STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088014	A. BUILDING: _____ B. WING _____	R-C 01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR MOUNTAIN HOUSE	11 SHERWOOD RIDGE ROAD BREVARD, NC 28712

(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 conduct a follow up survey and complaint investigation on 01/30/24 to 01/31/24. The complaint investigation was initiated by the Transylvania County Department of Social Services on 01/10/24.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide personal care according to the resident's care plan for 1 of 5 sampled residents (Resident #5) related to limited assistance with bathing. The findings are: Review of Resident #5's current FL2 dated 11/29/23 revealed: -Diagnoses included acute respiratory failure with hypoxia and hypertension. -The resident was intermittently disoriented and ambulatory. -There was an order for 2 liters per minute per nasal cannula as needed for shortness of breath. -The resident was a high fall risk. Review of Resident #5's Care Plan dated 11/29/23 revealed the resident required limited	D 269		

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D 269	Continued From page 1	D 269		

assistance with bathing.

Interview with Resident #5 on 01/30/24 at 10:14am revealed:
-She felt dizzy and weak "sometimes" when she showered.
-She had "almost" fallen 3 times in the bathroom.
-She showered independently.
-All of the staff but one would bring towels for her shower and then leave.
-She thought staff were supposed to stay in the bathroom with her while she showered to make sure she did not fall.
-After she showered, she would let staff know and they would return to her room to pickup the soiled towels.
-Staff did not stay in her room or outside the bathroom when she showered.

Review of the facility's shower schedule on 01/31/24 at 10:30am revealed:
-Resident #5 was scheduled to receive two showers a week on Tuesdays and Fridays on the 6:00pm to 6:00am shift.
-Resident #5 was listed on the shower schedule as "self."

Review of Resident #5's personal care services records dated 01/02/24 to 01/31/24 revealed:
-The resident was documented to have received 13 showers or baths.
-The resident was documented to have received 2 to 3 showers every week.

Interview with the Resident Care Coordinator (RCC) on 01/31/24 at 9:04am revealed:
-Resident #5 was independent with showering.
-The staff would collect the soiled towels once Resident #5 was finished with her shower.
-Resident #5 did not want staff to assist her with

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D 269	Continued From page 2	D 269		

showers.
-She completed Resident #5's care plan on 11/29/23.
-She documented Resident #5 as require limited assistance from staff with bathing.
-She was not sure what limited assistance meant.
-She thought limited assistance meant laying Resident #5's clothes and towels for her shower and then returning to pickup and soiled towels that needed to be laundered.

Telephone interview with a medication aide (MA) on 01/31/24 at 9:55am revealed:
-Resident #5 showered independently.
-Resident #5 was a "sit-in" which meant staff took towels to the resident and then stayed in her room until she completed her shower.
-The staff usually made Resident #5's bed while she showered.

Interview with a personal care aide (PCA) on 01/31/24 at 10:30am revealed:
-Resident #5 showered independently.
-The level of assistance Resident #5 required was documented on the shower assignment sheet as "self."
-Since Resident #5 was documented as self on the assignment sheet that meant staff were only required to bring clean towels to Resident #5 for her shower.

Interview with the Administrator on 01/31/24 at 1:35pm revealed:
-Resident #5 required limited assistance with showering.
-As far as she knew, staff were staying in the room while Resident #5 showered.
-She thought limited assistance meant staff should be "nearby" in case Resident #5 fell.
-"Nearby" meant in the resident's room, but not

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D 269	Continued From page 3 necessarily in the bathroom while the resident showered. -With residents who were documented as a "self shower," she expected staff to take towels to the resident, setup everything needed for the shower, and stay in the room to make sure the resident got dressed after the shower.	D 269		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 2 of 5 sampled residents (Residents #1 and #2) related to tooth pain not being reported to the primary care provider (PCP) (#1) and a delay in physical therapy after an above the knee amputation (#2). The findings are: 1. Review of Resident #1's current FL2 dated 11/29/23 revealed diagnoses included chronic urinary retention urinary self-catheterize, unspecified depressive disorder, and unspecified psychotic disorder. Interview with Resident #1 during the initial facility tour on 01/30/24 at 9:30am revealed: -She had a toothache for a over a week. -She was unable to chew food on the right side of	D 273		

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D 273	Continued From page 4	D 273		

her mouth because of the pain it caused her.
-She told the Resident Care Coordinator (RCC), a medication aide (MA), and a third staff about her toothache when it first started hurting "a little over a week ago."
-The staff told her she had to see her PCP before she could be referred to see a dentist.
-It took staff "too long" to start doing something about her tooth pain.
-None of the staff had offered her medication to help control the pain in her tooth.

Observation of Resident #1 during the lunch meal and beverage service on 01/30/24 at 11:48am revealed:
-Resident #1 was served a ham and cheese on white bread for her meal.
-She ate the sandwich slowly chewing mostly on the left side of her mouth.

Interview with Resident #1 in the dining room on 01/30/24 at 11:50am revealed:
-She asked for a sandwich for lunch because the sandwich would be easier for her to chew.
-She continued to experience pain as she chewed her food.

Interview with the RCC on 01/30/24 at 2:03pm revealed:
-Resident #1 had not said anything to her about having a toothache or mouth pain.
-None of the MAs or personal care aides (PCAs) had reported Resident #1's complaint of a toothache to her.

Telephone interview with a MA on 01/30/24 at 2:35pm revealed:
-Resident #1 asked her recently how she could make a dentist appointment.
-Resident #1 said her mouth or her gum hurt.

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	HAL088014	A. BUILDING: _____ B. WING _____	R-C 01/31/2024

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D 273	Continued From page 5	D 273		

-Resident #1 did not say anything to her about having pain in her tooth.
-She did not remember when Resident #1 told her about the pain in her mouth.
-Resident #1 told her and the RCC about the mouth pain at the same time.
-They thought Resident #1 only wanted a dentist appointment.
-She and the RCC told Resident #1 to tell the facility transport staff to see if they could schedule a dentist appointment for her.
-Resident #1 only mentioned the pain in her mouth that one time.

Review of Resident #1's physician's order dated 01/30/24 signed at 2:59pm revealed dental referral initiated.

Review of Resident #1's PCP and facility communication entry dated 01/30/24 at 3:02pm revealed:
-Resident #1's diagnosis was jaw pain disorder of teeth and supporting structures, unspecified.
-Looking for a dentist as soon as possible for this resident with a tooth ache.

Interview with Resident #1 on 01/30/24 at 3:02pm revealed:
-When she chewed food on the right side of her mouth, she experienced a pain level of 10 (0-10 pain scale, 10 is the most severe pain level.)
-She experienced a constant pain level of a 4 or a 5 in the tooth at all times.
-She was awoken by her "aching" tooth a "couple" of times at night.
-She had last spoken with an MA on Sunday (01/28/24) about her toothache.
-The MA told her she would put Resident #1 on the list to be seen by the PCP on his next visit on 01/30/24.

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D 273	Continued From page 6 -She saw her PCP in the hallway on 01/30/24 and told him about the toothache. -The PCP looked in her mouth with a light and did not see any swelling. -The PCP told her he would put in a dental referral for her. -The MA just brought her an over-the-counter pain reliever for the pain in her tooth. Telephone interview with Resident #1's PCP on 01/31/24 at 1:00pm revealed: -Resident #1 was not on the list for him to see on the 01/30/24 visit. -Resident #1 "flagged" him down in the hallway to tell him she had a toothache. -Resident #1 had expressed a pain score of 4 "at its worse" in the tooth when he spoke with her on 01/30/24. -The facility staff did not make him aware of Resident #1's toothache. -He found out about Resident #1's toothache for the first time when the resident told him on 01/30/24. Interview with the Administrator on 01/31/24 at 1:35am revealed: -The staff should have let the RCC know as soon as they knew about Resident #1's tooth pain, so a referral could have been made. -The RCC was responsible for scheduling an appointment with Resident #1's PCP. -The RCC could have contacted Resident #1's PCP sooner to get a referral started. -Resident #1's PCP could have electronically prescribed a medication to help control the residents pain as soon as he knew the resident had pain in her mouth. 2. Review of Resident #2's current FL2 dated	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 7 05/18/23 revealed: -Diagnoses included cardio vascular disease and right above the knee amputation. -There was an order for physical therapy (PT). Review of Resident #2's Resident Register revealed an admission date of 06/03/23. Review of Resident #2's Care Plan dated 11/29/23 revealed: -Resident #2 was ambulatory with a wheelchair. -Resident #2 needed extensive assistance with transfers, ambulation, toileting, and bathing. Review of a PT treatment note for Resident #2 dated 01/05/24 revealed: -Resident #2 started receiving PT services on 11/17/23. -Resident #2 was receiving PT to address functional mobility and strength deficits in order to maximize independence. Interview with Resident #2 on 01/31/24 at 11:13am revealed: -She had an above the knee amputation approximately 1 year earlier. -She did not know she had a physician's order for PT when she was admitted to the facility. -She was now receiving PT two times weekly. Interview with Resident #2's family member on 01/30/24 at 1:40pm revealed: -Resident #2 required PT due to the above the knee amputation and PT services started in November 2023. -She knew Resident #2 should have started PT when she was admitted in June 2023 and did not know why there was a 5 month delay. -She could not get any answers from the facility about why there had been a delay.	D 273		

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D 273	Continued From page 8 Interview with the Resident Care Coordinator (RCC) on 01/31/24 at 8:20am revealed: -She did not know why the previous RCC missed the order for PT for Resident #2. -She did not see the order for PT for Resident #2 until November 2023 and then she sent the referral for PT and it was started. -When an order for a referral was received, she notified the transportation staff and they help with setting up the appointments. -She followed up to ensure th appointments are made. -It only took a couple of days for a PT appointment to be scheduled. Interview with the facility's contracted primary care provider (PCP) on 01/31/24 at 1:00pm revealed: -Resident #2 had an above the knee amputation and required PT for assisting with transfers and strengthening. -His expectation was when an order for a referral was made was the appointment should be made within 1 to 2 weeks. -It was difficult to determine whether Resident #2 had a decline in her strength due to the delay in PT. Interview with the Administrator on 01/31/24 at 8:25am revealed she did not know why the previous RCC missed the PT referral for Resident #2. Attempted telephone interview with Resident #2's Physical Therapist on 01/31/24 at 9:45am was unsuccessful. _____ The facility's failure to notify Resident #1's PCP of a toothache in the right side of her mouth	D 273		

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	HAL088014	A. BUILDING: _____ B. WING _____	R-C 01/31/2024

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D 273	Continued From page 9 resulting in Resident #1 experiencing constant pain of a 4 on a pain scale of 0-10 for over a week. This failure was detrimental to the health, safety and welfare of Resident #1 and constitutes a Type B Violation. _____ The facility provided plan of protection in accordance with G.S. 131D-34 on 01/30/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 16, 2024.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 2 sampled residents (Resident # 8) who had a physician's order for a mechanical soft meats only ground diet. The findings are: Review of Resident #8's current FL2 dated 11/29/23 revealed: -Diagnoses included acute angle closure glaucoma, essential hypertension, and hyperlipidemia. -There was a physician's order for a mechanical	D 310		

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D 310	Continued From page 10 soft meats only ground diet. Review of the facility's therapeutic diet list posted on the kitchen bulletin board on 01/30/24 at 10:55am revealed mechanical soft meats only ground for Resident #8. Review of the facility's regular diet lunch menu for 01/30/24 revealed pork tenderloin, half of a baked sweet potato, collard greens, roll, margarine, and beverage of choice. Review of the facility's mechanical soft menu for 01/30/24 revealed pork tenderloin in 1/8 inch diced and tender cooked moistened with plenty of sauce thick enough to not let liquid and solids separate, sweet potato, collard greens, roll, margarine, and beverage of choice. Observation of the lunch meal and beverage service on 01/30/24 at 11:33am revealed Resident #8 was served pork tenderloin without sauce cut into 1/4 inch cubes, one-half of a baked sweet potato taken out of the peel and chopped on the plate, collard greens, a roll, margarine, iced tea and water. Interview with the Dietary Manager on 01/30/24 at 11:40am revealed: -She tried once to serve Resident #8 ground meat and the resident told her the meat was "horse meat" and refused to eat it. -She served Resident #8 cubed meat ever since. -She always cut up Resident #8's meat into 1/4 inch cubes by hand. -They never used a food processor to grind the meat. -Resident #8 would not eat ground consistency meat when it was served to her.	D 310		

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D 310	Continued From page 11 Interview with Resident #8 on 01/30/24 at 2:15pm revealed she was always served bite sized pieces of meat already cut up on her plate from the kitchen. Telephone interview with Resident #8's primary care provider (PCP) on 01/31/24 at 1:00pm revealed: -Resident #8 was ordered a mechanical soft meat only ground before he became her PCP. -He did not know if Resident #8 ever had a speech therapy evaluation for swallowing concerns. Interview with the Administrator on 01/31/24 at 1:35pm revealed: -Resident #8 should receive meals prepared as ordered by the PCP. -She thought ground meat consistency meant finely chopped meat with no big pieces in it. Attempted telephone interview with the facility's corporate dietician on 01/30/24 at 4:08pm was unsuccessful.	D 310		