STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL046020	A. BUILDING: _____ B. WING _____	R 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey from October 28, 2019 - November 01, 2019.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 3 of 7 exit doors accessible for residents' use on the Assisted Living halls had a sounding device that activated for safety for 6 of 8 sampled residents (#7, #10, #13, #14, #15, #16) who were all assessed to be disoriented. The findings are: Observation upon entrance to the facility on 10/28/19 at 10:15am revealed: -There were five exit doors on the front side of the facility. -There was no sounding device when the front	D 067		

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door located near the Administrator's office was opened.

Interview with a resident on 10/29/19 at 9:34am revealed:
-The resident went outside of the facility often to smoke a cigarette.
-The resident never heard any alarms on the exit doors when the doors were opened.

Interview with the Administrator on 10/28/19 at 3:10pm revealed:
-The alarm door status panel for the Assisted Living (AL) side was turned on every night at approximately 6:00pm and turned off every morning at 6:00am.
-She was not aware of a regulation requiring all doors to have a sounding alarm.
-The door located in the common living room on the A Hall, where the alarm door status panel was located, was unlocked daily at 6:00am and locked at dusk.
-Residents use that door in the common living room area to go out and smoke.
-If a resident wanted to smoke at night after the door was locked, a staff member would unlock the door while the resident went out to smoke.

Observation in the common living room on A Hall on 10/28/19 from 3:10pm - 3:25pm revealed:
-There were residents entering and exiting the front exit door.
-There were no audible alarm sounds observed.

Observation on 10/28/19 at 11:35am revealed:
-An exit door on C Hall at the end of the hallway had an alarm device attached to the door.
-The alarm device was set to "delayed alarm."
-The door was not locked.
-The alarm sounded when door opened.

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D 067	Continued From page 2 Interview with a C Hall personal care aide (PCA) on 11/01/19 at 11:20am revealed: -The AL female residents resided on the C-hall. -The exit doors on the C-hall were not locked or alarmed during the day, but were locked and the alarms set at night. -The AL residents were allowed to leave the facility whenever they wanted to. -The AL residents were required to sign out in a log book when they left the facility. -She did not know of any resident that was ever missing from the facility. Observation of the A Hall exit door (located by resident rooms #17 and #18) on 10/28/19 at 10:45am from 10:51am revealed: -The exit door opened when pushed and there was no alarm heard. -The exit door had a clear lockbox with a battery inside hanging loosely by a wire visible on the bottom of the clear lockbox that covered the alarm mechanism. -The exit door opened to the ungated grounds of the facility which could allow residents to leave the facility without staff knowledge and was accessible to the two lane highway in front of the facility. Interview with a housekeeper on the A Hall on 10/28/19 at 10:50am revealed: -The A Hall exit door (located by resident rooms #17 and #18) was where the trash was taken out. -The exit door was left unlocked until it was dark. -There was no alarm on the door and there were no residents who wandered on the A Hall. Second observation of the A Hall exit door (located by resident rooms #17 and #18) on 10/28/19 at 11:02am revealed a resident entered	D 067		

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the facility through the exit door and there was no alarm heard.

Interview with a medication aide (MA) on 10/28/19 at 6:00pm revealed:
-The door alarm did not work on the exit door on the A Hall near resident rooms #17 and #18.
-She did not know how long the door alarm had not been working.
-The staff locked the doors at night between 9:00pm and 11:00pm and turned on the door alarms.
-She had not known the door alarm on that exit door to have worked for two to three months.
-She did not report the door alarm had not been working because she thought "it was okay because the door still locked".
-It was possible for a resident to leave the facility without staff's knowledge if they exited through that exit door.
-There had not been any problems with residents leaving the facility without staff knowledge.
-She was not sure if any of the residents on the A Hall had a history of wandering or were considered to be disoriented.

Interview with a second MA on 10/31/19 at 4:40pm revealed:
-There were no door alarms activated on any of the exit doors during the day.
-The door alarms were activated every night at 11:00pm when staff locked the doors.
-The door alarm on the exit door at the far end of the A Hall had never worked since the staff started working at the facility.
-The staff reported having worked at the facility for greater than five years.

1. Review of Resident #7's current FL-2 dated 03/26/19 revealed:

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-Diagnoses included Alzheimer's disease with behavioral disturbances, tardive dyskinesia and syncope.
-There was documentation the resident was ambulatory and intermittently disoriented.

Review of Resident #7's Resident Register revealed the resident was admitted on 02/01/19.

Review of Resident #7's Assessment and Care Plan dated 05/13/19 revealed:
-There was documentation the resident was oriented, forgetful and needed reminders.
-There was documentation the resident required limited assistance from staff for ambulation and transfers.

Interview with the Administrator on 10/28/19 at 2:48pm revealed:
-Resident #7 was disoriented to time.
-Resident #7 did not have any exit seeking behaviors.
-Resident #7 was ambulatory.

2. Review of Resident #10's current FL-2 dated 09/17/19 revealed:
-Diagnoses included cerebral infarction, muscle weakness, aphasia following cerebral infarction and other abnormalities of gait and mobility.
-The section for disorientation and inappropriate behavior was blank.
-There was documentation the resident was semi-ambulatory.

Review of Resident #10's Resident Register revealed the resident was admitted on 09/16/19.

Review of Resident #10's Assessment and Care Plan dated 09/18/19 revealed:
-There was documentation the resident did not

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talk much and liked to stay in bed and smile.
-There was documentation the resident was sometimes disoriented, forgetful needing reminders.
-There was documentation the resident required extensive assistance from staff for ambulation and transferring.

Interview with Resident #10 on 10/28/19 at 10:45am revealed she had been living at the facility for a "few months".

Interview with the Administrator on 10/28/19 at 2:48pm revealed:
-Resident #10 was disoriented to time.
-Resident #10 did not have any exit seeking behaviors.
-Resident #10 was ambulatory.

3. Review of Resident #13's current FL-2 dated 08/05/19 revealed:
-Diagnoses included dementia and schizophrenia.
-The section for disorientation and inappropriate behavior was blank.
-There was documentation the resident was ambulatory.

Review of Resident #13's Resident Register revealed the resident was admitted on 02/01/19.

Review of Resident #13's Assessment and Care Plan dated 03/29/19 revealed:
-There was documentation the resident was sometimes disoriented, and the resident's memory was adequate.
-There was documentation the resident required supervision for ambulation and transferring.

Interview with the Administrator on 10/28/19 at

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2:48pm revealed:
-Resident #13 was disoriented to time and was "very confused".
-Resident #13 did not have any exit seeking behaviors.
-Resident #13 often thought he was leaving and his family member was coming to get him and asked to get all of his cigarettes.
-Resident #13 was ambulatory.

4. Review of Resident #14's current FL-2 dated 04/08/19 revealed:
-Diagnoses included vascular dementia without behavioral disturbances, schizoaffective disorder and psychotic disorder due to brain injury.
-There was documentation the resident was ambulatory and intermittently disoriented.

Review of Resident #14's Resident Register revealed the resident was admitted on 02/01/19.

Review of Resident #14's Assessment and Care Plan dated 09/04/19 revealed:
-There was documentation the resident was oriented, and the resident's memory was adequate.
-There was documentation the resident required supervision from staff for ambulation and transferring.

Interview with a personal care aide (PCA) on 11/01/19 at 2:53pm revealed:
-Resident #14 was confused "sometimes".
-Resident #14's memory was very poor.
-Resident #14 was moved to another room today (11/01/19) but continued to go to his old room, lying on the bed after being told about the new assigned room.
-Resident #14 went outside with other residents to smoke.

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D 067	Continued From page 7 Interview with Resident #14 on 11/01/19 at 2:55pm revealed: -He did not have a newly assigned room. -He went outside and smoked during the day. Interview with the Administrator on 10/28/19 at 2:48pm revealed: -Resident #14 was disoriented to time. -Resident #14 did not have any exit seeking behaviors. 5. Review of Resident #15's current FL-2 dated 04/01/19 revealed: -Diagnoses included dementia Alzheimer's type, mental retardation, depression disorder, borderline intellectual function, and a history of delusions. -There was documentation the resident was ambulatory and intermittently disoriented. Review of Resident #15's Resident Register revealed the resident was admitted on 02/01/19. Review of Resident #15's Assessment and Care Plan dated 03/02/19 revealed: -There was documentation the resident was sometimes disoriented, forgetful and needed reminders. -There was documentation the resident required supervision from staff for ambulation and transferring. Interview with the Administrator on 10/28/19 at 2:48pm revealed: -Resident #15 was disoriented to time. -Resident #15 did not have any exit seeking behaviors. 6. Review of Resident #16's current FL-2 dated	D 067		

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D 067	Continued From page 8 04/08/19 revealed: -Diagnoses included mild cognitive impairment, dementia with behavioral disturbance, anxiety disorder and mood disorder due to known physiological condition. -There was documentation the resident was ambulatory and intermittently disoriented. Review of Resident #16's Resident Register revealed the resident was admitted on 02/01/19. Review of Resident #16's Assessment and Care Plan dated 06/13/19 revealed: -There was documentation the resident was sometimes disoriented, forgetful and needed reminders. -There was documentation the resident required supervision from staff for ambulation and transferring. Interview with the Administrator on 10/28/19 at 2:48pm revealed: -Resident #16 was disoriented to time. -Resident #16 did not have any exit seeking behaviors.	D 067		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.	D 079		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure the facility was free of hazards as evidenced by an opened tub of beige colored paint covered with a clear plastic sheet and 2 five-gallon buckets of paint stored on the floor in a common resident area (the telephone room), a missing floor drain cover in the shower of the common shower room #2 on the A hall and an enclosed mouse traps and rat/mice poison pellets placed in common areas on the Assisted Living (AL) section; an unlocked and unmonitored linen closet used to store twin blade razors and the residents' personal hygiene items in the form of liquids and solids, an unlocked laundry room not monitored by staff and a damaged exit door with a cracked window with loose glass fragments and a missing push bar that left a circular hole in the interior side of the door on the Special Care Unit (SCU) .

The findings are:

1. Observation of the exit door at the end of the hallway on the Special Care Unit (SCU) on 10/28/19 at 11:44am and 2:37pm revealed:
-The door was locked.
-The push bar on the exit door was missing, leaving a circular opened area that was approximately 2 ½ inches wide that left an rough and irregular metal edges surrounding the opening.
-The opened hole in the door extended to the door's exterior side.
-There was a fiber type tape that covered the outer opening of the hole on the exterior side of

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the door.
-The exit door had a large square window that had a diamond shaped crack in the glass that extended to the edges of the window's frame.
-Small, sharp glass fragments fell from the window when the cracked area of the window was touched on the left side.
-The window frame moved slightly outward when pressure was applied against the glass.

Interview with a personal care aide (PCA) on 10/28/19 at 11:40am revealed:
-The glass window to the exit door at the end of the hall on the SCU had not been cracked long, she could not give an estimated time.
-She was not sure what happened to the window.
-The push bar on the exit door had loosened over time from residents pushing on it.
-The push bar had been off the door no more than 2 weeks.
-She thought the Maintenance Director was waiting on a part to repair the door.

Interview with a PCA on 10/29/19 at 11:04am revealed:
-She had worked at the facility since March 2019.
-She thought the window at the exit door at the end of the hallway on the SCU had been cracked since she had been hired but, she was not sure.
-The push bar to the exit door had not been off the door long.
-The push bar was damaged from residents pushing against it.
-No residents had been injured from the circular opening in the door where the push bar was missing or from the cracked glass window in the door.

Interview with the Special Care Coordinator/Resident Care Coordinator

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D 079	Continued From page 11 (SCC/RCC) on 11/01/19 at 2:03pm revealed: -The exit door on the SCU was damaged when a contracted provider with the door alarm system was at the facility checking the alarms on the exit door and the provider threw his whole weight against the door. This occurred sometime this past summer. -When the window to the exit door was damaged, she immediately reported it to the Administrator. -None of the residents had been injured by the cracked glass at the exit door. -She was not sure what happened to the exit door's push bar and was not aware of any residents being injured by the opened area in the door. Interview with the Administrator on 11/01/19 at 3:38pm revealed: -It was the responsibility of all staff to immediately report any hazards or concerns verbally to the Maintenance Director. -The cracked window at the exit door on the SCU occurred around the last week of May 2019. -The window did not crack at that time (May 2019), however, overtime the glass cracked gradually. -The Maintenance Director was told a "couple of weeks" ago to replace the door with an extra door the facility had. -The Managing Member for the facility told the Maintenance Director a couple of weeks ago to take the glass out of the extra door but the glass would not fit. 2. Observation in the hallway on the Special Care Unit (SCU) on 10/30/19 from 8:55am - 9:01am revealed: -There was a small hallway extending off the main SCU hall on the right side that led to the laundry room door.	D 079		

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D 079	Continued From page 12 -At 8:55am, the door to the SCU laundry room was closed. -The door had a keypad on the door knob. -The door was not locked. -The dryer in the laundry room was on. -There were no staff in the area of the laundry room. -At 8:55am, the Administrator in Training (AIT), the Quality Assurance (QA) Director and the medication aide (MA) were in the dining room with some of the residents. -At 9:01am, a personal care aide (PCA) entered the laundry room. -The laundry room door remained unlocked and not monitored by staff for 6 minutes. Observation in the SCU laundry room on 10/29/19 at 9:02am revealed: -There was one exit door on the opposite side of the room that was locked. -There was a one-gallon container of bleach stored beside the laundry machines. -There were labeled manufacturer's instructions "DANGER" on the front of the label. -There were labeled manufacturer's instructions on the side label of the bleach with precautionary instructions: hazards to humans; there was a second section labeled "DANGER: CORROSIVE", may cause severe skin and eye irritation or chemical burns to broken skin, causes eye damage, wear safety glasses and rubber gloves when handling this product. -There was one 1lb 2 ounce can of flying insect killer labeled as a pesticide. -There were labeled precautionary and hazard statements that the product was hazardous to humans, harmful if absorbed through the skin, take off contaminated clothing, rinse the skin immediately with plenty of water for 15-20 minutes and call poison control center or a doctor	D 079		

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for treatment advise.
-There were labeled instructions on the can of flying insect killer in the event of inhalation, move the person to fresh air, if the person is not breathing, call 911 and begin cardiopulmonary resuscitation, call a poison control center or doctor or go for treatment.
-There was a 32 ounce spray bottle containing a light green colored liquid with approximately ¼ of the liquid remaining.
-There was an opened 35 fluid ounce jug of fabric softener.
-There was an opened 28 ounce container of a cleansing powder with labeled caution instructions to avoid contact with eyes, skin and clothing, the product was moderately irritating to the eyes, skin and mucus membranes and if swallowed, drink a glassful of water, and call a physician.
-There was a one-gallon container of liquid soap with less than ¼ of the soap remaining with a labeled caution statement to keep out of eyes and if swallowed, consult a physician or a poison control center.

Interview with a PCA on 10/30/19 at 9:01am revealed:
-She was doing laundry today, (10/30/19) and had been in an out of the laundry room.
-The door to the laundry room should always remain locked.
-She was not sure why the door was unlocked.
-When she left the laundry room door, she shut the door but, she did not check to make sure the door was locked.

Interview with a second PCA on 10/30/19 at 9:40am revealed:
-It was important to keep the door locked to the laundry room because there were detergents in

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there.
-Staff were responsible to make sure doors were always locked.
-She was not sure why the laundry room door was unlocked and thought it could have been a dead battery for the lock.

Interview with a housekeeper on 10/30/19 at 9:46am revealed:
-She was not sure if the laundry door lock was operated by a battery.
-She thought if the door was connected and secured in the right location with the door frame, then the door would be locked.

Review of the facility's "Physical Environment, Feature design and Safety Services" policy and procedures for the SCU revealed any items that were deemed hazardous would be kept secured in designated storage areas and would only be accessible to staff.

3. Observation of a double door linen closet located in a small hallway extending off the main SCU hall 10/30/19 at 9:11am - 9:30am revealed:
-There was a sign posted "Clean linen closet, keep locked" on the left door.
-The linen closet was not locked.
-There was an open box of seven shaving razors and fifteen open plastic baskets that contained personal items which included razors, deodorant, hair care items and lotions.
-There was a sign posted on the wall across from the open closet that read "Please make sure all closets are locked at all times and only unlocked by staff and under the staff supervision while unlocked, then lock back after each use! No exceptions!"
-The sign was signed by the Special Care Unit/Resident Care Coordinator (SCU/RCC) and

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there was no date documented when the sign was posted.
-At 9:19am, a resident was standing in the hallway close to the linen closet.
-At 9:21am the AIT walked down the hall passing the linen closet.
-The closet was not under staff supervision and staff were providing care to the residents in the SCU living room and residents' rooms.

Interview with a PCA on 10/30/19 at 9:35am revealed:
-The linen closet was always locked.
-The linen closet was used to store the residents' personal items.
-She started her shift today, (10/29/19) at 7:00am and had not used or checked the linen closet.
-The doors to linen closet were always supposed to be locked because some residents would go in the closet and take other residents belongings.
-The PCA did not think there would be a risk of a resident being harmed by the unlocked door to the linen closet.

Interview with the AIT on 10/29/19 at 9:52am revealed:
-It was important for staff to keep all doors locked for the safety of the residents on the SCU.
-All residents on the SCU were on ingestion precautions.
-The laundry room and the linen closet should always have remained locked.

Review of the facility's "Ingestion Risk Assessment" revealed:
-There were assessment guideline entries on the left side of the form and a box to mark yes or no on the right side of the form.
-There was an entry that personal items that could be ingested were maintained by staff (all

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liquid personal items, aerosols, hearing aids, pins, buttons, clips, etc.) in a secured location until needed for resident use.
-There was an entry resident rooms/care area were inspected regularly for unsafe items that could be accidentally ingested or harmful.
-All utility closets and laundry areas were locked unless under direct supervision.
-All toxic substances would remain in the original container and secured in a locked area unless under direct supervision.
-Staff training included assessing residents for possible ingestion and initiating necessary emergency procedures, calling poison control center if necessary and monitoring the facility and resident rooms for substances that could be accidentally ingested.

Interview with the Special Care Coordinator/Resident Care Coordinator (SCC/RCC) on 11/01/19 at 2:03pm revealed:
-The laundry room door on the SCU should always remain locked when staff were not in the room.
-The linen closet doors should always remain locked.
-She was in the SCU "a few times a day".
-She had not observed the linen closet or the laundry door being unlocked and unattended by staff.

Interview with the Administrator on 10/30/19 at 9:58am revealed staff were always responsible to assure the door to the laundry room and linen closet remained locked.

4. Observation of the common shower room #2, A Hall (located by resident room #18) on the Assisted Living (AL) section on 10/28/19 at 10:47am revealed:

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D 079	Continued From page 17 -There was no drain cover over the drain in the shower and it exposed an opening approximately two inches in diameter in the bottom of the shower. -The open drain hole was covered with black stains. Interview with the Maintenance Director on 10/28/19 at 11:05 revealed: -He was not aware the drain cover was missing from the drain hole in the common shower room #2. -He had replaced the drain cover in the common shower room about a week ago. Observation of the common shower room #2 on the A Hall, AL section on 10/29/19 at 9:55am revealed the drain cover in the middle of the shower floor had not been replaced. Interview with the Administrator on 11/01/19 at 3:38pm revealed it was the responsibility of all staff to immediately report any hazards or concerns verbally to the Maintenance Director. 5. Observation of the residents' telephone room on the Assisted Living (AL) section on 10/28/19 at 10:22am revealed: -The door was opened to the residents' telephone room and there was a sign on the door that read "keep door opened". -There was an opened tub of beige colored paint covered with a clear plastic sheet and 2 five-gallon buckets of paint stored on the floor on the left side of the door entrance. Observation on 10/28/19 at 10:15am revealed there was a resident walking in the main facility hallway of the AL section passing the open door to the telephone room.	D 079		

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D 079	Continued From page 18 Interview with the Administrator on 11/01/19 at 3:38pm revealed it was the responsibility of all staff to immediately report any hazards or concerns verbally to the Maintenance Director. 6. Observation of the common shower room #1 on C Hall, Assisted Living (AL) section on 10/28/19 at 10:49am and 2:06pm revealed there was an enclosed mouse trap that contained poison inside placed against the wall in between the whirlpool tub and sink. Interview with the Administrator on 10/28/19 at 3:33pm revealed: -She was not aware an enclosed mouse trap that contained poison was in the common shower room #1 on C Hall, AL section. -The mouse trap should not be in the resident shower room. Observation of the common shower room #1 on C Hall, AL section on 10/29/19 at 9:20am revealed the enclosed mouse trap that contained poison had not been removed from the shower room. Interview with the Administrator on 10/30/19 at 12:15pm revealed: -The facility had a pest control contract with a pest control vendor. -The pest control vendor placed the enclosed mouse trap that contained poison in the common shower room #1 on C Hall, AL section. Telephone interview with a service technician from the pest control vendor on 11/01/19 at 11:15am revealed: -They provided pest control services to the facility once a month and every quarter. -They provided pest control services on an as	D 079		

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needed basis when they were notified by the facility Administrator.
-They did not treat the facility with the same enclosed mouse traps that contained poison or pellet bait that were observed in the facility.
-They had never used the pest control brand that the Administrator reported they used in the facility.
-There would be a risk of poisoning if an individual ingested or touched an enclosed mouse trap that contained poison or a pellet bait.
-Hands should be washed with warm water and soap for safety if the enclosed mouse trap that contained poison or a pellet bait was touched.

Interview with the Maintenance Director on 11/01/19 at 2:30pm revealed:
-He put out enclosed mouse traps that contained poison in the facility in the common shower room #1 on C Hall, AL section.
-He also put out rat/mice poison pellets in the residents' closets on the AL section.
-He did not put out rat/mice poison pellets in the residents' closets on the Special Care Unit (SCU) because those residents "were confused".
-He was not told by anyone to put out the enclosed mouse traps or the rat/mice poison pellets in the facility, he just did it on his own because residents had complained of mice.
-He did not tell anyone that he had put out the mouse traps or the rat/mice poison pellets.
-He knew the facility had a contract with a pest control vendor, and they came once a month.
-He felt the additional enclosed mouse traps or the rat/mice poison pellets he put out helped to lesson the number of mice in the facility.

Observation of the closet in resident room #1 on the AL section on 11/01/19 at 2:45pm revealed there were 11 rat/mice poison pellets on the right

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D 079	Continued From page 20 rear corner floor that had a resident's slipper sitting on top of them. Attempted interview with the two residents who resided in room #1 on the AL section on 11/01/19 at 2:45pm was unsuccessful. Observation of the closet in resident room #3 on the AL section on 11/01/19 at 2:48pm revealed there were 14 rat/mice poison pellets on the right rear corner floor. Attempted interview with the two residents who resided in room #3 on the AL section on 11/01/19 at 2:48pm was unsuccessful. Interview with Administrator on 11/01/19 at 3:00pm revealed: -She was responsible for overseeing the Maintenance Director's work. -The enclosed mouse trap that contained poison and pellet bait had been placed in the common shower room #1 on C Hall, AL section by the Maintenance Director. -She did not know that the Maintenance Director had put out rat/mice poison pellets in the residents' closets on the AL section. -She did not tell the Maintenance Director to put out the enclosed mouse traps or rat/mice poison pellets in the facility. -She would have all closets in the facility checked immediately and any mouse traps and rat/mice poison pellets removed immediately. -She did not have a copy of the pest control contract for the facility. -She was still waiting to receive the contract via email from the pest control vendor. _____ The facility failed to assure the environment was free of hazards including a tub of paint covered	D 079		

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D 079	Continued From page 21 with a clear plastic sheet and 2 five-gallon buckets of paint stored on the floor in a common resident area (the telephone room), a missing floor drain cover in the shower of the common shower room #2 on the A hall and a enclosed mouse traps and rat/mice poison pellets placed in common areas on the Assisted Living (AL) section; an unlocked and unmonitored linen closet used to store twin blade razors and the residents' personal hygiene items in the form of liquids and solids, an unlocked laundry room not monitored by staff and a damaged exit door with a cracked window with loose glass fragments and a missing push bar that left a circular hole in the interior side of door on the Special Care Unit (SCU). The facility's failure to assure an environment free of hazards was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 01, 2019.	D 079		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and	D 113		

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D 113	Continued From page 22 existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) for 3 of 6 sampled fixtures used by residents on the Assisted Living (AL) section of the facility (1 sink, 1 shower on the C Hall for common bathroom B, and 1 sink in a shared resident bathroom) and failed to assure hot water temperatures were maintained below 116 degrees F for 3 of 7 sampled fixtures (1 shower, one tub and one sink in the common bathroom A) on the Special Care Unit (SCU). The findings are: 1. Observations during of common bathroom A on the Special Care Unit (SCU) on 10/28/19 between 10:39am and 11:30am revealed: -At 10:46am, the hot water temperature at the sink in common bathroom A was 118 degrees Fahrenheit (F). -At 10:48 am, the hot water temperature at the shower in common bathroom A was 118 degrees F. -At 10:50am, the hot water temperature at the tub in common bathroom A was 120 degrees F. Interview with a personal care aide (PCA) on 10/28/19 at 10:50am revealed: -She had noticed that the water in common bathroom A was " ...a little warm" but staff checked the water temperatures by feeling the water without gloved hands before residents came into contact with the water to assure the water was not too hot or cold.	D 113		

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D 113	Continued From page 23 -She thought "probably" the Maintenance Director checked the water temperatures on the SCU. -She was not aware of any residents getting injured or burned from the water temperatures in common bathroom A. Interview with a resident residing in the SCU on 10/28/19 at 11:02am revealed: -The resident had not noticed the water in the SCU being too hot or too cold. -He "mixed" the hot and cold water to make the water warm. Interview with a medication aide (MA) on 10/29/19 at 10:10am revealed the water in the SCU gets "a little warmer" than the water on the Assisted Living side. Interview with a resident residing on the SCU on 10/29/19 at 10:55am revealed: -The resident used the shower yesterday, (10/28/19) in the common bathroom. -The water in the common bathroom A shower on the SCU would "scald you". Review of water temperature check logs for the common bathroom A in the SCU for September 2019 provided by the facility revealed: -On 09/02/19, water temperature readings at the sink were 109 degrees F, at the shower 109 degrees F, and at the tub 109 degrees F. -On 09/09/19, water temperature readings at the sink were 108 degrees F, at the shower 108 degrees F, and at the tub 107 degrees F. -On 09/16/19, water temperature readings at the sink were 107 degrees F, at the shower 108 degrees F, and at the tub 107 degrees F. -On 09/23/19, water temperature readings at the sink were 104 degrees F, at the shower 106 degrees F, and at the tub 109 degrees F.	D 113		

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-On 09/30/19, water temperature readings at the sink were 108 degrees F, at the shower 107 degrees F, and at the tub 107 degrees F.

Review of water temperature check logs for the common bathroom A in the SCU for October 2019 provided by the facility revealed:
-On 10/07/19, water temperature readings at the sink were 105 degrees F, at the shower 105 degrees F, and at the tub 104 degrees F.
-On 10/14/19, water temperature readings at the sink were 105 degrees F, at the shower 106 degrees F, and at the tub 107 degrees F.

On 11/01/19 at 1:36pm, the facility's digital thermometer and the surveyor's thermometer were calibrated using an ice water slurry. The facility thermometer displayed 33 degrees F. The surveyor's thermometer displayed 32.4 degrees F.

Refer to the interview with the Resident Care Coordinator/Special Care Coordinator (RCC/SCC) on 11/01/19 at 2:03pm

Refer to the interview with the Maintenance Director on 10/31/19 at 3:30pm.

Refer to the interview with the Administrator on 10/28/19 at 12:15pm.

2. Observations of common bathroom B on 10/28/19 between 10:56am and 11:30am on the C Hall, Assisted Living (AL) section revealed:
-At 11:23am, the hot water temperature at the shower in common bathroom B was 90 degrees Fahrenheit (F).
-At 11:30am, the hot water temperature at the sink in common bathroom B was 90 degrees F.

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D 113	Continued From page 25 Interview with a resident residing in room #4 on the C Hall of the AL section of the facility on 10/28/19 at 11:23am revealed: -She did not like to take showers because the water was too cold; she only wanted sponge baths. -She had not told anyone that the water had been cold. Interview with a personal care aide (PCA) on 10/28/19 at 11:08am revealed: -About two days per week, she noticed the water in bathroom B on the C Hall would not get warm. -The residents complain about the water being cold about twice per week. -When a resident complained, she would sponge bathe them. -She had already reported the cold water to management a few months back. -The water heater was the same one with the previous owners and there were cold water issues. A second observation on the C Hall, AL section in the common bathroom B on 10/29/19 at 10:33am revealed: -The hot water temperature at the shower was 90 degrees F. -The hot water temperature at the sink was 90 degrees F. Confidential interview with a staff revealed she and other staff had heard residents complaining about the hot water not getting warm enough. Review of water temperature check log for common bathroom B in the AL section for September 2019 provided by the facility revealed: -On 09/02/19, the water temperature reading at the sink was 106 degrees F and at the shower	D 113		

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was 106 degrees F.
-On 09/09/19, the water temperature reading at the sink was 106 degrees F and at the shower was 105 degrees F.
-On 09/16/19, the water temperature reading at the sink was 105 degrees F and at the shower was 106 degrees F.
-On 09/23/19, the water temperature reading at the sink was 106 degrees F and at the shower was 108 degrees F.
-On 09/30/19, the water temperature reading at the sink was 106 degrees F and at the shower was 106 degrees F.

Review of water temperature check logs for common bathroom B in the AL section for October 2019 provided by the facility revealed:
-On 10/07/19, water temperature readings at the sink were 105 degrees F and at the shower 105 degrees F.
-On 10/14/19, water temperature readings at the sink were 106 degrees F and at the shower 105 degrees F.

On 11/01/19 at 1:36pm, the facility's digital thermometer and the surveyor's thermometer were calibrated using an ice water slurry. The facility thermometer displayed 33 degrees F. The surveyor's thermometer displayed 32.4 degrees F.

Observation of water temperatures in the common bathroom B on the AL section with the Managing Member on 11/01/19 at 1:43pm revealed:
-The hot water temperature at the sink was 82 degrees F with the surveyor's thermometer, and 84 degrees F with the facility thermometer.
-The hot water temperature at the shower was 82 degrees F with the surveyor's thermometer, and

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84 degrees F with the facility thermometer.
-The shower's handle fixture would move past the cold and hot indicator lines on the base of the fixture and the handle had to moved back and forth to stop the flow of the water.

Interview with the Managing Member on 11/01/19 at 1:26pm and 1:46pm revealed:
-He discovered today (11/01/19) the low hot water temperatures on C Hall was caused by a pilot light that had blown out on the water heater "this week" when the pump house door had been knocked out by the wind.
-The shower's fixture might have to be replaced because of the movement of the handle required to control the water flow and temperature.

Refer to the interview with the Resident Care Coordinator/Special Care Coordinator (RCC/SCC) on 11/01/19 at 2:03pm

Refer to the interview with the Maintenance Director on 10/31/19 at 3:30pm.

Refer to the interview with the Administrator on 10/28/19 at 2:48pm.

3. Observations during the initial facility tour on 10/28/19 between 10:56am and 11:30am on the C Hall, Assisted Living (AL) section revealed at 10:56am, the hot water temperature at the sink in a shared resident bathroom for rooms #4 and #6 was 90 degrees Fahrenheit (F).

A second observation of the hot water temperature at the sink in a shared resident bathroom for rooms #4 and #6 was 90 degrees F on 10/29/19 at 10:34am revealed the hot water temperature at the sink was 98 degrees F.

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D 113	Continued From page 28 Interview a resident assigned to resident room 4 A on 10/29/19 at 10:34am revealed: -The resident used the water from the sink weekly in the shared bathroom to take sponge baths. -The hot water at the sink was warm but would not get "real warm". -The hot water had to run a long time to get warm. -She had not told staff about the hot water taking a long time to warm up or that the water was not real warm because all of the residents on the hall said the same about the hot water that she had spoken to. Interview with a resident residing on the C Hall of the Assisted Living section of the facility on 10/29/19 at 10:23am revealed it took a long time for the water to get hot. Confidential interview with a staff revealed she and other staff had heard residents complaining about the hot water not getting warm enough. Review of water temperature check logs for the shared bathroom for resident room #4 and #6 on the C Hall on the AL section for September 2019 provided by the facility revealed: -On 09/02/19, the water temperature reading at the sink was 105 degrees F. -On 09/09/19, the water temperature reading at the sink was 107 degrees F. -On 09/16/19, the water temperature reading at the sink was 105 degrees F. -On 09/23/19, the water temperature reading at the sink was 104 degrees F. -On 09/30/19, the water temperature reading at the sink was 108 degrees F. Review of water temperature check logs for the	D 113		

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shared bathroom for resident room #4 and #6 on the C Hall on the AL section for October 2019 provided by the facility revealed:
-On 10/07/19, the water temperature reading at the sink was 106 degrees F.
-On 10/14/19, the water temperature reading at the sink was 105 degrees F.

On 11/01/19 at 1:36pm, the facility's digital thermometer and the surveyor's thermometer were calibrated using an ice water slurry. The facility thermometer displayed 33 degrees F. The surveyor's thermometer displayed 32.4 degrees F.

Interview with the Managing Member on 11/01/19 at 1:26pm and 1:46pm revealed:
-He discovered today (11/01/19) the low hot water temperatures on C Hall was caused by a pilot light that had blown out on the water heater "this week" when the pump house door had been knocked out by the wind.
-He noticed "this week" when he was adjusting the water temperatures, the circulating pumps had been removed by the previous owners.
-A circulating pump kept warm water readily available at the fixtures.

Interview with the Administrator on 10/29/19 at 11:30am revealed the hot water temperatures on the C Hallway on the AL side of the facility could have been low again today, (10/29/19) because a resident (named) had taken a 40 minute shower.

Refer to the interview with the Resident Care Coordinator/Special Care Coordinator (RCC/SCC) on 11/01/19 at 2:03pm

Refer to the interview with the Maintenance Director on 10/31/19 at 3:30pm.

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D 113	Continued From page 30 Refer to the interview with the Administrator on 10/28/19 at 2:48pm. Interview with the Resident Care Coordinator/Special Care Coordinator (RCC/SCC) on 11/01/19 at 2:03pm revealed: -No one had reported or complained about the water temperature being too hot, but she would get the "normal" complaints of the water being too cold. -She had not "personally" seen the Maintenance Director checking water temperatures in the facility. Interview with the Maintenance Director on 10/31/19 at 3:30pm revealed: -He was responsible for checking water temperatures at the facility. -He checked water temperatures at the facility weekly or within an 8-9 day period. -When he checked the water temperatures, he always alternated times when he checked temperatures checking them both in the morning and afternoon. -He rotated the times when water temperatures were checked because the temperature might be related to water usage which was "85%" related to reasons there would be cold water. -The hot water heater was set on 120 degrees. Interview with the Administrator on 10/28/19 at 2:48pm revealed: -The Maintenance Director was responsible for checking water temperatures for the facility one time a week. -There had been no reports of any water temperatures that were too cool or too hot.	D 113		

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for 1 of 5 sampled residents (#1) who was supposed to have thirty-minute checks by staff due to aggressive and assaultive behaviors; was observed panhandling, and reportedly ate out of the garbage. The findings are: Review of Resident #1's current FL-2 dated 03/25/19 revealed: -Diagnoses included paranoid schizophrenia, hyperlipidemia, and hypertension. -This was no documentation of his orientation status. -Resident #1 was ambulatory and verbally abusive. Review of the Resident Register revealed	D 270		

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Resident #1 was admitted to the facility on 06/14/18 and he was his own responsible person.

Review of Resident #1's care plan dated 06/13/19 revealed:
-Resident #1 was oriented and had adequate memory.
-Resident #1 was resistant to care; had a history of disruptive behaviors and being socially inappropriate.

Review of a psychiatric evaluation note for Resident #1 dated 09/26/19 revealed:
-He was seen for a routine psychiatric visit for evaluation and management.
-Resident #1 appeared calm and was walking around with a clear bag of his belongings.
-He reported that he liked to walk with his belongings.
-He presented with low energy and avoidance.
-He was calm, quiet, and cooperative.
-His delusions were reported as improved, but he continued to refuse to have labs done.
-His symptoms overall were reported as moderate and improved.
-Resident #1 was still labile (Emotions that are easily aroused or freely expressed.), guarded, and with poor eye contact
-Resident #1's thought processes and intelligence were still difficult to assess.
-He had a short attention span, but was oriented to person, place, and time.

Review of the facility's aggressive and assaultive management tool for Resident #1 dated 07/23/19 revealed:
-Resident #1 was assessed for aggressive behaviors.
-It was checked "yes" for "needing observation of agitation or concerns regarding behavior".

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D 270	Continued From page 33 -His mental health provider had been changed and his primary care provider was notified of aggressive behaviors and medication changes. Review of a progress note for Resident #1's aggressive and assaultive management tool dated 07/23/19 revealed: -It was documented Resident #1 had "aggressive behaviors". -Staff was to implement 2 hours checks on Resident #1. Review of the facility's aggressive and assaultive management tool for Resident #1 dated 10/18/19 revealed: -It was checked "yes" for "needing observation of agitation or concerns regarding behavior". -Resident #1 was receiving mental health services. Review of a progress note for Resident #1's aggressive and assaultive management tool dated 10/18/19 revealed: -Resident #1 was reassessed for management of aggressive and assaultive behaviors. -Resident #1 continued to talk to himself and became angry when things did not go his way. -He responded to redirection from staff. -Resident #1 was monitored by his primary care provider and psychiatry provider. -Staff were to continue thirty-minute checks and Resident #1 would be reassessed in three months. a. Observation of Resident #1 on 10/28/19 at 9:45am revealed: -He was alone at a gas station approximately a mile and half from the facility. -He was dressed appropriately, but his hair was unkept.	D 270		

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D 270	Continued From page 34 -He was carrying a pink bag and a long wooden stick. Observation of Resident #1 on 10/28/19 at approximately 10:05am revealed Resident #1 was walking on the side of a highway unsupervised approximately two and half miles from the facility. Interview with the Administrator in Training on 10/28/19 at 2:35pm revealed: -She wrote the progress note dated 10/18/19 for Resident #1's aggressive and assaultive management tool. -Resident #1 was supposed to have thirty-minute checks by staff because he sometimes had problems with controlling his anger. -She had the staff to implement the thirty-minute checks and notified Resident #1's primary care provider that thirty-minute checks were being implemented for aggressive behaviors on 10/18/19. -The personal care aides documented Resident #1's thirty-minute checks in the personal care log book that was kept on the A Hall. -The staff did not do thirty-minute checks on Resident #1 when he left the facility. -Resident #1 was his own responsible person and did not require thirty-minute checks when he left the facility alone. -Resident #1 signed himself out the facility using the sign-out book, but he sometimes forgot to sign-out when he left the facility. -He ususally left the facility every day. -She would contact Resident #1's health provider to clarify that thirty-minute checks were not required when Resident #1 was out in the community. Interview with a medication aide (MA) on	D 270		

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D 270	Continued From page 35 10/28/19 at 2:15pm revealed: -Resident #1 had "just left the facility about ten minutes before lunch" on 10/28/19. -She was not sure where Resident #1 went, but Resident #1 usually "hung out" at two known fast food restaurants and a local store in the community. -Resident #1 left whenever he wanted and there were no thirty-minute checks being done on Resident #1 by the staff. Observation of Resident #1 on 10/28/19 at 5:55pm revealed Resident #1 was walking alone in the grass, approximately two feet from the side of a highway, about a half of a mile from the facility, with cars driving by him. Interview with Resident #1 on 10/28/19 at 6:04pm revealed: -He had just walked back to the facility from being in the local town alone since that morning after breakfast. -He walked alone nearly every day to the local town a few miles away. -He was supposed to sign out in the log book before he left the facility, but sometimes he forgot, or he could not find the sign-out log book. -He always tried to get back before dark which was around 8:00pm. -He once got back at 11:00pm because he was so tired, he had to stop and rest in a rocking chair at a building near a church. Interview with a concerned citizen in the community on 10/28/19 at 5:58pm revealed: -He frequently saw Resident #1 walking down the road from the facility. -He was concerned with Resident #1's safety and was afraid that he may be hit by a car when he saw him walking alone down the busy road.	D 270		

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D 270	Continued From page 36 Interview with Resident #1 on 10/29/19 at 12:05pm in the dining room revealed: -He left the facility often to walk to town alone. -He understood the facility's policy for leaving the facility. -He explained that he had to sign out on the "log" before he left and when he returned to the facility. -He knew the location of the facility sign-out log. -He enjoyed walking to town several times a week. -He would tell a staff member when he left. -He enjoyed stopping at a convenience store, fast food restaurant and a local variety store in the community. Interview with a MA on 10/28/19 at 6:00pm revealed: -Staff had not been doing thirty-minute checks on Resident #1 regarding his behaviors. -If Resident #1 got upset or angry; she could talk to him and get him to calm down. -She was sometimes afraid for Resident #1's safety when he was out in the community because he was alone and sometimes, he came back to the facility and it was "kind of late". -He usually came back to the facility between 6:00pm and 9:00pm. -Resident #1 was known to go the gas station (down the road from the facility), a local fast food restaurant, and a local retail store. -When Resident #1 was late coming back to facility, she worried that "he may be on the side of road or in the gutter dead". -She called law enforcement once back in April 2019 when Resident #1 had not returned to the facility and it was almost 11:00pm. -Resident #1 had returned to the facility on his own by the time law enforcement arrive. -Resident #1 had not been late returning to the	D 270		

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D 270	Continued From page 37 facility for over two months. Review of an accident/incident report for Resident #1 dated 10/19/19 at 11:35pm revealed: -Resident #1 was acting out and had increased paranoia. -He barricaded himself alone inside his room. -The police came out and spoke with Resident #1 and calmed him down. -Resident slept the rest of the night. -There was no documentation of any increased supervision of Resident #1 as a result of his behaviors on 10/19/19. Telephone interview with a MA on 10/31/19 at 12:32pm revealed: -She wrote the accident/report dated 10/19/19 for Resident #1. -He was in his room alone and Resident #1 "jammed" the room door and she could not get inside the room. -She heard Resident #1 throwing things inside of his room and she knocked on the door two times. -Resident #1 did not answer the door and the door was locked from inside the room. -She called the Administrator and "the Administrator told her to call 911". -Resident #1 had calmed down and had come out his room by the time the law enforcement officer arrived at the facility. -Staff watched Resident #1 for the rest of the night but she could not specify how often staff checked on Resident #1. -She did not receive any additional instructions from the Administrator regarding Resident's #1 behaviors or the need to monitor the resident on 10/19/19. -She did not know if Resident #1 was on thirty-minute checks regarding his behaviors.	D 270		

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D 270	Continued From page 38 Interview with a second MA on 10/28/19 at 10:48am revealed: -Resident #1 had gotten angry one weekend about a week and half ago. -He punched holes in both closet doors and broke the front of the paper towel dispenser in the common shower room across hall. -She did not know what triggered Resident #1 to become so angry to punch holes in the closet doors and break the paper towel dispenser. -Resident #1 had a problem with anger issues sometimes, but he was not a threat to others. -Staff did not provide any increased supervision of Resident #1 due to anger issues. Attempted review of Resident #1's thirty-minute check logs on 10/28/19 from 2:35pm to 4:15pm revealed the logs were unavailable. Interview with Resident #1 on 10/29/19 at 9:34am revealed: -He could not sleep last night, (10/28/19). -He stayed awake all night in his room reading a book. -No staff checked on him during the night, (10/28/19) when he was in his room. -He was not aware of staff ever checking on him when he was in the facility. Interview with the Administrator on 10/28/19 at 3:00pm revealed: -She was not aware of any aggressive behaviors by Resident #1 that required staff to perform thirty-minute checks. -She was not aware of Resident #1 punching the closet doors in his room or breaking the paper towel dispenser in the common shower room on the A Hall. -She would have to check with the Special Care Coordinator/Resident Care Coordinator or the	D 270		

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Administrator in Training to find out what was going on with Resident #1.
-She did not know if Resident #1 required thirty-minutes checks by staff due to aggressive behaviors.

Interview with the Administrator on 10/28/19 at 6:20pm revealed there were no thirty-minute check logs for Resident #1 because the Administrator in Training forgot to implement the thirty-minute checks with staff when Resident #1's last aggressive management tool was completed.

Interview with Resident #1's health care provider on 10/29/19 at 3:00pm revealed:
-Resident #1 needed some type of supervision due to his mental diagnosis, but he would not specify how.
-He was aware that Resident #1 had some type of mental outburst about a week or two before.
-Resident #1 had a mental health provider and he left supervision decisions up to them.

Interview with Resident #1's mental health provider on 11/01/19 at 3:32pm revealed:
-She had taken over as Resident #1's mental health provider on 10/15/19.
-She had not physically seen Resident #1 since she took over as his mental health provider or been to the facility.
-She did not know about the aggressive management tool used by the facility for Resident #1.

b. Observation of Resident #1 on 10/28/19 at 9:45am revealed:
-He was alone at a gas station approximately a mile and half from the facility.
-He approached a member of the public and

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asked for money.
-He walked away quietly when his request for money was denied.

Observation of Resident #1 on 10/28/19 at 5:55pm revealed:
-Resident #1 was walking alone on the side of a highway about a half mile from the facility with cars driving past him.
-Resident #1 was smoking a cigarette and drinking a yellow colored fluid from a coffee can.

Interview with Resident #1 on 10/28/19 at 6:04pm revealed:
-That morning (10/28/19) he asked someone at the local drugstore for money.
-He wasn't sure how much money he got, but it was enough that he bought cigarettes and a soda with it.
-He never had any money until "pay day" when the facility gave him money.
-He would ask people for money to buy his lunch while he was in town.

Interview with a MA on 10/28/19 at 6:00pm revealed:
-Resident #1 was known to go the gas station (down the road from the facility), a local fast food restaurant, and a local retail store.
-She was not sure how Resident #1 got money for food or drink when he was out in the community.

Interview with the Administrator on 10/28/19 at 6:20pm revealed she was not aware Resident #1 was panhandling in the community.

Interview with Resident #1's health care provider on 10/29/19 at 3:00pm revealed:
-Resident #1 needed some type of supervision

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due to his mental diagnosis, but he could not specify how.
-Resident #1 had a mental health provider and he left supervision decisions up to them.
-He knew Resident #1 sometimes went out in to the community and presented himself as homeless by the way Resident #1 dressed.
-He did not know Resident #1 was panhandling.
-It was concerning and needed to be addressed.
-No one from the facility had notified him about the panhandling.

Interview with Resident #1's mental health provider on 11/01/19 at 3:32pm revealed:
-She had taken over as Resident #1's mental health provider on 10/15/19.
-She did not know Resident #1 had a history of panhandling in the community and no staff at the facility had notified her.
-She had not physically seen Resident #1 since she took over as his mental health provider or been to the facility.
-She would address any concerns about Resident #1's panhandling with the staff at the facility.

c. Observation of Resident #1 on 10/28/19 at approximately 10:05am to 10:06am revealed:
-Resident #1 was walking on the side of a highway unsupervised approximately two and half miles from the facility.
-Resident #1 stopped, reached down in a shallow ditch, picked up a can, and attempted to drink from the can.
-Resident #1 threw the can back in to the ditch when it appeared that he could not get anything to drink from it.
-Resident #1 continued walking on the side of the highway.

Interview with Resident #1 on 10/28/19 at 6:04pm

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revealed:
-He had just walked back to the facility from being in the local town alone since that morning after breakfast.
-He never had any money until "pay day" when the facility gave him money.
-He did not have enough money for lunch on 10/28/19 so he got a piece of chicken and some french fries out of the garbage can at a local fast-food restaurant.

Interview with the Administrator on 10/28/19 at 6:20pm revealed:
-She was not aware Resident #1 was eating out of garbage in the community.
-Resident #1 went in to the community on his own but there was food available for him to eat at the facility.

Interview with Resident #1's health care provider on 10/29/19 at 3:00pm revealed:
-Resident #1 needed some type of supervision due to his mental diagnosis, but he could not specify how.
-Resident #1 had a mental health provider and he left supervision decisions up to them.
-He did not know Resident #1 was eating food out of garbage in the community.
-It was concerning and needed to be addressed.
-No one from the facility had notified him about the eating from the garbage.

Interview with Resident #1's mental health provider on 11/01/19 at 3:32pm revealed:
-She had taken over as Resident #1's mental health provider on 10/15/19.
-She did not know Resident #1 had a history of eating out of garbag in the community and no staff at the facility had notified her.
-She had not physically seen Resident #1 since

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D 270	Continued From page 43 she took over as his mental health provider or been to the facility. The facility failed to assure 1 of 5 residents (#1) was supervised according to his current symptoms. The facility's failure to supervise residents resulted in Resident #1 leaving the facility without needed supervision, Resident #1 panhandling money for cigarettes and food while unsupervised in the community, and Resident #1 eating and drinking from the garbage while unsupervised in the community. The facility's failure to supervise the resident was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 16, 2019.	D 270		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	D 276		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 1 of 5 sampled residents (#5) who had an order for a bed/chair alarm to prevent falls.

The findings are:

Review of Resident #5's current FL-2 dated 10/18/19 revealed:
-Diagnoses included vascular dementia with behavior disturbances, non-insulin dependent diabetic Type 2, hypertension, hyperlipidemia, benign prostatic hypertrophy, chronic heart failure, and frequent urinary tract infections.
-There was documentation the resident was constantly disoriented and required total personal care assistance.

Review of Resident #5's Assessment and Care Plan dated 02/25/19 revealed:
-There was documentation the resident was always disoriented and had a significant memory loss and required direction.
-There was documentation the resident had a stroke in the past.
-There was documentation the resident required staff supervision with eating, total dependent on staff for toileting, bathing, dressing and transferring, extensive assistance from staff for ambulation and transferring.

Review of a Fall Risk Reduction Protocol for Resident #5 dated 02/26/19 revealed:

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D 276	Continued From page 45 -There was an entry that the Fall Risk Assessment should be completed if there were any signs of a fall risk per history, family, documentation and per observations. -On the left side of the form there were pre-printed assessment and intervention entries and on the right of the form there were areas to check yes or no and a space to add comments. -There was documentation made by a check the resident had a history of falls and observations of an unsafe ambulation status at admission. Review of Resident #5's Fall Risk Progress Notes revealed on 02/26/19, there was an entry the resident was assessed upon admission as a fall risk due to limited ambulation and an unsteady gait. The resident would be placed on 30 minute checks. Review of an Accident and Incident report for Resident #5 dated 03/04/19 revealed: -The date of the incident was 03/02/19 at 8:13pm. -The resident was trying to stand up and fell out of his wheelchair. -The resident had no injuries present and was not sent to the emergency department (ED). Review of Resident #5's Fall Risk Progress Notes revealed on 03/15/19, there was documentation the resident was found on the floor in the hallway by staff and sent to the ED, evaluated at the ED and found with no injuries or changes. Review of a 72 Hour Monitoring Report for Resident #5 revealed there was an entry on 03/28/19 the resident fell trying to move from the chair to a wheelchair without assistance, the resident had no complaints of pain or injuries and did not hit his head.	D 276		

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D 276	Continued From page 46 Review of Resident #5's Fall Risk Progress Notes revealed on 04/13/19, there was documentation the resident fell in the hallway trying to stand up out of his wheelchair attempting to walk and received a bruise on his right knee. Review of an order documented on a "Consultation Sheet" for Resident #5 dated 05/29/19 revealed: -There was documentation the resident was getting out of his wheelchair and bed without assistance and had "a couple of falls lately, do you recommend a chair/bed alarm to prevent further falls?" -There was an order for a bed/chair alarm for the resident. Review of Resident #5's Fall Risk Progress Notes revealed: -On 05/31/19, there was documentation the resident was reassessed for fall risks. The resident had two falls since last assessment, continued to try to stand up and walk without assistance. A consultation was sent to the resident's primary care provider (PCP) to question if a bed/chair alarm would help falls. -On 05/31/19, there was a second entry, the resident's PCP sent an order for the resident to use a bed/chair alarm to help prevent falls. Review of Resident #5's Fall Risk Progress Notes dated 06/17/19 revealed: -There was documentation the resident was standing in the hallway and his hand slipped off the handrail, the resident fell in the hallway sideways into the wheelchair. -A "consult sheet" was sent to the resident's PCP, the residents family member was called, and the resident was placed on 72 hour monitoring. -There would be continued 30 minute checks.	D 276		

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D 276	Continued From page 47 Review of Resident #5's Nursing Progress Note dated 06/17/19 revealed: -There was documentation the resident was seen by staff standing in the hallway holding onto the handrail. -When staff approached the resident to assist, the resident's hand slipped, and the resident fell sideways into a wheelchair. -Staff asked the resident why he stood up and why he was not wearing the "clip" for his chair alarm, the resident could not answer. Review of a "Physician's Orders with current orders as of 06/26/19" for Resident #5 dated 06/27/19 revealed an order for a bed/chair alarm, use as directed for fall prevention. Review of a Fall Risk Reduction Protocol for Resident #5 dated 08/22/19 revealed there was documentation made by a check that the resident had a history of falls and observations of an unsafe ambulation status at admission. Review of Resident #5's Fall Risk Progress Notes revealed: -On 08/22/19, there was a documentation the resident was reassessed for fall risks. The resident had one fall since 05/31/19, evaluated by physical therapy but, did not qualify due to the resident's diagnosis and unable to follow directions. The resident would continue to be on 30 minute checks and a reassessment would be done in 3 months. -On 09/06/19, there was documentation the resident fell trying to stand up without assistance, the resident was sent to the ED for evaluation and there were no injuries or medication changes. The resident was placed on 72 hour monitoring and 30 minute checks would continue.	D 276		

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D 276	Continued From page 48 Observation of Resident #5 on 10/28/19 at 11:30am revealed: -The resident was sitting in a wheelchair. -There was no chair alarm observed. Observation of Resident #5 on 10/29/19 from 9:20am - 10:21am revealed: -The resident was sitting in a wheelchair. -There was no chair alarm observed. Interview with a medication aide (MA) on 10/31/19 at 4:40pm revealed: -Resident #5 had a chair alarm because he would try to stand up without assistance. -Resident #5 "usually" kept the chair alarm in place. Interview with a personal care aide (PCA) on 11/01/19 at 12:56pm revealed: -Staff would occasionally forget to place Resident #5's chair alarm on him when he was up in his wheelchair. -Resident #5 often pulled the chair alarm off. -The PCA tried to apply the chair alarm when she thought about it. -Resident #5 did not have a separate bed alarm because the same chair alarm was used when he was in bed. Confidential interview with a staff revealed: -The staff had not seen Resident #5 wear the chair alarm when he was in his wheelchair or when he was in bed. -The staff person saw Resident #5 wear the chair alarm for the first time yesterday. Interview with the Special Care Coordinator/Resident Care Coordinator (SCC/RCC) on 11/01/19 at 2:03pm revealed:	D 276		

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D 276	Continued From page 49 -She knew that Resident #5 had an order for a bed/chair alarm. -Resident #5 hid his chair alarm because when it alarmed it would alert staff where he was at. -Staff might not have realized Resident #5's chair alarm was off on 10/28/19 and 10/29/19. -She had not contacted Resident #5's PCP about the resident removing the chair alarm but she had reminded staff to make sure the chair alarm was applied to prevent the resident from falling. Based on observations, record reviews and interviews, Resident #5 resident was not interviewable. Interview with the Administrator on 11/01/19 at 3:38pm revealed: -She was not aware Resident #5 had an order for a bed/chair alarm. -She expected staff to follow the order given by Resident #5's PCP for the bed/chair alarm. -She expected staff to check to assure Resident #5 had the bed/chair alarm in place during the resident's every 30 minute checks. Telephone interview with Resident #5's PCP on 10/31/19 at 2:30pm revealed: -She was aware that Resident #5 had a history of falls. -Resident #5 had an order for a bed/chair alarm to prevent falls. -The bed/chair alarm should not be used as an as needed order but should always have been used.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care	D 283		

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Homes:
(2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure foods being stored, prepared, and served to residents were protected from contamination related to a wet pink, brown and black build-up substance in the ice machine, opened and undated food containers in the refrigerator, freezer and pantries, chemical and cleaning agents stored near food, a fly trap with dead flies touching clean cooking pans, and enclosed mouse traps containing poison and rat/mice poison pellets placed near food.

The findings are:

Observation of the kitchen on 10/30/19 at 10:45am revealed:
-There was a fly trap that had 10 dead flies stuck to it on the outside which was hanging above clean cooking pans and touching a pan.
-There were chemicals and cleaning agents (32 oz window cleaner spray, 14 oz wasp/hornet insecticide spray, one gallon delimer, and 2 gallon floor cleaner degreaser), on two shelves just below the shelves contaning food for dry storage.
-There were two 1.33 gallon spray containers of grass killer and insect killer with the open spray nozzles on the floor under the sink that was used to wash dishes.

Observation of the pantry in the kitchen on

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D 283	Continued From page 51 10/30/19 at 11:00am revealed: -There was an enclosed mouse trap that contained poison against a shelf above a container full of flour that was approximately 3 feet long, 1 foot wide and 2 feet deep, that had a broken lid. -There was an enclosed mouse trap that contained poison on the right side floor under stored food. -There was an enclosed mouse trap that contained poison on the left side floor under stored food. -There were 11 rat/mice poison pellets on the floor in the corner behind the door. -There were large containers approximately 5 gallons each that were labeled with the name of contents (cornmeal mix, fish breader, brown sugar, mash potato flakes) but had no date for when they were last filled. -There was another approximately 5 gallon container of a cornmeal like substance that had no name or date label. -There were 2 separate one gallon containers of what appeared to be cereal with no name or date label. -There were two containers on wheels, each approximately 3 feet long, 1 foot wide and 2 feet deep, that had sugar in one and flour in the other that were not labeled with a date. Observation of the pantry across the hall from the kitchen on 10/30/19 at 11:36am revealed: -There was an enclosed mouse trap that contained poison on the left side floor under stored food. -There were 2 large containers approximately 5 gallons each that were labeled with the name of contents (biscuit mix and oatmeal) but had no date for when they were last filled. -There was a sticky pest strip that had 3 dead	D 283		

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roaches stuck to it on the right side floor under stored food.
-There was a bag of charcoal and a gallon charcoal lighter fluid on the floor to the right of the stored food.

Observations of the freezer on 10/30/19 at 11:45am revealed there were three approximately 2 gallon bags each of white meat that were all opened, not dated or labeled.

Observation of the refrigerator in the kitchen on 10/30/19 at 11:45am revealed:
-On the top shelf, there were two opened 12-ounce cans of soda, slices of turkey breast wrapped in plastic, a bowl of red meat slices wrapped in plastic, a block of cheese wrapped in plastic, and slices of bologna wrapped in plastic that were all opened, not dated or labeled.
-On the second shelf of the refrigerator, there was a 1.12 gallon container that had "vanilla ice cream" on the original label, that contained a red unknown substance that was not labeled or dated.
-On the second shelf of the refrigerator, there was a 2-gallon container that had a clear unknown substance that was not labeled or dated.
-On the second shelf of the refrigerator, there was a 3-gallon container of light brown liquid with small brown spots on the dispenser, that had a label with "apple juice" written on it with no date.
-On the second shelf of the refrigerator, there was a 3-gallon container of dark purplish black liquid with small brown spots on the dispenser, that was not labeled or dated.

Observation of the ice machine in the kitchen on 10/30/19 at 12:00pm revealed:
-The kitchen staff had just completed filling cups

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of ice in preparation for lunch.
-It was approximately 75% full of cubed ice.
-On the upper inside right wall of the ice machine was a scattered build-up of a wet pink, brown and black substance that measured approximately 7 inches by 7 inches diameter and was touching the ice.
-Under the inside of the ice machine lid there was a scattered black substance that measured the length of the lid.
-Under the inside of the ice machine lid on the back-right corner, there was a scattered black substance two inches by two inches diameter and was touching the ice when the lid was opened.

Interview with the cook on 10/29/19 at 11:10am revealed:
-She oversaw the meals and dietary aides only on the days she worked.
-All dietary staff were responsible for cleaning the kitchen every day.
-The staff performed a deep clean on the kitchen once a week usually on Tuesdays that involved cleaning the oven and refrigerator.

Interview with a second cook on 10/20/19 at 11:45am revealed:
-She knew that all food should be labeled with name and date when opened.
-She did not know that all food was not labeled in the pantries, refrigerators and freezer.
-She did not know there were mouse traps and rat/mice poison pellets in the pantry and did not know if they could be there.

Interview with the Administrator on 10/30/19 at 12:20pm revealed:
-She did not know that the ice machine had scattered build-up of a wet and pink brown and black substance in it.

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AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(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 283	Continued From page 54 -She was not sure what the exact cleaning schedule for the ice machine was for the facility. -The maintenance director was responsible for cleaning the ice machine. -The facility had a pest control contract with a pest control vendor. -The pest control vendor placed the enclosed mouse trap that contained poison and the rat/mice poison pellets in the pantry. Telephone interview with a service technician from the pest control vendor on 11/01/19 at 11:15am revealed: -They provided pest control services to the facility once a month and every quarter. -They provided pest control services on an as needed basis when they were notified by the facility Administrator. -They treated the entire facility inside and outside on a quarterly basis. -They sprayed the common areas monthly. -They did not treat the facility with the same enclosed mouse traps that contained poison or pellet bait that were observed in the facility. -They had never used the pest control brand that the Administrator reported they used in the facility. -She did not think the brand of the enclosed mouse trap that contained poison was available to be used in a facility. -They treated the facility with a different "soft" bait. -They used soft bait for traps on the outside of the facility. -There could be a risk of poisoning if an individual touched an enclosed mouse trap that contained poison or a pellet bait. -Hands should be washed with warm water and soap for safety if the enclosed mouse trap that contained poison or a pellet bait was touched.	D 283		

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D 283	Continued From page 55 Interview with the Maintenance Director on 11/01/19 at 2:30pm revealed: -He put out enclosed mouse traps that contained poison, in the kitchen pantry and in the dry storage pantry across the hall from the kitchen. -He also put out rat/mice poison pellets in the kitchen pantry behind the door. -He was not told by anyone to put out the enclosed mouse traps or the rat/mice poison pellets in the facility, he just did it on his own and did not tell anyone. -He knew the facility had a contract with a pest control vendor, and they came once a month. -He felt the additional enclosed mouse traps or the rat/mice poison pellets he put out helped to lessen the number of mice in the facility. -He was responsible for cleaning the ice machine in the kitchen. -In the past he had always wiped down the inside of the ice machine once a week. -He did not keep a log of when the ice machine was cleaned. -He last wiped down the inside of the ice machine a week ago. Interview with Administrator on 11/01/19 at 3:00pm revealed: -She was responsible for overseeing the kitchen staff, food supply and cleanliness. -The kitchen was cleaned daily by all kitchen staff, and every Tuesday a deep cleaning was performed. -She was responsible for overseeing the Maintenance Director's work. -The enclosed mouse trap that contained poison and rat/mice poison pellets had been placed in the kitchen pantry by the Maintenance Director. -She did tell the Maintenance Director to put out the enclosed mouse traps, but not the rat/mice	D 283		

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D 283	Continued From page 56 poison pellets in the facility. -She did not have a copy of the pest control contract for the facility. The facility failed to assure foods being stored and served in the facility's refrigerator, freezer, and pantries were protected from contamination related to pink, brown and black build-up substance in the ice machine, opened and undated food containers in the refrigerator, freezer and pantries, chemical and cleaning agents stored near food, a fly trap with dead flies touching clean cooking pans, and enclosed mouse traps containing poison and rat/mice poison pellets placed near food.. The facility's failure resulted in food items being exposed and contaminated, which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 01, 2019.	D 283		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(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 310	Continued From page 57 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 2 residents sampled who had an order for honey thickened liquids (#6) and a resident who had a history of stroke and was ordered a pureed diet (#5). The findings are: 1. Review of Resident #6 's current FL-2 dated 02/05/19 revealed: -Diagnoses included schizoaffective disorder, mild intellectual disability, diabetes and hypertension. -Resident #6 required assistance with feeding. -There was no diet order. Review of subsequent physician's orders for Resident #6 on 8/30/19 revealed there was an order for honey thickened liquids (thickened liquids are a medical dietary adjustment used to prevent choking and aspiration). Interview with a cook on 10/29/19 at 11:00am revealed: -Dietary staff had recently started adding the thickening agent to Resident #6's liquids. -A week ago, the medication aide (MA) brought a container of thickening agent to the kitchen staff and "told us to start using it" in his water. -Dietary staff read the instructions on the back of the thickening agent container. -Dietary staff had not received training on how to use the thickening agent. -They added one spoonful of the thickening agent to his water. -Prior to a week ago, the MA was coming into the	D 310		

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dining room to add the thickening agent to Resident #6's water prior to meals.

Observation on 10/29/19 at 12:10pm at the table revealed:
-Resident #6's glass of water was already on the table and did not have the thickening agent mixed in it.
-A cook asked the dietary aide to bring Resident #6's glass of water back to the kitchen.
-The cook informed the dietary aide that Resident #6's water required the thickening agent to be added.
-A dietary aide removed the dual ended blue measuring device from the thickening agent container.
-She read the instructions on the back of the thickening agent container but was unsure what consistency was required for Resident #6.
-One end of the blue measuring device was labeled one tablespoon and the other end labeled one teaspoon.
-The dietary aide looked at the blue measuring device and stated, "I'm not sure what to use, today is the first time I've seen the thickening agent in here."
-The dietary aide added one tablespoon of the thickening agent to Resident #6's eight-ounce glass of water.
-The dietary aide returned Resident #6's glass of water to his table with one tablespoon of the thickening agent mixed in his water.

Review of the directions on the back of the thickening agent container revealed for honey thickened consistency, add 4-5 teaspoons of thickening agent for every 4 ounces of liquid.

Observation of Resident #6 on 10/29/19 from 12:18pm to 12:27pm revealed:

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-He had not stopped eating to drink his water since he began eating at 12:18pm.
-Resident #6 completed 100% of his meal.
-Resident #6 took his first sip of water.
-Resident #6 coughed.
-The MA told Resident #6 that he needed to drink water.
-Resident #6 took another sip of his water.
-Resident #6 drank ¾ of his water.

Interview with the medication aide (MA) on 10/29/19 at 12:30pm revealed:
-Her role was to make sure residents eat and to make sure they do not choke or aspirate.
-She did not know that she needed to spoon feed Resident #6 honey thickened liquids.
-She was responsible for adding the thickening agent to Resident #6's liquids prior to this duty being assigned to dietary staff.
-The dietary staff were now responsible for adding the thickening agent to Resident #6's liquids.
-Prior to the thickening agent container being brought to dietary staff she would provide Resident #6's water with ½ teaspoon of the thickening agent in his liquids.
-She was trained a few years ago on using the thickening agent for residents.
-She would stir until consistency became thicker after adding ½ teaspoon of the thickening agent to Resident #6's water.

Interview with a personal care aide (PCA) on 10/29/19 at 12:35pm revealed:
-Her role was to make sure Resident #6 did not get choked.
-She did not know he required a thickening agent to be added to his liquids.
-She did not know that she needed to spoon feed to Resident #6 honey thickened liquids.

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D 310	Continued From page 60 Interview with a MA on 10/29/19 at 12:48pm revealed: -She was taught how to use the thickening agent a few years ago. -She did not follow directions on the back of the thickening agent container because she was taught to use ½ teaspoon of the thickening agent. -She had continued using ½ teaspoon of the thickening agent in Resident #6's water and was not aware that she needed to add more than ½ teaspoon. -She only mixed it to a nectar consistency now. Observation of Resident #6 on 10/29/19 at 12:50pm revealed: -Resident #6 reached over the table and took another resident's water which did not contain the thickening agent and drank approximately ½ a cup. -The MA sitting next to Resident #6 removed the water from Resident #6 and gave Resident #6 his water to drink. Interview with a cook on 10/29/19 at 12:55pm revealed: -She did not read the thickening agent container instructions. -She did not know which directions to use on the container since there were several types of instructions. -She had not been trained on how to use the thickening agent. Interview with a dietary aide on 10/30/19 at 10:15am revealed: -She had placed 3-4 teaspoons in Resident #6's water at all meals. -She had not had training from the facility on how to use the thickening agent.	D 310		

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D 310	Continued From page 61 -She read the back of the thickening agent container to obtain the measurement of 3-4 teaspoons. -She had been adding 3-4 teaspoon of thickening agent to Resident #6's water for 5 months. Observation of Resident #6 in the dining room on 10/31/19 at 12:10pm revealed: -His meal consisted of 1 cup of chopped meat loaf, ½ cup of green beans, ½ cup of corn bread and pudding. -His water was the consistency of nectar thick. -He did not drink any of his water. Interview with a second cook on 10/31/19 at 12:30pm revealed: -She added one tablespoon of the thickening agent to residents 8-ounce glass of water. -She did not read the instructions on the back of the thickening agent container. Attempted telephone interview with Resident #6's primary care provider (PCP) on 11/01/19 at 2:10pm was unsuccessful. Interview with the Administrator on 10/30/19 at 12:20pm revealed: -She expected staff to follow all dietary orders as written by Resident #6's PCP. -She expected staff to use thickener for Resident #6's liquids as ordered. 2. Review of Resident #5's current FL-2 dated 10/18/19 revealed: -Diagnoses included vascular dementia with behavior disturbances, non-insulin dependent diabetic Type 2, hypertension, hyperlipidemia, benign prostatic hypertrophy, chronic heart failure, and frequent urinary tract infections. -There was not an ordered diet on the FL-2.	D 310		

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D 310	Continued From page 62 Review of a previous diet order signed by Resident #5's primary care provider (PCP) dated 06/27/19 revealed an order for a pureed diet. (Pureed diets are ordered for those with swallowing difficulties in efforts to prevent choking and aspiration.) Review of a diet order signed by Resident #5's PCP dated 10/30/19 revealed an order for a pureed diet. Review of Resident #5's Assessment and Care Plan dated 02/25/19 revealed: -There was documentation the resident was on a regular, pureed diet and had a stroke in the past. -There was documentation the resident required staff supervision with eating. Review of the facility's therapeutic diet list dated 10/28/19 revealed Resident #5 was on a pureed diet. Observation of the lunch meal in the Special Care Unit (SCU) dining room on 10/29/19 at 12:13pm revealed: -A personal care aide (PCA) served Resident #5 his plated food. -Resident #5's food was pureed except for the coleslaw which was in finely chopped texture. -Resident #5 began to eat his food but did not eat the coleslaw. Interview with a Transporter/personal care aide (PCA) on 10/29/19 at 12:16pm revealed: -Resident #5 was on a pureed diet. -The food served to Resident #5 was pureed, except for the coleslaw, it had "pieces in it". Interview with a medication aide (MA) on	D 310		

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D 310	Continued From page 63 10/29/19 at 12:17pm revealed: -Resident #5 was on a pureed diet. -Resident #5 "probably" would not eat the coleslaw and she would watch the resident. Interview with a PCA on 10/29/19 at 12:17pm revealed Resident #5 would not eat the coleslaw. Observation of the MA and a PCA in the dining room on 10/29/18 at 12:18pm revealed: -The PCA nor the MA removed the coleslaw from Resident #5's plate after being prompted. -The Administrator was prompted to come to the SCU dining room. -Resident #5 was not attempting to eat the coleslaw. Observation in the SCU dining room on 10/29/19 at 12:19pm - 12:43pm revealed: -The Administrator told Resident #5 she would get him another vegetable from the kitchen and Resident #5 agreed. -The Administrator removed the plated coleslaw from Resident #5's plate. -Resident #5 continued to eat his plated food without any coughing or gagging -At 12:39pm, the Administrator served Resident #5 pureed green beans that were in a pureed, smooth consistency. Based on observations, record reviews and interviews, Resident #5 resident was not interviewable. Interview with the Resident Care Coordinator/Special Care Coordinator (RCC/SCC) on 11/01/19 at 2:03pm revealed: -When Resident #5 was first admitted to the facility, he was throwing up a lot and aspirating on food.	D 310		

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-Resident #5 was ordered a pureed diet and the resident's vomiting stopped.
-She monitored the meals in the SCU as often as she had time which was at least one meal per day.
-When she monitored the meals in the SCU, she had not noticed any issues or concerns with Resident #5 being served foods that were not in a pureed consistency except in the "very beginning" she remembered there were issues with the cook preparing the right consistency of foods for Resident #5.
-Pureed foods were in the same consistency as baby food or pudding.
-She had not observed Resident #5 having any coughing or gagging during meals.

Attempted telephone interview with Resident #5's Primary Care Provider (PCP) was unsuccessful on 11/01/19 at 11:30am.

Interview with the Administrator on 11/01/19 at 3:38pm revealed:
-Resident #5 had a known history of a stroke and had swallowing precautions in the past.
-When Resident #5 was admitted to the facility from the hospital, the resident was on a regular diet.
-Resident #5's PCP at the facility knew the resident from another facility and checked on the residents diet history and then the resident was placed on a pureed diet.
-Resident #5 ate fast and staff had to remind the resident to slow down when he was eating.
-The cooks were responsible to serve the residents the plated meals by passing the plates out in the dining room and dietary staff were responsible for plating the food as ordered for the residents.
-She monitored meals approximately every other

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D 310	Continued From page 65 day in the SCU and the Supervisor was always in the dining room during meals. -She was not aware of Resident #5 having any coughing or gagging during a meal nor being served foods that were not in a pureed consistency. _____ The facility failed to assure therapeutic diets were served as ordered for Resident #6 who was ordered honey thick liquids and was observed receiving thin liquids during a meal and Resident #5 who had a history of stroke and was ordered a pureed diet. The facility's failure to assure Resident #6 received honey thick liquids and Resident #5 to receive pureed foods posed a risk of aspiration pneumonia or choking which was detrimental to the health and safety of the residents, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 01, 2019.	D 310		
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.	D 358		

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D 358	Continued From page 66 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 out of 3 residents (#8, #5) observed during the medication pass including errors with Depakote, Prilosec, Clozaril, Ditropan, Abilify, Theragran-M, Synthroid, Lorazepam (#8); Colace (#5). The findings are: The medication error rate was 27% as evidenced by the observation of 9 errors out of 33 opportunities during the 9:00 am medication pass on 10/29/19. 1. Observation of the 9:00am medication pass on 10/29/19 from 9:20am to 9:45am in the Special Care Unit (SCU) revealed: -There were nine residents present sitting in the SCU living room. -Resident #8 was ambulating in and out of the SCU living room through the main hall door. -The medication aide (MA) was standing in front of the medication cart. - The MA prepared medication for Resident #8 by emptying a carton of nutritional supplement into a plastic cup and adding six capsules of Depakote DR 125 mg sprinkles (Depakote is used to treat psychiatric disorders.). - The MA placed the plastic cup with the nutritional supplement on the top right side of the medication cart. -The MA prepared medications for Resident #8 and placed Prilosec 40 mg (one tablet), Clozaril 50 mg (one tablet), Ditropan 5 mg (one-half	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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tablet), Abilify 2 mg (one tablet), Theragran-M (one tablet), Synthroid 112mcg (one tablet) and Lorazepam 0.5mg (one tablet) in a clear medication cup (Prilosec is used to treat gastroesophageal disease. Clozaril is used to treat behaviors. Ditropan is used to treat an overactive bladder. Abilify is used to treat psychiatric disorders. Theragran-M is a nutritional supplement. Synthroid is used to treat thyroid disorders. Lorazepam is used to treat agitation.).
- The MA placed the medication cup filled with the medications and the drinking cup with the nutritional cup mixture on a ledge on the top right side of the medication cart.
-Resident #8 was positioned on the right and slightly behind the MA on the right side of the medication cart.
-The MA looked towards Resident #8 and verbally directed Resident #8 to take her medications.
-The MA turned away from Resident #8; began digging through the bottom two drawers of the medication cart; and proceeded to remove and replace medication blister packages from the medication cart.
- Resident #8 picked up the plastic cup of nutritional supplement and the medication cup filled with the medications and drank from the plastic cup of nutritional supplement.
- Resident #8 placed the medication cup to her lips and tossed her head backwards two times to swallow the medications in the medication cup.
-The MA remained turned with her back towards Resident #8 as she continued rummaging through the drawers of the medication cart and looking at the medication blister packs in the medication cart drawers.
-Resident #1 was still holding the medication cup and one orangish tablet remained in the medication cup.
-Resident #8 extended her hand in a tossing

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motion towards the trash can located on the bottom right side of the medication cart.
-The MA then turned back towards Resident #8 and upon seeing the tablet still in the medication cup; she stopped Resident #1 from disposing of the medication cup and verbally instructed Resident #8 to take the remaining tablet in the medication cup.
-Resident #8 took the remaining tablet in the medication cup and drank the remaining nutritional supplement, that contained medication, under the direct supervision of the MA.

Review of Resident #8's current FL-2 dated 6/17/2019 revealed:
-Diagnoses included vascular dementia, schizoaffective disorder bipolar type, obsessive behaviors, diabetes mellitus type 2, hyperlipidemia, hypothyroidism, gastroesophageal reflux disease, overactive bladder, chronic kidney disease 3 with acute renal insufficiency and respiratory failure.
-Resident #8's level of care was documented as the SCU.
-There were medication orders for Depakote DR 500mg twice daily, Prilosec 40mg every day before breakfast, Clozaril 50mg every morning, Ditropan 5mg one-half tablet twice daily before meals, Abilify 2mg every day, Theragran-M one tablet every day and Synthroid 112mcg every morning (Depakote DR is used to treat psychiatric disorders. Prilosec is used to treat gastroesophageal disease. Clozaril is used to treat behaviors. Ditropan is used to treat an overactive bladder. Abilify is used to treat psychiatric disorders. Theragran-M is a nutritional supplement. Synthroid is used to treat thyroid disorders.).

Review of physician's orders dated 10/17/19 for

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D 358	Continued From page 69 Resident # 8 revealed medication orders for Depakote DR 125 mg sprinkles six capsules twice daily and nutritional supplement one carton three times daily. Review of a subsequent physician's order dated 10/18/2019 for Resident #8 revealed a medication order for Lorazepam 0.5 mg one tablet every morning. Review of resident #8's Resident Register revealed an admission date of 4/25/19. Review of Resident #8's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer printed entry for Depakote DR 125mg Capsule Sprinkle take six capsules by mouth two times a day scheduled for 9:00am -There was a computer printed entry for Prilosec 40mg take one capsule by mouth every day before breakfast scheduled for 9:00am. -There was a computer printed entry for Clozaril 50mg tablet take one tablet by mouth every morning at 9:00am -There was a computer printed entry for Ditropan 5mg tablet take one-half tablet by mouth two times a day scheduled for 9:00am. -There was a computer printed entry for Abilify 2mg take one tablet by mouth every day scheduled for 9:00am. -There was a computer printed entry for Theragran-M one tablet by mouth take one tablet by mouth every day scheduled for 9:00am. -There was a computer printed entry for Synthroid 112mcg tablet take one tablet by mouth every day scheduled for 9:00am. -There was a computer printed entry for Lorazepam 0.5mg take one tablet by mouth every	D 358		

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day scheduled for 9:00am.
-There was a computer printed entry for Mighty Shakes drink one can by mouth every day scheduled for 9:00am.

Interview on 10/29/19 at 12:10 pm with the MA who administered medications to Resident #8 on 10/29/19 during the 9:00am medication pass revealed:
-The MA has been a MA since March 2019.
-The MA worked primarily on the SCU on the day shift.
-The MA has been trained to observe residents when they take their medications.
-She was rushing to finish administering her other medications and forgot to watch Resident #8 take her medications.

Based on observations, interviews and record reviews it was determined Resident #8 was not interviewable.

Telephone interview with Resident #8's primary care provider (PCP) on 10/31/19 at 2:21 pm revealed the PCP expected the MAs to watch residents when administering medications to ensure residents took all medications as ordered.

Review of the facility's pharmacy and procedure manual revealed:
-No resident shall be left alone while taking medication.
-The staff (MAs) would ensure that medications were taken properly and, in the quantities, prescribed.

Interview with the Administrator on 10/29/19 at 4:45pm revealed she did not have anything to say about the MA not watching to ensure Resident #8's medications were administered as ordered

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during the 9:00am morning medication pass in the SCU on 10/29/19.

2. a. Observation during the medication pass in the Special Care Unit (SCU) on 10/29/19 from 9:20 to 9:45am revealed:
-Resident #8 had already finished eating her breakfast.
-The computer screen displayed the electronic Medication Administration Record (eMAR) for Resident #8 revealing an entry for Prilosec 40mg one tablet to be administered by mouth before breakfast at 9:00 am (Prilosec is used to treat gastroesophageal disease).
-The MA removed Resident #8's blister pack of Prilosec from the medication cart drawer and punched one tablet from a blister pack into a medication cup.
-The MA placed the medication cup with the Prilosec on the top right ledge of the cart.
-Resident #8 picked up the medication cup and swallowed the medication at approximately 9:42am.

Review of Resident #8's current FL-2 dated 6/17/2019 revealed:
-Diagnoses included vascular dementia, schizoaffective disorder bipolar type, and gastroesophageal reflux disease.
-There was a medication order for Prilosec 40mg every day before breakfast.

Review of current physician's order dated 10/17/19 for Resident #8 revealed an order for Prilosec 40mg one capsule every day before breakfast.

Review of Resident #8's Resident Register revealed an admission date of 4/25/19.

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D 358	Continued From page 72 Based on observations, interviews and record reviews it was determined Resident #8 was not interviewable. Interview on with the medication aide (MA) on 10/30/19 at 12:15pm who administered Prilosec 40mg to Resident #8 during the 9:00am medication pass revealed: -The MA primarily has worked as the SCU MA on day shift since March 2019. -Breakfast was served to the residents in the SCU unit at 8:00am. -Breakfast in the SCU unit was served at 8:00am on 10/29/19. -She administered Resident #8's medications as scheduled at 9:00am including the Prilosec. -She administered Resident #8's Prilosec after breakfast on 10/29/19. Interview with the facility cook on 10/30/19 at 12:10pm revealed: -Breakfast trays were scheduled to be delivered to the SCU at 8:00am. -When she cooked the resident's breakfast trays were ready and sent to the SCU between 8:00-8:05 am every morning. Interview on 10/30/19 at 12:20pm with a personal care aide (PCA) who worked in the SCU revealed breakfast was served at 8:00am daily to the residents when the breakfast trays arrive on the unit. Interview with the MA on 10/30/19 at 12:15pm who administered medications to Resident #8 on 10/29/19 during the mediation pass revealed: -Resident #8 ate her breakfast before she administered Resident #8's 9:00am scheduled medications. -The 9:00am medication pass was completed	D 358		

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D 358	Continued From page 73 between 9:30am and 10:00am for Resident #8. Telephone interview with Resident #8's primary care provider (PCP) on 10/31/19 at 2:21pm revealed: -The PCP expected medications to be administered as ordered. -Resident #8's Prilosec was ordered to be administered before breakfast and should be given at least thirty minutes to an hour before Resident #8 ate breakfast. -Prilosec not administered until after the resident had eaten breakfast would not be effective or as effective. Telephone interview with the facility's contracted consultant pharmacy on 10/31/19 at 12:52pm revealed: -Prilosec 40mg every day before breakfast was the current PCP order last ordered 10/17/19. -If a medication was ordered before breakfast then it should have been given before breakfast. -If a medication was scheduled before breakfast, the eMAR should show the scheduled administration time before breakfast. Interview with MA on 11/01/19 at 10:45am who administered Resident #8's 9:00am medication on 10/29/19 revealed: -The only residents who received medications before breakfast were those who received insulin. -Resident #8 was not a resident who received insulin and did not receive any medications before breakfast. -Resident #8 had Prilosec 40mg scheduled on the eMAR to be administered at 9:00am -She started her work day at 6:45am and did not administer Prilosec 40mg until after Resident #8 had finished eating her breakfast.	D 358		

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D 358	Continued From page 74 Review of the label on Resident #8's blister pack containing the Prilosec 40mg tablets on 11/1/19 at 10:52am revealed "Prilosec 40mg one tablet by mouth before breakfast" and was scheduled to be administered at 8:00am. Interview with the MA on 11/01/19 at 10:58am and 11:15am who administered Resident #8's medication on 10/29/19 during the 9:00am medication pass revealed: -She did not read all the medication administration information on the eMAR entry or blister pack label for Resident #8's Prilosec 40 mg tablet prior to medication administration. -She did not know Resident #8's eMAR entry or label information was for Prilosec 40 mg tablet to be administered before breakfast. Interview on 11/1/19 at 11:05am with the Special Care Unit Coordinator/Resident Care Coordinator (SCC/RCC) revealed: -The PCP's order read for Resident #8's Prilosec to be administered before breakfast. -Before breakfast medications usually were scheduled between 7:00-7:30 am and depended upon the time the pharmacy selected. -The MAs administer medications by scanning the blister card and looking for a check on the eMAR verifying correct medication had been selected to administer. -The SCC/RCC was not sure if their policy required MA's to read the labels or eMAR entries. Interview with the Administrator on 10/29/19 at 4:45pm revealed she did not have anything to say about staff not administering Prilosec before breakfast for Resident #8 during the 9:00am morning medication pass in the SCU on 10/29/19. b. Review of Resident #5's current FL-2 dated	D 358		

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D 358	Continued From page 75 10/18/19 revealed: -Diagnoses included vascular dementia with behavior disturbances, non-insulin dependent diabetic Type 2, hypertension, hyperlipidemia, benign prostatic hypertrophy, chronic heart failure, and frequent urinary tract infections. -There was an order Senna 8.6mg twice daily (Senna is used to treat constipation.). -There was no current order for Colace 100mg (Colace is used to treat occasional constipation.). Review of physician's consultation sheet for Resident #5 dated 10/08/19 revealed there was a signed physician order to change Colace to Senna twice daily. Observation during a medication pass on 10/29/19 revealed the medication aide (MA) administered both Colace 100mg and Senna 8.6mg to Resident #5 at 9:42am. Review of Resident #5's October 2019 electronic medication administration record (eMAR) revealed: -There was a computer-generated entry for Colace 100mg twice daily and it was scheduled to be administered at 9:00am and 9:00pm. -Colace 100mg was documented as administered at 9:00am and 9:00pm from 10/01/19 through 10/28/19 and at 9:00am on 10/29/19. -There was a computer-generated entry for Senna 8.6mg twice daily and it was scheduled to be administered at 9:00am and 9:00pm. -Senna 8.6mg was documented as administered at 9:00am at 9:00pm on 10/10/19 through 10/28/19 and at 9:00am on 10/29/19. Interview with a MA on 10/29/19 at 12:05pm and 11/01/19 at 12:55pm revealed: -She administered the medications to Resident	D 358		

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D 358	Continued From page 76 #5 scheduled at 9:00am on 10/29/19. -She did not know there was an order to change Resident's #5 Colace to Senna. -New medication orders were usually handled by the Special Care Unit Coordinator/Resident Care Coordinator (SCC/RCC). -The SCC/RCC was responsible to ensure the medication orders were sent to the pharmacy and any discontinued medications were removed from the resident's eMAR and from the medication carts. -She was not aware of Resident #5 having any episodes of loose stools or diarrhea. Telephone interview with a second MA on 10/31/19 at 12:32pm revealed the SCC/RCC was responsible to send physician's medication orders to the pharmacy and to ensure the residents' eMARs were updated when there were any medication changes. Interview with SCC/RCC on 10/29/19 at 11:30am revealed: -She was responsible for ensuring new medication orders were implemented for the residents. -She reviewed the medication orders and made sure new orders were faxed to the pharmacy. -She reviewed the eMAR for accuracy when new medications were ordered or if there were medication dosage changes. -She removed the discontinued medications from the medication cart when medications were discontinued. -She was not aware of the Colace was supposed to be discontinued for Resident #5. -She must have overlooked the order when it was written for Resident #5 to start taking Senna and to stop taking Colace. -She did not realize the Colace was not on	D 358		

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D 358	Continued From page 77 Resident #5's new FL-2 either. Telephone interview with Resident #5's primary care provider on 10/31/19 at 2:21pm revealed: -She wrote the medication order dated 10/08/19 to change Colace to Senna for Resident #5. -She expected the staff to stop administering the Colace when she wrote the medication order for Senna. -If staff continued to give the Colace with the new order for Senna, it may cause Resident #5 to have diarrhea. -Since Resident #5 was incontinent of bowel and was semi-ambulatory with a wheelchair, the diarrhea may irritate the resident's skin and cause skin breakdown. -She was not aware if Resident #5 had any problems with his skin since she wrote the medication order on 10/08/19. -She did not include Colace on Resident #5's new FL-2 because she expected the staff to stop administering it since she wrote the medication order to stop the Colace on 10/08/19. Interview with the Administrator on 10/29/19 at 4:45pm revealed she did not have anything to say about Resident #5 continuing to be administered Colace after it was ordered for the medication to be discontinued on 10/08/19. _____ The facility failed to assure medications were administered as ordered as evidenced by staff failing to observe a resident (#8) swallow eight medications which included a controlled substance and three medications used to treat mood disorders and agitation; staff administered a medication used to treat gastroesophageal acid disease an hour and fifty minutes after breakfast for a resident (#8) with a physician order to be administered before breakfast; and staff	D 358		

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D 358	Continued From page 78 continued to administer a medication used to treat constipation for 21 days after it was discontinued to a resident (#5) who was incontinent of bowel. The failure of the facility to assure medications were administered as ordered was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/29/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOTE EXCEED DECEMBER 16, 2019.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a	D 367		

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D 367	Continued From page 79 signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure medication records (MARs) were accurate for 2 of 8 sampled residents (#1 and #5). The findings are: 1. Review of Resident #1's current FL-2 dated 03/25/19 revealed diagnoses included paranoid schizophrenia, hyperlipidemia, and hypertension. Review of a physician's order for Resident #1 dated 07/01/19 revealed there was an order for Depakene 250mg/5ml - 10ml daily at lunch and 5ml at dinner (Depakene is used to treat mood disorder). Review of Resident #1's electronic medication administration records (e-MARs) for October 2019 received on 10/28/19 revealed: -There was a computer-generated entry for Depakene 250mg/5ml - 10ml to be administered at 12:00pm and 5ml to be administered 5:00pm. -Resident #1's Depakene 250mg/5ml - 10ml scheduled for 12:00pm on 10/22/19 was documented as not administered and in the comments, it was documented that Resident #1	D 367		

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was out the facility at 1:25pm.
-Resident #1's Depakene 250mg/5ml - 10ml scheduled for 12:00pm on 10/25/19 was documented as not administered and in the comments, it was documented that Resident #1 was out the facility at 11:50am.
-Resident #1's Depakene 250mg/5ml - 10ml scheduled for 12:00pm on 10/28/19 was documented as not administered and in the comments, it was documented that Resident #1 was out the facility at 1:20pm.

Review of Resident #1's e-MARs for October 2019 received on 10/29/19 revealed:
-There was a computer-generated entry for Depakene 250mg/5ml - 10ml to be administered at 12:00pm and 5ml to be administered 5:00pm.
-Resident #1's Depakene 250mg/5ml - 10ml scheduled for 12:00pm on 10/22/19 was documented as not administered and in the comments, it was documented that Resident #1 refused his medication at 1:25pm.
-Resident #1's Depakene 250mg/5ml - 10ml scheduled for 12:00pm on 10/28/19 was documented as not administered and in the comments, it was documented that Resident #1 refused his medication at 1:20pm.

Interview with a medication aide (MA) on 10/30/19 at 4:45pm revealed:
-She was responsible for administering Resident #1's Depakene at lunch on 10/22/19.
-She verified she documented Resident #1 was out of the facility 10/22/19 at 1:25pm on Resident #1's eMAR printed on 10/28/19.
-She documented Resident #1 was out of the facility because he left the facility and walked "uptown" to the local gas station, fast food restaurant, or store.
-Resident #1 sometimes forgot to sign-in and

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sign-out of the facility when he left.
-Resident #1 had not refused any medications she administered in October 2019.
-She could not explain why the documented comments changed to "resident refused" his medication on 10/22/19 at 1:25pm on the eMAR received on 10/29/19.
-She did not have the ability to amend the eMARs.
-If something needed to be amended on a resident's eMAR, the MA had to get the Special Care Unit Coordinator/Resident Care Coordinator (SCC/RCC) to make the changes.

Review of the facility's resident sign-out log revealed:
-Resident #1 signed out of the facility on 10/22/19.
-There was no documentation of the time he left or returned to the facility on 10/22/19.

Attempted telephone interview with the MA, who documented Resident #1's medication refusal on 10/26/19 at 11:50am, on 10/30/19 at 3:25pm and 10/31/19 at 11:38am were unsuccessful.

Interview with the Quality Assurance Director on 10/29/19 at 1:48pm revealed:
-She had given the survey team the copy of Resident #1's eMAR printed 10/29/19.
-Resident #1 had been involuntarily committed for psychiatric evaluation related to reports from staff his recent medication refusals and aggressive behaviors.
-She acknowledged Resident #1's medication refusals were only documented in the eMAR printed on 10/29/19.
-She could not explain the discrepancies between Resident #1's eMAR printed on 10/28/19 and Resident #1's eMAR printed on 10/29/19

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regarding medication refusals.
-The SCC/RCC may be able to better explain the discrepancies between the two eMARs since she printed Resident #1's eMAR on 10/28/19.

Review of an affidavit and petition for involuntary commitment for Resident #1 dated 10/29/19 revealed:
-The petitioner who signed the affidavit was the Quality Assurance Director.
-It was documented on 10/19/19 that resident began to refuse his medication (Depakene).
-Resident #1 began again to refuse his medication (Depakene) on 10/25/19.

Review of Resident #1's record revealed there was no documentation Resident #1 had refused any medications from 10/01/19 to 10/29/19.

Interview with the SCC/RCC on 10/31/19 at 11:30am revealed:
-She acknowledged she provided the copy of Resident #1's eMAR printed on 10/28/19.
-She could not explain the discrepancies between Resident #1's eMAR printed on 10/28/19 and Resident #1's eMAR printed on 10/29/19 regarding medication refusals.
-She could not give any insight on Resident#1's medication refusals other than what as documented on Resident #1's eMAR printed on 10/29/19.
-She did have administrative rights to amend residents' eMARs when the MAs reported making errors.
-She could not confirm how the copies of Resident #1's eMARs were changed from 10/28/19 to 10/29/19.

Interview with a staff member in the information technology department of the facility's contracted

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pharmacy on 10/31/19 at 1:45pm revealed:
-He saw that Resident #1's October 2019 eMAR had been modified.
-He was unable to provide the information on who modified Resident #1's October eMAR or when the eMAR was modified.
-He identified the Quality Assurance Director, Administrator in Training, and SCC/RCC had the administrative rights for the facility's eMAR system which included the rights to amend residents' eMARs.

Interview with the Administrator on 11/01/19 at 2:55 pm revealed:
-She could explain the discrepancies between the Resident #1's eMARs printed on 10/28/19 and 10/29/19.
-There must have been "a glitch" in their eMAR system that caused the discrepancies in Resident #1's eMARs.
-She was not sure exactly who had administrative rights to amend residents' eMARs at the facility.
-She believed the SCC/RCC had administrative rights to amend the facility's eMAR.

2. Review of Resident #5's current FL-2 dated 10/18/19 revealed:
-Diagnoses included vascular dementia with behavior disturbances, non-insulin dependent diabetic Type 2, hypertension, hyperlipidemia, benign prostatic hypertrophy, chronic heart failure, and frequent urinary tract infections.
-There was an order Senna 8.6mg twice daily (Senna is used to treat constipation.).
-There was no current order for Colace 100mg (Colace is used to treat occasional constipation.).

Review of physician's consultation sheet for Resident #5 dated 10/08/19 revealed there was a signed physician order to change Colace to

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D 367	Continued From page 84 Senna twice daily. Observation during a medication pass on 10/29/19 revealed staff administered both Colace 100mg and Senna 8.6mg to Resident #5 at 9:42am. Review of Resident #5's October 2019 electronic medication administration record (eMAR) revealed: -There was a computer-generated entry for Colace 100mg twice daily and it was scheduled to be administered at 9:00am and 9:00pm. -Colace 100mg was documented as being administered at 9:00am and 9:00pm from 10/01/19 through 10/28/19 and at 9:00am on 10/29/19. -There was a computer-generated entry for Senna 8.6mg twice daily and it was scheduled to be administered at 9:00am and 9:00pm. -Senna 8.6mg was documented as administered at 9:00am at 9:00pm on 10/10/19 through 10/28/19 and at 9:00am on 10/29/19. Interview with a medication aide (MA) on 10/29/19 at 12:05pm revealed: -She was the MA who administered the medications to Resident #5 scheduled at 9:00am on 10/29/19. -She did not know there was an order to change Resident's #5 Colace to Senna. -Changes to the eMAR were usually handled by the Special Care Unit Coordinator/Resident Care Coordinator (SCC/RCC). -The SCC/RCC was responsible to ensure the resident's eMARs were correct when medication orders were written. -She did not know to discontinue the Colace for Resident #1 because she gave the medications to the residents as they appeared for their	D 367		

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designated times on the resident's eMAR.
-She did not check for resident's medication orders to ensure they were valid.

Telephone interview with a second MA on 10/31/19 at 12:32pm revealed:
-The SCC/RCC was responsible for checking medication orders and sending new medication orders to the pharmacy.
-The SCC/RCC was also responsible for ensuring the residents' eMARs were accurate.
-The MAs only saw the medication changes or discontinuation when they were changed on the eMARs after the SCC/RCC had sent the medications orders to the pharmacy and the residents' eMARs were updated.

Interview with SCC/RCC on 10/29/19 at 11:30am revealed:
-She was responsible for ensuring new medication orders were implemented and updated on eMAR for the residents.
-She was responsible to review the residents' eMARs for accuracy when new medications were ordered or if there were medications discontinued.
-She was not aware of the Colace was supposed to be discontinued for Resident #5.
-She must have overlooked the order when it was written for Resident #5 to start taking Senna and to stop taking Colace.

Interview with the Administrator on 10/29/19 at 4:45pm revealed she did not have anything to say about Resident #5's October 2019 eMAR not being accurate to reflect a physician's order written to discontinue Colace on 10/08/19.

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D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure medications were administered in accordance with infection control measures as evidenced by staff contaminating medications prior to administration for a resident (#5). The findings are: Observation on during the medication pass on 10/29/19 from 9:26am to 9:36am revealed: -The medication aide (MA) removed four capsules of Divalproex DR 0.125mg and one capsule of Omeprazole DR 40mg from a clear medication cup that contained 16 ½ pills prepared for Resident #5, using an ungloved hand and placed the medications on a writing tablet that the MA had previously written on (Divalproex is used to treat mood disorders. Omeprazole is used to treat gastroesophageal disease). -The MA used an ungloved hand and opened a capsule of Divalproex DR that was on the writing table and mixed it in cup that contained a nutritional supplement. -The MA took the remaining three capsules of Divalproex and the Omeprazole from the top of	D 371		

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D 371	Continued From page 87 the writing pad and put them back in the medication cup with the remaining medications. Interview with the MA on 10/29/19 at 9:30am revealed: -She had been a MA since March 2019. -She was preparing the medications as she had been trained to do. -She realized that she should not be handling medications with her bare hands, but she forgot. -She would dispose of the contaminated medications. Based on observations, interviews and record reviews it was determined Resident #5 was not interviewable. Interview with the Administrator on 10/29/19 at 4:45pm revealed she did not have anything to say about the MA the ensuring to administration of medication to the residents in safe manner free of contamination.	D 371		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration This Rule is not met as evidenced by: TYPE B VIOLATION	D 378		

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D 378	Continued From page 88 Based on observations, interviews, and record reviews, the facility failed to assure medications were under locked security related to a liquid antipsychotic medication, and a liquid mixture of 2 medications and a cup with 12 medications designated to be wasted, left unsecured on top of the medication cart in the Special Care Unit (SCU) without direct physical supervision and accessible to Resident (#5) who had a history of being disoriented, a wanderer and assessed to be at ingestion risk. The findings are: 1. Observation of the SCU on 10/29/19 from 9:20am to 9:26am revealed: -The Medication Aide (MA) left the SCU living room area to administer an injection to a resident in another area of the unit. -There were no other staff present in the SCU living room. -There was a box labeled Haloperidol oral solution (concentrate) 2mg/ml sitting on top of the medication cart (Haloperidol is an antipsychotic medication used to treat mood disorders). -Nine residents were in the living room, including two residents who were ambulatory, and all were within at least eight feet of the unattended Haloperidol solution on top of the medication cart. -The MA returned to the SCU living room at 9:26am, picked up the box that contained the Haloperidol from the top, removed the bottle from its box and began preparing medication for another resident. -The MA returned the Haloperidol to the medication cart and secured it inside the medication cart at approximately 9:27am. Interview with the MA on 10/29/19 at 9:27am	D 378		

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revealed:
-She left the Haldoperidol on top of the medication cart when she went to administer medication to another resident on the morning of 10/29/19.
-She knew all medications were supposed to be secured in the medication cart.

Review of the facility's medication policies and procedures revealed there was no documentation regarding how to ensure medications, other than controlled substances, were stored in a safe and secure manner.

Refer to interview with the Special Care Unit Coordinator/Resident Care Coordinator (SCC/RCC) on 10/29/19 at 11:30am.

Refer to interview with the Administrator on 10/29/19 at 4:45pm.

2. Review of Resident #5's current FL-2 dated 10/18/19 revealed:
-Diagnoses included vascular dementia with behavior disturbances.
-It was documented Resident #5 was constantly disoriented and a wanderer.
-Resident #5's level of care was documented for the SCU.

Review of Resident #5's care plan dated 02/25/19 revealed he was always disoriented; had significant memory loss which required him to be directed; and was assessed to be an ingestion risk.

Review of Resident #5's care note dated 08/22/19 revealed:
-Resident #5 was assessed for ingestion risk.
-Resident #5 continued to pick-up random items

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and "mess with them".
-All items that could possibly be ingested by the resident were supposed to be secured by staff.
-Staff would continue to monitor Resident #5 every thirty minutes and he would be reassessed in three months.

Observation of the morning medication pass in the Special Care Unit (SCU) on 10/29/19 from 9:36am to 10:15am revealed:
-The medication aide (MA) was in the living room of the SCU preparing medications for Resident #5.
-The MA used ungloved hands to prepare Resident #5's medications and touched medications, placed medications on a writing tablet on top of the medication cart that the MA had previously written on, removed medications from the tablet and placed them into a medication cup already containing medications.
-The MA placed a drinking cup on top of the medication care that contained a mixture of a nutritional supplement, a capsule of Divalproex DR 0.125mg (used to treat mood disorders), and 0.5ml of Haldol 2mg/ml (Haloperidol is an antipsychotic medication used to treat mood disorders).
-The MA placed a clear medicine cup next to the drinking cup on top of the medication cart that contained Colace 100mg (one capsule) (used to treat constipation), Cogentin 1mg (one tablet) (used to treat tremors), Carvedilol 25mg (one tablet) (used to treat hypertension), Senna 8.6mg (one tablet) (used to treat constipation), Clonidine 0.1mg (one tablet) (used to treat hypertension), Divalproex 0.125mg (three capsules) (used to treat mood disorders), Lexapro 10mg (one and one-half tablets) (used to treat mood disorders), Vitamin B1 (one tablet) (a nutritional supplement), Seroquel 100mg (one tablet) (used to treat mood

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disorders), Omeprazole DR 40mg (one capsule) (used to treat gastroesophageal disease), Lisinopril 10mg (one tablet) (used to treat hypertension), and a multivitamin (one tablet) (a nutritional supplement).
-The medications in the mixture in the drinking cup and clear cup were designated as waste due to contamination.
-The MA administered medications to two residents in the living room of the SCU while the drinking cup and medication cup with the medications remained on top of the medication cart and there were nine residents in the living room area of the SCU.
-The MA turned her back away from the medication cart at various times when she administered medications to the two residents and could not clearly visualize the drinking cup and medication cup with the medications.
-The MA moved the medication cart, with the cups of medications still on the top of the medication cart, out of the living room and placed it across the doorway of a resident's room located across the hallway from the living room entrance.
-The MA went inside the resident's room and administered medication to a third resident while the cups with the medications were still on top of medication cart.
-The medication cart was not in the MA's view while she administered medications to the third resident and the cups of medications were within easy reach from the backside of the medication cart facing outward in the SCU hallway.
-There were no residents observed in the hallway of the SCU while the MA administered medications to the third resident.
-The MA moved the medication cart, with the cups of medications still on the top of the medication cart, down toward the far-left end of the SCU unit hallway next to the doorway of a

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resident's room.
-The MA went inside the resident's room and administered medications to a fourth resident while the cups with the medications were still on top of medication cart.
-The medication cart was not in the MA's view while she administered medications to the fourth resident and the cups of medications were easily accessible from the backside of the medication cart facing outward in the SCU hallway.
-Resident #5 was in his wheelchair and approached the backside of the medication cart in the hallway while the MA was administering medications to the fourth resident inside the resident's room.
-There were no staff in the hallway supervising Resident #5 as he sat in his wheelchair.
-The medications left in the drinking cup and medication cup were easily accessible to Resident #5 who was in his wheelchair on the opposite side of the medication cart.
-The MA returned from administering medications to the fourth resident and the medications were still left on top of the medication cart and Resident #5 was on the opposite side of the medication cart.
-The MA removed the drinking cup and medication cup from the top of the medication cart at 10:15am to dispose of them.

Interview with the MA on 10/29/19 at 10:15am revealed:
-She knew the drinking cup and the medication cup were left on top of the medication cart.
-The medications in the mixture in the drinking cup and clear medication cup were to be wasted due to contamination occurring while she prepared the medications.
-She was going to waste the medications in those cups once she finished passing the medications

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(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 378	Continued From page 93 to the other residents in the SCU. -She should have disposed of the contaminated medications before she continued to administer medications to other residents. -Resident #5, who was by the medication cart, was confused at times and he wandered the hallway sometimes. -She did not think Resident #5 would bother the medications left on top of the medication cart. Review of the facility's medication policies and procedures revealed there was no documentation regarding how to ensure medications were handled in a safe and secure manner prior to their disposal. Refer to interview with the SCC/RCC on 10/29/19 at 11:30am. Refer to interview with the Administrator on 10/29/19 at 4:45pm. Interview with the SCC/RCC on 10/29/19 at 11:30am revealed: -The MA should not have left any medications on the medication cart unsupervised. -It was not the facility's policy for medications to be left unsecured on top of the medication cart. -It was possible for residents in the SCU to ingest medications that was left unsecured on top of the medication cart. -All nineteen residents in the SCU were assessed to have ingestion risks. Interview with the Administrator on 10/29/19 at 4:45pm revealed she did not have anything to say about the medications that were left unsecured on top of the medication cart in the Special Care Unit on the morning of 10/29/19.	D 378		

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D 378	Continued From page 94 The facility failed to assure medications were maintained under locked security or under direct supervision of staff in charge of medication administration by leaving medication unsecured in the living room of the SCU with nine residents who were unsupervised and left fourteen medications in a drinking mixture and a medication cup on top of the medication cart that was accessible to a resident (#5) with a diagnosis of vascular dementia and was assessed to have an ingestion risk. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ The facility provided the following plan of protection in accordance with G. S. 131D-34 on 10/30/19. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOTE EXCEED DECEMBER 16, 2019.	D 378		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents	D912		

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D912	Continued From page 95 received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration, medication storage, food and nutrition, supervision, and housekeeping and furnishings. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure medications were under locked security related to a liquid antipsychotic medication, and a liquid mixture of 2 medications and a cup with 12 medications designated to be wasted, left unsecured on top of the medication cart in the Special Care Unit (SCU) without direct physical supervision and accessible to Resident (#5) who had a history of being disoriented, a wanderer and assessed to be at ingestion risk. [Refer to Tag 378 10A NCAC 13F .1006(b) Medication Storage (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure the facility was free of hazards as evidenced by an opened tub of beige colored paint covered with a clear plastic sheet and 2 five-gallon buckets of paint stored on the floor in a common resident area (the telephone room), a missing floor drain cover in the shower of the common shower room #2 on the A hall and an enclosed mouse traps and rat/mice poison pellets placed in common areas on the Assisted Living (AL) section; an unlocked and unmonitored linen closet used to store twin blade razors and the residents' personal hygiene items in the form of liquids and solids, an unlocked laundry room not monitored by staff and a damaged exit door with a cracked window with loose glass fragments and a missing push bar	D912		

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D912	Continued From page 96 that left a circular hole in the interior side of the door on the Special Care Unit (SCU). [Refer to Tag 0079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure foods being stored, prepared, and served to residents were protected from contamination related to a wet pink, brown and black build-up substance in the ice machine, opened and undated food containers in the refrigerator, freezer and pantries, chemical and cleaning agents stored near food, a fly trap with dead flies touching clean cooking pans, and enclosed mouse traps containing poison and rat/mice poison pellets placed near food. [Refer to Tag 283 10A NCAC 13F .0904(a)(2) Nutrition and Food Service (Type B Violation)]. 4. Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for 1 of 5 sampled residents (#1) who was supposed to have thirty-minute checks by staff due to aggressive and assaultive behaviors; was observed panhandling, and reportedly ate out of the garbage. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 2 of 2 residents sampled who had an order for honey thickened liquids (#6) and a resident who had a history of stroke and was ordered a pureed diet (#5). [Refer to Tag 310 .0904(e)(4) Nutrition and Food Service (Type B Violation)].	D912		

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D912	Continued From page 97 6. Based on observations, interviews and record reviews the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 out of 3 residents (#8, #5) observed during the medication pass including errors with Depakote, Prilosec, Clozaril, Ditropan, Abilify, Theragran-M, Synthroid, Lorazepam (#8); Colace (#5). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		