered at 8:00pm from 03/01/19 through 03/19/19. -There was no documentation explaining the reason Resident #2 was not administered lantus insulin from the evening of 03/20/19 through 03/31/19, as ordered by her primary care physician (PCP). Review of Resident #2's April 2019 eMAR from 04/01/19 to 04/16/19 revealed: -There was no entry for lantus 15 units twice daily, to be administered at 6:30am and 8:00pm. -Resident #2's FSBS ranged from 156 to 242 at 6:30am. -Resident #2's FSBS ranged from 168 to 268 at 8:00pm. Review of an eMAR order entry record revealed lantus U-100 insulin to be administered twice a day to Resident #2 was discontinued by the Director of Resident Care (DRC), on 03/20/19 at 7:40pm. Observation of Resident #2's medications available for administration on 04/24/19 at	{D 358}		

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{D 358}	Continued From page 53 2:55pm revealed: -Resident #2 had a vial of lantus on the medication cart with orders to inject 15 units twice per day and discard 42-days after opening. -The lantus was filled by the after-hours pharmacy on 03/03/19 and opened on 03/05/19. Further review of Resident #2's record on 04/25/19 revealed there was no physician's order to discontinue Resident #2's lantus to be administered twice a day. Interview with the DRC on 04/24/19 at 2:35pm revealed: -She did not know Resident #2's insulin order had been discontinued on 03/20/19 through 4/16/19. -She noticed when she reviewed the eMARs in mid-March, the entries for insulin orders did not have parameters. -She entered parameters (notify the PCP if blood sugar readings were <60 or >400) for the insulin orders as best practice. -She did not know when she entered the parameters on the insulin order, the order would be discontinued. -The eMAR system she had previously worked with did not discontinue the order if parameters were added to an existing order. -She frequently checked with the MAs on the floor to determine if there were any problems with medications or orders. -The MAs on first and second shift did not mention Resident #2's lantus insulin was discontinued on the eMAR. Interview with the medication aide (MA) on 04/24/19 at 2:45pm revealed: -The last time she administered insulin to Resident #2 was on 03/20/19 at 9:00am. -She did not know why Resident #2 no longer	{D 358}		

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{D 358}	Continued From page 54 received lantus twice per day after 03/20/19. -She was unable to locate an order for Resident #2 to discontinue lantus twice per day. -The administration history on the eMAR did not show lantus from 03/20/19 to present. -She only administered medications that populated on the computer screen for administration. -Resident #2's lantus did not populate to be administered) red. -She never reported to the supervisor or the DRC that Resident #2's blood sugars were high. -The MA was not responsible for entering the medication orders in the computer system. -She only administered what appeared on the computer screen. Interview with a second shift MA on 04/25/19 at 3:30pm revealed: -She only administered medications that populated on the eMAR computer screen. -She had administered Resident #2's insulin in the evening, but she did not have a current order to administer the medication. -She recorded Resident #2's FSBS in the evening. -She did not report to supervisor or the DRC that Resident #2's blood sugars were elevated. -She did not report to the supervisor or the DRC that Resident #2 was not currently receiving any insulin. -She thought Resident #2's insulin was discontinued because the medication did not populate on the screen to be administered. -The RCC, the RCD and the pharmacy were responsible for entering orders on the eMAR. Interview with the Resident Care Coordinator (RCC) on 04/24/19 at 3:45pm revealed. -She would only discontinue an order if she had	{D 358}		

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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 358}	Continued From page 55 the original order in front of her written and signed by a physician. -She was not employed at this facility when Resident #2's lantus was discontinued. Interview with the Administrator on 04/24/19 at 3:55pm revealed: -He delegated responsibility for medications and medication orders to the clinical staff. -He did not know Resident #2's insulin had been discontinued without a physician's order. -The facility had recently implemented a new eMAR system. -The technology support service was providing on going training and support to the staff. -It was his expectation the MAs would report any medication concerns to the DRC as well as their supervisors. Interview with Resident #2's PCP on 04/24/19 at 4:00pm revealed: -He was scheduled to see Resident #2 on 04/26/19 to follow-up with the control of her blood sugar. -He did not know Resident #2 was in the hospital. -Resident #2 should be receiving lantus 15 units twice a day to maintain proper control of her blood sugar. -He did not know Resident #2 was not administered lantus twice a day from 03/20/19 to 04/16/19 when she was admitted to the hospital. on 04/15/19. -If Resident #2 did not receive insulin as ordered, her blood sugars could become too high and she could be hospitalized. 4. Review of Resident #6's current FL2 dated 01/17/19 revealed diagnoses included hypertension, insomnia, and diabetes mellitus type 2.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060077	A. BUILDING: _____ B. WING _____	R 04/25/2019

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{D 358}	Continued From page 56 Review of Resident #6's physician's orders dated 02/13/19 revealed an order for cyclobenzaprine 5mg (used to treat muscle spasms) three times daily. Review of February 2019 electronic Medication Administration Records (eMAR) revealed there was a no entry for cyclobenzaprine 5mg. Review of Resident #6's physician's orders dated 03/13/19 revealed an order for cyclobenzaprine 5mg three times daily as needed, discontinue scheduled dose. Review of March 2019 eMAR revealed: -There was an entry for cyclobenzaprine 5mg three times daily at 8:00am, 12:00pm, and 8:00pm. -There was documentation cyclobenzaprine 5mg had been administered 39 out of 39 opportunities from 03/01/19-03/13/19. -There was an entry for cyclobenzaprine 5mg three times daily as needed. -There were no documented administrations of cyclobenzaprine 5mg from 03/14/19-03/31/19. Review of April 2019 eMAR revealed: -There was an entry for cyclobenzaprine 5mg three times daily as needed. -There were no documented administrations of cyclobenzaprine 5mg from 04/01/19-04/24/19. Observation of Resident #6's medications available for administration on 04/25/19 at 11:52am revealed cyclobenzaprine 5mg was not available for administration. Interview with a pharmacist at the contracted pharmacy on 04/25/19 at 4:00pm revealed:	{D 358}		

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{D 358}	Continued From page 57 -There was an order received 02/13/19 for Resident #6 for cyclobenzaprine 5mg one tablet three times daily. -There was an order received 03/13/19 for Resident #6 for cyclobenzaprine 5mg three times daily as needed. -There were 66 tablets of cyclobenzaprine 5mg dispensed on 02/13/19. -There were 90 tablets of cyclobenzaprine 5mg dispensed on 03/19/19. Interview with Resident #6 on 04/25/19 at 11:00am revealed: -He was ordered cyclobenzaprine for muscle spasms in his neck. -He remembered receiving the cyclobenzaprine. -He felt all of his medications were administered as ordered. Interview with a medication aide (MA) on 04/25/19 at 11:52am revealed: -She administered medications as they appeared on the eMAR. -If medications did not appear on the eMAR she did not administer the medication. -She had not noticed Resident #6's cyclobenzaprine was not listed on the eMAR. -Cart audits were completed monthly. "I don't know how it was missed". -The previous Resident Care Coordinator (RCC) was responsible for processing and entering orders on the eMAR. Interview with the Director of Resident Care (DRC) on 04/25/19 at 4:38pm revealed: -She knew Resident #6 had an order for cyclobenzaprine 5mg. -The medication order was entered on the eMAR and discontinued on 02/13/19 in error by a regional trainer for the eMAR system on	{D 358}		

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{D 358}	Continued From page 58 02/13/19. -"I don't know how this happened". -The eMAR was reviewed and verified when orders were originally entered onto the eMAR. -There was no process to check the eMAR monthly to ensure that medications were administered as ordered. -None of the MAs notified her the cyclobenzaprine was not on the eMAR. -She entered the order on the eMAR when the physician wrote a new order on 03/13/19. Interview with the Primary Care Provider (PCP) on 04/25/19 at 9:50am revealed: -She ordered cyclobenzaprine for Resident #6 due to pain in his neck. -She noticed that the medication was not administered in February 2019 after reviewing the eMAR. -She wrote a new order for the medication 03/13/19. -She expected the facility to administer medications as ordered. -Failure to administer cyclobenzaprine as ordered would cause increase neck pain. Refer to interview with the Administrator on 04/24/19 at 3:45pm. --- Interview with the Administrator on 04/24/19 at 3:45pm. -He delegated responsibility for medications and medication orders to the clinical staff. -He did not know medications on the eMAR had been discontinued without a physician's order. -The facility had recently implemented a new eMAR system. -The technology support service was providing on going training and support to the staff. -It was his expectation the MAs would report any	{D 358}		

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{D 358}	Continued From page 59 medication concern to the DRC as well as their supervisors. --- The facility failed to administer medications as ordered for 4 of 7 sampled residents including Resident #2 with a diagnosis of diabetes mellitus who had not received insulin, for 47 days, resulting in elevated blood sugar levels; Resident #7 with a diagnosis of diabetes mellitus type II and hyperglycemia, not being administered a nightly dose of insulin for 34 consecutive days, resulting in elevated morning blood sugars, Resident #1 with a diagnosis of pneumonia, not being administered albuterol nebulizer treatments, resulting in an extended hospital stay for respiratory failure; and Resident #6 with muscle spasms not being administered cyclobenzaprine for 16 days resulting in neck pain. This failure resulted in substantial risk of neglect and harm to the residents and constitutes an unabated Type A2 Violation. The facility provided a Plan of Protection on 04/25/19 in accordance with G.S. 131D-34 for this violation.	{D 358}		
{D 421}	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained	{D 421}		

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{D 421}	Continued From page 60 in the home. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure a record of each transaction involving use of a resident's personal funds was signed by the resident, legal representative, or payee at least monthly for 4 of 5 sampled residents (Residents #4, #10, #11, and #12). The findings are: Interview with the Business Office Manager (BOM) on 04/25/19 at 10:01am revealed: -When residents came to the office to request funds, they were allowed to request a certain amount or the remaining balance in their account. -She notified residents how much was available in their account and the remaining balance on their pharmacy bill. -She paid pharmacy bills for the residents who had an outstanding balance. -She discussed pharmacy bills with the residents prior to paying on them, however she had not had them sign a statement reflecting how much would be paid to the pharmacy from their account. -A cash transaction log was kept to record monthly transactions, however she did not get the resident to sign the transaction log before a payment was made to the pharmacy. -She thought one signature on the cash transaction log at the beginning of the month consented to all the remaining transactions for the month. 1. Review of Resident #4's personal fund trust account ledger revealed: -The beginning balance in Resident #4's account as of 04/01/19 was $154.04.	{D 421}		

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{D 421}	Continued From page 61 -The pharmacy was paid $133.02 on 04/10/19. Review of Resident #4's personal fund cash transaction log revealed: -Resident #4 had not signed agreeing to the pharmacy transaction on 04/10/19. -Resident #4 had an account ending balance of $.02. Review of Resident #4's pharmacy statement dated 03/27/19 revealed there was a balance due of $534.02. Interview with Resident #4 on 04/24/19 at 1:35pm revealed: -He agreed to allow the facility to pay a portion of his pharmacy bill. -He did not know $133.02 was paid for the pharmacy balance. -He would like to have known when and how much the pharmacy was paid before funds were deducted from his account. Refer to the interview with the Administrator on 04/25/19 at 4:25pm. 2. Review of Resident #10's personal fund trust account ledger revealed: -The beginning balance in Resident #10's account as of 04/01/19 was $29.14. -On 04/01/19, the pharmacy was paid $35.00. -On 04/10/19, the pharmacy was paid $15.00. -The ending balance in Resident #10's account as of 04/04/19 was $50.09. Review of Resident #10's personal fund cash transaction log did not reflect the resident had signed for the pharmacy transactions on 04/01/19 and 04/10/19 and there not a pharmacy statement provided by the facility for review.	{D 421}		

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{D 421}	Continued From page 62 Interview with Resident #10 on 04/23/19 at 10:08am revealed: -She received about $30.00 to $40.00 each month for spending money. -The facility paid her pharmacy bill each month. -She was unaware how much money was paid to pharmacy each month. -She realized she had a pharmacy copay each month, but she did not know how much her pharmacy bill was each month. Refer to the interview with the Administrator on 04/25/19 at 4:25pm. 3. Review of Resident #11's personal fund trust account ledger revealed: -The beginning balance in Resident #11's account as of 04/01/19 was zero. -On 04/01/19 the pharmacy was paid $30.00. -The ending balance in Resident #11's account as of April 11, 2019 was zero. Review of Resident #11's personal fund cash transaction log did not reflect the resident had signed for the pharmacy transaction on 04/01/19 and there not a pharmacy statement provided by the facility for review. Interview with Resident #11 on 04/23/19 at 10:16am revealed: -She had lived in the facility for over a year, but there was no consistency with the amount of her personal funds each month. -She felt the facility had a big problem with personal funds money each month being inconsistent and not available for distribution. -She understood there was a copay required for prescriptions each month. -She was unaware how much her pharmacy bill	{D 421}		

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{D 421}	Continued From page 63 was each month. -She was aware that her pharmacy bill was paid out of her $66 she received each month. -She was only on a few medications, and she did not know how much her pharmacy bill was each month. Refer to the interview with the Administrator on 04/25/19 at 4:25pm. 4. Review of Resident #12's personal fund trust account ledger revealed: -The beginning balance in Resident #12's account as of 04/01/19 was .39 cents. -On 04/01/19 the pharmacy was paid $25.00. -On 04/10/19 the pharmacy was paid $10.00. -The ending balance in Resident #12's account as of 04/10/19 was .39 cents. Review of Resident #12's personal fund cash transaction log did not reflect the resident had signed for the pharmacy transactions on 04/01/19 and 04/10/19 and there not a pharmacy statement provided by the facility for review. Interview with Resident #12 on 04/23/19 at 10:24am revealed: -She felt there was a problem with the personal fund's money. -She was told she had no money when she requested funds. -She did not understand why she did not have money. -She was only on a few medications. -The cost of the medications should not take her entire $66 each month. Refer to the interview with the Administrator on 04/25/19 at 4:25pm.	{D 421}		

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{D 421}	Continued From page 64 Interview with the Administrator on 04/25/19 at 4:25pm revealed: -The facility allowed residents to dictate how much of their personal funds was paid towards their pharmacy bill. -He expected the BOM to get consent from each resident, with a signature, before any funds were paid to the pharmacy. -"We should not be paying any funds to the pharmacy without a signature from the resident".	{D 421}		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Resident Rights. The finding are: Based on observations, interviews and record reviews, the facility failed to assure residents were treated with dignity in regards to failing to provide bath towels and washcloths for residents to use on shower days, not providing spoons to consume their meal when requested, and failure to assure residents were treated with respect and dignity regarding staff speaking to residents in a disrespectful manner. [Refer to Tag 338, 10A	D911		

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D911	Continued From page 65 NCAC 13F. 0909 Resident Rights (Type Unabated B Violation).]	D911		
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 related to other care and services. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 7 sampled residents (Resident #5) was provided transportation to scheduled physician's appointments related to missed Neurologist appointments, resulting in a delay of treatment and hospitalization for seizures. [Refer to tag 321, 10A NCAC 13F .0906 Other Resident Care And Services (Type Unabated B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights	D914		

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D914	Continued From page 66 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 in compliance with federal and state laws and rules and regulations related physician's notification for referral and follow-up and medication administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure physician notification for 4 of 7 sampled residents related to a missed appointment to the orthopedic practice after sustaining a fall requiring a total left hip replacement (Resident #1), symptoms of a urinary tract infection and abdominal pain (Resident #2), not notifying the physician of missed neurological appointments resulting in a delay in treatment and a four day hospitalization (Resident #5), and regarding a delayed urology consult (Resident #6). [Refer to tag 0273 10A NCAC 13F .0902 (b) Health Care (Type Unabated A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 7 sampled residents (Residents #2, #7, #6 and #1) related to a resident not receiving her insulin (Resident #2), a resident not receiving the evening dose of long acting insulin (Resident #7), a resident	D914		

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D914	Continued From page 67 diagnosed with pneumonia not receiving nebulizer treatments as ordered (Resident #1), and a resident experiencing muscle spasm and not administered pain medication (Resident #6). [Refer to Tag 358, 10A NCAC 13F .1004 Medication Administration (Type Unabated A2 Violation).]	D914		

Provider Plan of Correction East Towne
4815 N Sharon Amity Rd
Charlotte, NC 28205
Provider #: HAL-060077
Date of Survey Completed: April 25th, 2019

D 273 10A NCAC 13F .0902(b) Health Care

The facility shall assure referral and follow-up to meet routine and acute health care needs of residents.

Charlotte Opco Holdings, LLC, Licensee, specifically the East Towne Community, will ensure that the facility assure referral and follow-up to meet the routine and acute health care needs of residents (specifically for residents #1,2,5 & 6). The following practices and systems has been executed:

1. Strategic planning and follow up of the transportation department, with new transportation driver in place to focus on transportation.

2. Director of Resident Care and Executive Director have retrained staff on follow up for healthcare appointments and will verify that Residents will be transported, scheduled and followed up with next scheduled appointment day during daily transportation meetings. Initiated on 4/25/19 and driven and monitored by the Executive Director and the Resident Care Coordinator.

3. Ombudsman and ED provided in-service on Resident Rights as it relates to the above rule and is ongoing from 2/05/2019; 4/15/2019 and 5/15/2019.

4. Resident Care Coordinator (RCC), Resident Care Director (RCD) and/or Designee to follow up during daily communication meetings on Resident needs and concerns, along with new orders.

5. Use the company Order Processing System "Bucket System" to identify resident needs are followed up.

6. The DRC/RCC will notify Physician promptly regarding changes in condition and schedule appointments accordingly. Communication follows via company processing system and reviewed with team during morning meetings.

7. The DRC/RCC to Document appropriately/timely to support findings and follow up in Mattrix.

To be completed by: May 25, 2019
Person(s) responsible: Executive Director, Director of Resident Care and Resident Care Coordinator

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Date of Survey Completed: April 25th, 2019

D 282 10A NCAC 13F - .0904 (a)(1) Nutrition and Food Service

Charlotte Opco Holdings, LLC, Licensee, specifically the East Towne Community, will ensure the kitchen, dining and food storage areas shall be clean and orderly as evidenced by the following practices and systems executed:

1. Training kitchen staff on proper cleaning - 4/25/2019
2. Hire new DSM to put systems in place for cleaning - 5/30/2019
3. Train on cleaning schedule which shall be posted for staff to use daily - 5/27/19
4. Staff obtained ServSafe Certificates to ensure proper protocol for food handling and cleaning - 5/20/2019
5. Kitchen, Dining and Storage areas shall be clean and orderly - 5/16/2019
6. Kitchen and Dining Room will continue to be protected from contamination. A cleaning checklist will be documented of the necessary cleaning task to ensure protection from contamination.

To be completed by: May 30, 2019
Person(s) responsible: Executive Director and Dining Service Supervisor

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D 296 10A NCAC 13F .0904 (c) Menus in Adult Care Homes
(7) The facility shall have matching therapeutic menu with food items listed for all physician-ordered therapeutic diets for guidance of food service staff.

Charlotte OPCO Holdings, LLC, Licensee, specifically the East Towne Community, will ensure the facility have matching therapeutic menu with food items listed for all physician-ordered therapeutic diets for guidance of food service staff. It should be noted that the following practices and systems has been executed and followed by Dining Service Manager (DSM), Executive Director (ED) and/or Designee for continued compliance.

1. Training for dining services staff regarding diet orders completed to teach alterations needed for Residents on textured diets. DSM and ED completed on 4/25/2019 and ongoing.

2. ED has hired new Dining Service Manager with AL experience and certification 5/30/2019.

3. Resident Care Director (RCD)/ Resident Care Coordinator (RCC) will continue to follow up with new physician orders as related to diets and process through "Bucket System" for follow through.

4. Menus are printed and posted on a weekly basis with both Liberalized and Regular diets with textures for food service staff guidance.

To be completed by: May 30, 2019
Person(s) responsible: Executive Director, Director of Resident Care, Resident Care Coordinator and Dining Service Supervisor

Provider Plan of Correction East Towne
4815 N Sharon Amity Rd
Charlotte, NC 28205
Provider #: HAL-060077
Date of Survey Completed: April 25th, 2019

D 321 10A NCAC 13F .0906 (a) Transportation – The Administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles.

Charlotte OPCO Holdings, LLC, Licensee, specifically the East Towne Community Executive Director (ED), will ensure provisions for Transportation to necessary resources and activities including nearest health facilities, social service agencies, shopping and recreational facilities, as well as religious activities of the residents' choices. The following practices has been executed:

1. Executive Director (ED) has hired new driver dedicated to transportation schedule. Meetings with ED and Resident Care Coordinator (RCC) to review daily appointment schedule for the following day. The ED and RCC will follow up to ensure that resident appointments were met.

2. Follow up with RCC upon return with new folder system that is carried to the appointment and brought back to the RCC for scheduling of next appt. ED to follow up on scheduled appointments with RCC and Driver during daily meetings. (Purple folders implemented 5/28/2019)

3. Appointments are scheduled by RCC and reviewed with transportation. Driver will inform of missed appointments for scheduling and rescheduling. If an appointment is missed, the Resident Care Director and the RCC to notify family members and/or Guardians of appointments as well as the Physician(s) of the missed appointments. New appointments are then scheduled by the DRC/RCC and set up in the appointment binder and discussed at the transportation meeting.

4. Follow up via "Bucket System" to ensure appointments are scheduled and processed. DRC/RCC monitoring and following up. Appointment schedules are reviewed 24 hours in advance to ensure Residents are being seen according to physician's orders. Meeting notes kept for review.

5. Coordination for transportation reviewed daily with ED/RCC/Driver. Communication between Resident/Family Member; Physician office; Driver and Community facilitated via daily meeting and processed by DRC and RCC. ED is back up.

To be completed by: May 28, 2019 Person(s) responsible: Executive Director, Director of Resident Care, Resident Care Coordinator and Dining Service Supervisor

Provider Plan of Correction East Towne
4815 N Sharon Amity Rd
Charlotte, NC 28205
Provider #: HAL-060077
Date of Survey Completed: April 25th, 2019

D 338 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.

Charlotte OPCO Holdings, LLC, Licensee, specifically the East Towne Community ED, will ensure the rights of all residents are maintained and may be exercised without hindrance.

1. Staff training with Ombudsman; Executive Director (ED) and APS regarding Resident Rights as related to all rule areas completed and continues with Resident Rights during monthly meetings. Completed 5/25/2019 and ongoing.

2. All Staff continues to have consistent training on a monthly basis to ensure Residents are treated with dignity and respect. ED to monitor, train and provide APS and Ombudsman speakers.

3. Bath towels, wash cloths and linens provided as needed for Resident care and use. Purchased 4/25/2019 and order placed for extra supply.

4. Toilet paper, paper towels and eating utensils provided for Resident use as needed. Monitoring continues and purchased as needed. Dining Service Manager (DSM)/ED to continue monitoring. The ED will conduct daily rounds while communicating with Residents and Staff to ensure residents are being treated with dignity and respect.

5. The Ed will participate in Resident Council Meetings to hear stated concerns directly from Residents that need to be addressed. In addition, the ED will continue to invite the local Ombudsman to participate in Resident Rights discussions.

6. Resident concerns will be addressed by the ED as they arise and are brought to the attention of the team.

To be completed by: May 25, 2019 Person(s) responsible: Executive Director and Dining Service Supervisor

Provider Plan of Correction East Towne
4815 N Sharon Amity Rd
Charlotte, NC 28205
Provider #: HAL-060077
Date of Survey Completed: April 25th, 2019

D 358 10A NCAC 13F .1004 (a) Medication Administration: 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 residents record; and (2) rules in this Section and the facility's policies and procedures.

Charlotte OPCO Holdings, LLC, Licensee, specifically the East Towne Community clinical team, will ensure medications will continue to be administered as per physician's orders and according to the rules related to this section.

1. Appropriate Medication Pass observations by company Regional Nurse and Clinical Team continues for QA review and monitoring.

2. Cart reconciliations completed on a monthly bases by Licensed Nurse and Physician.

3. Hired new DRC – RN for Clinical Oversite – Starts 6/10/2019.

4. Director of Resident Care (DRC)/Regional Nurse monitors medication cart audits weekly for each cart. Performed by Med Tech and/or RCC and reviewed by Regional Nurse.

5. Ongoing Med Tech and C N A and PCA training on a monthly bases by DRC and/or Designee. Trainings done by licensed, clinical personnel.

6. Resident Rights reviewed along with re-training by ED, Ombudsman and/or APS Representative. Ongoing

7. All medication carts have been audited, cleaned and organized to aid in accuracy for medication pass and promote organization.

8. Medical professional will continue to provide training on obtaining blood sugars and notifying physicians as ordered.

9. Glucometer trainings ongoing on use and readings. Company MD providing trainings.

10. Follow up and processing of orders and medications monitored and maintained by DRC and RCC. Follow up through the company's Order Processing System, "Bucket System." It should be noted that any identified concerns will be addressed with the Executive Director.

11. See approved Plan of Protection from 4/24/2019.

To be completed by: May 25, 2019 Person(s) responsible: Executive Director, Director of Resident Care and Resident Care Coordinator.

Provider Plan of Correction East Towne
4815 N Sharon Amity Rd
Charlotte, NC 28205
Provider #: HAL-060077
Date of Survey Completed: April 25th, 2019

D 421 10A NCAC 13F .1104 – Accounting for Resident Personal Funds
(c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home.

Charlotte OPCO Holdings, LLC, Licensee, specifically the East Towne Community clinical team, will ensure accounting for Resident Personal Funds are recorded for each transaction and signed by the resident, legal representative or payee…if not adjudicated incompetent with two witnesses' signatures at least monthly verifying accuracy of the disbursement of personal funds. Therefore, the following systems and practices have been executed:

1. Transactions of personal funds are identified via Resident signature during each transaction.

2. Records of such actions are kept in the business office and maintained by the Business Office Manager. Executive Director oversite of the Resident Trust Fund reconciliation signed off for approval on a weekly basis. Signed copies will be kept in the business office for the Regional Director of Operations (RDO) and Regional Business Office Manager (RBOM) to follow up and review.

3. Each transaction, including but not limited to pharmacy account payments are signed by Resident and/or Family Member prior to payment.

- D 911 G.S. 131 D-21 (1) – Declaration of Residents' Rights
- D 912 G.S. 131 D-21 (2)
- D 914 G.S. 131 D-21 (4)

  Residents will be treated with dignity and respect. See approved Plan of Protection in above rule.

To be completed by: May 25, 2019 Person(s) responsible: Executive Director, Director of Resident Care and Resident Care Coordinator.