STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL062014	A. BUILDING: _____ B. WING _____	R-C 12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE HAVEN OF STAR ASSISTED LIVING	327 FREEMAN STREET STAR, NC 27356

(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 and the Montgomery County Department of Social Services conducted an annual and follow-up survey on 12/03/19 to 12/05/19.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (Resident #1) was tested for tuberculosis (TB) disease upon admission. The findings are: Review of Resident #1's current FL2 dated 08/07/19 revealed diagnoses included neurocognitive deficits, chronic obstructive pulmonary disease, and schizoaffective disorder. Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on	D 234	Resident #1 obtained TB test. Administrator/Marketing will ensure all residents have received their first TB test upon admission and Resident Care Coordinator/Designee will ensure all residents have received their second TB test in compliance with the control measures adopted by the commission of health services. Administrator/Designee will conduct audits randomly of charts to include checking for documentation of TB testing or on as needed basis. Compliance Director/QI Department will conduct audits of charts to include checking for documentation of TB testing quarterly or on as needed basis.	12/18/19 1/20/2020 & ongoing 1/20/2020 & ongoing 1/20/2020 & ongoing

Reviewed and Accepted
Date: 01/17/20
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D 234	Continued From page 1 08/07/19. -The resident was admitted directly from a local hospital. -The resident had lived at another assisted living facility prior to hospitalization. Review of Resident #1's immunization records revealed: -There was documentation of a TB skin test placed on 07/09/19 and read as negative on 07/11/19. -There was no documentation of any other TB skin tests or chest x-rays read for TB for Resident #1. Interview with the former Administrator on 12/05/19 at 9:10am revealed: -They had been unable to find an admission TB test for Resident #1. -"If we can't find it, we can get one done tomorrow." -She was aware of the regulation requiring residents be tested for TB upon admission. Interview with Resident #1 on 12/05/19 at 11:55am revealed: -He remembered having had a TB test "a long time ago." -He was unsure of when he had last had a TB test.	D 234		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an	D 259		

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D 259	Continued From page 2 individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure care plans were developed for 2 of 6 sampled residents (Residents #1 and #3) within 30 days following admission. The findings are: 1. Review of Resident #3's current FL2 dated 08/16/19 revealed: -Diagnoses included dementia, acute metabolic encephalopathy, and hypoglycemia. -Resident #3 was constantly disoriented, semi-ambulatory, incontinent of bladder and bowel. -Resident #3 required personal care assistance with bathing and dressing. Review of Resident #3's previous FL2 dated 06/19/19 revealed: -Diagnoses included Alzheimer's dementia without behavioral disturbance, acute renal failure chronic kidney disease stage 3, chronic atrial fibrillation, essential hypertension, type II diabetes mellitus with neurologic complication, and dyslipidemia. -Resident #3 was constantly disoriented, semi-ambulatory with walker, incontinent of bladder and bowel. -Resident #3 required required personal care assistance with bathing, feeding, and dressing. Review of Resident #3's Resident Register revealed an admission date of 06/19/19. Review of Resident #3's personal care services	D 259	Care Plan was completed for Resident #3. Special Care Unit Director/Designee will audit all care plans to assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule 10 NCAC 13F .0801. Any care plans found not completed will be done immediately. Resident tickler will be updated to ensure Special Care Unit Coordinator knows when care plans are due. Administrator will audit at least 5 care plans/ resident profiles per month x 4 months, then randomly thereafter to assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule 10 NCAC 13F .0801. Quality Improvement Department/Compliance Department will conduct audits of the facility at least quarterly or as needed basis to monitor resident rights and ensure compliance.	1/14/2020 1/10/2020 - 1/20/2020 1/20/2020 & Ongoing 1/20/2020 & Ongoing 1/20/2020 & Ongoing

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D 259	Continued From page 3 assessment dated 04/11/19 revealed: -The resident required extensive assistance with toileting, bathing, dressing, and grooming. -The resident required limited assistance with transfers and eating. Review of Resident #3's Care Plan dated 07/19/19 revealed: -The assessment date was 07/19/19. -There was no assessment of the required level of staff assistance required for all activities of daily living. -The Care Plan was signed by Resident #3's Nurse Practitioner on 08/21/19. -There was no name, signature, and date of who assessed the resident and completed the Care Plan. Review of Resident #3's Record revealed he was admitted to a local hospital on 08/10/19 for treatment of a urinary tract infection. Interview with the Administrator on 12/05/19 at 8:25am revealed: -Resident #3 should have had a new Care Plan when he was admitted to the facility. -When Resident #3 went to the hospital and then came here he may have "declined" and "something may have changed." -The Special Care Coordinator (SCC) would have been responsible for completing a new care plan for Resident #3. Interview with the former Administrator on 12/05/19 at 9:10am revealed: -When a resident was admitted to the facility, the SCC looked at the personal care services assessment to see if the resident needed to be reassessed or if the activities of daily living levels "still matched."	D 259		

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D 259	Continued From page 4 -She had been told by corporate management they could use the personal care services assessments for activities of daily living. -She had been told by corporate management they just needed to attach the personal care services assessment to their Care Plan for activities of daily living information. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to the interview with the Special Care Coordinator (SCC) on 12/04/19 at 2:25pm. 2. Review of Resident #1's current FL2 dated 08/07/19 revealed: -Diagnoses included neurocognitive deficits, chronic obstructive pulmonary disease, schizoaffective disorder, and hepatitis C. -Resident #1 was intermittently disoriented and ambulatory. Review of Resident #1's Resident Register revealed the admission date was 08/07/19. Review of Resident #1's Care Plan dated 10/09/19 revealed: -The resident required supervision with all activities of daily living. -The resident was assessed 09/26/19. -The resident's Nurse Practitioner signed the Care Plan on 10/09/19. Interview with Resident #1 on 12/04/19 at 3:26pm revealed: -He used oxygen as needed and received breathing treatments. -He tired easily when he ambulated outside.	D 259		

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D 259	Continued From page 5 Refer to the interview with the Special Care Coordinator (SCC) on 12/04/19 at 2:25pm. Interview with the Special Care Coordinator (SCC) on 12/04/19 at 2:25pm revealed: -She was responsible for new admissions for the Special Care Unit and Assisted Living Unit. -She was also responsible for ensuring Care Plans were completed within 30 days of admission.	D 259		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure follow-up for 1 of 5 sampled residents related to a rollator walker (Resident #1). The findings are: Review of Resident #1's current FL2 dated 08/07/19 revealed: -Diagnoses included neurocognitive deficits, chronic obstructive pulmonary disease, and	D 273		

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D 273	Continued From page 6 schizoaffective disorder. -Resident #1 was intermittently disoriented and ambulatory. Review of Resident #1's Care Plan dated 10/09/19 revealed the resident required supervision with ambulation and transfers. Review of Resident #1's Nurse Practitioner's (NP) order dated 08/08/19 revealed an order for a physical therapy evaluation. Review of Resident #1's Home Health daily visit notes revealed: -Resident #1 received five physical therapy visits from 08/21/19 to 10/01/19. -On 10/01/19, the Physical Therapist noted he had left a message with Resident #1's NP the resident would benefit from an as needed rollator walker. Review of Resident #1's NP's order dated 10/02/19 revealed an order for a rollator walker for mobility and safety. Interview with Resident #1 on 12/04/19 at 3:26pm revealed: -He thought a rollator walker had been ordered for him, but he had not yet received it. -He got "winded" when he walked outside the facility to smoke and "sometimes needed to sit down." -His knees "killed him" and he had a difficult time making it to the bench outside the facility to sit down. Interview with a medication aide (MA) on 12/05/19 at 10:50am revealed: -She had sent the order for Resident #1's rollator dated 10/02/19 to the Home Health service on	D 273	Facility will review all recent (60 days) therapy notes and assure any recommendations made are followed up on immediately. Special Care Unit Director, and/or Designee will review new orders daily to ensure each order is referred to and appropriate agency if indicated. Special Care Unit Director/Designee will audit all orders once per week x 4 weeks, then once per month ongoing to assure staff are giving medications per physicians' orders. Any staff not following physicians' orders will receive re-training and/or disciplinary action up to termination.	1/10/2020 & 1/20/2020 1/20/2020 & ongoing 1/20/2020 & ongoing

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D 273	Continued From page 7 12/04/19. -The order had not been followed up on until it was brought to her attention by management on 12/04/19. -The Home Health service stated they would be out with the rollator walker for Resident #1 "this week or next." Interview with the Special Care Coordinator (SCC) on 12/04/19 at 2:25pm and on 12/05/19 at 11:26am revealed: -She was responsible for reviewing new orders with the MA's and making sure the orders were referred to the appropriate provider. -She had not been aware there was an order for a rollator walker dated 10/02/19 for Resident #1. -She thought a rollator walker would be "helpful" for Resident #1 "if he took it outside with him."	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents on the special care unit (SCU) were provided with a	D 287		

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D 287	Continued From page 8 non-disposable place setting including a knife, spoon and fork. The findings are: Interview with the Administrator on 12/03/19 at 9:00am revealed the current census on the SCU was 22. Observation of the lunch meal service on 12/03/19 from 12:15pm to 1:00pm revealed: -There was one dining room in the SCU which contained 2 tables. -All place settings included a napkin, fork and a spoon. -There was a plastic box with a lid that contained napkins, forks, spoons and 4 knives on the cart that was brought out of the kitchen to the SCU dining room. -The meal consisted of chicken, rice, okra and tomatoes, dinner rolls and pound cake with peaches. -Three of the residents in the dining room picked up the chicken breast and ate it with their fingers. -Two residents stuck their fork into the chicken and then took a bite while holding up the chicken breast on the fork. -Staff working in the dining room did not offer assistance with cutting the residents' chicken until prompted. Observation of knives available on 12/03/19 at 12:15pm revealed: -Resident knives for the SCU were kept in a clear box with a lid in the kitchen. -There were enough knives for every resident in the SCU to have a knife at meals. Interviews with two residents in the dining room during the lunch meal service on 12/03/19 from	D 287	Non disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers will be placed at each meal time for all residents unless otherwise documented based on needs or resident preference. Special Care Unit Director/Designee will monitor 2 meals per week x3 weeks, then randomly thereafter to ensure all residents receive place settings in accordance to 10A NCAC 13F .0904(b)(2). Administrator will monitor meals randomly to ensure all residents receive place settings in accordance to 10A NCAC 13F .0904(b)(2). Quality Improvement Department will audit quarterly or on an as needed basis to ensure all residents receive place settings in accordance to 10A NCAC 13F .0904(b)(2).	1/20/2020 & Ongoing 1/20/2020 & Ongoing 1/20/2020 & Ongoing 1/20/2020 & Ongoing

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D 287	Continued From page 9 12:00pm to 12:40pm revealed: -One resident said he would like a knife to use with his meals. -One resident said they were not allowed to have knives because some residents were not nice. Interview with a personal care aide (PCA) on the SCU on 12/03/19 at 12:27pm revealed: -The residents on the SCU would not use a knife. -Some of the residents on the SCU would not be safe to use a knife. Interview with the Special Care Coordinator (SCC) on 12/04/19 at 12:28 pm revealed: -The residents on the SCU had diagnosis of dementia and couldn't have knives. -Some of the residents had been known to throw their plates and the staff were afraid those residents would throw a knife at the other residents if they had one. -Staff would cut residents' food upon request. -There were no physician orders that addressed residents on the SCU were not allowed to have a knife with their meal. -Resident care plans did not contain any information regarding the exclusion of knives at mealtimes. -The kitchen had enough knives for every resident to have a knife available at meals. Interview with a second PCA on the SCU on 12/03/19 at 12:40pm revealed: -The residents do not get a knife because some of the residents get "aggressive." -The other residents got knives. -There was really no reason why the residents didn't get a knife for their meal today. -The residents really did not need a knife for their meal. -She could assist a resident if they needed their	D 287		

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D 287	Continued From page 10 meal cut up as the kitchen sent out some knives at meals for staff in the plastic box on the cart with the other silverware and napkins. Interview with the Cook on 12/03/19 at 2:45pm revealed: -He thought staff would cut food for residents if they requested help. -He had forgot to put enough knives in the box before it was sent to the SCU dining room. Interview with the Administrator on 12/05/19 at 8:25am revealed: -She was aware a knife was to be included in the place setting for residents at all meals. -Residents in the SCU should be given a knife in their place settings at meals. -"It's a dignity issue." -She did not know why knives had not been included in the place settings for the residents in the SCU.	D 287		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were served nutritious and palatable meals. The findings are:	D 297		

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D 297	Continued From page 11 Review of the lunch menu for 12/03/19 revealed: -The menu listed was rotisserie style turkey, turkey gravy, rice, roasted beets, wheat dinner roll or bread and pudding swirl. -The residents on a pureed meal were to have a scoop of pureed rotisserie style turkey, gravy, a scoop of pureed rice, a scoop of roasted beets, a scoop of pureed bread or roll, and pudding parfait with their beverage of choice. Observation of lunch meal service in the special care unit dining room on 12/03/19 at 12:15 am revealed: -The meal served was chicken, rice, okra and tomatoes, dinner rolls and pound cake with peaches. -The residents who received the pureed meal received a white plate with a light brown mixture covering the entire surface of the plate with a glob of gravy in the middle of the plate. -The same residents also received blended up pound cake. -A resident ate one bite of the pureed meal and turned around making a face at the staff. -A second resident drank his water and tea and left his pureed plate without eating the food. Interview with the Cook on 12/03/19 at 2:45pm revealed: -He had prepared breaded chicken breast, rice, okra with tomatoes, a roll, and pound cake with peaches for the lunch meal. -He had substituted the rotisserie turkey for breaded chicken, roasted beets for okra and tomatoes, and pudding swirl for pound cake with peaches. -He made everyone the same meal and then used the food processor to make the pureed food by adding water until he reached the desired consistency.	D 297	Dietary Staff will be retrained on preparation and serving of pureed meals. Special Care Unit Director/Designee will monitor 2 meals per week x3 weeks, then randomly thereafter to ensure all residents receive palatable meals. Quality Improvement Department will audit quarterly or on an as needed basis to ensure all residents receive palatable meals. Administrator will monitor meals randomly to ensure all residents receive palatable meals	1/16/20 - 1/21/20 1/20/2020 & ongoing 1/20/2020 & ongoing 1/20/2020 & ongoing

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D 297	Continued From page 12 -He did not puree the food items separately, but mixed the entire meal together. -The residents on pureed diets received breaded chicken, gravy, rice and a roll mixed together in the same bowl. -He blended the pound cake up and the poured peach juice on top of the blended cake. -He stated he could separate each item, but it all gets mixed up between the kitchen and being transported to the unit. -He was not concerned about mixing all the food together as "it all goes to the same place anyway." Observation of the breakfast meal service in the SCU dining room on 12/04/19 at 8:15am revealed: -Residents who received a regular diet were served eggs, grits, sausage and toast. -The four residents who received a pureed meal received eggs, grits, sausage and a piece of toast all pureed together. -A resident drank all of his liquids but did not eat his pureed meal. Interview with the resident who did not eat his meal during either observation on 12/05/19 at 8:35am revealed: -He did not eat the pureed meal as he did not like the pureed meal. -It did not taste good nor was it appealing. -He would drink what they gave him, but would only eat if he was really hungry. Interview with a personal care aide (PCA) on the special care unit on 12/04/19 at 8:22am revealed: -The residents on pureed diets did not like the pureed foods. -They really only had one resident that would usually eat all of her pureed meal.	D 297		

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D 297	Continued From page 13 -The other residents on the SCU who were on a pureed meal would eat about half to nothing at all. -"It looks nasty." Interview with the Special Care Coordinator (SCC) on 12/05/19 at 11:00am revealed: -She did not know how the kitchen prepared the pureed meals for the residents. -She did not think all the pureed meal should be mixed together. -It did not look good to her but a pureed meal was challenging to make look good. Interview with the former Administrator on 12/04/19 at 3:30pm revealed: -The corporate office had a warehouse and she thought they had divided plates they could get for the residents who were served pureed. -The Cook had been trained and had also worked previously in another facility. -All pureed diets should have been prepared according to the the serving instructions and not all mixed together in one plate or bowl.	D 297		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 298	Staff will serve snacks in the facility 3 times a day in accordance with rule 10A NCAC 13F .0904 (d)(2). Administrator/designee will ensure there are snacks in the facility and that they are offered 3 times a day in accordance with rule 10A NCAC 13F .0904 (d)(2).	1/14/2020 & ongoing 1/14/2020 & ongoing

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D 298	Continued From page 14 reviews, the facility failed to offer or make available three snacks a day and shown on the menu as snacks. The findings are: Interviews with four residents during the initial tour on 12/03/19 from 8:55am to 9:52am revealed: -"Sometimes" the residents received three snacks per day of peanut butter crackers or animal crackers. -Snacks were served "occasionally" in the evening. -Snacks were offered one time a day. -Snacks like peanut butter crackers used to be served only in the evening, but were no longer served in the evening. Review of the facility's cycle menu for the week revealed: -There were three snacks a day listed on the menu (AM snack, PM snack, and HS snack). -There was no menu for the snack items to be served. Interview with the former Administrator on 12/03/19 at 4:50pm revealed: -There was not a separate snack menu. -The facility's food supplier just sent foods for snacks such as peanut butter crackers, pudding, apple sauce, and graham crackers. Observation of a cart in the kitchen on 12/03/19 at 2:45pm revealed: -There was a box with orange peanut butter crackers, sugar free cookies, graham crackers, juice and fruit flavored beverage which sat on the top shelf of a three-tiered cart. -There was a bowl with bananas which sat beside	D 298	QI Department/Compliance Director will conduct audits of facility at least quarterly to there are snacks in the facility and that they are offered 3 times a day in accordance with rule 10A NCAC 13F .0904 (d)(2).	1/20/2020 & Ongoing

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D 298	Continued From page 15 the cart in the kitchen. Interview with the Cook on 12/03/19 at 2:45pm revealed: -He prepared the snack cart for 10:00am and 3:00pm snacks and another for third shift he prepared between 7:00pm-8:00pm before he left for the night. -He would put peanut butter crackers, sugar free cookies, graham crackers, juice and punch on the cart and take it out to the staff for the residents. -Once the snacks went out to the floor, he did not know who passed them out or how the process worked from there. Interview with a resident on 12/04/19 at 10:35am revealed: -There was not a set time for snacks. -"I don't get any snacks unless I ask for something." -The snacks were always the same (peanut butter crackers). Interview with a second resident on 12/04/19 at 10:45am revealed: -Snacks were set out on a cart and left in the hallway by the kitchen staff. -There was no fresh fruit available most days. -Snacks were not made available in the facility where residents could get them when they wanted them. -The staff would bring some fruit if asked if there was any fruit available. Interview with a third resident on 12/04/19 at 11:00am revealed: -Snacks were not given out on a regular basis. -The snacks were always the same (peanut butter crackers).	D 298		

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D 298	Continued From page 16 -There was no morning snack offered. Interview with a fourth resident on 12/04/19 at 11:15am revealed: -The resident had not received any snacks. -The resident was not aware of a set schedule for snacks. Interview with a fifth resident on 12/04/19 at 11:30am revealed: -Snacks were left on a tray by the residents' family room. -Residents were not informed that the snacks were there. -Residents were not allowed to keep snacks in their room due to the threat of roaches in the rooms. Interview with a Personal Care Aide (PCA) on 12/04/19 at 11:50am revealed: -Snacks were only offered two times per day. -Peanut butter crackers, cranberry juice and ice cream sometimes were offered for snacks. -Residents had to ask for fruit when fruit was available. Observation on 12/04/19 at 2:15pm revealed: -The dietary staff placed a cart by the living room on the assisted living unit. -There were peanut butter crackers, cookies, and a pitcher of fruit flavored beverage on the cart. Interview with the former Administrator on 12/04/19 at 3:45pm revealed: -Staff served snacks two times per day at 3:00pm and 8:00pm. -Residents were given fresh fruit "sometimes" but had to ask for the fruit because it was kept in the kitchen to avoid having all of the residents handle or contaminate the fruit.	D 298		

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D 298	Continued From page 17 -Residents were given choices for snacks most days of peanut butter crackers, cookies, ice cream, mini marshmallows, apple sauce and drinks.	D 298		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observation, record review and interviews the facility failed to assist 1 of 5 residents (Resident #11) in the special care unit (SCU) during the meal service in a manner that enhanced the residents dignity and respect. The findings are: Observation of the lunch meal service on 12/03/19 from 12:15pm-1:00pm revealed: -Resident #11 was bent over in her wheelchair seated at the end of the table. -When Resident #11 received her meal, the staff member handed her the spoon and encouraged her to eat. -Resident #11 received a pureed meal of breaded chicken, rice and a roll. -Resident #11 used the spoon to eat her meal at times throughout her lunch. -Resident #11 would also use her fingers to try and scoop up the the puree meal and eat it off	D 312	Special Care Unit Coordinator and Administrator will assess to see how many residents need assistance with eating. Administrator will schedule adequate staff to meet the needs of residents needing assistance with eating. Special Care Unit Coordinator will ensure that all residents needing assistance with eating receive help upon receipt of the meal. Administrator will monitor meals x2 per week x3 weeks then randomly thereafter, to ensure that all residents needing assistance with eating receive help up[on receipt of the meal.	1/10/2020 - 1/20/2020 1/20/2020 & ongoing 1/20/2020 & ongoing 1/20/2020 & ongoing

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D 312	Continued From page 18 her fingers. -When Resident #11 received her dessert she used her spoon for several bites and then began eating her dessert with her fingers. -At times throughout the meal, Resident #11 would place her mouth on the side of the bowl and use her fingers to scoop the food directly into her mouth. -Staff told her twice during the meal to use her spoon and picked up the spoon and handed her spoon to her. -Resident #11 would use the spoon for several bites and then put the spoon down and returned to eating with her fingers. -Staff did not offer to assist Resident #11 eat her meal. Observation of the breakfast meal service on 12/04/19 from 8:15am-8:29am revealed: -Resident #11 was seated at the dining room table. -Resident #11 received a pureed meal of eggs, grits, sausage and a piece of toast. -Resident #11 used a spoon at times throughout her breakfast to eat her meal. -Resident #11 would also use her fingers to try and scoop up the the puree meal and eat it off her fingers. -At times throughout the breakfast meal, Resident #11 would place her mouth on the side of the bowl and use her fingers to scoop the food directly into her mouth. -Resident #11 began using the butter knife in an attempt to eat her thickened cranberry juice. -Staff immediately removed the butter knife and handed Resident #11 a spoon and told her to eat with a spoon. -Staff walked by Resident #11 and told her to use her spoon, picking up the spoon and handing it to the resident on three different occasions during	D 312		

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D 312	Continued From page 19	D 312		

the breakfast meal observation.
-Staff did not offer any other assistance to Resident #11 with her meal.

Review of the current FL2 for Resident #11 revealed diagnoses included vascular dementia, pulmonary embolism, hypertension, hiatal hernia and mood disorder.

Review of Resident #11's current care plan dated 10/05/18 revealed:
-She required verbal prompting and limited assistance in her ability to feed herself daily with her meals.
-She required verbal prompting and limited assistance in her ability to chew and swallow her food daily.
-She normally did not speak but could understand.

Interview with a personal care aide (PCA) on the special care unit (SCU) on 12/03/19 at 12:50pm revealed:
-Resident #11 could feed herself for the most part but would forget to use her spoon and would use her fingers at times.
-Resident #11 had been "declining" and had become more dependent and had recently been placed on Hospice.

Interview with the Special Care Coordinator (SCC) on 12/05/19 at 11:00am revealed:
-She was aware the Resident #11 had been declining and she had recently been admitted to Hospice.
-Staff should be notifying her if residents were having changes in what they can do for themselves.
-Her expectation would have been for staff to put the spoon in Resident #11's hand or sit and assist

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D 312	Continued From page 20 with her meal by feeding her. Interview with the former Administrator on 12/04/19 at 3:30pm revealed if a resident was using their fingers to eat their meal, the expectation was for staff to assist the resident with the feeding of her meal.	D 312		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a minimum of 14 hours of planned group activities was provided each week for the residents. The findings are: Interviews with two residents during the initial tour	D 317	Activities Coordinator will develop scheduled activities minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Administrator/designee will ensure that there are at least 14 hours of activities each week. QI Department/Compliance Director will conduct audits of facility at least quarterly to ensure activities minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills.	1/15/2020 & ongoing 1/20/2020 & ongoing 1/20/2020 & ongoing

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D 317	Continued From page 21 on 12/03/19 from 8:55am-9:52am revealed: -Activities were not being carried out in the facility. -There were not many activities. Review of the December 2019 activity calendar revealed: -There were 14 hours of scheduled activities offered each week. -Residents were scheduled for a daily stroll on 12/03/19 from 10:00am-11:00am. -Residents were scheduled for bible study on 12/03/19 from 3:00pm-4:00pm. -Residents were scheduled for an art class on 12/04/19 from 2:00pm-3:00pm. -Residents were scheduled for a daily stroll on 12/05/19 from 10:00am-11:00am. -Residents were scheduled for quarter bingo on 12/05/19 from 1:00 pm-2:00pm. Interview with a resident on 12/04/2019 at 10:35am revealed: -There was an activity calendar posted but residents never did what was on the calendar. -The activities coordinator did not work with the residents very much. -The personal care aides (PCA's) performed more activities with the residents than the activity coordinator. -There were hardly ever consistent activities at the facility. Interview with a second resident on 12/04/19 at 10:50am revealed: -There were no regularly scheduled activities. -The residents had participated in making Christmas decorations. -The residents did not have sufficient space to complete activities. -The facility needed more art and craft supplies	D 317		

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D 317	Continued From page 22 for residents use. Interview with a third resident on 12/04/19 at 10:30am revealed: -Residents would like to have more supplies for activities. -The facility did not have an adequate supply for arts and crafts. -The resident would like to have more choices of activities. -Residents were very bored most days due to lack of activities. Interview with a fourth resident on 12/04/19 at 11:15am revealed: -The residents played bingo and had church service at least once per week. -Bingo and the church service were the only two activities the facility offered for residents to participate in. -The facility needed more activities. Observation on the Special Care Unit (SCU) on 12/04/19 at 10:11am revealed: multiple residents were sitting in the living room watching television. Interview with a Personal Care Aide (PCA) on 12/04/19 at 10:12am revealed: -"We were just tossing the ball around to the residents." -However, the residents sitting in the dining and living room had not expressed interest in participating. Observations on 12/04/19 at various times between 10:00am-11:00am revealed: -Multiple residents were sitting in the living room watching TV. -Residents were not participating in any scheduled activities at this time.	D 317		

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D 317	Continued From page 23 -There was no staff or an activity coordinator available to coordinate scheduled activities. Observation on 12/04/19 at various times between 2:00pm-4:00pm revealed: -The art class scheduled on 12/04/19 from 2:00pm-3:00pm did not occur. -Multiple residents were still watching TV in the resident living room. -Residents were hanging out in their rooms. Interview with a second PCA on 12/04/19 at 11:30am revealed: -The Activities Coordinator did very few activities with the residents. -The PCA's and other staff performed more activities with the residents than the Activity Coordinator did. -Bingo and a weekly church service were the primary events that the residents participated in. Interview with the former Administrator on 12/04/19 at 4:10 pm revealed: -The Activity Coordinator was scheduled to conduct 14 hours of activities with the residents each week. -The Activities Coordinator was scheduled for Tuesday and Thursday on one week and then scheduled for Monday, Wednesday, and Friday the next week. -Staff worked with the residents during the summer with planting flowers and growing a vegetable garden. -The facility tried to plan some activities with the families of residents during the holidays. -A list of planned activities included daily walks, coloring, painting, watching movies, weekly bingo and weekly church service. -A list of planned activities for residents in the SCU included Congo line, throwing balls, oversize	D 317		

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D 317	Continued From page 24 bowling pins and range of motion exercise.	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 1 of 5 sampled residents (Resident #2) related to medications for shortness of breath, cholesterol, dry eyes, nasal congestion, thyroid disease, and pain. The findings are: Review of Resident #2's current FL2 dated 08/15/19 revealed diagnoses included seizure disorder, fibromyalgia, emphysema, congestive heart failure, diabetes, clotting disorder, and hyperlipidemia. Review of the Resident Register for Resident #2 revealed an admission date of 08/20/19. Review of an electronically signed hospital discharge summary dated 10/15/19 revealed	D 358	RCC/Designee will audit MARs to ensure they match all current orders Med Aides will be retrained on medication administration and medications errors. RCC, and/or Designee to audit at least 5 medication administration records weekly x 4 weeks, then monthly thereafter to assure that medications are being given per physicians' orders. RCC, and/or Designee to audit medication passes once per week x 4 weeks, then once per month ongoing to assure staff are giving medications per physicians' orders.	12/4/2019-12/18/2019 12/4/2019-12/18/2019 1/4/2020 & Ongoing 1/4/2020 & Ongoing

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 25 Resident #2 had been admitted to the local hospital on 10/12/19 with a diagnosis of acute bronchitis and discharged on 10/15/19. a. Review of Resident #2's electronically signed hospital discharge medication orders dated 10/15/19 revealed an order for albuterol (medication that quickly opens up the breathing passages) HFA 90mcg inhaler 2 puffs every 6 hours as needed for wheezing. Review of Resident #2's 10/15/19 - 12/03/19 electronic Medication Administration Record (eMAR) revealed there was no entry for albuterol HFA 90mcg inhaler on the eMAR and no documentation of administration. Observation of Resident #2's medications on hand on 12/04/19 at 10:16am revealed there was no albuterol HFA 90mcg inhaler available for administration. Telephone interview with the Resident #2's Nurse Practitioner (NP) on 12/04/19 at 11:54am revealed: -Resident #2 was a smoker and had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). -Resident #2 needed the albuterol inhaler due to her COPD. -Without the albuterol inhaler Resident #2 was at an increased risk of shortness of breath and respiratory distress. Telephone interview with the facility's contracted pharmacy on 12/04/19 at 12:21pm revealed the pharmacy had not received an order for albuterol HFA 90mcg for Resident #2 from the facility and had not dispensed the albuterol.	D 358		

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D 358	Continued From page 26 Interview with Resident #2 on 12/05/19 at 9:00am revealed: -She would get short of breath frequently "just walking around". -It helped her shortness of breath to sit down and rest. -Having an inhaler would help her breathing. Review of a physician's telephone order dated 12/04/19 revealed start albuterol HFA 90mcg inhale 2 puffs every 6 hours as needed for wheezing. Refer to the interview with the Resident Care Coordinator (RCC) on 12/04/10 at 9:33am. Refer to the interview with the former Administrator on 12/04/19 at 9:36am. Refer to the second interview with the former Administrator on 12/04/19 at 10:48am. Refer to the telephone interview with the Resident #2's Nurse Practitioner (NP) on 12/04/19 at 11:54am. Refer to the telephone interview with the pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm. Refer to the interview with a first shift Medication Aide (MA) on 12/04/19 at 10:21am. Refer to the interview with the Administrator on 12/05/19 at 8:07am. b. Review of signed physician's order dated 09/03/19 revealed atorvastatin 40mg daily. Review of Resident #2's electronically signed	D 358		

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D 358	Continued From page 27 hospital discharge medication orders dated 10/15/19 revealed an order for atorvastatin (treats high cholesterol) 80mg daily. Review of laboratory results for Resident #2 dated 10/13/19 revealed LDL (the "bad" cholesterol in the blood that contributes to fatty buildups in the arteries and increases the risk of heart attack and stroke) of 112 (normal is 0 - 100) Review of Resident #2's 10/15/19- 10/31/19 eMAR revealed: -There was an entry for atorvastatin 40mg daily with an administration time of 10:00pm. -There was documentation the atorvastatin 40mg had been administered at 10:00pm from 10/15/19 - 10/31/19 Review of Resident #2's November 2019 eMAR revealed: -There was an entry for atorvastatin 40mg daily with an administration time of 10:00pm. -There was documentation atorvastatin 40mg had been administered at 10:00pm from 11/01/19 - 11/23/19, 11/25/19 -11/26/19, 11/28/19, and 11/30/19. Review of Resident #2's 12/01/19 - 12/03/19 eMAR revealed: -There was an entry for atorvastatin 40mg daily with an administration time of 10:00pm. -There was documentation atorvastatin 40mg had been administered at 10:00pm on 12/01/19 and 12/02/19. Observation of Resident #2's medications on hand on 12/04/19 at 10:18am revealed: -There was one bubble pack labeled atorvastatin 40mg take 1 tablet at bedtime. -Twenty-eight tablets had been dispensed on	D 358		

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D 358	Continued From page 28 11/22/19 and there were 14 left. Telephone interview with Resident #2's NP on 12/04/19 at 11:54am revealed: -The atorvastatin had been ordered for Resident #2 because she had increased lipids (cholesterol and fats in the blood). -Resident #2 was at an increased risk of stroke and heart attack by not receiving the correct dose of atorvastatin. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/04/19 at 12:21pm revealed: -The pharmacy had received an order from the facility for atorvastatin 40mg daily for Resident #2 on 09/03/19. -The pharmacy had no other atorvastatin orders on file for Resident #2. Interview with Resident #2 on 12/05/19 at 9:00am revealed: -She did not know what dose of atorvastatin she was administered. -She had a "mini stroke" in the distant past. Review of a physician's telephone order dated 12/04/19 revealed an order to increase atorvastatin to 80mg daily. Refer to the interview with the Resident Care Coordinator (RCC) on 12/04/10 at 9:33am. Refer to the interview with the former Administrator on 12/04/19 at 9:36am. Refer to the second interview with the former Administrator on 12/04/19 at 10:48am. Refer to the telephone interview with Resident	D 358		

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D 358	Continued From page 29 #2's Nurse Practitioner (NP) on 12/04/19 at 11:54am. Refer to the telephone interview with the pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm. Refer to the interview with a first shift Medication Aide (MA) on 12/04/19 at 10:21am. Refer to the interview with the Administrator on 12/05/19 at 8:07am. c. Review of Resident #2's electronically signed hospital discharge medications dated 10/15/19 revealed an order for Refresh Plus (treats dry eyes) 0.5% administer 1 drop into both eyes every 2 hours as needed for dry eyes. Review of Resident #2's 10/15/19-12/03/19 eMAR revealed there was no entry for Refresh Plus 0.5% eye drops and no documentation of administration. Observation of Resident #2's medications on hand on 12/04/19 at 10:16am revealed there were no Refresh Plus 0.5% eye drops available for administration. Telephone interview with Resident #2's Nurse Practitioner (NP) on 12/04/19 at 11:54am revealed: -Refresh Plus eye drops were used for dry eyes. -Resident #2 would need the eye drops if she was having dry eyes. Telephone interview with the pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm revealed the pharmacy had not received an order dated 10/15/19 for Refresh Plus 0.5%	D 358		

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D 358	Continued From page 30 eye drops for Resident #2 and had not dispensed any. Interview with Resident #2 on 12/05/19 at 9:00am revealed: -She had "severe" dry eyes. -Staff had not administered any eye drops to her. -It would give her relief of her dry eyes to have drops. Review of a physician's telephone order dated 12/04/19 revealed Refresh Plus 0.5% 1 drop into both eyes every 2 hours as needed. Refer to the interview with the Resident Care Coordinator (RCC) on 12/04/10 at 9:33am. Refer to the interview with the former Administrator on 12/04/19 at 9:36am. Refer to the second interview with the former Administrator on 12/04/19 at 10:48am. Refer to the telephone interview with the facility's Nurse Practitioner (NP) on 12/04/19 at 11:54am. Refer to the telephone interview with the pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm. Refer to the interview with a first shift Medication Aide (MA) on 12/04/19 at 10:21am. Refer to the interview with the Administrator on 12/05/19 at 8:07am. d. Review of Resident #2's electronically signed hospital discharge medication orders dated 10/15/19 revealed an order for Flonase (treats nasal congestion) 50mcg nasal spray, 1 spray	D 358		

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D 358	Continued From page 31 into each nostril daily. Review of Resident #2's 10/15/19 - 12/03/19 eMAR revealed there was no entry for Flonase 50mcg nasal spray and no documentation of administration. Observation of Resident #2's medications on hand on 12/04/19 at 10:16am revealed there was no Flonase 50mcg nasal spray available for administration. Telephone interview with the Resident #2's Nurse Practitioner (NP) on 12/04/19 at 11:54am revealed: -Flonase was used for nasal congestion. -It would relieve Resident #2's nasal congestion. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm revealed the pharmacy had not received an order dated 10/15/19 for Flonase 50mcg nasal spray for Resident #2 and had not dispensed any. Interview with Resident #2 on 12/05/19 at 9:00am revealed: -She frequently had nasal congestion. -Staff had not administered any nasal spray to her. -It would help her nasal congestion to have nasal spray. Review of a physician's telephone order for Resident #2 dated 12/04/19 revealed start Flonase 50mcg nasal spray 1 spray into each nostril daily. Refer to the interview with the Resident Care Coordinator (RCC) on 12/04/10 at 9:33am.	D 358		

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D 358	Continued From page 32 Refer to the interview with the former Administrator on 12/04/19 at 9:36am. Refer to the second interview with the former Administrator on 12/04/19 at 10:48am. Refer to the telephone interview with the facility's Nurse Practitioner (NP) on 12/04/19 at 11:54am. Refer to the telephone interview with the pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm. Refer to the interview with a first shift Medication Aide (MA) on 12/04/19 at 10:21am. Refer to the interview with the Administrator on 12/05/19 at 8:07am. e. Review of a signed physician's order dated 08/21/19 revealed levothyroxine 125mcg daily. Review of a signed physician's order dated 08/28/19 revealed increase levothyroxine to 150mcg daily. Review of Resident #2's electronically signed hospital discharge medications dated 10/15/19 revealed an order for levothyroxine (treats thyroid disease) 125mcg daily. Review of laboratory results for Resident #2 dated 10/13/19 revealed a TSH (thyroid hormone) level of 0.18 (normal is 0.45 - 5.33). Review of Resident #2's 10/15/19 - 10/31/19 eMAR revealed: -There was an entry for levothyroxine 150mcg daily with an administration time of 7:00am. -There was documentation the levothyroxine	D 358		

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D 358	Continued From page 33 150mcg had been administered at 7:00am from 10/16/19 - 10/29/19, and 10/31/19. Review of Resident #2's November 2019 eMAR revealed: -There was an entry for levothyroxine 150mcg daily with an administration time of 7:00am. -There was documentation levothyroxine 150mcg had been administered at 7:00am from 11/01/19 - 11/15/19, and 11/17/19 - 11/30/19. Review of Resident #2's December 1 - 3, 2019 eMAR revealed: -There was an entry for levothyroxine 150mcg daily with an administration time of 7:00am. -There was documentation the levothyroxine 150mcg had been administered on 12/01/19 at 7:00am. Observation of Resident #2's medications on hand on 12/04/19 at 10:16am revealed: -There was one bubble pack labeled levothyroxine 150mcg 1 tablet daily. -Twenty-eight tablets had been dispensed on 11/22/19 with 11 tablets remaining. Telephone interview with Resident #2's Nurse Practitioner (NP) on 12/04/19 at 11:54am revealed: -She had been unaware of the current levothyroxine order on the hospital discharge summary. -Resident #2 would need a current TSH level (thyroid hormone) before implementing the order for levothyroxine 125mcg daily. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm revealed: -The pharmacy had received an order for	D 358		

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D 358	Continued From page 34 levothyroxine 150mcg on 08/28/19 for Resident #2. -The pharmacy had no other levothyroxine orders for Resident #2. Review of a physician's telephone order for Resident #2 dated 12/04/19 revealed continue the current order (150mcg daily) and get a TSH (thyroid hormone) level on next lab draw. Interview with Resident #2 on 12/05/19 at 9:00am revealed she did not know the dose of her thyroid medication. Refer to the interview with the Resident Care Coordinator (RCC) on 12/04/10 at 9:33am. Refer to the interview with the former Administrator on 12/04/19 at 9:36am. Refer to the second interview with the former Administrator on 12/04/19 at 10:48am. Refer to the telephone interview with the facility's Nurse Practitioner (NP) on 12/04/19 at 11:54am. Refer to the telephone interview with the pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm. Refer to the interview with a first shift Medication Aide (MA) on 12/04/19 at 10:21am. Refer to the interview with the Administrator on 12/05/19 at 8:07am. f. Review of Resident #2's electronically signed hospital discharge medication orders dated 10/15/19 revealed an order for Biofreeze (treats pain) 4% gel apply to back every 12 hours as	D 358		

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D 358	Continued From page 35 needed for pain. Review of Resident #2's 10/15/19 - 12/03/19 eMAR revealed there was no entry for Biofreeze 4% gel and no documentation of administration. Observation of Resident #2's medications on hand on 12/04/19 at 10:16am revealed there was no Biofreeze 4% gel available for administration. Telephone interview with Resident #2's Nurse Practitioner (NP) on 12/04/19 at 11:54am revealed: -Resident #2 had back pain. -The Biofreeze had been ordered for back pain relief. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm revealed the pharmacy had no orders for Biofreeze 4% gel for Resident #2 and had not dispensed any. Interview with Resident #2 on 12/05/19 at 9:00am revealed: -She had rods in her back and it hurt all the time. -The pain would be an 8 or 9 (pain scale 0-10) after an hour of lying in the bed. -Having Biofreeze applied would give her some pain relief. Review of a physician's telephone order for Resident #2 dated 12/04/19 revealed start Biofreeze 4% gel apply every 12 hours to back as needed for pain. Refer to the interview with the Resident Care Coordinator (RCC) on 12/04/10 at 9:33am. Refer to the interview with the former	D 358		

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D 358	Continued From page 36 Administrator on 12/04/19 at 9:36am. Refer to the second interview with the former Administrator on 12/04/19 at 10:48am. Refer to the telephone interview with the facility's Nurse Practitioner (NP) on 12/04/19 at 11:54am. Refer to the telephone interview with the pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm. Refer to the interview with a first shift Medication Aide (MA) on 12/04/19 at 10:21am. Refer to the interview with the Administrator on 12/05/19 at 8:07am. Interview with the Resident Care Coordinator (RCC) on 12/04/19 at 9:33am revealed: -The RCC or the Medication Aides would call the Nurse Practitioner (NP) for clarification of orders when a resident returned from the hospital. -The hospital discharge medication list would be faxed to the pharmacy. -The RCC would follow up to ensure the medications arrived from the pharmacy and were listed on the eMAR. -She did not know what had happened with the hospital discharge medications for Resident #2. Interview with the former Administrator on 12/04/19 at 9:36am revealed: -The MA would call the NP to clarify orders after a resident returned from the hospital. -The hospital discharge medication list would then be faxed to the pharmacy. -The RCC was responsible for reviewing the electronic Medication Administration Record (eMAR) to ensure the medications had been	D 358		

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entered into the record.
-The Administrator and RCC were responsible for auditing charts quarterly and comparing the medications on the medication cart to the eMAR for accuracy.

Second interview with the former Administrator on 12/04/19 at 10:48am revealed:
-The electronically signed hospital discharge summary for Resident #2 dated 10/15/19 with the medications had been sent by the hospital to the facility's back up pharmacy.
-The MA had faxed the unsigned medication list from the hospital to the facility's contracted pharmacy.
-The back up pharmacy faxed the signed hospital discharge summary to the facility's contracted pharmacy but the medications were not attached.

Telephone interview with Resident #2's Nurse Practitioner (NP) on 12/04/19 at 11:54am revealed:
-When residents returned from the hospital the facility faxed the hospital discharge summaries to the pharmacy.
-Staff placed the discharge summaries in her book to be viewed on her next facility visit.
-She did not know if she had reviewed the discharge summary for Resident #2.
-Sometimes she had difficulty locating the paperwork during her facility visits.
-Staff would tell her they were "behind" in filing the paperwork.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/04/19 at 12:21pm revealed:
-The facility would fax the hospital discharge summary to the pharmacy.
-The pharmacy would compare the orders on the

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D 358	Continued From page 38 discharge summary with the orders entered on the eMAR and make the changes accordingly. -The hospital had faxed the discharge summary to the facility's back up pharmacy and that pharmacy had faxed the report to the facility's contracted pharmacy. -The medications were not listed on the discharge summary the pharmacy had received from the back up pharmacy. Interview with a first shift Medication Aide (MA) on 12/04/19 at 10:21am revealed: -She had been on duty when Resident #2 arrived back to the facility from the hospital on 10/15/19. -She had faxed the hospital discharge summary to the facility's contracted pharmacy on 10/15/19. -She had received a fax verification form but did not know what had happened to it. -The fax verification forms were put in a basket to be filed. -The MAs and Resident Care Coordinator were responsible for ensuring new medication orders were listed on the eMAR. Interview with the Administrator on 12/05/19 at 8:07am revealed: -When a resident was admitted from the hospital the MA would contact the Nurse Practitioner (NP) to clarify orders and make changes. -The hospital discharge summary would then be faxed to the pharmacy. -The RCC or the Administrator were responsible for faxing the orders to the pharmacy and ensuring the medications were in the facility and matched the eMAR. -She did not know why the pharmacy had not received Resident #2's hospital discharge summary medication orders. The facility failed to administer albuterol inhaler,	D 358		

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D 358	Continued From page 39 atorvastatin, biofreeze, Refresh eye drops, Flonase, and levothyroxine as ordered to Resident #2 who had shortness of breath, increased cholesterol, back pain, severe dry eyes, nasal congestion, and thyroid disease. This failure of the facility to administer these medications as ordered was detrimental to the health, safety, and welfare of Resident #2 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/04/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 19, 2020.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure staff documented the administration of medications	D 366	Medication aides will be retrained on the procedures of passing medications and observing a resident taking medications. SCUD/Designee will observe a minimum of two medication passes weekly x4, will observe a minimum of 3 medication passes monthly x3 and then randomly thereafter to ensure medications are observed being taken by the resident prior to recording of the administration of the medication. Any staff member found not following policy and procedure will receive disciplinary action up to and including termination.	1/21/20 1/20/2020 & Ongoing 1/20/2020 & Ongoing

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D 366	Continued From page 40	D 366		

immediately following the administration and observation of the residents actually taking the medications for 2 of 5 sampled residents (Resident #1 and #5) related to medications found in the residents' rooms.

The findings are:

1. Review of Resident #1's current FL2 dated 08/07/19 revealed diagnoses included neurocognitive deficits and schizoaffective disorder bipolar type.

Obervation during the initial tour on 12/03/19 at 9:09am revealed:
-Resident #1 was sitting on the side of his bed.
-There was a clear medication cup with approximately 30ml of a gold colored liquid in it on the nightstand.
-There was a second clear medication cup with approximately 15ml of a gold colored liquid in it on the nightstand.

Interview with Resident #1 on 12/03/19 at 9:10am revealed:
-The medication in the cups was lactulose (used to treat constipation).
-The medication was for his constipation.
-The Medication Aide (MA) had left the medication in the room for him to take.
-The MAs usually watch him take the medication.

Observation of Resident #1's medications on hand on 12/04/19 at 3:05pm revealed:
-There was a white bottle labeled lactulose 10gm/15ml solution.
-Take 30ml once daily for constipation.
-The date dispensed was 10/15/19.
-The liquid in the bottle matched the liquid in the medication cups in Resident #1's room.

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D 366	Continued From page 41 Review of a signed physician's order for Resident #1 dated 10/15/19 revealed take lactulose 30ml twice daily for 3 days then one time daily for constipation. Review of the 12/03/19 electronic Medication Administration Record (eMAR) for Resident #1 revealed: -There was an entry for lactulose 10gm/15ml take 30ml once daily for constipation with an administration time of 8:00am. -There was documentation that lactulose 30ml had been administered at 8:00am. Interview with the MA on 12/03/19 at 12:00pm revealed: -She had administered the 8:00am dose of lactulose to Resident #1 on 12/03/19 and had watched him take his medication. -She had been trained to watch the residents take their medications. -The medication in his room might have been his night medications. -She did not notice any medication on the bedside table. Interview with a second MA on 12/04/19 at 3:00pm revealed: -She worked from 7:00pm to 7:00am. -She had administered medications to Resident #1 the evening of 12/02/19. -The lactulose was not scheduled for the evening and she had not administered lactulose to Resident #1. -She had been trained to watch the residents take their medications. Refer to the interview with the Resident Care Coordinator (RCC) on 12/04/19 at 9:40am.	D 366		

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D 366	Continued From page 42 Refer to the interview with the Administrator on 12/05/19 at 8:07am. Refer to the facility's Medication Administration Policy and Procedure. 2. Review of Resident #5's current FL2 dated 06/14/19 revealed: -Diagnoses included depression and suicidal ideations. -There were medications orders for omeprazole (treats acid reflux) 40mg daily, gabapentin (treats nerve pain) 600mg daily, atenolol (treats high blood pressure) 50mg daily, and levothyroxine (treats thyroid disease) 25mcg daily. Review of a signed physician's order dated 07/17/19 revealed ferrous sulfate (iron supplement) 325mg twice daily. Review of a signed physician's order dated 10/15/19 revealed increase gabapentin to 800mg three times daily. Review of a signed physician's order dated 11/25/19 revealed metformin (treats high blood glucose) 500mg twice daily. Observation during the initial tour on 12/03/19 at 8:55am revealed: -Resident #5 was sitting on the side of his bed. -There was a white paper medication cup with 6 medications in the cup on the nightstand. Interview with Resident #5 on 12/03/19 at 8:55am revealed: -The medications in the cup were his morning medications. -The MA had left the medications in the room this	D 366		

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D 366	Continued From page 43 morning (12/03/19) because Resident #5 had been asleep. -The MAs did not usually leave his medications. Observations of Resident #5's medications on hand on 12/04/19 at 10:18am revealed: -There was one bubble pack labeled omeprazole 40mg once daily with 14 capsules remaining and the omeprazole capsules matched the capsule in the medication cup. -There was one bubble pack labeled gabapentin 800mg three times daily with 15 tablets remaining and the gabapentin tablet matched the tablet in the medication cup. -There was one bubble pack labeled atenolol 50mg daily with 14 tablets remaining ant the atenolol tablet matched the tablet in the medication cup. -There was one bubble pack labeled levothyroxine 50mcg daily with 14 tablets remaining and the levothyroxine tablet matched the tablet in the medication cup. -There was one bubble pack labeled ferrous sulfate 325mg twice daily with 20 tablets remaining and the ferrous sulfate tablet matched the tablet in the medication cup. -There was one bubble pack labeled metformin 500mg twice daily with 12 tablets remaining and the metformin tablet matched the tablet in the medication cup. Review of Resident #5's 12/03/19 electronic Medication Administration Record (eMAR) revealed: -There was an entry for omeprazole 40mg once daily with an administration time of 7:00am with documentation the omeprazole had been administered at 7:00am. -There was an entry for gabapentin 800mg three times daily with administration times of 8:00am,	D 366		

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D 366	Continued From page 44 2:00pm, and 8:00pm with documentation the gabapentin had been administered at 8:00am. -There was an entry for atenolol 50mg once daily with an administration time of 7:00am with documentation the atenolol 50mg had been administered at 7:00am. -There was an entry for levothyroxine 50mcg once daily with an administration time of 7:00am with documentation the levothyroxine 50mcg had been administered at 7:00am. -There was an entry for ferrous sulfate 325mg twice daily with administration times of 8:00am and 5:00pm with documentation the ferrous sulfate 325mg had been administered at 8:00am. -There was an entry for metformin 500mg twice daily with administration times of 8:00am and 5:00pm with documentation the metformin had been administered at 8:00am. Interview with the Medication Aide (MA) on 12/03/19 at 12:00pm revealed: -Resident #5 had told her to leave his morning medications in his room on 12/03/19. -She had intended to go back and check with the Resident to see if he had taken the medications but she had forgotten. -She had been trained to observe the residents take their medications. Refer to the interview with the Resident Care Coordinator (RCC) on 12/04/19 at 9:40am. Refer to the interview with the Administrator on 12/05/19 at 8:07am. Refer to the facility's Medication Administration Policy and Procedure. Interview with the Resident Care Coordinator (RCC) on 12/04/19 at 9:40am revealed:	D 366		

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D 366	Continued From page 45 -The MAs received five days of training on the medication cart from the supervisor when hired. -After the training the MAs are "checked off" by the pharmacy nurse consultant. -A nurse observed the medication pass to ensure medications were being administered correctly. -The MAs receive "several" tests and inservices related to medications. -She did not know why the MA had left the medications in the rooms. Interview with the Administrator on 12/05/19 at 8:07am revealed: -She had started in the facility on 11/26/19. -Medications should not be left in resident rooms. -The MAs should observe the residents take their medications. -When residents refused to take their medications, the medications should be taken out of the room. -She did not know why the MA had left the medications in the rooms. Review of the facility's Medication Administration Policy and Procedure with a revision dated documented as 07/07/14 revealed staff would provide documentation on the Medication Administration Record after observing the resident take the medications and before administering to another resident.	D 366		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement	D 453		

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D 453	Continued From page 46 authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to immediately notify the local department of social services and law enforcement authorities as required after a reported allegation of staff misappropriation of resident property. The findings are: Interview with a resident during the initial tour on 12/3/19 at 10:20 am revealed: -One staff had borrowed money from her and refused to pay the money back. -She had loaned the staff at least $105.00 dollars. -The staff had always asked her for a money loan. -The staff no longer worked at the facility. -The resident really needed her money back, but did not know how to go about getting her money back. a. Review of the Health Care Personnel Investigations Report dated 11/12/19 revealed: -There was an allegation against a former staff member for misappropriation of resident property with an estimated value of $100. -The date the facility became aware of the incident was documented as 11/05/19. -The allegation was documented as substantiated and the investigation ended on 11/11/19. -The local county department of social services was documented as being notified by the facility on 11/11/19.	D 453	Administrator/Ombudsman/Designee will provide training with staff to ensure that resident's rights are not being violated Administrator/Designee will randomly interview residents weekly x4 weeks, then monthly x2 months and randomly thereafter, to ensure they are free from abuse, neglect or exploitation. Quality Improvement Department/Compliance Department will conduct audits of the facility to include random interviews of residents at least quarterly or as needed basis to monitor resident rights and ensure compliance.	1/21/20 1/20/2020 & Ongoing 1/20/2020 & Ongoing

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D 453	Continued From page 47 Interview with the Adult Home Specialist from the local department of social services on 12/04/19 at 9:30am revealed: -The facility had not informed him of an allegation of misappropriation of resident property by a staff member immediately upon discovery on 11/05/19. -He had not received the faxed copy of the Health Care Personnel Investigations Report dated 11/12/19. -He found out about the allegation by interviewing the affected resident on 12/03/19. Interview with the Administrator on 12/04/19 at 3:10pm and on 12/05/19 at 8:25am revealed: -She had begun working in the facility on 11/26/19. -From her understanding, the department of social services had been notified of the incident against a staff member for misappropriation of resident property. -She was not involved in the notification of social services, so she did not know when it had occurred. Interview with the former Administrator on 12/05/19 at 9:15am revealed: -She found out about the allegation of misappropriation of resident property on 11/05/19. -The incident was reported to the local county department of social services on 11/11/19. Refer to the interview with the former Administrator on 12/05/19 at 9:10am. b. Review of the Health Care Personnel Investigations Report dated 11/12/19 revealed: -There was an allegation against a former staff member for misappropriation of resident property with an estimated value of $100.	D 453		

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D 453	Continued From page 48 -The date the facility became aware of the incident was documented as 11/05/19. -The allegation was substantiated and the investigation ended on 11/11/19. -Local law enforcement was documented as being notified by the facility on 11/11/19. -Law enforcement "stated that this is a civil matter" and the officer "would not even log the call" however [the department of social services] could call to confirm the facility had reported the incident to them. Interview with the Administrator on 12/04/19 at 3:10pm and on 12/05/19 at 8:25am revealed: -She had begun working in the facility on 11/26/19. -From her understanding, law enforcement had been notified of the incident against a staff member for misappropriation of resident property. -She was not involved in the notification of law enforcement, so she did not know when it had occurred. Interview with the former Administrator on 12/05/19 at 9:15am revealed -She found out about the allegation of misappropriation of resident property on 11/05/19. -The incident was reported to law enforcement on 11/11/19. Refer to the interview with the former Administrator on 12/05/19 at 9:10am. Interview with the former Administrator on 12/05/19 at 9:10am revealed: -Her understanding of reporting allegations to the local county department of social services and local law enforcement was they were required to report only allegations that were substantiated.	D 453		

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D 453	Continued From page 49 -Facility staff had completed the 24 hour report to Health Care Personnel Registry (HCPR) as required. -Facility staff had completed a 5 day investigation and made the required report to the HCPR. -It was her understanding that if an allegation was substantiated, they were to contact the local county department of social services and local law enforcement after their internal investigation was completed.	D 453		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record review and interviews, the	D 464	Special Care Unit Director/Designee will audit all care plans to assure a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment have been completed within 30 days of admission and quarterly thereafter. Any resident profiles and Care Plans found not completed will be done immediately. Resident tickler will be updated to ensure Special Care Unit Coordinator knows when care plans and quarterly reviews are due. Administrator will audit at least 5 care plans/ resident profiles per month x 4 months, then randomly thereafter to assure a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment have been completed within 30 days of admission and quarterly thereafter. Quality Improvement Department/Compliance Department will conduct audits of the facility at least quarterly or as needed basis to monitor resident rights and ensure compliance.	1/10/2020 - 1/20/2020 1/20/2020 & Ongoing 1/20/2020 & Ongoing 1/20/2020 & Ongoing

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D 464	Continued From page 50	D 464		

facility failed to complete quarterly care plans for 2 of 2 sampled residents (Resident #3 and #4) in the Special Care Unit (SCU).

The findings are:

1. Review of Resident #3's current FL2 dated 08/16/19 revealed:
-Diagnoses included dementia, acute metabolic encephalopathy, and hypoglycemia.
-Resident #3 was constantly disoriented, semi-ambulatory, incontinent of bladder and bowel.
-Resident #3 required personal care assistance with bathing and dressing.

Review of Resident #3's Resident Register revealed an admission date of 06/19/19.

Review of Resident #3's personal care services assessment dated 04/11/19 revealed:
-The resident required extensive assistance with toileting, bathing, dressing, and grooming.
-The resident required limited assistance with transfers and eating.

Review of Resident #3's Care Plan dated 07/19/19 revealed:
-The assessment date was 07/19/19.
-There was no assessment of the required level of staff assistance required for all activities of daily living.
-The Care Plan was signed by Resident #3's Nurse Practitioner on 08/21/19.
-There was no name, signature, and date of who assessed the resident and completed the Care Plan.

Review of Resident #3's Record revealed:
-There were care plan updates on 07/09/19 and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 464	Continued From page 51 10/09/19. -The care plan updates on 07/09/19 and 10/09/19 did not include a comprehensive revision of environmental, social and health care strategies to assist Resident #3 to maintain the maximum level of functioning possible and compensate for lost abilities. Interview with the Special Care Coordinator (SCC) on 12/04/19 at 2:25pm revealed she was responsible for ensuring quarterly Care Plans were completed on the residents in the SCU. Refer to the interview with the Administrator on 12/05/19 at 8:25am. Refer to the interview with the former Administrator on 12/05/19 at 9:10am. 2. Review of Resident #4's current FL2 dated 05/23/19 revealed: -Diagnoses included dementia, seizures, symbolic dysfunction, major depressive disorder, hypertension, prostatic hyperplasia, anxiety disorder and osteoarthritis. -Resident #4 was intermittently confused. -Resident #4 required personal care assistance with bathing, feeding, and dressing. Review of Resident #4's Care Plan dated 06/18/19 revealed: -He required verbal prompting and limited assistance in his ability to feed himself daily with his meals. -The assessment date was 06/01/19. -There was no assessment of the required level of staff assistance required for all activities of daily living. -The Care Plan was signed by Resident #4's Nurse Practitioner on 06/19/19/19.	D 464		

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D 464	Continued From page 52 -There was no name, signature, and date of who assessed the resident and completed the Care Plan. Review of Resident #4's Resident Register revealed an admission date of 05/24/19. Review of Resident #4's Record revealed: -There were care plan updates on 07/09/19 and 10/09/19. -The care plan updates on 07/09/19 and 10/09/19 did not include a comprehensive revision of environmental, social and health care strategies to assist Resident #3 to maintain the maximum level of functioning possible and compensate for lost abilities. Interview with the Special Care Coordinator (SCC) on 12/04/19 at 2:25pm revealed she was responsible for ensuring quarterly Care Plans were completed on the residents in the SCU. Refer to the interview with the Administrator on 12/05/19 at 8:25am. Refer to the interview with the former Administrator on 12/05/19 at 9:10am. Interview with the Administrator on 12/05/19 at 8:25am revealed: -The SCC was responsible for completing quarterly Care Plans on the SCU residents. -To complete an assessment for a quarterly Care Plan, the assessor needed to talk to and observe the resident. -The assessor should also speak with direct care staff to find out what help the resident needed. -The assessor would need to observe the resident for changed behaviors.	D 464		

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D 464	Continued From page 53 Interview with the former Administrator on 12/05/19 at 9:10am revealed the date and signature of the staff who signed the quarterly Care Plan indicated a staff member assessed the SCU resident and the resident did not have any changes in all the areas outlined in the regulation.	D 464		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week. The findings are: Observations in the SCU on 12/03/19 from 8:59am to 9:50am revealed: -There were 22 residents residing in the SCU. -There were two personal care aides in the SCU on duty. -At 9:42am, there was a medication aide (MA) from the Assisted Living Unit (ALU) passing medications in the SCU. Interview with a personal care aide (PCA) on 12/04/19 at 9:51am revealed:	D 466	Special Care Unit Coordinator/Care Coordinator will be on duty in the unit at least eight hours a day, five days a week. Administrator/designee will ensure adequate care coordinator coverage on the Special Care Unit in accordance with rule 10A NCAC 13F .1308(b) Quality Improvement Department/Compliance Department/Chief Operating Officer will conduct audits of facility at least quarterly or as needed basis to monitor rule areas and ensure compliance.	1/1/2020 & ongoing 1/20/2020 & Ongoing 1/20/2020 & Ongoing

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D 466	Continued From page 54 -The PCA routinely worked in the SCU on day shift. -She had been employed at the facility since May 2019. -Routine staffing on the SCU included two PCAs and one MA who worked "both sides" ALU and SCU administering medications. -There was a Special Care Coordinator (SCC), but the PCA was not sure what the SCC was supposed to do. -The SCC floated "back and forth" between the SCU and ALU. -If there was an admission in the ALU, the SCC "goes over there." -The facility did not have a Resident Care Coordinator. -The SCC had to perform "both roles." -The SCC routinely worked 8:00am to 5:00pm, 5 days a week. Interview with a medication aide (MA) on 12/04/19 at 10:10am revealed: -The SCC worked 8:00am to 5:00pm, 5 days a week. -The SCC did "a little bit of everything now." -When the facility did not have an Executive Director the SCC "did that too." -The SCC was responsible for Resident Care Coordinator duties. Interview with the SCC on 12/04/19 at 2:25pm revealed: -Her job title was Special Care Coordinator however, "we don't have an RCC (Resident Care Coordinator), so I have to do both sides." -She was responsible for new admissions for the SCU and ALU which involved making sure FL2's "look good" and faxing them to the contracted facility pharmacy. -She reviewed all new orders for the SCU and	D 466		

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D 466	Continued From page 55 ALU with the MA's when the primary care providers came to see residents and was responsible for making sure the referrals were made. -She was responsible for transporting residents to appointments. -"I have to help out with transportation if we don't have a transport person." -If transport staff was not available and the Business Office Manager was unable to transport, "I do it." -"Typically the Business Office Manager has her own job to do and can't transport, so then it's supposed to be up to me." -She was responsible for ensuring FL2's, diet orders, standing orders, Care Plans were completed (annuals and quarterly) Licensed Health Professional Support new tasks and quarterly Care Plans were completed timely. -She was responsible for ensuring the medications on hand matched the electronic medication administration records and ensuring those are reviewed by the physician every 6 months. -She was the temporary Resident Care Coordinator when the Special Care Coordinator went out on leave in August 2019. -She had been responsible for SCC and RCC duties since August 2019. -She was responsible to fill in as the Administrator-In-Charge if the Administrator was not there. -The facility had not had a dedicated Administrator from 09/04/19 until 11/26/19. -The Former Administrator had been the acting Administrator since 09/04/19 and coming to the facility and helping two days a week. -On her regular work week, she worked 6 hours a day 5 days a week in the SCU. -She helped the PCAs in the SCU with resident	D 466		

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D 466	Continued From page 56 care if they needed it. -She was responsible for duties in the SCU and ALU and was "back and forth" between the SCU and ALU. Interview with the former Administrator on 12/04/19 at 2:41pm revealed when the SCC had to go to the ALU side, the Administrator could go to the SCU side to "help out." Interview with the Administrator on 12/0519 at 8:25am revealed: -She believed the SCC was on the SCU "most of the time." -She could go back to the SCU "to cover" when the SCC was needed on the ALU. -The SCC was "supposed" to be on the SCU 5 days a week 8 hours a day. -The Administrator was available "now" to help with transport, so the SCC did not have to transport. Interview with the former Administrator on 12/05/19 at 9:10am revealed: -She knew the regulation required a SCC be on the SCU 5 days a week for 8 hours a day. -They had difficulty in finding a replacement for the previous SCC. -It had been two months that she had been coming to the facility just two days a week. -"Before" her there had been another Administrator who had worked six or seven weeks before leaving the position. -The current Administrator started on 11/26/19.	D 466		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights:	D911		

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D911	Continued From page 57 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to treat residents with dignity and respect by not having sufficient space for the meal service in the special care unit (SCU). The findings are: Interview with the Administrator on 12/03/19 at 9:00am revealed the current census on the SCU was 22. Observation of the SCU dining room on 12/03/19 between 12:15pm-1:00pm revealed: -There were two tables set up to accommodate 22 residents. -The female residents sat at the table on the left and the male residents sat at the table on the right. -There were 16 residents sitting at the two tables. -There was one female resident and 1 male resident who were sitting in chairs along the wall behind the tables where the other residents were eating and were watching the other residents eat their meal. -There was one male resident who did not want to eat at the table with the other men and staff had placed his tray on the seat of a straight chair in the living room where he ate his meal. -The male resident who was waiting on a seat to be available at the table got up and walked out of the dining room/living room 3 different times with staff having to encourage him to return to the dining room that it would not be long before he could sit down and eat his lunch.	D911	Staff were trained to serve all residents meals so that no one is waiting on their food. The Special Care Unit had adequate seating for all residents to eat. There were 22 residents and seating for 22. Special Care Unit Director/Designee will monitor 2 meals per week x3 weeks, then randomly thereafter to ensure that all residents are served meals so that no one is waiting on their food. Administrator will monitor meals randomly to ensure that all residents are served meals so that no one is waiting on their food.	1/16/2020-1/20/2020 12/3/19 1/20/2020 & Ongoing 1/20/2020 & Ongoing

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D911	Continued From page 58 -The female resident continued to sit in the chair behind the other female residents who were eating. -When two residents left the table after they had completed their meal, staff directed both the male and female resident to the table and served them their meal. Confidential interviews with SCU staff revealed: -The facility just didn't have enough room for everyone to eat at a table for the meal service in the SCU. -The dining room was large enough to hold another table, but the facility did not have any more tables or chairs for all residents to be able to eat together. -It was "not fair" that there were residents who had to watch others eat in front of them because there was not enough seating. Interview with the Special Care Coordinator (SCC) on 12/03/19 at 12:28pm revealed: -The male and female resident that were waiting to eat was because the facility did not have enough seats for everyone to eat at one setting. -As soon as one of the other residents finished their meal the staff would move one of the residents who were waiting to eat over to the table for their meal. Interview with a resident who waited on his meal on 12/03/19 at 12:20pm revealed: -He didn't like to wait. -He was "hungry too". Attempted interview with a SCU resident's family on 12/03/19 at 4:03am and 12/04/19 at 8:49am was unsuccessful. Attempted interview with a SCU resident's	D911		

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D911	Continued From page 59 guardian on 12/03/19 4:05pm and 12/04/19 at 8:51pm was unsuccessful. Interview with the Administrator on 12/04/19 at 3:30pm revealed: -She was not aware there was not enough seating for each resident on the SCU. -She could not offer an explanation as to why there was not enough seating in the dining room on the SCU.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services relevant to federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 1 of 5 sampled residents (Resident #2) related to medications for shortness of breath, cholesterol,	D912	Administrator/Ombudsman/Designee will provide training with staff to ensure they are receiving care and services which are adequate, appropriate and in compliance with rules and regulations. Administrator/Designee will randomly interview residents weekly x4 weeks, then monthly x2 months and randomly thereafter, to ensure they are receiving care and services which are adequate, appropriate and in compliance with rules and regulations. Quality Improvement Department/Compliance Department will conduct audits of the facility to include random interviews of residents at least quarterly or as needed basis to monitor resident rights and ensure compliance.	1/21/20 1/20/2020 & Ongoing 1/20/2020 & Ongoing

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D912	Continued From page 60 dry eyes, nasal congestion, thyroid disease, and pain.[Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		