

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/14/2015
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NAME OF PROVIDER OR SUPPLIER PACIFICA SENIOR LIVING WILMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2744 S 17TH STREET WILMINGTON, NC 28412
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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover Department of Social Services conducted an annual survey and a complaint investigation on 4/7/2015 through 4/10/2015, and 4/13/2015 and 4/14/2015. The complaint investigation was initiated by the New Hanover Department of Social Services on 2/24/2015.	D 000		
D 075	<p>10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on interviews and observation, the facility failed to assure no unpleasant odors (urine and feces odors) in the residents living areas of the facility. The findings are:</p> <p>The facility tour on 4/7/15 at 12:00 p.m. revealed urine odors in room 232, 233, and 236.</p> <p>Upon entrance to small memory care on 4/14/15 at 4:10 p.m. a urine odor could be smelled.</p> <p>Interview with housekeeper on 4/9/15 at 10:25 a.m. revealed:</p> <ul style="list-style-type: none"> - Four to 5 rooms are deep cleaned (bathroom, windows, dusting, changing sheets, cleaning vents, and window seals) every day. - Other rooms are spot checked for any needed attention. - Taking out trash was the main thing done if room is not being deep cleaned. 	D 075		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 075	<p>Continued From page 1</p> <p>Observations made on 4/7/15 at 1:15pm and 4/8/15 at 8:35am, 10:05am and 11:05am revealed a strong urine odor permeating into the hallway near room 124 extending around the corner.</p> <p>Observation made on 4/7/15 at 11:50am and 1:00pm; 4/9/15 at 11:35am and 1:30pm, 4/10/15 at 1:20pm and 4/13/15 at 4:15pm revealed a strong urine odor in the hallway and in room 119. Interview with a medication aide on 4/9/15 at 11:30 revealed:</p> <ul style="list-style-type: none"> - Resident # 14 urinated on the carpet, on purpose. - The resident did not urinate on his clothes, he intentionally urinated on the floor. - The carpet in the resident's room was shampooed on 4/6/15 and is usually shampooed 2x/week. - The carpet was supposed to be taken up and replaced this week. <p>Observation of Resident # 14's room on 4/14/15 revealed the carpet pulled up from the floor and replaced.</p> <p>Interview with Regional Director of Operations on 4/14/15 at 6:10pm revealed:</p> <ul style="list-style-type: none"> - Resident # 14 urinated on the floor intentionally, because he thought it would get him kicked out of the facility. - Resident # 14 did not want to be in the facility and he thought urinating on the floor would "get him put out". <p>Interview with Resident #5's family member on 4/14/15 at 12:04pm revealed the following:</p> <ul style="list-style-type: none"> -The family member stated "My biggest issue was housekeeping". 	D 075		

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D 075	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Resident #5's room and bathroom was only cleaned 1 to 2 times a week. -The resident's room/bathroom had a constant urine and feces odor. -The family member stated "I let the facility 's supervisor and Executive Director know on numerous occasions" of concern regarding the lack of housekeeping and the urine odor, but it did not get better. -The family member stated "I brought in my own bleach and other cleaning supplies and cleaned Resident #5 's bathroom on my own". -She was concerned because the facility recently had 3 outbreaks of infectious disease and should be cleaning and disinfecting the resident's rooms better. -The facility has "failed" on housekeeping. Interview with the facility 's interim Executive Director on 4/14/15 at 4:00pm revealed the following: <ul style="list-style-type: none"> -She was not aware Resident #5's family member was bringing in cleaning supplies to clean the resident 's room/bathroom. -The facility's housekeeping issue to be addressed and resident's rooms/bathroom to be cleaned at least daily. 	D 075		
D 080	<p>10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall</p> <p>(6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times;</p> <p>This Rule shall apply to new and existing facilities.</p>	D 080		

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D 080	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to have a supply of washcloths and towels adequate for residents use on hand at all times. The findings are:</p> <p>The facility census was 89 residents on 4/07/15.</p> <p>Interview with a Medication Aide (MA) on 4/8/15 at 10:10 a.m. revealed: -The facility does not have enough towels and washcloths most of the time. -The facility usually has just enough to give daily baths. -The facility would not have enough towels and washcloths if a resident had an accident and needed another bath without having to go look for towels and/or washcloths. -Management is aware of the shortage of towels and washcloths.</p> <p>Interview with a Personal Care Aide (PCA) on 4/8/15 at 10:30 a.m. revealed: -The shortage of towels and washcloths at the facility is "horrible". -Facility does not have enough towels most of the time but definitely do not have enough washcloths. -Most of the time staff has to go all over the building to find towel or washcloth. -There have been times when NA had to go to laundry to get a towel and cut towels up to make washcloths. -Management is aware of the shortage and nothing has been done.</p> <p>Interview with another MA on 4/8/15 at 11:00 a.m. revealed: -Facility does not have enough towels,</p>	D 080		

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D 080	<p>Continued From page 4</p> <p>washcloths. -Nursing aides usually have to hunt down towels and washcloths to give residents a bath or provide assistance with personal care. -Management is aware.</p> <p>Interview with the Licensed Professional Nurse (LPN) on 4/8/15 at 4:50 p.m. revealed: -Facility does not have enough towels and washcloths. -Most of the time staff has to go around and look for towels or washcloths when they need them. -Residents should get towel and washcloth left in room at night for morning staff.</p> <p>Observation of 3 of 3 linen closets in the facility on 4/8/15 between 4:50 p.m. and 5:30 p.m. revealed: -7 towels, 1 hand towel, and 14 wash cloths.</p> <p>Observation on 4/8/2015 at 5:00 p.m. on the second floor Memory Care Linen closet and the Assisted Living linen closet revealed: -No towels or wash clothes were available in the Assisted Living linen closet. -The Memory Care Unit linen closet had 13 wash clothes and 1 towel.</p> <p>Interview with a Medication Aide (MA) on 4/8/2015 at 5:00 p.m. revealed: -There was always a shortage of towels and washcloths. -Management had been told and is aware. -There were no towels or washcloths in the Memory Care Unit laundry room that morning and the Maintenance man supplied 10 - 12 towels. -The Maintenance man will not put more out because staff were told they disappear.</p> <p>Interview with Interim Executive Director on</p>	D 080		

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D 080	<p>Continued From page 5</p> <p>4/8/15 at 6:00 p.m. revealed: -She confirmed the facility had 3 linen closets for storage of towels and washcloths. -The laundry service was responsible for putting towels and washcloths in linen closets. -She talked with the Memory Care Director on 4/7/15 about shortage of towels and washcloths in the memory care unit.</p> <p>Observation on 4/9/15 at 10:40 a.m. revealed a resident was observed looking in cabinets behind nursing station on Hall 2.</p> <p>Confidential interview with this resident revealed: -The resident was looking for a towel. -The resident indicated most times when you ask staff for a towel the staff has to go look for one.</p> <p>Interview with a second PCA on 4/8/15 at 3:30pm revealed: -She does laundry for the whole building. -They run out of wash cloths and towels every week, this has been ongoing. -Even when she washes the whole barrel they still run out. -They are just low on them right now. -The maintenance man was responsible for ordering towels and wash cloths and he was aware that they keep running out.</p> <p>Interview with an LPN on 4/8/15 at 4:00pm revealed: -They run out of wash cloths and towels a lot. -They often have to wait for towels to provide personal care for residents.</p> <p>Review of a receipt received from the Regional Director of Operations on 4/9/15 revealed: -Bath towels (16 cases) were ordered on 4/9/15. -Hand towels (12 cases) were ordered 4/9/15.</p>	D 080		

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D 080	Continued From page 6 -Washcloths (3 cases) were ordered 4/9/15.	D 080		
D 113	<p>10A NCAC 13F .0311(d) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures for 8 of 10 fixtures located in 4 rooms used by 7 residents of the second floor rear hallway were maintained between 100 degrees Fahrenheit (F) and 116 degrees F, with water temperatures ranging from 120 to 134 degrees F.</p> <p>The findings are:</p> <p>Twenty hot water fixtures were checked during the initial facility tour on 4/7/15 from 10:50am to 1:00pm.</p> <p>Observations on 4/7/15 during the facility tour of the revealed excessively hot water temperatures in 4 of 4 resident rooms located on the second floor, rear hall in the Assisted Living section of the</p>	D 113		

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D 113	<p>Continued From page 7</p> <p>facility:</p> <ul style="list-style-type: none"> - Hot water temperature at both the bathroom sink and the shower in Room 221 was 120 degrees F at 11:30am. - Hot water temperature at both the bathroom sink and the shower in Room 222 was 120 degrees F at 11:40am. - Hot water temperature at the kitchen sink, the bathroom sink, and the shower in Room 223 was 120 degrees F at 11:50am. - Hot water temperature at the kitchen sink in Room 220 was 134 degrees F at 12:10pm. <p>Interview with the Interim Executive Director at 12:30pm on 4/7/15 revealed:</p> <ul style="list-style-type: none"> - The Maintenance person was away from the building and not available for interview. - She was not aware of the high hot water temperatures in the Assisted Living resident rooms located on the rear hallway of the second floor.- She would obtain the water temperature log book from the Maintenance person. - She would post signs stating "Caution - Hot Water - Do Not Use" above the hot water fixtures in Rooms 220, 221, 222, and 223. <p>Continued observation of facility hot water temperatures on 4/7/15 from 5:00pm to 5:40pm revealed:</p> <ul style="list-style-type: none"> - Hot water temperatures were unchanged in Room 220. - Hot water temperature at both the bathroom sink and the shower in Room 221 was 120 degrees F at 5:20pm. - Hot water temperature at both the bathroom sink and the shower in Room 222 was 120 degrees F at 5:30pm. - Hot water temperature at the kitchen sink, the bathroom sink, and the shower in Room 223 was 120 degrees F at 5:40pm. 	D 113		

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D 113	<p>Continued From page 8</p> <p>Further interview with the Interim Executive Director at 5:10pm revealed:</p> <ul style="list-style-type: none"> - She had found the hot water temperature log book kept by the Maintenance person. - She stated water temperature checks were supposed to be done weekly by the Maintenance person. - Review of the book with the Interim Executive Director revealed water temperatures were within the acceptable range of 100 - 116 degrees F for all facility resident fixtures. <p>Recheck of water temperatures on 4/8/15 revealed:</p> <ul style="list-style-type: none"> - Hot water temperature at the kitchen sink in Room 220 was 130 degrees F at 9:45am. A sign was posted above the kitchen sink warning of the hot water. - Hot water temperature at both the bathroom sink and the shower in Room 221 was 120 degrees F at 9:50am. No sign was posted in the bathroom warning of the hot water. - Hot water temperature at both the bathroom sink and the shower in Room 222 was 122 degrees F at 9:55am. No sign was posted in the bathroom warning of the hot water. - Hot water temperatures at the kitchen sink, the bathroom sink, and the shower in Room 223 ranged from 120 - 122 degrees F at 10:00am. No sign was posted in the bathroom warning of the hot water. <p>Interview with the Interim Executive Director at 10:30am on 4/8/15 revealed:</p> <ul style="list-style-type: none"> - She had contacted a plumber to fix hot water temperature regulation. - The plumber ordered a mixing valve to bring the hot water temperatures in compliance. - The plumber would replace the mixing valve for 	D 113		

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D 113	<p>Continued From page 9</p> <p>the rear hallway on the second floor on 4/9/15.</p> <p>Interim Executive Director was asked to immediately post signs stating "Caution - Hot Water - Do Not Use" above the hot water fixtures in Rooms 220, 221, 222, and 223.</p> <p>Interviews on 4/8/15 with Resident #11 and #12 revealed:</p> <ul style="list-style-type: none"> - They needed total care in bathing. - They had staff adjust hot water temperatures for them. - They had no complaints about the hot water temperatures. - Resident #12 stated she never used her kitchen sink hot water. <p>Interview with Resident #13 on 4/8/15 at 3:30pm revealed:</p> <ul style="list-style-type: none"> - The bathroom sink water was usually cold, she had to run it a minute or two and then it was too hot. She had to add cold water for a good temperature. - Staff helped her shower, got things ready for her. - "The water was running nice and warm" when she showered. <p>Residents of Room 220 and 221 were not available for interview.</p> <p>Observation of Rooms 220, 221, 222, and 223 from 4:00 - 4:10pm on 4/8/15 revealed a sign stating "Caution - Hot Water - Do Not Use" was placed above each hot water fixture in the rooms.</p> <p>Interview with the Interim Executive Director at 5:00pm on 4/9/15 revealed:</p> <ul style="list-style-type: none"> - The mixing valves and water pipes of the facility were inspected by a contracted plumber on 	D 113		

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D 113	<p>Continued From page 10</p> <p>4/9/15.</p> <ul style="list-style-type: none"> - The facility was without hot water during the day. - Repairs were completed by 5:00pm on 4/9/15. <p>Observation of hot water temperatures on 4/10/15 revealed the following:</p> <ul style="list-style-type: none"> - Hot water temperature at the kitchen sink in Room 220 was 114 degrees F at 9:45am. - Hot water temperature at both the bathroom sink and the shower in Room 221 was 114 degrees F at 9:50am. - Hot water temperature at both the bathroom sink and the shower in Room 222 was 112 degrees F at 9:55am. - Hot water temperatures at 10:00am in Room 223 were 114 degrees F at the kitchen sink, and 110 degrees F in the bathroom sink and shower. <hr/> <p>Review of the facility's plan of protection dated 4/8/2015 revealed:</p> <ul style="list-style-type: none"> -Signs were placed on the sinks and in the showers in each affected apartment. -Water temperatures were lowered by the maintenance director. -A plumber on site ordered a new mixing valve for installation on 4/9/2015. -Upon replacement of the mixing valve water temperatures will be taken every two hours for an eight hour period. -Water temperatures are to be checked once daily for 20 days and after that weekly. <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2015.</p>	D 113		

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D 131	Continued From page 11	D 131		
D 131	<p>10A NCAC 13F .0406(a) Test For Tuberculosis</p> <p>10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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, NC 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 2 of 7 sampled staff (Staff C and Staff F) had the two step tuberculosis (TB) skin test in compliance with control measures adopted by the Commission for Health Services. The findings are:</p> <p>1. Review of Staff C's personnel records revealed the following: -Staff C was hired on 10/22/13 as a personal care aide (PCA). -Documentation of a TB skin test dated 9/26/13. -No other documentation of a TB skin test.</p> <p>Refer to interview with the facility's interim Executive Director on 4/14/15 at 5:50pm.</p> <p>Staff C was not available for interview.</p> <p>2. Review of Staff F's personnel record revealed: -Staff F was hired on 2/6/15 as a laundry aide. -There was no documentation of a TB test or a TB screen.</p>	D 131		

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D 131	Continued From page 12 Refer to interview with the facility's interim Executive Director on 4/14/15 at 5:50pm. _____ Interview with Interim Executive Director on 4/14/15 at 5:50pm revealed: -The business office manager (BOM) would have been responsible for making sure staff have the required TB test, but the executive Director is ultimately responsible. -The BOM position is vacant at this time. -She will make sure it is done as soon as possible	D 131		
D 176	10A NCAC 13F .0601 Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, and interview, the Administrator and Manager failed to assure that	D 176		

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D 176	<p>Continued From page 13</p> <p>all required duties were carried out in the facility related to the rule areas of housekeeping and furnishings, other requirements (hot water), test for tuberculosis, staffing, providing personal care and supervision, health care, nutrition and food service, resident rights, medication administration, reporting of accidents and incidents, special care unit resident profile and care plan, special care unit staff orientation and training, adult care home medication aides training and competency. The findings are:</p> <p>Interview with the Interim Executive Director on 4/7/2015 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> -She had been at the facility as the acting Interim Executive Director since approximately 2/24/2015. -There was a Memory Care Director who started one week ago. -There was a Director of Nursing for the facility who was in charge of staffing for the residents in the Assisted Living. -There were 2 Licensed Practical Nurses who were the Supervisors for the facility and managed physician's orders and gave medications as needed. -There was a Registered Nurse who was the Compliance Director who managed staffing for the Memory Care Unit. -There was a Regional Director of Operations not located on site who she reported to. <p>Noncompliance was identified in the following areas:</p> <ol style="list-style-type: none"> 1. Based on observation, interview and record review, the facility failed to provide supervision of residents according to their assessed needs for 4 of 7 sampled residents who sustained repeated observed and unobserved falls (Residents #2, #5, #6,) with injury and one resident who eloped 	D 176		

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D 176	<p>Continued From page 14</p> <p>(Resident #7). [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]</p> <p>2. Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures for 8 of 10 fixtures located in 4 rooms used by 7 residents of the second floor rear hallway were maintained between 100 degrees Fahrenheit (F) and 116 degrees F, with water temperatures ranging from 120 to 134 degrees F. [Refer to Tag D113 10A NCAC 13F .0311(d) Other Requirements (Type A2 Violation)]</p> <p>3. Based on observation, interview and record review, the facility failed to assure minimum staffing requirements were met and failed to assure sufficient staffing to meet the needs of the 55 residents residing in the assisted living. [Refer to Tag D201 10A NCAC 13F .0604 Personal Care And Other Staffing (Type A2 Violation)]</p> <p>4. Based on observations, record review and interviews, it was determined that the facility failed to provide appropriate personal care for 2 of 3 residents in the sample, one requiring toileting assistance (Resident # 3) and one needing assistance to dining room for meals (Resident # 8). [Refer to Tag D269 10 NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)]</p> <p>5. Based on observation, interview and record review, the facility failed to assure referral and follow-up to meet the acute needs for 2 of 7 sampled residents; one who fell and hit her head (Resident #2) and one with skin excoriation and an open wound (Resident #3). [Refer to Tag D273 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)]</p>	D 176		

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D 176	<p>Continued From page 15</p> <p>6. Based on observation, interview and record review, the facility failed to assure minimum staffing requirements were met and failed to assure sufficient staffing to meet the needs of the 35 residents residing in the Special Care Unit (SCU). [Refer to Tag D465 10A NCAC 13F .1308 Special Care Unit Staff (Type A2 Violation)]</p> <p>7. Based on interviews, observations and record review, the facility failed to assure medications and treatments were administered as ordered for 4 of 9 sampled residents (#1, 5, 10 and 11). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]</p> <p>8. Based on interviews and observation, the facility failed to assure no unpleasant odors (urine and feces odors) in the residents living areas of the facility. [Refer to Tag D075 10A NCAC 13F .0306(a)(2) Housekeeping and Furnishings]</p> <p>9. Based on observation and interview the facility failed to have a supply of washcloths and towels adequate for resident use on hand at all times. [Refer to Tag D080 10A NCAC 13F .0306(a)(6) Housekeeping and Furnishings]</p> <p>10. Based on record review and interviews, the facility failed to assure 2 of 7 sampled staff (Staff C and Staff F) had the two step tuberculosis (TB) skin test in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for Tuberculosis]</p> <p>11. Based on observation and interviews, the facility failed to ensure the provision of sufficient staff and equipment for safe and sanitary food service. [Refer to Tag D286 10A NCAC 13F</p>	D 176		

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D 176	<p>Continued From page 16</p> <p>.0904(b)(1) Nutrition and Food Service]</p> <p>12. Based on observation and interview, the facility failed to assure residents had table service during meals and at snack times that included a napkin and non-disposable place settings consisting of at least a knife, fork, spoon, plate, and beverage containers appropriate for the foods served. [Refer to Tag D287, 10A NCAC 13F .0904(b)(2) Nutrition and Food Service]</p> <p>13. Based on observations, interviews, and record reviews, the facility failed to ensure food and beverages were offered or made available to all residents as snacks between each meal for a total of three snacks per day for all 89 residents residing in the facility. [Refer to Tag D298 10A NCAC 13F .0904(d)(2) Nutrition and Food Service]</p> <p>14. Based on observations and interviews, the facility failed to serve water with each meal to each resident. [Refer to Tag D0306 10A NCAC 13F .0904(d)(3)(h) Nutrition and Food Service]</p> <p>15. Based on interviews and record review, the facility failed to notify the Department of Social Services (DSS) by mail, telefacsimile, electronic mail, or in person of all accidents or incidents resulting in residents' injury requiring referral for emergency medical evaluation for 2 of 2 residents (#2, #6). [Refer to Tag D451 10A NCAC 13F .1212(a) Reporting of Incidents and Accidents]</p> <p>16. Based on interviews and record review, the facility failed to assure 4 of 4 sampled residents on the Special Care Unit (#1, #2, #8, and #9) had care plans done quarterly. [Refer to Tag D464 10A NCAC 13F .1307 Special Care Unit Resident Profile and Care Plan]</p>	D 176		

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D 176	<p>Continued From page 17</p> <p>17. Based on observation, interview and record review, the facility failed to assure 3 of 3 sampled staff (Staff B, D, and E) assigned to perform duties in the special care unit received 6 hours of orientation training within the first week of employment and 20 hours of training within six months of employment. [Refer to Tag D468 10A NCAC 13F .1309 Special Care Unit Staff Training and Orientation]</p> <p>18. Based on observation, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with the rules and regulations as related to other requirements (hot water temperatures) and medication administration. [Refer to Tag D912 G.S. 131D-21(2) Declaration of Resident Rights]</p> <p>19. Based on interview, observation, and record review the facility failed to assure residents were free from neglect as related to management, staffing, health care and personal care and supervision. [Refer to Tag D914 G.S. 131D-21(4) Declaration of Resident Rights]</p> <p>20. Based on observations, interview and record review, the facility failed to assure all medication Aides (MA) hired after 10/01/13 received required 5 hour, 10 hour or 15 hour medication aide training or verified 24 month employment as a MA for 1 of 3 sampled MA (Staff E). [Refer to Tag D935 G.S. 131D 4.5B(b) Adult Care Home Medication Aides; Training and Competency]</p> <p>Review of the facility's plan of protection dated 4/14/2015 revealed: -An experienced North Carolina Administrator</p>	D 176		

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D 176	<p>Continued From page 18</p> <p>was hired with a start date of 4/16/2015.</p> <ul style="list-style-type: none"> -A consulting Registered Nurse will be on-site beginning 4/17/2015 7 days a week until the deficient practices are resolved. -A new Resident Services Director (RSD) who is a North Carolina Registered Nurse will begin 5/18/2015. - The Regional Director of Operations will provide oversight on a daily basis via telephone, fax results of daily audits, staffing, etc. -Medication Aides will be checked off (competency validated by the Pharmacy Consultant) every 3 months. -Quality Assurance Audits by the consulting nurse on or before 5/1/2015. -Staff will be inserviced on Activities of Daily Living (ADL) care, Memory care, Cardiopulmonary Resuscitation (CPR) (all staff), and fire safety. -The Resident Director of Operations (RDO) will provide community oversight on a monthly basis for 6 months and quarterly thereafter. -Quality Assurance audits will be done by corporate personnel every 3 months for 1 year. -A plan of correction will be developed immediately. <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 14, 2015.</p>	D 176		
D 201	<p>10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing</p> <p>10A NCAC 13F .0604 Personal Care And Other Staffing</p> <p>(e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the</p>	D 201		

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D 201	<p>Continued From page 19</p> <p>home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply.</p> <p>(1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:</p> <p>(A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)</p> <p>(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)</p> <p>(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observation, interview and record review, the facility failed to assure minimum staffing requirements were met and failed to assure sufficient staffing to meet the needs of the 55 residents residing in the assisted living. The findings are:</p> <p>Review of the current posted staff schedule revealed:</p>	D 201		
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D 201	<p>Continued From page 20</p> <ul style="list-style-type: none"> - The staff schedule did not match the staff who were currently working. - Multiple changes to the schedule each day to reflect call outs. - Staff working in Assisted Living were pulled mid shift during 1st and 2nd shift to cover staff shortages in memory care. <p>Interview with the Interim Executive Director on 4/7/15 upon entrance at 10:35am revealed:</p> <ul style="list-style-type: none"> - The facility is set up in three sections. - The assisted living comprises the entire first floor (hallway #1 and hallway #2). - Half of the second floor hallway is assisted living and referred to as the cottage.. - The cottage and the small memory care share a hallway separated by a locked door. - The cottage and small memory care also share staffing. - The census for assisted living was 55 for 4/7/15 and the census remained the same throughout the survey. - She was unable to provide documentation to show what staff or how many staff had been on duty in the facility at any given time. <p>Observation of the first floor on 4/8/15 at 3:30pm revealed one personal care assistant (PCA) working both hallways of the first floor and one medication aide on each hallway.</p> <p>Interview with the Interim Executive Director on 4/8/15 at 5:50pm revealed, staffing for the assisted living should be as follows:</p> <ul style="list-style-type: none"> - The first floor (hallway #1 and hallway#2) should be staffed with one medication aide and one PCA working on each hallway on first and second shift. - The first floor should be staffed with one medication aide and one PCA working the whole 	D 201		

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D 201	<p>Continued From page 21</p> <p>first floor on third shift.</p> <ul style="list-style-type: none"> - The cottage was staffed to share staff with the small memory care. <p>Observation of the 1st floor assisted living and cottage (second floor assisted living) at various times throughout the survey revealed:</p> <ul style="list-style-type: none"> - One staff working in the cottage section. - The PCA assigned to the cottage were assisting residents on memory care. - Before and after meal times the PCA was not assisting residents in the cottage due to, assisting residents in memory care. - Residents, families and staff were looking for a staff member and unable to find any on the floor. <p>Interview with a Personal Care Aide (PCA), Staff M, on 4/7/15 at 12:40 p.m. revealed:</p> <ul style="list-style-type: none"> - The PCA was assigned to work on the cottage but was asked to sit with residents on the big memory care hall while residents in the memory care ate meals. - With the PCA being on the big memory care hall there was no staff in the cottage. - The PCA was asked regularly to leave hall the cottage to help somewhere else in the building. - Staff were working 12 and 16 hour shifts and having to leave midway through an 8 hour shift to accommodate call outs. <p>Interview with PCA, Staff P, on 4/8/15 at 12:45pm revealed:</p> <ul style="list-style-type: none"> - She worked the first shift on assisted living, but gets pulled to work memory care or float one hallway of the first floor and the cottage of the second floor, if there is a call out. - The facility was usually understaffed, but today they are full staffed. 	D 201		

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D 201	<p>Continued From page 22</p> <ul style="list-style-type: none"> - She is usually scheduled to work both hallways on the first floor, hallway #1 and #2. <p>Interview with PCA, Staff Q, on 4/8/15 at 3:30pm revealed:</p> <ul style="list-style-type: none"> - The first floor assisted living consist of 2 hallways (hallway #1 and Hallway #2). - There are about 15 residents on each hallway. - She is the only PCA working on the first floor today from 3:00pm to 11:00pm. - When there is a call out for memory care, staff is pulled from the first floor. - Each PCA assigned to hallway #1 and hallway #2 have to pull all of the trash out of each resident room and share the responsibility of doing the laundry for the entire building, and provide personal care for the residents in their hallway. - When they are short a PCA on the first floor, like today she is responsible for doing all of the laundry, pulling all of the trash on the first floor, assisting in the dining room and assisting all of the residents on the first floor with personal care. - There is a medication aide (MA) assigned to each hallway and the medication aide sometimes help the PCAs. <p>Interview with PCA, Staff S, on 4/10/15 at 4:35pm:</p> <ul style="list-style-type: none"> - She is working both hallways on the first floor. She is doing laundry also. - There was a mix up and no one knew there was not a PCA scheduled in hallway #1 since 3:00pm today, until about 5 minutes ago. - Someone should be coming in to work on hallway #1 shortly. <p>Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision.</p>	D 201		

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D 201	<p>Continued From page 23</p> <p>Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision.</p> <hr/> <p>Review of the facility's plan of protection dated 4/10/2015 revealed:</p> <ul style="list-style-type: none"> - We signed a Health Care agreement with a staffing agency to maintain staffing ratios. - We will begin immediately the evening of April 10, 2015. - Recruiting is ongoing and interviewing. - Eight care staff are being interviewed on Saturday. - We will continue using the staffing agency until all staff positions are filled. <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2015.</p>	D 201		
D 269	<p>10A NCAC 13F .0901(a) Personal Care and Supervision</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record review and interviews, it was determined that the facility failed to provide appropriate personal care for 2</p>	D 269		

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D 269	<p>Continued From page 24</p> <p>of 3 residents in the sample, one requiring toileting assistance (Resident # 3) and one needing assistance to dining room for meals (Resident # 8). The findings are:</p> <p>1. Review of Assisted Living Resident #3's current FL2 dated 4/7/15 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included chronic back pain, depression, chronic heart failure, hypertension and pulmonary embolism. -Resident was incontinent of bladder. <p>Review of Resident #3's resident register revealed she was admitted to the facility 5/30/14 to the assisted living section.</p> <p>Review of Resident #3's care plan dated 4/7/15 revealed:</p> <ul style="list-style-type: none"> -Resident toilets self during the day -Resident needs encouraging and prompting for toileting at times. <p>Review of a note from the physician dated 9/15/14 for Resident #3 revealed:</p> <ul style="list-style-type: none"> -Resident returned for a follow up of excoriation of the inner thighs. -The physician ordered nystatin cream (used in treatment of fungal infection from diaper rash) and recommended Resident #3's undergarments be changed multiple times during the day. <p>Review of a physician order dated 9/17/14 for Resident #3 revealed staff ordered to push fluids and a void schedule of 60-90 minutes while awake.</p> <p>Confidential interview with staff member revealed:</p> <ul style="list-style-type: none"> -Resident #3 sleeps in a motorized recliner in her room. 	D 269		

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D 269	<p>Continued From page 25</p> <ul style="list-style-type: none"> -The chair is soaked with urine, she wets herself while sleeping. -Her clothing is always soaked with urine when staff get her up to the bathroom. -Resident #3 is unable to change her clothing without assistance. -The floor in her room had to be replaced, because it was soaked with urine from urine soaked clothing due to trails of urine, when Resident got up from the chair to go to the bathroom. -Staff do not get Resident up in the morning, she just sits in the chair until staff get her cleaned up. -Staff change the dry flow pad on her chair and spray the chair with air freshener, but it stays wet. -On 4/2/15 the facility was short staffed, like many other days. -Resident #3 was sitting in her chair wet, and asking for someone to assist her to the bathroom to. -Resident started asking for staff assistance between 9:00am and 10:00am. -The staff assigned to her hallway did not go in the room to assist her until 1:00pm. -Resident #3's clothing was so wet it left a trail of urine from the chair to the bathroom. -Resident was upset that no one came to assist her earlier. -The MA went in the room and stripped Resident #3 down and sat her on the toilet and left her for an hour. -It is a daily thing for Resident #3 to sit in the chair soaked until staff assist her into dry clothing. -The chair was always wet and there's always a strong odor of urine in her room. -Resident #3 has a dog so you would think the scent is coming from the dog, but the odor is actually coming from Resident #3. <p>Observation of Resident #3 on 4/7/15 at 1:15pm</p>	D 269		

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D 269	<p>Continued From page 26</p> <p>revealed: -Resident sitting in her chair and a strong urine odor that could be smelled in the hallway leading up to Resident #3's apartment. -The dog laying on linoleum floor sleeping.</p> <p>Observation of Resident #3 on 4/8/15 at 8:35am revealed she was sitting in the chair sleeping, her room and hallway had a strong urine odor.</p> <p>Observation of Resident #3 on 4/8/15 at 10:05am revealed she was sitting in the chair sleeping the room and hallway had a strong urine odor.</p> <p>Observation of Resident #3 on 4/8/15 at 11:05am revealed: -Resident #3 sitting in her chair peeling an orange. -The odor of urine permeated in the room and hallway.</p> <p>Interview with a personal care assistant (PCA) on 4/8/15 at 11:05am revealed: -She had been working on hallway #2 since 7:00am. -She was the only PCA working on hallway #2. -She toileted Resident #3 one time this morning around 9:00am.</p> <p>Observation of Resident #3 on 4/8/15 at 11:30am revealed: -Resident was in the bathroom being toileted by the PCA. -Resident's buttocks and upper thighs were deep pink/ purple in color and had multiple ridges of excoriation with an open bleeding stage 2 pressure ulcer about ¾ of an inch long on the right upper thigh, just below the buttock and another ridge that looked as if it would open just above it.</p>	D 269		

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D 269	<p>Continued From page 27</p> <ul style="list-style-type: none"> -Resident's incontinent brief, pants, a cloth dry flow pad and the paper chuck pad had been removed from the resident and the chair and were all soaked with urine and smelled of urine were laying on the floor of the bathroom shower. -Resident's chair was urine soaked [felt through gloved hand] with a clean cloth dry flow pad and paper chuck pad placed on top of it. -Resident's room was sprayed with a deodorizer, with a subdued urine smell. -The PCA applied the resident's Endit cream (diaper rash, bed sore cream) to Resident's buttock. <p>Interview with Resident #3 on 4/8/15 at 11:30am revealed:</p> <ul style="list-style-type: none"> -She had been toileted earlier in the morning, but she did not know what time that was, it had been quite a while. -She does not remember who it was that took her to the bathroom earlier, it was not the same person toileting her now. -She could not remember how often she was toileted. <p>Interview with the Licensed Practical Nurse (LPN) on 4/8/15 at 11:50am revealed:</p> <ul style="list-style-type: none"> -Resident #3 is not on a toileting schedule. -She heard the PCA ask Resident #3 if she wanted to get up. -She documented on the medication administration record that the PCA had toileted Resident #3 this morning. -She did not remember what time she documented that. -She did not toilet Resident #3 that morning. -If the PCA assigned to hallway #2 did not toilet Resident #3 then no one else would have, unless it was done prior to 7:00am. -She had not assessed Resident #3's skin, but 	D 269		

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D 269	<p>Continued From page 28</p> <p>there are skin assessment sheets that are done on each resident every week.</p> <ul style="list-style-type: none"> -Resident #3 gets so wet because of the medication she is taking. -Resident is also able to toilet herself and apply the Endit cream to her bottom. <p>Interview with the PCA on 4/8/15 at 12:45pm revealed:</p> <ul style="list-style-type: none"> -She was the same PCA that said she toileted Resident #3 this morning at 9:00am. -She did not toilet Resident #3 this morning at 9:00am. -The 11:00pm - 7:00am shift had gotten resident out of bed to the bathroom this morning, because she had not. -The first time she toileted Resident #3 was at 11:30am. -Resident's bottom looks much better than it had been looking. -Resident #3 does not usually go to the dining room for breakfast. -She is not usually awake in time for breakfast. -She went in Resident #3's room around 8:00am to get her up, but she did not wake up. -When she went back in the room at 11:15am she was awake let the aide toilet her. -Sometimes Resident #3 will get up and go to the bathroom by herself also. -She falls asleep on the toilet. -She was aware of the open area on Resident #3's bottom and she reported it to the RCD last Friday. -The PCAs and LPNs apply cream to Resident's bottom. -When she works this assignment she usually encourages Resident #3 to use the bathroom 2 times per shift, about every 4 hours. <p>Interview with a second PCA on 4/8/15 at 3:30pm</p>	D 269		

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D 269	<p>Continued From page 29</p> <p>revealed:</p> <ul style="list-style-type: none"> -She was assigned to Resident #3's hallway today on the evening shift. -Resident #3 toilets herself. -She had the assignment in Resident #3's hallway yesterday evening. -When she went in to take Resident #3 to the bathroom in the beginning of her shift Resident was really soiled. -Resident #3's briefs, pants and chucks were soaked. -She had found Resident #3 like that before. -She did not see any open areas on Resident #3's bottom, when she changed her out of wet clothing last night. -She applied Endit cream on Resident #3's bottom every time she toileted her. -There is no set schedule to when staff is supposed to check her for toileting. -She offered to take resident #3 bathroom 7-8 times a shift when she worked, at 3:00pm, once between 5:30 and 6:00pm, around 8:00pm and at 10:00pm before she left. -She had not found Resident #3's chair wet on any occasion. -She had already toileted Resident #3 today at 3:30pm. <p>Interview with LPN #2 on 4/8/15 at 4:00pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 gets up by herself, "a lot of urine pours out off of her". -Resident falls asleep in the chair and will not get up. -Most of the time Resident #3 is coherent. -She had not known Resident #3 to soil herself until yesterday. -Most of the time Resident #3 will toilet herself and apply Endit cream, A&D ointment and nystatin powder to her bottom herself. 	D 269		

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D 269	<p>Continued From page 30</p> <ul style="list-style-type: none"> -Staff prompt Resident #3 one time per shift to see if she needs to use the bathroom. -When she is prompted to go to the bathroom by staff she will usually go with them. -Sometimes it takes a few minutes to awaken Resident when she was asleep. -Resident #3 is not being seen by home health at this time. -She was seen by a home health nurse, from 9/5/14 through 10/4/14, for excoriation to her buttock, she never had any open areas. -She had not seen Resident #3's bottom lately. -She is not aware of any open areas on Resident #3's bottom. -Skin assessments are done on every resident once a week at shower time by MAs and LPNs. -She had not done an assessment on Resident #3's skin. -She worked evenings, the skin assessments are done on day shift. -She was unable to find any skin assessment dated after 1/25/15, in the skin assessment book and in the Resident's record. <p>Review of documentation on the skin integrity monitoring sheets for Resident #3 revealed:</p> <ul style="list-style-type: none"> - Skin assessments had been completed for Resident #3 through 1/25/15. - Skin assessment dated 1/25/15, documented Resident had topical creams to buttock area of redness. - The column labeled "improving yes/no" had only a checkmark. - There was no description noted for the area of redness. - Skin assessment dated 1/21/15, the picture to describe the location of the area was circled around the perineum and redness was circled with a comment; home health nurses treated excoriated skin still red. 	D 269		

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D 269	<p>Continued From page 31</p> <p>Interview with LPN #2 on 4/8/15 at 5:00pm revealed: -She assessed Resident #3's bottom an hour ago. -She saw an opening about 1/2 inch or so on Resident's right upper thigh and ridges and excoriation on both upper thighs and lower buttock. -She will contact the physician and get a home health consult. -Resident had not been seen by home health since October 2014.</p> <p>Interview with the Resident Care Director (RCD) on 4/8/15 at 5:15pm revealed: -She is responsible for reviewing orders and supervising direct care staff, assessments and monitoring. -The medication aides and LPNs do skin assessments on every resident, every week and place the documentation in a book. -She does not know when the last skin assessment was done on Resident #3. -Staff should be offering toileting to Resident #3 every 2 hours and they are told, not to take no for an answer. -The floor in Resident #3's room was just replaced. -Between Resident #3 "and the dog urinating on the floor it was destroyed". -Resident #3 "sits in the chair all day and does not feel like getting up". -Her chair stays wet and she sleeps in it and does not want to be disturbed. -No one told her Resident #3 had any open areas on her bottom. -The MA or Nurse should be applying the creams to the Resident's bottom.</p>	D 269		

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D 269	<p>Continued From page 32</p> <p>Interview with the Interim Executive Director on 4/8/15 at 5:50pm revealed: -She was not aware of the issue with toileting Resident #3, or of issues with her skin. -Resident #3's family was supposed to come and pick up the Resident's chair.</p> <p>Review of Nurse's note for Resident #3 revealed: -She was seen by home health nurse on 4/9/15. -Resident was treated for 2 areas on her leg/buttock. -Resident to be toileted every 2 hours and staff applying Endit cream and vitamin A&D ointment on the area. -This was faxed to the physician by home health.</p> <p>Attempts to contact Resident #3's physician for an interview was not successful.</p> <p>2. Review of Resident #8's FL-2 dated 9/12/14 revealed: -Diagnoses included dementia, glaucoma, constipation, Vitamin D Deficiency, seborrheic keratosis, history of dysphagia, Vitamin B Deficiency, gastroesophageal reflux disease, attention deficit disorder, hyperlipidemia, coronary artery disease, diverticulosis, hyperkalemia, peptic ulcer disease, gait disturbance, and history of falls. -Resident #8 was intermittently disoriented. -Resident #8 required personal care assistance with bathing, feeding, and dressing.</p> <p>Review of Resident #8's care plan dated 10/12/14 revealed: -Resident's #8 was sometimes disoriented. -Resident #8's memory was forgetful-needs requiring reminders. -Resident #8 had occasional incontinence with bowel and bladder.</p>	D 269		

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D 269	<p>Continued From page 33</p> <ul style="list-style-type: none"> -Resident #8 was independent with eating, ambulation, and transferring. -Resident #8 needed supervision with toileting, dressing, and grooming/personal hygiene. -Resident #8 needed limited assistance with bathing. <p>Observation on 4/7/15 at 11:45 a.m. revealed lunch meal was served in memory care unit.</p> <p>Observation on 4/7/15 at 12:20 p.m. revealed Resident #8 sleeping in recliner in resident's room.</p> <p>Interview with Memory Care Director on 4/7/15 at 12:28 p.m. revealed she had no knowledge of any residents in memory care who eat in their rooms.</p> <p>Interview with Medication Aide (MA) on 4/7/15 at 12:30 p.m. revealed</p> <ul style="list-style-type: none"> -Resident #8 was not in the facility on 4/7/15. -The resident goes to an Adult Day Program on Mondays and Wednesdays. -(Tuesday was the day of the interview and the resident would not have been at the Adult Day Program.) <p>Interview with Personal Care Aide (PCA) on 4/7/15 at 12:35 p.m. revealed:</p> <ul style="list-style-type: none"> -She believed Resident #8 was in her room and would go check. -She was not aware Resident #8 did not go to lunch and would get the resident and take her to dining room to eat. -At meal times, staff should go down halls to make sure all residents are in the dining room to eat. -The PCA did not check to see if Resident #8 was in her room and should not have assumed the 	D 269		

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D 269	<p>Continued From page 34</p> <p>resident was in the dining room.</p> <p>Interview with another PCA on 4/7/15 at 12:45 p.m. revealed: -Staff is to go down halls at meal times to make sure all residents were in dining room. -She was not aware Resident #8 was not in the dining room and did not get lunch. -The PCA's report they have checked the halls.</p> <p>Observation on 4/7/15 at 12:55 p.m. revealed Resident #8 was sitting at a table in the dining room eating food from a disposable plate.</p> <p>Interview with the Interim Executive Director on 4/7/15 at 12:55 p.m. revealed: -She asked why Resident #8's food was in a disposable plate. -The PCA reported someone had thrown Resident #8's food out and the kitchen sent a disposable plate up to the memory care unit.</p> <p>Interview with Interim Executive Director on 4/7/15 at 1:10 p.m. revealed: -She would assume and expect all residents are brought to dining room at meal times. -PCA's are to go down halls to ensure all residents are in dining room. -The MA should check rooms to make sure the PCA's have all residents in dining room. -At no time is a tray to be left in a residents' room. -Staff should try to get resident to eat even if it takes another staff to try to get resident to eat.</p> <p>Interview with MA on 4/8/15 at 10:10am revealed the MA personally walks down hall at meal times to check all rooms to make sure everyone gets in the dining room.</p>	D 269		

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D 269	<p>Continued From page 35</p> <p>Review of the facility's plan of protections dated 4/10/2015 revealed:</p> <ul style="list-style-type: none"> -Appropriate staffing levels will be maintained by utilizing a staffing agency. -A manager will be on site Saturday and Sunday to do routin rounds to ensure safety. -the primary responsibility is to be resident care and safety during resident care hours. -This process is to begin immediately. -The Executive Director or designee will monitor to ensure process will be followed on an on going basis. -A list of residents at risk will be compiled to include residents who wander and fall frequently. -Staff will monitor theses residents on an ongoing basis every 60 minutes <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2015.</p>	D 269		
D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision</p> <p>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on observation, interview and record review, the facility failed to provide supervision of residents according to their assessed needs for 4</p>	D 270		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 36</p> <p>of 7 sampled residents who sustained repeated observed and unobserved falls (#2, #5, #6,) with injury and one resident who eloped (#7). The findings are:</p> <p>1. Review of Resident #6's current FL-2 dated 3/2/15, revealed the following:</p> <ul style="list-style-type: none"> - Diagnoses included traumatic brain injury, expressive aphasia, hemiparesis of right side, and seizure disorder. - The resident was non-ambulatory and used a wheelchair to ambulate. <p>Record review revealed Resident #6 was admitted to the facility on 12/01/10 and resided on the assisted living hall.</p> <p>Review of the Resident #6's current care plan dated 10/08/14 revealed the following:</p> <ul style="list-style-type: none"> - The resident required extensive assistance with bathing and limited assistance with dressing. - The resident transferred independently and toileting was independent. <p>Review of documentation on the facility's incident/accident reports, "Occurrence-First Responder Forms", Nurses Notes and "Healthcare Provider Communication Form" from 12/10/14 to 3/4/15 revealed:</p> <ul style="list-style-type: none"> - From 12/10/14 to 3/4/15, Resident #6 had 26 falls in the facility (24 falls were unwitnessed). - On 12/10/14, at 9:00am, the resident was "found at 7:00am on the bathroom floor. The resident hit her head, had abrasions to forehead and right knee and complained of head pain". The resident was sent to the local emergency room and diagnosed with a head injury/concussion. - On 12/16/14 at 6:30am. "Heard resident yelling for help at this time and found [Resident 	D 270		

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D 270	<p>Continued From page 37</p> <p>#6] [lying] on floor on right side. Resident yelling "pee pee" and was [lying] on the bathroom floor".</p> <ul style="list-style-type: none"> - On 12/17/14, at 4:15am, the resident was heard yelling for help and found on the floor, near the bed. The resident stated she was trying to go to the bathroom, had to go very bad. The resident stated she had pain in her head. The resident was transported to the local emergency room by emergency medical service. The resident was diagnosed with a closed head injury (concussion). - On 1/1/15, at 9:30am, the resident was "found in her bedroom on the floor. The resident hit her head and complain of head pain". The resident was transported to the local emergency room and treated for contusion of the head and diagnosed with a concussion. - On 1/19/15, at 3:15pm, the resident was "found lying on the bathroom floor on her right side. Bruising was noted on the resident's right forearm and right side of back/rib area at 10:30pm". The resident was not sent to local emergency room. - On 2/08/15, (no time) the resident "pulled the call bell, resident was lying on the bathroom floor on back. The resident has some red areas on her back. Will monitor. - On 2/10/15 at 9:00am, the resident was "found [lying] on the floor on her right side. Resident right arm, elbow with old bruising, area swollen and warm to touch. 911 called, EMS assessed and didn't feel she needed to be seen in [emergency room]". - On 2/10/15 at 5:30pm, the resident was "found on the floor on the right side. Arm swollen and discolored. Sent to the emergency room. Resident returned to the facility, no fractures, [Cat Scan] of head negative". - On 2/12/15, at 10:30am, the resident "pulled the call bell. Resident was on the bathroom floor 	D 270		

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D 270	<p>Continued From page 38</p> <p>laying on her right side. Resident does have a bruised area on the right arm near elbow from previous fall." The resident's primary provider ordered "x-ray of right elbow area." According to x-ray results on 2/12/15, there were no fractures.</p> <ul style="list-style-type: none"> - On 2/24/15 at 8:00pm, the resident was "found sitting on the floor beside wheelchair. When resident is asked why she fell, she stated "timber is dead, dead". - On 3/4/15, at 7:10am, the resident "found lying on the floor, beside the bed, had urinary incontinence". <p>Interview with Resident #6's Guardian on 4/14/15 at 1:40pm revealed the following;</p> <ul style="list-style-type: none"> - The facility had informed her of the resident's falls which began in December, 2014. - She was aware the resident has sustained multiple falls but did not know how many falls the resident had. - The resident falls were sustained while attempting to get out of bed or trying to go to the bathroom. - The guardian had talked to the facility staff about placing the resident on a toileting schedule in January, 2015, but the facility had never implemented a schedule for toileting. - There was a sign posted on the resident door and at the nurse's station instructing the staff to do 30 minute checks, but she never observed the staff doing 30 minute checks and there were never documentation of 30 minute checks in the resident's record. - The resident received physical therapy in December 2014 through January 2015 and occupational therapy for 3 weeks in January 2015 (related to falls). - The resident was admitted to a local skilled nursing facility on 3/4/15 and has sustained no falls since admission. 	D 270		

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D 270	<p>Continued From page 39</p> <p>Interview with a medication aide (MA) on 4/14/15 at 10:35am revealed the following:</p> <ul style="list-style-type: none"> - She was aware Resident #6 had multiple falls. - The resident was independent and always attempted to dress self, transfer to wheelchair without assistance and go to bathroom without assistance. - The resident has never been on 30 minute supervisory checks, but the staff checked on the resident every 2 hours at times to assist her to the bathroom if needed. - If the staff instructed the resident to "stay right here and don't move" (in wheelchair or bed), she would most of the time. - There were no other fall prevention interventions put in place for the resident. - The resident had injuries from some of the falls (bruises, head injuries) and was sent to the local emergency room for care because the resident had a ventricular shunt from a past head injury. - The resident was admitted to a local skilled nursing facility in March 2015 because of the multiple falls. <p>Interview with a PCA on 4/14/15 at 4:15pm revealed the following:</p> <ul style="list-style-type: none"> - Resident #6 was weak and had multiple falls while in wheelchair and when she attempted to get out of bed. - The facility staff did checks every 2 hours (to assist the resident to bathroom and to find out if she needed anything). - The resident did not require 30 minute checks because she was independent. - The resident was never placed on 15 minute or 30 minute checks. - The resident never used her call bell to ask 	D 270		

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D 270	<p>Continued From page 40</p> <p>for assistance to the bathroom or to ask for something to drink. The staff always found her on the floor, either beside her bed or in her bathroom.</p> <p>2. Review of Resident #5's current FL-2 dated 4/6/15 revealed the following:</p> <ul style="list-style-type: none"> - Diagnoses of dementia, post-inflammatory pulmonary fibrosis, osteoarthritis, glaucoma, thoracic aneurysm and aortic regurgitation. - The resident was intermittently disoriented and was incontinent of bowel and bladder at times. - The resident was semi-ambulatory. <p>Record review revealed Resident #5 was admitted to the facility on 8/18/14 and resided on the assisted living hall.</p> <p>Interview with Resident #5's private sitter on 4/10/15 at 10:25am revealed the following:</p> <ul style="list-style-type: none"> - The resident has private sitters (24 hours every day) to assist with resident care and prevent the resident from getting up unassisted. - Private Sitter service started a few days ago (on 4/7/15). - Someone has to stay with the resident at all times to prevent him from falling. - The resident required assistance with all transfers and ambulation. - The staff did not check on the resident and only came in his room to administer medications. - The staff instructed the sitter to call if the resident needed anything. <p>Review of a hospice social worker visit note dated 4/02/15 revealed the following documentation:</p> <ul style="list-style-type: none"> - "Found patient [Resident #5] lying on the floor in his room." - [The resident] "Reports he fell out of bed" 	D 270		

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D 270	<p>Continued From page 41</p> <ul style="list-style-type: none"> - "Staff state 2nd fall of the day." - "Patient with poor memory, remains at risk secondary to weakness." <p>Review of facility's "Nurse's Notes" revealed the following documentation:</p> <ul style="list-style-type: none"> - On 3/27/15 at 8:00am, Resident #5 "fell while trying to sit in a chair at breakfast" - On 3/27/15 at 5:56pm, Resident #5 "fell out of his chair in the dining room, hitting his head on the wall." - On 4/2/15 at 7:30am, Resident #5 was "found on the floor, in the bedroom. Resident states he was trying to stand up to get into his chair and just fell." - On 4/2/15 (no time documented), "resident found on the floor, 2nd time. Resident trying to go to bathroom and fell coming back". - On 4/2/15 (no time documented), "resident found on the floor 3rd time. Resident states he just fell." <p>Review of facility's "Healthcare Provider Communication Form" revealed the following documentation:</p> <ul style="list-style-type: none"> - On 3/27/15, "resident [#5] fell this AM at breakfast. Resident was trying to sit in his chair and missed the seat." - On 3/27/15, "resident fell forward out of his wheelchair, hitting his head". - On 4/2/5 at 7:30am, Resident #5 was "found on floor in bedroom, no signs of injuries." - On 4/2/15 at 11:00am, "resident found on the floor in the bedroom, no signs of injuries." - On 4/2/15 at 1:30pm, "resident found on the floor in bedroom, no signs of injuries." <p>Interview with a 1st shift medication aide (MA) on 4/10/15 at 4:15pm revealed the following:</p> <ul style="list-style-type: none"> - The facility staff was not doing supervision 	D 270		

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D 270	<p>Continued From page 42</p> <p>checks for Resident #5.</p> <ul style="list-style-type: none"> - A private duty sitter was with the resident 24 hours a day and the resident did not require staff to check him. - The staff was doing 2 hour checks after the resident falls on 4/2/15, but stopped after private duty sitter services started. - Before the falls occurred, the staff only checked on resident if he needed something, the resident would use call light. <p>Interview with Resident #5's family member on 4/14/15 at 12:04pm revealed the following:</p> <ul style="list-style-type: none"> - The family member was aware of the 3 falls the resident sustained on 4/2/15 and the falls on 3/27/15. - The resident was ambulatory and ambulated without assistance, but was weaker now and required assistance with all transfers and ambulation to prevent falls. - The resident had to be reminded constantly not to get out of chair/bed without assistant. - The facility staff has never checked on resident every 2 hour to offer assistance with transfers/ambulation. - The staff only came to resident's bedroom periodically to administer his medications (once a shift). <p>Interview with a personal care aide (PCA), who worked 1st and 2nd shift, on 4/14/15 at 4:15pm revealed the following:</p> <ul style="list-style-type: none"> - The PCA was working on the days Resident #5 fell (3/27/15 and 4/2/15). - The PCA stated she was not assigned to work on Resident #5's hall. - PCAs were never assigned to that hall (rooms 100 to 120) due the residents were independent with all personal care and other activities of daily living (ADL). 	D 270		

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D 270	<p>Continued From page 43</p> <ul style="list-style-type: none"> - Before his falls, Resident #5 was independent and did not require assistance with ADL's. - The resident has private duty sitters "around the clock" and the staff did not provide any supervisory checks. - The PCA did not know if the resident had 1 or 2 hour checks after he sustained falls on 3/27/15 or 4/2/15. <p>Interview with the facility's interim Executive Director on 3/10/15 at 3:50pm revealed the following;</p> <ul style="list-style-type: none"> - She was not aware the staff was not doing supervisory checks on all residents at least every 2 hours. - Resident #5 should be checked by staff and they should not rely on the private sitters to provide all care. - We will "fix these things." <p>3. Review of Resident #7's current FL2 dated 1/10/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included dementia, memory loss, migraine headaches, and hypertension. - Resident described as constantly disoriented and ambulatory. <p>Review of resident register for Resident #7 revealed:</p> <ul style="list-style-type: none"> - Resident # 7 was admitted to the facility on 2/14/13. - Resident # 7 was in the assisted living section. <p>Observation of facility on 4/7/15 between 10:35am and 1:30pm revealed:</p> <ul style="list-style-type: none"> - All of the doors to the facility were locked, with the exception of the front door. - The front door was an automatic door that 	D 270		

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D 270	<p>Continued From page 44</p> <p>opens by sensor when someone stood in front of it.</p> <ul style="list-style-type: none"> - The receptionist office had a service window that opened out facing the front lobby. - Upon entrance to the facility there was no staff person in the lobby. The door opened automatically, when survey staff entered the facility on 4/7/15 at 10:35am. The receptionist was not at her desk or in the lobby. <p>Interview with a personal care aide on 4/7/15 at 12:00pm revealed:</p> <ul style="list-style-type: none"> - The lobby doors are unlocked between the hours of 8:00am and 8:00pm. - All other doors that led to the outside are locked. - The receptionist is usually at the front door, to keep residents from attempting to exit. - About 2 months ago Resident #7 walked right out the front door, past the receptionist. - She does not know how far Resident got. - The staff at the facility did not know Resident had left the facility until they got a call from the emergency management systems EMS. - She was not working on the day of the resident exit, this information was relayed to her from other employees. <p>Review of Nurse's notes for Resident #7 revealed an entry dated 2/15/15 describing the following:</p> <ul style="list-style-type: none"> - 3:00pm- The facility received a call from EMS from outside of the building reporting that they had Resident #7 in their possession. - Resident #7 apparently walked out through the front door of the facility fully dressed with her pocket book. - She was seen by someone living in the apartments next door to the facility and they called 911. - Resident was very confused, not knowing 	D 270		

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D 270	<p>Continued From page 45</p> <p>why she was outside.</p> <ul style="list-style-type: none"> - The facility completed an assessment and attempted to reach her physician. - Resident had increased confusion, weakness and difficulty ambulating. - The family was contacted and assistance was requested for 1:1 monitoring by family or a sitter the family member said she was not able to provide it. - Wander guard bracelet was applied to resident. - 4:30pm - Will send resident to emergency for evaluation. - Resident was sent to emergency for evaluation at 6:00pm. <p>Review of hospital discharge paperwork for Resident #7 revealed:</p> <ul style="list-style-type: none"> - Resident #7 was admitted to the ER on 2/15/15 and discharged the same day. - Her admitting diagnosis was dementia. <p>Interview with a second personal care aide on 4/13/15 at 4:20pm revealed:</p> <ul style="list-style-type: none"> - She reported to work at 3:00pm on 2/15/15. - Staff had just started looking for Resident #7 when EMS called and said she was next door. - Resident #7 is constantly confused. - Resident # 7 was someone you definitely had to keep an eye on. - Resident # 7 had a wanderguard bracelet on but she did not think she was wearing it the day that happened. - The receptionist in the lobby must have just turned her head and the resident scooted right past her. - Resident # 7 walked straight out the front door and went next door. - Resident # 7 ambulated pretty steady, just slow. 	D 270		

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D 270	<p>Continued From page 46</p> <ul style="list-style-type: none"> - Resident # 7 did not know who was assigned to work that hallway that day. <p>Interview with an LPN on 4/13/15 at 4:25pm revealed:</p> <ul style="list-style-type: none"> - Resident #7 got confused one day and walked straight out the front door. - There was a receptionist that was working that day, but she is no longer employed at the facility. - The LPN was not working that day but she heard about the incident. <p>Interview with a receptionist on 4/13/15 at 4:35pm revealed:</p> <ul style="list-style-type: none"> - She was not working on the day Resident #7 eloped, but she had been told about it when she returned to work. - No one was aware Resident #7 was missing until they received a call from the EMS. - She had never had an issue with Resident #7 trying to get out the door. - When residents try to exit out the front door she tries to redirect them. - If she is unable to redirect the resident then she will get a member of direct care staff to come get the resident. <p>Interview with a medication aide on 4/13/15 at 4:45pm revealed:</p> <ul style="list-style-type: none"> - Resident #7 got a little confused. - Resident used to go the front lobby saying she was waiting on her daughter. - She would have to go to the front and get Resident # 7 to redirect her. She had not seen her do that lately. - She was not working the day Resident #7 exited the building, she was told by another staff member to watch out for her. 	D 270		

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D 270	<p>Continued From page 47</p> <p>Observation of Resident #7 on 4/14/15 at 9:00am revealed:</p> <ul style="list-style-type: none"> - She resided on the first floor of the assisted living section. - Resident #7 was alert, but confused. - She was wearing a wander guard bracelet. <p>Based on interview and record review it was determined Resident #7 was not interviewable.</p> <p>Interview with a family member of Resident #7 on 4/14/15 at 9:40am revealed:</p> <ul style="list-style-type: none"> - To her knowledge Resident #7 had never tried to leave the facility before 2/15/15. - Resident #7 had a wander guard bracelet on, since she was admitted to the facility, but it had been taken off prior to her walking out of the building. - She was called by staff and informed Resident #7 walked outside of the building and someone saw her and brought her right back inside. - She was asked if she could sit with Resident #7 or provide a sitter she informed them, she could not, so they put the wander guard bracelet back on her. <p>Interview with a second medication aide on 4/14/15 at 10:40am revealed:</p> <ul style="list-style-type: none"> - When a medication aide or a Nurse felt like a resident needed a wander guard they would tell the Resident Care Director and she would get one for the resident. - Resident #7 got a wanderguard bracelet placed just after being admitted to the facility. - She had never seen a wanderguard bracelet removed from a resident unless they were moving to a locked unit like memory care. - She does not know why the wanderguard bracelet was removed from Resident #7 prior to 	D 270		

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NAME OF PROVIDER OR SUPPLIER PACIFICA SENIOR LIVING WILMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2744 S 17TH STREET WILMINGTON, NC 28412
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D 270	<p>Continued From page 48</p> <p>her elopement, but she does have it on now.</p> <p>Interview with a second receptionist on 4/14/15 at 1:15pm revealed:</p> <ul style="list-style-type: none"> - She was not working the desk on the day Resident #7 exited the building. - Resident #7 would come to the lobby and look out the window, because she wanted to go home. - She would call staff and they would tell her to keep an eye on Resident #7. <p>4. Review of Resident #2's current FL-2 dated 10/15/2015 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included: Alzheimer's Dementia, Rheumatoid Arthritis, and a history of cervical spinal surgery. -Resident #2 was constantly disoriented. -Resident #2 was non-ambulatory and used a wheelchair. <p>Review of Resident #2's resident register revealed she was admitted on 3/16/2012.</p> <p>Review of Resident #2's care plan dated 3/5/2015 revealed:</p> <ul style="list-style-type: none"> -Resident #2 required total care with all activities of daily living. -"Cognitive decline limits her abilities to express her needs." -"She communicates much less and words are limited most of the time." - "Increased fall protected. Turn bed to the wall." <p>Review of Resident #2's record revealed:</p> <ul style="list-style-type: none"> -Resident #2 had a history of falls from her wheelchair: 1/2/2014, 8/23/2014, 9/4/2014, 1/18/2015, 1/19/2015, 2/11/2015, and 3/18/2015. -On 1/11/2015 a bruise was noted on Resident 	D 270		

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D 270	<p>Continued From page 49</p> <p>#2's right cheek from a possible fall but no documentation was noted.</p> <p>-On 2/11/2015 Resident #2 was found on the floor with vomit on her and a red mark on her cheek and she was not transported to the hospital for evaluation despite the family's request for an assessment for possible concussion.</p> <p>-On 3/18/2015 Resident #2 fell at approximately 7:30 a.m. hitting her head and was not sent out to the hospital for evaluation until 3 hours later.</p> <p>Review of the facility's falls management policy revealed:</p> <p>-There was a first responder form to be completed by the first responder to the event.</p> <p>-The Resident Care Director was to complete a form after each fall regarding fall information, possible causes, and new approach suggestions warranting a new evaluation and care plan.</p> <p>-The results of this form were to be transferred to a post fall tracking and intervention log.</p> <p>-There was an occurrence trending form which documented the resident event tracking summary.</p> <p>-There was a form used to investigate events and injuries of unknown origin to be reviewed and signed by the Executive Director.</p> <p>Review of Resident #2's record revealed:</p> <p>-First responder forms on 1/18/2015 (no injury), 1/19/2015 (laceration to left eyebrow and below left eye), 2/11/2015 (no description), and 3/18/2015 (gash to left eye brow).</p> <p>-There was no further documentation of Resident #2's falls.</p> <p>Interview with the Interim Executive Director on 4/14/2015 at 4:00 p.m. revealed:</p> <p>-She had been at the facility as the acting Interim Executive Director since approximately</p>	D 270		

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D 270	<p>Continued From page 50</p> <p>2/24/2015.</p> <ul style="list-style-type: none"> -She was not aware of Resident #2's falls. -There was no documentation in Resident #2's record the physician was made aware. -There had not been any discussion with the family prior to Resident #2 being admitted to the hospital on 3/18/2015 regarding the facility being able to meet the supervision needs of Resident #2 or a higher level of care to prevent falls. -There were notes posted in Resident #2's room for falls prevention but she had thought the family had posted them but found out from the family after Resident #2 was admitted to the hospital the physical therapist had posted them. -Residents are checked every 2 hours. <p>Interview with the Supervisor (Licensed Practical Nurse) on 4/14/2015 at 12:30 p.m. revealed:</p> <ul style="list-style-type: none"> -She was aware of Resident #2's increased falls. -She was the supervisor for the whole building but did not know what was being done about Resident #2's increased falls. -She was aware physical therapy had been working with Resident #2 but was no longer. <p>Interview with the Health and Wellness Director on 4/7/2015 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #2 was a falls risk. -Staff tried to keep her in the Activity room but there were no further interventions to prevent falls. -The family wanted a table in front of her to prevent falls but that is considered a restraint and we were unable to accommodate that. -Management met with the family to do care planning after Resident #2's last fall while she was still in the hospital but it was invalid since we did not know what her level of functioning would be when she was discharged from the hospital. 	D 270		

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D 270	<p>Continued From page 51</p> <p>Interview with a Medication Aide (MA) on 4/8/2015 at 11:00 a.m. revealed: -Resident #2 was a falls risk. -Resident #2 appeared to have a postural issue and leaned forward in her wheelchair. -The family wanted a lap buddy or a table in front of her but we cannot do that because those are considered restraints. -Staff tried to keep Resident #2 out in the Activity area where she could be watched.</p> <p>Interview with Personal Care Aide (PCA) on 4/14/2015 at 11:00 a.m. revealed: -Staff put Resident #2 in the Activity room wheeled up to the edge of a table with a pillow in front of her on the table. -The physical therapist had posted notes in Resident #2's room and at the nurse's station of interventions to prevent falls for Resident #2.</p> <p>Interview with the Home Health agency on 4/14/2015 at 3:30 p.m. revealed: -There was a physician's order for a physical therapy evaluation for Resident #2 on 8/28/2014 to assess for functionality, and modifications to decrease the risk for falls. -Resident #2 was seen once a week for 5 weeks and transfers was on the list of interventions. -The facility was instructed to call if Resident #2 fell and their protocol is to inform the physician. -Facility staff were supposed to monitor Resident #2's progress and report any issues. -There was no documentation in Resident #2's record of the facility notifying them of Resident #2 falling or communication with the physician regarding falls for January, February, or March 2015.</p> <p>Interview with the physician's assistant on 4/14/2015 at 3:45 p.m. revealed:</p>	D 270		

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D 270	<p>Continued From page 52</p> <ul style="list-style-type: none"> -Anytime a resident falls the facility notifies him but he could not be specific as to dates he had been notified regarding Resident #2's falls except for to say it should be documented in her chart. -Resident #2 had been markedly declining over the past 6 months. -Resident #2 was not able to follow instructions and he relied on nursing interventions to prevent falls. -He last saw Resident #2 on 2/24/2015 and stated she was doing ok, her behavior was at baseline and there was no change in her treatment. -He had not spoken with the family. -There had been no discussion regarding a higher level of care for Resident #2 and it was his understanding the family wanted Resident #2 to remain at the facility. <p>Interview with one family member on 4/10/2015 at 4:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Nothing the facility said would be put into place to prevent falls was. -Resident #2 had a chair alarm which was only witnessed by family on her twice during visits. -Staff told her they forgot to put the chair alarm on. -On one visit Resident #2 had yellow and green bruising around the orbital of her eye which she could not recall the date. -Staff told her there was no documentation of a fall and it may be because staff had been told if you document everything the state might shut the facility down. -There were only 2 observed staff the day of that visit. -She witnessed another resident fall and staff told her the resident likes to lay on the floor. -There appeared to be a "nonchalant attitude" of residents falling by staff. 	D 270		

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D 270	<p>Continued From page 53</p> <p>Interview with another family member on 4/10/2015 at 4:45 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #2 was repeatedly falling. -The family had not been called for a care planning meeting in the past 3 years until the last hospitalization on 3/18/2015. -She visited once and Resident #2 had a bruised chin and skinned knee. -The staff informed her there was no documentation in Resident #2's record she had fallen. -She was told the former Executive Director had told staff they would get in trouble if there were too many falls. -The physical therapist had placed notes for the staff to not leave the resident unattended, put a table in front of her, and to put leg rests on her wheelchair. -She wanted physical therapy to remain involved in her treatment to avoid contractures, strengthening, and maintenance. -The physical therapist had recommended to keep the bed 2 feet away from the wall. -She observed the physical therapist signs had been taken down from the wall when she visited last and the bed was pushed back against the wall. -She was concerned there were sheet metal boxes underneath the air conditioning vent in the room which were an environmental hazard for Resident #2 with potential falls. -It took 1 week to get those out of the way and she had brought a telephone table to put behind the bed to protect Resident #2. -Resident #2 had a chair alarm which she would find clipped to her shirt but the other part was not clipped to the chair. -She never saw the whole chair alarm intact and she would find it on the window sill and put it on 	D 270		

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D 270	<p>Continued From page 54</p> <p>Resident #2. -She brought a card table into Resident #2's room so the staff could put it in front of her as an activity table to prevent falls in her room. -She had found Resident #2 in bed with a depends and t-shirt on with her eyes crusted shut and difficulty breathing and did not understand why Resident #2 had not been put on the norovirus medication regimen by the physician's assistant. -Resident #2 was admitted to the hospital on 1/19/2015 with a diagnosis of pneumonia.</p> <hr/> <p>Review of the facility's plan of protection dated 4/10/2015 revealed: -Appropriate staffing levels will be maintained by utilizing staffing agency. -The manager will be on site Saturday and sunday to do routine rounds to ensure safety. -The primary responsibility is to be resident care and safety during resident care hours. -This process is to begin immediately. -The Executive Director or designee will monitor to ensure process will be followed on an on going basis. -A list of residents at risk will be compiled to include reidents who wander and fall frequently. -Staff will monitor theses residents on an ongoing basis every 60 minutes.</p> <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 14, 2015.</p>	D 270		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>10A NCAC 13F .0902 Health Care</p>	D 273		

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D 273	<p>Continued From page 55</p> <p>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observation, interview, and record review, the facility failed to assure referral and follow-up to meet the acute needs for 2 of 7 sampled residents; one who fell and hit her head (Resident #2) and one with skin excoriation and an open wound (Resident #3). The findings are:</p> <p>1. Review of Resident #2's current FL-2 dated 10/15/2014 revealed: -Diagnoses included: Alzheimer's Dementia, Rheumatoid Arthritis, and a history of cervical spinal surgery. -Resident #2 was constantly disoriented. -Resident #2 was non-ambulatory and used a wheelchair. -Resident #2 resided on the memory care unit.</p> <p>Review of Resident #2's resident register revealed she was admitted on 3/16/2012.</p> <p>Interview with the Medication Aide (MA) on 4/14/2015 at 10:30 a.m. revealed: -She was counting the cart at the change of shift on 3/18/2015 at approximately 7:15 a.m. -Resident #2's roommate reported Resident #2 had fallen on the floor. -She called the Supervisor to come up and evaluate the resident. -She observed Resident #2 lying on the floor and noticed a "gash" on the resident's forehead.</p>	D 273		

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D 273	<p>Continued From page 56</p> <ul style="list-style-type: none"> -Resident #2 was placed in a sitting position, cleaned up, and put in a wheelchair. -Resident #2 was brought to the nurse's station and the family was informed of the fall "after a while". -The Supervisor put steri-strips on the " gash " . -She faxed the physician and he did not respond. - " We weren't sure if staff was to follow the policy of the former Executive Director to not send the resident out unless cleared by the Executive Director " . <p>Interview with the Supervisor (Licensed Practical Nurse) on 4/14/2015 at 12:30 p.m. revealed:</p> <ul style="list-style-type: none"> -She cleaned up Resident #2's facial wound and put steri strips on Resident #2's eyebrow. -Resident #2 seemed to be cognitively "ok" with no impairments. -The former Executive Director 1-2 months ago had told her residents do not necessarily need to be sent out to the hospital for evaluation if they hit their head even though that was the corporate policy. -The Interim Executive Director must have found out in the morning stand up meeting and said to send Resident #2 to the hospital for evaluation. <p>Review of the incident accident report dated 3/18/2015 revealed:</p> <ul style="list-style-type: none"> -The MA was informed by Resident #2's roommate that Resident #2 was on the floor at 7:30 a.m. -The facility's Supervisor (Licensed Practical Nurse) cleaned and dressed the wound on Resident #2's left eye brow. -The family was notified of the fall at 10:00 a.m. -The family was very upset and wanted to know the protocol for falls and why it took so long to notify them. -The physician was notified of the fall at 1:30 p.m. 	D 273		

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D 273	<p>Continued From page 57</p> <p>Interview with the Interim Executive Director on 4/14/2015 at 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> -She had been at the facility as the Interim Executive Director since approximately 2/24/2015. -If a resident hits their head it is the corporate policy to send them to the hospital for an evaluation. -On 3/18/2015 she found out in the morning stand up meeting with staff at approximately 9:00 a.m. Resident #2 had fallen at approximately 7:15 a.m. and hit her head. -She gave the directive to the Resident Care Director (RCD) to send Resident #2 to the hospital for an evaluation at 9:00 a.m. -The MA and the RCD were supposed to send Resident #2 out immediately for evaluation. -Staff did not send Resident #2 to the hospital until after 10:30 a.m. and she was unsure of the reason for the delay. -She was aware the previous Executive Director had informed staff that residents do not need to automatically be sent out if they hit their head and approval was needed by the Executive Director but she did not endorse this and had given the directive to send her out immediately. -The Emergency Medical chief had decided to take Resident #2 to the hospital he thought Resident #2 would be evaluated the quickest since Resident #2 had hit her head 3 hours earlier. -Staff did not ask the Emergency Medical Services what hospital Resident #2 was going to on the morning of 3/18/2015 like they should have. -The family called from one of two local hospitals to find out where Resident #2 was after being notified she had been sent. -She located the hospital Resident #2 was at the 	D 273		

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D 273	<p>Continued From page 58</p> <p>same time the family found her.</p> <p>-Resident #2 was evaluated and returned to the facility that day.</p> <p>-Resident #2 was fed tomato soup for dinner by staff.</p> <p>-Resident #2 developed vomiting, diarrhea, and a fever later in the day and was resent to the hospital despite the physician's order to check her every 30 to 60 minutes.</p> <p>Review of hospital records for Resident #2 documenting the first emergency room visit on 3/18/15 revealed:</p> <p>-Resident #2 arrived at the local hospital emergency department at 11:05am.</p> <p>-The chief complaint was documented as unwitnessed fall at facility's memory care unit. Resident was found on the floor of her room near her wheelchair. A laceration is beside the left eyebrow.</p> <p>-The laceration was repaired and no fractures were found.</p> <p>-The resident was discharged from the emergency department at 1:48pm.</p> <p>Review of hospital records for Resident #2 documenting the second emergency room visit on 3/18/15 revealed:</p> <p>-Resident #2 arrived at the local hospital emergency department at 10:58pm.</p> <p>-The chief complaint was documented as patient presents with complaints of nausea, vomiting, diarrhea and fever of 102 today.</p> <p>-Resident #2 was admitted to the hospital on 3/18/15, discharged on 3/24/15 to palliative care at the Hospice Center, and died on 3/30/2015.</p> <p>2. Review of Resident #3's current FL2 dated 4/7/15 revealed:</p>	D 273		

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D 273	<p>Continued From page 59</p> <ul style="list-style-type: none"> - Diagnoses included chronic back pain, depression, chronic heart failure, hypertension and pulmonary embolism. - Resident was incontinent of bladder. <p>Review of Resident #3 ' s Resident register revealed she was admitted to the facility 5/30/14.</p> <p>Review of Resident #3's care plan dated 4/7/15 revealed:</p> <ul style="list-style-type: none"> - Resident toilets self during the day - Resident needs encouraging and prompting for toileting at times. <p>Observation of Resident #3 on 4/8/15 at 11:30am revealed:</p> <ul style="list-style-type: none"> - Resident was in the bathroom being toileted by the personal care assistant (PCA). - Resident ' s buttocks and upper thighs were deep pink/ purple in color and had multiple ridges of excoriation with an open bleeding stage 2 pressure ulcer about ¾ of an inch long on the right upper thigh, just below the buttock and another ridge that looked as if it would open just above it. <p>Interview with the Licensed Practical Nurse (LPN) on 4/8/15 at 11:50am revealed:</p> <ul style="list-style-type: none"> - She had not assessed Resident #3 ' s skin, but there are skin assessment sheets that are done and kept in a binder for each resident every week. - Resident is also able to toilet herself and apply the Endit cream to her bottom. <p>Interview with the PCA on 4/8/15 at 12:45pm revealed:</p> <ul style="list-style-type: none"> - Resident ' s bottom looks much better than it had been looking. - She was aware of the open area on Resident 	D 273		

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D 273	<p>Continued From page 60</p> <p>#3 ' s bottom and she reported it to the Resident Care Director (RCD) last Friday.</p> <ul style="list-style-type: none"> - The PCAs and LPNs apply cream to Resident ' s bottom every time they toilet her. <p>Interview with LPN #2 on 4/8/15 at 4:00pm revealed:</p> <ul style="list-style-type: none"> - Most of the time Resident #3 toilets herself and applies Endit cream, A&D ointment and nystatin powder to her bottom herself. - Resident #3 is not being seen by home health at this time. - She was seen by a home health skilled Nurse from 9/5/14 through 10/4/14, for excoriation to her buttock. - She had not seen Resident ' s bottom lately. - She is not aware of any open areas on Resident ' s bottom. - Skin assessments are done on every resident once a week at shower time and documented on skin integrity monitoring sheets. - She was unable to find any skin assessment dated after 1/25/15 in the binder or Resident record. <p>Review of documentation on the skin integrity monitoring sheets for Resident #3 revealed:</p> <ul style="list-style-type: none"> - Skin assessments had been completed for Resident #3 through 1/25/15. - Skin assessment dated 1/25/15,documented Resident had topical creams to buttock area of redness. - The column labeled "improving yes/no" had only a checkmark. - There was no description noted for the area of redness. - Skin assessment dated 1/21/15, the picture to describe the location of the area was circled around the perineum and redness was circled with a comment; home health nurses treated 	D 273		

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D 273	<p>Continued From page 61</p> <p>excoriated skin still red.</p> <p>Interview with LPN #2 on 4/8/15 at 5:00pm revealed:</p> <ul style="list-style-type: none"> - She just assessed Resident #3 ' s bottom. - She saw an opening about ½ inch or so on Resident ' s right upper thigh and ridges and excoriation on both upper thighs and lower buttock. - She will fax the physician and get a skilled Nurse consult. - Resident had not been seen by a skilled Nurse since October 2014. <p>Interview with the Resident Care Director (RCD) on 4/8/15 at 5:15pm revealed:</p> <ul style="list-style-type: none"> - She is responsible for reviewing orders and supervising direct care staff, assessments and monitoring. - The medication aides and LPNs do skin assessments on every resident, every week and place the documentation in a binder. - She does not know when the last skin assessment was done on Resident #3. - No one told her Resident #3 had any open areas on her bottom. - The MA or LPN should be applying the creams to Resident #3 ' s bottom. <p>Interview with the Interim Executive Director on 4/8/15 at 5:50pm revealed she was not aware of the skin issues with Resident #3.</p> <p>Review of Nurse ' s note on 4/9/15 for Resident #3 revealed:</p> <ul style="list-style-type: none"> - She was seen by a home health skilled Nurse on 4/9/15. - Resident was treated for 2 areas on her leg/buttock. - Resident to be toileted every 2 hours and 	D 273		

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D 273	<p>Continued From page 62</p> <p>staff placing Endit cream and vitamin A&D ointment on the area.</p> <p>Attempts to contact Resident #3 ' s physician for an interview was unsuccessful.</p> <hr/> <p>Review of the facility's plan of protection dated 4/10/2015 revealed:</p> <ul style="list-style-type: none"> -Any referral that comes into the community will be documented on a communication log which will be checked daily by the Executive Director or designee. -The use of the communication log and the process will be inserviced to the team effective immediately. -The above process will be continued on an ongoing basis. -The Supervisor will document all orders on the communication log. -The Executive Director will follow up for accuracy or the designee of the Executive Director. <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2015.</p>	D 273		
D 286	<p>10A NCAC 13F .0904(b)(1) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes:</p> <p>(1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews, the facility</p>	D 286		

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D 286	<p>Continued From page 63</p> <p>failed to provide sufficient staff and equipment for safe and sanitary food service.</p> <p>The findings are:</p> <p>The facility census on 4/7/15 was 89 residents. The Assisted Living census was 55 residents, the Memory Care census was 34 residents.</p> <p>1. The facility failed to ensure that sufficient equipment, a sanitizable, stable lap tray table, hospital bed tray table, or table and chair, was provided for residents who chose to eat in their rooms.</p> <p>A. Confidential interview with family members of Memory Care residents revealed:</p> <ul style="list-style-type: none"> - No portable tables or TV tray tables were provided by the facility. - Requests for a table and chair to use for eating and other activities were denied; staff stated resident rooms were too small to accommodate additional permanent furniture. <p>Observation of a family member's cell phone pictures taken February 2015 (during a norovirus outbreak) revealed:</p> <ul style="list-style-type: none"> -A plate sitting in an upholstered chair instead of on a table, in front of a seated resident in the residents' room. <p>Observation on 4/7/15 at 11:45am revealed:</p> <ul style="list-style-type: none"> - The noon meal was served in the Memory Care unit. -On 4/7/15 at 12:20pm, Resident #8 was sleeping in a recliner in her room. - On 4/7/15 at 12:25pm, Resident #9 was sleeping in bed. - Resident #9's lunch plate was untouched and uncovered sitting on seat of rollator along with a 	D 286		

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D 286	<p>Continued From page 64</p> <p>glass of tea and water.</p> <ul style="list-style-type: none"> - There was no table and chair in the room for safe, comfortable food service. <p>Interview with the Memory Care Director on 4/7/15 at 12:28pm revealed she had no knowledge of any residents in memory care who eat in their rooms.</p> <p>Interview with the Interim Executive Director on 4/10/15 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - The facility did not have/offer individual tables or hospital bed tables for residents to use when dining in their room, as the facility was an assisted living. -Bedside tables were associated with a higher level of care. <p>Observation on 4/13/15 at 12:15pm revealed a hospital tray table located in Room 230, an unoccupied room, on the Memory Care Unit.</p> <p>Interview with a Personal Care Aide on 4/13/15 at 12:30pm revealed she was not aware the facility had a hospital tray table, stating "we never used this."</p> <p>B. Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> - She would like to have a small table in her room so she could eat meals in her room comfortably. - She sat in a chair and had to hold the plate with one hand and an eating utensil or a beverage with the other hand. - She felt it was clumsy for her to not have a table where she could keep her plate, eating utensils, and beverages within easy reach during the meal. - "I only have two hands, I need three to hold my plate, cup, and [eating utensil] during meals. I end up putting the cup on the floor or on my bed". 	D 286		

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D 286	<p>Continued From page 65</p> <p>Interview with a PCA on 4/8/15 at 1:00pm revealed:</p> <ul style="list-style-type: none"> - The facility had no TV trays or hospital bed tray tables available for use by residents when they ate meals in their rooms. - Residents were encouraged to take all meals in the dining room. - Some residents brought their own TV tables to use for activities such as crafts and eating meals. <p>2. The facility failed to provide sufficient staff to meet the requests and needs of residents for additional food, beverages, and tableware during mealtimes; timely food service; timely feeding assistance; and monitoring and assistance for residents' safe meal consumption.</p> <p>A. Interview with the personal care aides (PCAs) in the Memory Care Units on 4/8/15 at 12:10pm revealed:</p> <ul style="list-style-type: none"> - They were busy encouraging residents to clean hands and to sit at the table for the meals, setting up the meal, encouraging meal intake, supervising safe food intake, replacing dropped utensils, and cleaning up after residents during meal times. - They sat next to the residents who required extensive feeding assistance and supervision during meal times. - They were aware they should not leave the dining room during meal times or attend to other residents needs for assistance in other areas of personal care, but there was not enough staff to attend to all 34 residents during meals. - One PCA stated she spent meal times making sure residents stayed in the dining room, received their food and did not wander away from the dining area during meals. - One PCA stated they could use four PCAs in each of the two dining rooms on the Memory 	D 286		

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D 286	<p>Continued From page 66</p> <p>Care Unit, in order to serve meals in a timely and safe manner.</p> <p>Observation on 4/8/15 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - Three PCAs were observed to work during the noon meal on the Memory Care Unit with a census of 34 residents. - Two residents had family members sit with them and assist in feeding. - One resident was served the meal at 12:15pm, and a PCA began feeding the meal to the resident at 12:35pm. The bottom of the plate was cool to touch. <p>Based on observation, interview and record review, Memory Care residents were not interviewable.</p> <p>B. Observation of dinner meal in the Assisted Living dining room on 4/8/15 at 5:10pm revealed:</p> <ul style="list-style-type: none"> -Nine of 40 residents had a beverage. -Some residents were still waiting on their meal while some residents had completed their meal without having a beverage. -Residents were agitated, asking surveyor for assistance. <p>Interview with a personal care aide (PCA) on 4/8/15 at 5:20pm in the Assisted Living dining room revealed:</p> <ul style="list-style-type: none"> -The PCA was responsible for helping in dining room with serving beverages and getting plates out to residents. -The PCA could not help in dining room during dinner meal on 4/8/15 due to assisting a resident in the bathroom. -The PCA was with the resident for about 30-45 minutes. -The PCA was the only aide working downstairs in the Assisted Living halls. 	D 286		

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D 286	<p>Continued From page 67</p> <p>Observation on 4/9/15 from 4:30pm to 6:00pm in the Assisted Living dining room revealed:</p> <ul style="list-style-type: none"> - Several residents waved to the dietary aides and PCAs or spoke up to try to get their attention. - The staff were not consistently in the dining room to respond to verbal requests and to waving and other body language by residents. <p>Observation on 4/9/15 from 4:30pm to 6:00pm in the Assisted Living dining room revealed: - Five residents were observed to exit the dining room before they were served their dessert.</p> <ul style="list-style-type: none"> - None of the five residents returned to the dining room during the meal service to be served dessert. <p>Confidential interviews with two of the five residents who exited the dining room early revealed:</p> <p>They were served their main meal at the beginning of the meal period.</p> <ul style="list-style-type: none"> - They assumed the dessert was not available, since it was not served with the other foods. <p>Observation on 4/9/15 from 4:30pm to 6:00pm in the Assisted Living dining room revealed:</p> <ul style="list-style-type: none"> -One non-ambulatory resident requested coffee when she was served her plate of food at 4:45pm. - The PCA pointed to the two 12-ounce cups of water and iced tea at her place setting. - The resident continued to wave her arms throughout the meal, repeating asking the staff to get her coffee during the meal as they passed by her. <p>At 5:20pm a PCA served a cup of coffee to the resident, after the PCA cleared her place setting.</p> <p>Random observations during the evening meal in</p>	D 286		

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D 286	<p>Continued From page 68</p> <p>4/9/15 revealed:</p> <ul style="list-style-type: none"> - From 4:30pm to 5:00pm on 4/9/15, Dietary Aides worked in the kitchen, coming out to the Dining Room only to deliver plates of food to residents. - No plates of food were delivered to residents from 5:00pm to 5:15pm. - Only one PCA was circulating in the dining room with beverages. - Two PCAs sat next to residents who required hands-on assistance with feeding. - One family member sat with a resident, stating she came daily to feed the resident dinner. She complained the meal was almost an hour late today [4/9/15]. - Dietary aides delivered plates of food when the Dietary Manager returned from a Management meeting and entered the kitchen. - There appeared to be no one in charge of the kitchen when the Dietary Manager was not there. - Two dietary aides stated they worked in the kitchen, were only in the dining room to deliver plates of food to residents. <p>Confidential interviews with six additional residents revealed:</p> <ul style="list-style-type: none"> - They were dissatisfied with the lack of condiments available to them during meal times. - The staff moved on to serve other residents in other areas of the large dining room. <p>Confidential interviews with three of six residents revealed:</p> <ul style="list-style-type: none"> - They would like second helpings, but observed the staff was too busy to get them additional food. - They "did not bother" the staff with requests for second helpings when the staff appeared to be busy getting the meal out to everyone or assisting a resident with feeding. - "There is not enough staff in the building to take 	D 286		

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D 286	<p>Continued From page 69</p> <p>care of us properly".</p> <ul style="list-style-type: none"> - Three of six residents stated they were unable to talk very loudly, and the facility staff appeared to not hear them when they requested additional food and beverages. - One of six residents stated he was slow and unsteady on his feet, and could not easily walk to the dining room to get served at the same time as his tablemates. He preferred to get to meals late, as staff seemed less busy at the end of the meal. He did not want to ask for assistance in getting to the dining room. <p>Confidential interview with one of six residents interviewed revealed:</p> <ul style="list-style-type: none"> - She liked to have coffee with all her meals and snacks. - She stated she rarely received a beverage during snack times, and needed a beverage to help her consume her snack foods. - She stated she knew the staff was busy, and she had to wait to have her requests for beverages met. - She stated sometimes she had to wait until all other residents had exited the dining room before she received a beverage. <p>Interview with the Resident Care Coordinator (RCC) at 3:30pm on 4/10/15 revealed:</p> <ul style="list-style-type: none"> - She was not aware the staff were not fulfilling personal requests for additional food, beverages, and assistance during meals. - She stated she heard no complaints from residents about service during the meals. - The facility tried to meet staffing guidelines set by the company who owned the facility. - She rarely observed resident meals. 	D 286		

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D 287	Continued From page 70	D 287		
D 287	<p>10A NCAC 13F .0904(b)(2) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes:</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure residents had table service during meals and at snack times that included a napkin and non-disposable place settings consisting of at least a knife, fork, spoon, plate, and beverage containers appropriate for the foods served.</p> <p>The findings are:</p> <p>1. Observations of table service in the Memory Care Unit on 4/7/15 revealed:</p> <ul style="list-style-type: none"> - At 12:55pm, Resident #8 was at table in dining room eating food from a disposable plate. - At 5:00 p.m. revealed 1 resident's meal was served on a disposable styrofoam plate. <p>Interview with the Interim Executive Director on 4/7/15 at 12:55 p.m. revealed:</p> <ul style="list-style-type: none"> - She asked the PCA why Resident #8's food was in a disposable plate. - The PCA reported someone had thrown Resident #8's food out and the kitchen sent a disposable plate up to the memory care unit. 	D 287		

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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 287	<p>Continued From page 71</p> <p>Confidential interview with a resident's family member revealed:</p> <ul style="list-style-type: none"> - It was not unusual to get meals served on a disposable styrofoam plate. - This usually occurred when a resident was having a meal delivered to their room. - It seemed that between-meal beverages were offered in Styrofoam cups. <p>Based on record review and observations, Memory Care Unit residents were determined not to be interviewable.</p> <p>Observation of the noon meal on 4/8/15 and on 4/13/15 in the small Memory Care dining room revealed residents were given only a spoon for eating.</p> <p>Confidential interviews with staff and family members revealed:</p> <ul style="list-style-type: none"> - They were afraid Memory Care residents could use knives and forks as a weapon. - They were afraid Memory Care residents could injure themselves when using a fork or butter knife. - Staff and family members would be more careful than the residents when using a fork or butter knife to help a resident eat safely. - Residents were denied the opportunity to use their self-feeding skills with a fork and knife, and were denied self-feeding until it was shown they were able to use a fork or butter knife safely. <p>Interview with the Memory Care Director at 12:30pm on 4/8/15 revealed:</p> <ul style="list-style-type: none"> - She did not realize all residents were to be provided a fork, spoon, and knife. - She was not aware that cognitively impaired residents should get all utensils unless identified in the resident's Care Plan that the utensil should 	D 287		

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D 287	<p>Continued From page 72</p> <p>not be received.</p> <p>Refer to confidential interviews with dietary staff.</p> <p>Refer to interview with the Interim Executive Director on 4/7/15 at 12:55 p.m.</p> <p>Refer to interview with the Dietary Manager on 4/9/15 at 5:40pm.</p> <p>2. Observations in the Assisted Living Unit during the 4/9/15 evening meal revealed:</p> <ul style="list-style-type: none"> - The Dietary Manager was not present in the kitchen or dining room during the first 45 minutes of the meal. - Dessert was served to fifteen residents in a Styrofoam bowl. - Three residents did not have butter knives, only forks and spoons at their place setting. - Three residents complained that they were unable to cut up food into smaller pieces for ease of chewing and spearing with a fork, and to prevent picking up large pieces of food, such as meat and sandwiches, with their hands. - Three residents complained that the large pieces of crisp vegetables and whole sandwiches served for dinner were not easily eaten without being cut into smaller pieces. - Two of the three residents missing a butter knife residents gave up eating until a staff member got them dining utensils 45 minutes after the start of the meal. - One resident stated the food was too tough and cold, so she would go to her room and eat some snacks out of a vending machine or from the nurses station snack basket. - Dietary Aides delivered plates to 10 residents by 5:00pm. They did not serve the remaining plates of food until the Dietary Manager returned to the kitchen at 5:15pm. 	D 287		

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D 287	<p>Continued From page 73</p> <ul style="list-style-type: none"> - Fourteen residents did not receive any beverages until 5:30pm. <p>Interview on 4/9/15 at 6:00pm with the PCA who was serving beverages at that meal revealed she had to provide personal care to a resident from 5:00pm to 5:30pm, and there was no other PCA available to take her place in the dining room at that meal.</p> <p>During the 4/13/15, noon meal, a dietary aide served one resident his beverage in a lidded Styrofoam cup at 1:15pm.</p> <p>Interview with a dietary aide at 1:20pm on 4/13/15 revealed:</p> <ul style="list-style-type: none"> - She knew the resident liked to carry a beverage back to his room if s/he ate a meal all alone. - She thought the lidded cup would prevent spillage as the resident returned to his/her room. <p>.Confidential interviews with two residents of the Assisted Living Unit revealed:</p> <ul style="list-style-type: none"> - Residents' meals were usually served on a disposable styrofoam plate if they ate in their room. - Residents eating in their room usually got the meal at least 30 minutes after food service for a meal was supposed to occur. - This had been going on for months. <p>Refer to confidential interview with dietary staff.</p> <p>Refer to interview with the Interim Executive Director on 4/7/15 at 12:55pm.</p> <p>Refer to interview with the Dietary Manager on 4/9/15 at 5:40pm.</p>	D 287		

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D 287	<p>Continued From page 74</p> <p>Confidential interview with dietary staff revealed:</p> <ul style="list-style-type: none"> - Paper products were used because of "convenience, to save time" . - Paper products were used because they were accessible during the meal delivery. - They had not been told not to use disposable products. - No one person was put in charge of food service while the Dietary Manager was absent. <p>Interview with the Interim Executive Director on 4/7/15 at 12:55 p.m. revealed Styrofoam and paper products were not supposed to be used during meal service.</p> <p>Interview with the Dietary Manager on 4/9/15 at 5:40pm revealed:</p> <ul style="list-style-type: none"> - She was attending a management meeting during the first 45 minutes of the meal. - The dietary staff were supposed to use non-disposable dishes. - The facility had plenty of regular tableware, silverware, and non-disposable beverage containers available. - More staff is needed to serve residents their meals. - Dietary aides work in the kitchen, set up place settings in the dining room, and serve plates to residents in the main dining room. - A PCA is to circulate in the dining room and serve beverages. - PCAs are assigned to help residents who need assistance with feeding. - She stated more staff is needed in order to serve resident needs in the resident rooms and in the dining room. - Too often "staff is stretched, PCAs must attend to [activities of daily living] in the resident rooms, and were also assigned to work in the dining 	D 287		

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D 287	Continued From page 75 room at the same time". - Dining services tried to be flexible about resident meal times and last-minute food preferences, it is difficult to meet all their needs and preferences with a small staff.	D 287		
D 298	<p>10A NCAC 13F .0904(d)(2) Nutrition And Food Service</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure food and beverages were offered or made available to all residents as snacks between each meal for a total of three snacks per day for all 89 residents residing in the facility.</p> <p>The findings are:</p> <p>Review of the facility's daily menu posted in the kitchen on 4/7/15 revealed: - The menu developed by the Registered Dietitian listed three meals and one snack daily to be served to the residents.</p> <p>Observation on 4/8/15 from 8:30am until 5:30 pm on the Assisted Living Unit revealed: -There were no snacks served to the residents. -Two residents were observed to request a snack from the Medication Aide (MA) on the first floor,</p>	D 298		

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D 298	<p>Continued From page 76</p> <p>on the Room 100-120 Hall at 10:30am.</p> <ul style="list-style-type: none"> - The MA offered them a packet containing two graham cracker squares. <p>The residents accepted the crackers and took them back to their room.</p> <ul style="list-style-type: none"> - No beverage was offered to the residents. <p>Interview with the Medication Aide at 2:30pm on 4/8/15 revealed:</p> <ul style="list-style-type: none"> - The kitchen staff stocked a large tray basket with an assortment of regular and sugar-free cookies and crackers. - The large tray basket was stored behind the counter in the nurses' station, not directly accessible to residents unless by request. - The types of snacks were rotated, but they were all prepackaged, individual servings of snack items. - The kitchen prepared sandwiches for the MAs to give to diabetic residents as an evening snack. - Other residents were not offered sandwiches as an evening snack. - Residents must come to the nurses' station to request a snack. - Facility staff did not offer a snack to all residents three times daily. - No beverages were served by the facility to go along with the snacks. - Fruit or juice was not offered as a snack. - Residents often bought their own snacks or their family provided snacks for them to keep in their room. <p>Confidential interviews on 4/9/15 with twelve residents revealed:</p> <ul style="list-style-type: none"> - Snacks were not served three times daily. - Three of twelve residents interviewed did not know how many snacks were served but reported they got enough to eat. - Two of twelve residents interviewed reported 	D 298		

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D 298	<p>Continued From page 77</p> <p>they were "always hungry".</p> <ul style="list-style-type: none"> - Two of twelve residents interviewed reported if they asked for a snack, the MA stated, "you don't need it now, lunch or supper is coming up" or "I don't have time now, but I will get with you later". - Two of twelve residents interviewed stated they would like a variety of snacks to be provided to them, along with some of the facility activities. - Two of twelve residents interviewed requested snacks other than store-bought packets of crackers, pretzels, cookies and ice pops. They stated fresh fruit such as bananas, ice cream, and desserts were favorites here. - Two of twelve residents interviewed stated beverages needed to be offered with snacks, they need a beverage with snacks. - One of twelve residents interviewed stated "The diabetics get a whole sandwich, I just get a few cookies with nothing good to drink. I asked for a sandwich once when my roommate got one, and was told 'No'." - One resident asked for a sandwich one afternoon. She stated she got a sandwich as an evening snack, and asked that it be served earlier to her that day. She stated the MA tossed her a small packet of graham crackers. She stated she was highly insulted, she was not an animal begging for a treat. She did not like the MA deciding for her what she wanted for a snack. - One of twelve residents interviewed requested and received cookies for snacks every day, and stated she would like the facility to provide coffee to go with them. - One resident of twelve residents stated she bought her own snacks. - One of twelve residents stated she had never asked for a snack. "No one asks". - None of the twelve residents were aware the facility was required to provide or offer snacks 3 times a day. 	D 298		

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D 298	<p>Continued From page 78</p> <p>Interview with the Dietary Manager on 4/9/15 at 3:00pm revealed:</p> <ul style="list-style-type: none"> - She was not aware snacks were not being served to the residents three times daily. The kitchen provided the snacks, the floor staff were responsible for giving out the snacks. - She was aware most residents had their own stash of favorite snacks, most residents had a refrigerator in their room for beverages. - No residents had voiced concerns or complained about being hungry or not having snacks available to her. - There was currently no system in place for monitoring to ensure snacks were being served three times daily. - She would review the facility menus to ensure three snacks were planned for each day for all regular, modified texture, and therapeutic diets - Registered Dietitian would be notified that the snack menu had to be changed from two to three snacks per day. - The Registered Dietitian Consultant for the facility would need to sign off on revised therapeutic menus to ensure snack offers met health and safety standards for therapeutic diets. <p>Further interview with the Dietary Manager on 4/13/15 at 11:00am revealed:</p> <ul style="list-style-type: none"> - Snack foods were not placed out in the open or made available for self serve because some residents would take more than they needed and others would eat snacks that were not appropriate for their diet. - Observation of resident rooms by facility staff revealed some residents were taking multiple snacks and were "hoarding" them in their room. - Snack food cost have increased in the past year, so the facility will now have PCAs offer every resident one snack three times daily. 	D 298		

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D 298	Continued From page 79 - Snacks were going to be offered three times daily from now on by nursing staff. Review of the facility's monthly menu, posted on each dining table in the Assisted Living units revealed no snacks were listed on the menus.	D 298		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve water with each meal to each resident. The findings are: 1. Observation of the noon meal to 34 residents in the Memory Care Unit on 4/8/15 from 11:30am to 1:00pm revealed: - Seven residents were not offered water along with another beverage during the meal. - Four of the seven residents received additional iced tea as a beverage. - No resident was heard to make a verbal request for beverages. - Residents were not all seated at one time in the two dining rooms in the Memory Care Unit. Confidential interviews with 2 staff revealed: - Keeping residents well hydrated was a major	D 306		

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D 306	<p>Continued From page 80</p> <p>priority in the Memory Care Unit..</p> <ul style="list-style-type: none"> - Residents were not very verbal, but expressed thirst through body language, and reaching for beverages. - Residents "drank more when fluids had a taste", they drank sweet beverages better than water. <p>Interview with the Memory Care Director at 12:30pm on 4/8/15 revealed:</p> <ul style="list-style-type: none"> - She did not realize all residents were to be offered a beverage of choice plus water. - She had not heard a resident ask for water. - They offered ice pops at snack times to keep residents well hydrated, residents enjoyed them. <p>2. Observation of the noon meal to 40 residents in the Assisted Living Unit on 4/8/15 from 11:30am to 1:30pm revealed:</p> <ul style="list-style-type: none"> - Twelve residents were not offered water along with another beverage during the meal. - Four of the twelve residents who did not receive water requested and received additional iced tea as a beverage. - One of the twelve residents who was not offered water made a verbal request for water. - Residents were not all seated at one time in the Assisted Living Unit dining room. <p>Confidential interviews with five of twelve residents interviewed revealed:</p> <ul style="list-style-type: none"> - They preferred to have water available at their place setting at the beginning of their meal service. - They were not offered water as part of meal service. <p>Confidential interviews with two of twelve residents interviewed revealed they did not care for iced tea, the PCAs knew to offer them water.</p>	D 306		

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D 306	<p>Continued From page 81</p> <p>Confidential interviews with two of twelve residents interviewed revealed they had asked for water as a beverage with meals, and did not receive water without asking for it.</p> <p>Confidential interviews with one resident of twelve residents interviewed revealed:</p> <ul style="list-style-type: none"> - She did not want water with all meals, the water tasted terrible. - She reprimanded staff for pouring water for her, told them to remove it from her place setting. - She complained there were too many beverage containers on tables at meal times. <p>Interview with the Dietary Manager on 4/9/15 at 5:15pm revealed:</p> <ul style="list-style-type: none"> - She was not aware that all residents had not received water with their meals. - She knew water should be part of resident meals. - A facility PCA was to circulate in the dining room at mealtimes and fill beverage requests. - Dietary aides under her direct supervision did not pour water or offer beverages. <p>Confidential interviews with two PCAs dining room revealed:</p> <ul style="list-style-type: none"> - They had PCA duties on their assigned hallway during her shift, and then must shift gears and cover the dining room to serve beverages during meals. - Sometimes a resident on their assigned hallway needed assistance, and they must attend to them during meal times instead of serving beverages. - At least 1 aide was needed to circulate in the dining room during the entire meal to attend to beverage requests of residents. - They were unaware of the requirement that water be served to each resident at each meal. 	D 306		

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D 358	Continued From page 82	D 358		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews, observations and record review, the facility failed to assure medications and treatments were administered as ordered for 4 of 9 sampled residents (#1, 5, 10 and 11). The findings are:</p> <p>1. Review of Resident #5's current FL-2 dated 4/6/15 revealed the following:</p> <ul style="list-style-type: none"> - Diagnoses of dementia, post-inflammatory pulmonary fibrosis, osteoarthritis, glaucoma, thoracic aneurysm and aortic regurgitation. - Orders for Budesonide suspension, 0.5mg/2. 1 vial via nebulizer 2 times a day (used to treat symptoms of pulmonary fibrosis); Ipratropium solution 0.02%, use every morning along with Budesonide via nebulizer (used to treat symptoms of pulmonary fibrosis). <p>Review of a physician's order dated 3/30/15 revealed oxygen at 2 - 3 liters via nasal cannula ordered as needed for shortness of breath/comfort.</p>	D 358		

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D 358	<p>Continued From page 83</p> <p>Review of Resident #5's medication administration record (MAR) for February, March, and April 2015 revealed the following:</p> <ul style="list-style-type: none"> - The resident's Budesonide nebulizer treatment was scheduled for 8:00am and 6:00pm every day and documented as administered at 8:00am and 6:00pm. - The resident's Ipratropium nebulizer treatment was scheduled for 9:00am (use every morning along with Budesonide via nebulizer) and documented as administered with Budesonide at 8:00am. <p>Observation made on 4/10/15 at 10:25am revealed the following:</p> <ul style="list-style-type: none"> - Resident #5 was sitting up in room and receiving a nebulizer treatment. - At 10:35am, the resident complained of left chest discomfort while receiving nebulizer treatment. - At 10:39am, the private sitter turned the nebulizer machine off and removed mask. The resident asked the sitter to assist him to bed. - At 10:42am, the MA and PCA came in the resident's room and assisted him to bed, took vital signs, applied oxygen via nasal cannula and started the oxygen concentrator at 2 liters per minute. <p>Interview with Resident #5's private sitter on 4/10/15 at 10:25am revealed the following:</p> <ul style="list-style-type: none"> - The private duty sitter had started providing services for Resident #5 on Tuesday (4/7/15) and duties included assisting the resident with his bath, dressing, and shaving, assisting to bathroom, change incontinent briefs and transfers. - The sitter was assisting the resident with his bath when the MA came in earlier (around 8:45am) with the resident's medications and 	D 358		

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D 358	<p>Continued From page 84</p> <p>breathing treatment.</p> <ul style="list-style-type: none"> - The MA came back to the resident's room and administered the resident's morning medication at 10:20am and started the resident's nebulizer treatment - The MA usually administered the resident's morning medications between 8:30am and 9:00am. - The nebulizer usually takes about 10-15 minutes to complete and "I [the sitter] always stop the machine and remove the mask". - Once the MAs started the nebulizer treatment, they never come back to check on the resident while receiving the treatment. - If the resident needed oxygen started due to "breathing problems (breathing too hard or shortness of breath), I put it on". - The private sitter stated she did not know how many liters of oxygen the resident was ordered, but she just "applied the cannula and turned the oxygen on". - I don't tell the staff, but sometimes they do come in and look at the oxygen concentrator and ask if the resident was short of breath. <p>Interview with the 1st shift MA on 4/10/15 at 4:15pm revealed the following:</p> <ul style="list-style-type: none"> - Resident #5 was getting a bath when I came in to administer his 8:00am and 9:00am medications nebulizer treatment. - The MA stated she came back later (after 10:00am) and administered the resident's morning medications and started his nebulizer treatment (both Budesonide and Ipratropium). - The MA stated according to the facility's medication administration policy, medications and treatments were to be administered 1 hour before to 1 hour after scheduled times on MAR's. - The sitter usually turned the nebulizer machine off when finished. 	D 358		

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D 358	<p>Continued From page 85</p> <ul style="list-style-type: none"> - The MA did not know if the private duty sitter was trained to operate a nebulizer machine. - The MA stated the private duty sitter started and stopped the resident's oxygen (example- if resident was taken to bathroom or to dining room for meals). - The MA did not know if the private duty sitter was trained to administer oxygen therapy, but was aware the the private duty sitter did apply the nasal cannula and started/stop the resident's oxygen as needed. <p>Interview with the Interim Executive Director on 4/10/15 at 4:50pm revealed the following:</p> <ul style="list-style-type: none"> - The facility's policy for medication/treatment administration was always administer medications/treatments 1 hour before or 1 hour after scheduled times on the resident's MAR. - Medication and treatment administration was the duty of the facility's MA and should never be done by a private sitter. - The facility "will fix these things". <p>Interview with the Resident #5's family member on 4/14/15 at 12:04pm revealed the following:</p> <ul style="list-style-type: none"> - The family member was aware the resident was often short of breath and required oxygen therapy and nebulizer treatments. - The family member was not aware the private duty sitter was removing the nebulizer treatment mask or starting the resident's oxygen. - The family member stated the facility's MA's or nurses should be providing all ordered treatments. <p>2. Review of Resident #1's FL-2 dated 1/19/15 revealed diagnoses which included Alzheimer's Dementia, Hypertension, Immobility, and D/T Chronic back pain.</p>	D 358		

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D 358	<p>Continued From page 86</p> <p>Review of Resident #1's record revealed: -The facility made contact with the physician on 1/2/15 indicating the residents' buttocks was getting red and asked if an order for cream could be obtained. -A physician's order to apply Endit Cream daily was given on 1/2/15 . -There was not an order to discontinue the Endit Cream prior to the FL-2 dated 1/19/2015. -The order for Endit Cream was not on the current FL-2.</p> <p>Review of Resident #1's Medication Administration Records (MAR) for January 2015, February 2015, March 2015, and April 2015 revealed Endit was not listed as a medication.</p> <p>Interview with Pharmacist on 4/9/15 at 11:00 a.m. revealed the pharmacy does not have an order for Endit Cream, therefore it would not be on MAR and dispensed to facility.</p> <p>Interview with MA on 4/9/15 at 11:20 a.m. revealed: -Resident #1 has no irritation on her bottom requiring use of Endit Cream. -MA had never used Endit Cream on Resident #1. -She had no knowledge of the physician's order on 1/2/15 order for Endit Cream.</p> <p>Interview with nurse at Resident #1's physician office on 4/9/15 at 3:35 p.m. revealed: -The facility contacted physician on 1/2/15 about Resident #1's buttocks being red. -Order for Endit Cream given on 1/2/15. -No other concerns of buttock being red after 1/2/15. -Endit Cream should have been listed on 1/19/15 FL-2 since no discontinue order was given for Endit Cream.</p>	D 358		

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D 358	<p>Continued From page 87</p> <p>-The physician was not aware Endit Cream was not administered to Resident #1 as the intent was for facility to apply Endit Cream daily when the order was given.</p> <p>Interview with Personal Care Aide (PCA) on 4/9/15 at 3:50 p.m. revealed: -Resident #1 had a little redness on bottom. -She should have reported the redness to MA. -She was not aware of any cream applied to Resident #1's bottom.</p> <p>Observation of Resident #1's bottom on 4/9/15 at 4:00 p.m. revealed the resident had some irritation her bottom which was pinkish/red in color.</p> <p>Interview with MA on 4/9/15 at 4:15 p.m. revealed: -She had no knowledge of skin irritation on Resident #1's bottom. -She had never has applied Endit Cream on Resident #1. -Endit cream was not on MAR. -The facility nurse is responsible for sending orders to pharmacy.</p> <p>Interview with Licensed Practical Nurse (LPN) on 4/9/15 at 4:45 p.m. revealed: -The physician's order was not sent to pharmacy if the medication is not listed on the MAR. -Sending orders to the pharmacy is the responsibility of the nurse. -Endit Cream order will be sent to pharmacy.</p> <p>Fax confirmation sheet to pharmacy attached to 1/2/15 Endit Order is dated 1/20/15.</p> <p>Observation on 4/13/15 at 3:15 p.m. revealed: -Endit Cream was on hand with instructions to</p>	D 358		

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D 358	<p>Continued From page 88</p> <p>apply to affected area every day. -Endit Cream was opened and had been used. -Endit Cream was dispensed to facility on 4/10/15.</p> <p>3. Review of Resident # 10's current FL-2 dated 2/3/2015 revealed diagnoses which included: history of falls with syncope, fractured left humerous, Encephalopathy, unspecified, Hypertension, diffuse Osteopenia, and cardiac arrhythmia.</p> <p>Review of Resident #10's record revealed medications which included Tylenol 325 mg, take 2 tablets three times a day for pain.</p> <p>Observation on 4/8/2015 at 11: a.m. revealed the MA for the small memory care hall and the second floor assisted living hall finished passing her 9:00 a.m. medications at 10:55 a.m.</p> <p>Interview with MA passing medications for the small memory care hall and the second floor assisted living on 4/8/2015 at 11:05 revealed: -She passed 9:00 a.m. medications to 5 residents in assisted living from 10:00 a.m. to 11:00 a.m. which included Resident #10 who had medication ordered three times daily. -She realized that the 9:00 a.m. medications could be given between 8:00 a.m. and 10:00 a.m. but she was unable to accomplish this with the number of residents who had 9:00 a.m. medications scheduled. -Resident #10 received his scheduled 9:00 a.m. Tylenol late between 10:00 a.m and 11:00 a.m. that day.</p> <p>4. Review of Resident #11's current FL-2 dated 8/6/2015 revealed diagnoses which included: mild dementia, urinary urgency, depression,</p>	D 358		

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D 358	<p>Continued From page 89</p> <p>osteoporosis, esophageal reflux, history of back surgery for a disk, history of bilateral hip surgeries, chronic back pain, and right hip trochanteric bursitis.</p> <p>Review of Resident #11's record revealed medications which included: Hydroco/APAP (Vicodin) tab 5-325 mg three times a day, and MAPAP (acetaminophen) 325 mg three times a day with each Vicodin dose.</p> <p>Interview with MA passing medications on 4/8/2015 at 11:05 revealed: -She passed Resident #11's 9:00 a.m. medication which included Vicodin and acetaminophen order 3 times daily late between 10:00 a.m. and 11:00 a.m. -It is hard to give medications in an appropriate timeframe when passing medications on the small memory care hall and the second floor assisted living hall.</p> <hr/> <p>Review of the facility's plan of protection dated 4/10/2015 revealed: -The Medication Aides and Licensed Practical Nurses will be inserviced on appropriate medication administration by the Executive Director. -The Medication Aide will contact the supervisor if medication administration is not completed within the allotted time frame. -A second Medication Aide will be requested to assist with the medication pass completion. -The pharmacy will be requested to complete competency check offs for Medication Aides every 6 months beginning immediately. -Staffing levels will be maintained immediately.</p> <p>CORRECTION DATE FOR THE TYPE B</p>	D 358		

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D 358	Continued From page 90 VIOLATION SHALL NOT EXCEED MAY 29, 2015	D 358		
D 451	<p>10A NCAC 13F .1212(a) Reporting of Accidents and Incidents</p> <p>10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.</p> <p>This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to notify the Department of Social Services (DSS) by mail, telefacsimile, electronic mail, or in person of all accidents or incidents resulting in residents' injury requiring referral for emergency medical evaluation for 2 of 2 residents (#2, #6). The findings are:</p> <p>1. Review of Resident #2's FL-2 dated 10/15/14 revealed: -Diagnoses included Alzheimer's Dementia, rheumatoid arthritis, history of cervical spinal surgery, history of bilateral carpal tunnel syndrome surgery, urge incontinence, and varicosity surgery for legs. -Resident #2 was constantly disoriented. -Resident #2 was incontinent of bowel and bladder. -Resident #2 required personal care assistance with bathing, dressing, and cueing with feeding.</p> <p>Review of a "Report of Occurrence (ROO) Form" dated 3/18/15 revealed:</p>	D 451		

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D 451	<p>Continued From page 91</p> <p>-At 7:30am, Resident #2 was found lying on the floor on her left side facing the bed.</p> <p>-A wheel chair was at the resident's feet.</p> <p>-When resident was turned over by staff, a laceration was noted on the left eyebrow.</p> <p>-The resident was transferred to the hospital at 10:00am.</p> <p>The County DSS was not notified of the incident.</p> <p>Refer to interview with Interim Executive Director on 4/14/15 at 10:35am.</p> <p>2. Review of Resident #6's FL-2 dated 3/2/15 revealed:</p> <p>-Diagnoses included expressive aphasia, hemiparesis right side, B12 deficiency, seizure disorder, and traumatic brain injury.</p> <p>-The resident was non-ambulatory and used a wheelchair to ambulate.</p> <p>-Resident requires personal care assistance with bathing and dressing.</p> <p>-Resident #6 was admitted to the facility on 12/01/10 and resided on the assisted living hall.</p> <p>Review of the Resident #6's current care plan dated 10/08/14 revealed the following:</p> <p>-The resident required extensive assistance with bathing and limited assistance with dressing.</p> <p>-The resident transferred and toileted independently.</p> <p>-Review of documentation on the facility's incident/accident reports, "Occurrence-First Responder Forms", Nurses Notes and "Healthcare Provider Communication Form" revealed:</p> <p>-On 12/10/14, at 9:00am, the resident was "found at 7:00am on the bathroom floor. The resident hit her head, had abrasions to forehead and right</p>	D 451		

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D 451	<p>Continued From page 92</p> <p>knee and complained of head pain". The resident was sent to the local emergency room and diagnosed with a head injury/concussion.</p> <p>-On 12/17/14, at 4:15am, the resident was heard yelling for help and found on the floor, near the bed. The resident stated she was trying to go to the bathroom, had to go very bad. The resident stated she had pain in her head. The resident was transported to the local emergency room by emergency medical service. The resident was diagnosed with a closed head injury (concussion).</p> <p>-On 2/12/15, at 10:30am, the resident "pulled the call bell. Resident was on the bathroom floor laying on her right side. Resident does have a bruised area on the right arm near elbow from previous fall." The resident's primary provider ordered "x-ray of right elbow area." According to x-ray results on 2/12/15, there were no fractures.</p> <p>The County DSS was not notified of the incidents.</p> <p>Refer to interview with Interim Executive Director on 4/14/15 at 10:35am.</p> <p>Interview with Interim Executive Director on 4/14/15 at 10:35am revealed:</p> <ul style="list-style-type: none"> -The person who witnesses the incident starts the complete the First Responders Form (Incident Report). -The MA is to investigate the incident and complete the First Responders Form. -The First Responder Form should then be given to the manager to review and manager gives to Executive Director to file in binder for incidents and accidents. -Up until Resident Service Director's termination on 4/10/15, Resident Service Director was responsible for sending incident reports to the Department of Social Services. -A fax confirmation report should be attached with 	D 451		

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D 451	Continued From page 93 incident report indicating it was sent successfully to the Department of Social Services. -As of 4/16/15 the new Executive Director will be responsible for sending incident reports to the Department of Social Services. -Interim Executive Director would be responsible for sending incident reports to the Department of Social Services from 4/10/15 to 4/15/15.	D 451		
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 interviews and record review, the facility failed to assure 4 of 4 sampled residents on the Special Care Unit (#1, #2, #8, and #9) had	D 464		

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D 464	<p>Continued From page 94</p> <p>care plans done quarterly. The findings are:</p> <p>1. Review of Resident #1's FL-2 dated 1/19/15 revealed: -Diagnoses included Alzheimer's Dementia, Hypertension, Immobility, and due to chronic back pain. -Resident #1 was intermittently disoriented. -Resident #1 was semi-ambulatory and uses a wheelchair. -Resident #1 was incontinent of bowel and bladder. -Resident #1 was sometimes disoriented. -Resident#1's memory was forgetful requiring reminders. - Resident #1 requires personal care assistance with bathing and dressing.</p> <p>Review of Resident #1's record revealed resident was admitted to the Special Care Unit on 9/20/13.</p> <p>Review of Resident #1's care plan dated 10/14/14 revealed: -Resident #1 wandered and was verbally abusive at times. -Resident #1 was ambulatory with wheelchair/rollator. -Resident #1 had occasional incontinence with bowel and bladder. -Resident #1 needed limited assistance with eating, toileting, grooming, and transfer. -Resident #1 needed extensive assistance with ambulation, bathing, and dressing.</p> <p>Review of Resident #1's record revealed no quarterly care plan had been completed since the care plan dated 10/14/14.</p> <p>Refer to interview with the Interim Executive Director on 4/10/15 at 12:15 p.m.</p>	D 464		

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D 464	<p>Continued From page 95</p> <p>2. Review of Resident #2's FL-2 dated 10/15/14 revealed: -Diagnoses included: Alzheimer's Dementia, rheumatoid arthritis, history of cervical spinal surgery, history of bilateral carpal tunnel syndrome surgery, urge incontinence, and varicosity surgery for legs. -Resident #2 was constantly disoriented. -Resident #2 was incontinent of bowel and bladder. -Resident #2 required personal care assistance with bathing, dressing, and cueing with feeding.</p> <p>Review of Resident #2's record revealed resident was admitted to the Special Care Unit on 3/16/2012.</p> <p>Review of Resident #2's care plans revealed: -Resident #2 had an annual care plan on 3/5/2014 and 3/15/2015 and a quarterly care plan on 6/24/2014. -There was no quarterly care plan in September 2014. -The Registered Nurse signed on the 6/24/2014 quarterly care plan no changes had occurred dated 12/10/2014. -An annual care plan dated 3/5/2015 documented falls but did not address the increase in falls, considered to be significant change, with clear interventions.</p> <p>Refer to interview with the Interim Executive Director on 4/10/15 at 12:15 p.m.</p> <p>3. Review of Resident #8's FL-2 dated 9/12/14 revealed: -Diagnoses included dementia, glaucoma,</p>	D 464		

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D 464	<p>Continued From page 96</p> <p>constipation, Vitamin D Deficiency, seborrheic keratosis, history of dysphagia, Vitamin B Deficiency, gastroesophageal reflux disease, attention deficit disorder, hyperlipidemia, coronary artery disease, diverticulosis, hyperkalemia, peptic ulcer disease, gait disturbance, and history of falls.</p> <p>-Resident #8 was intermittently disoriented.</p> <p>-Resident #8 had inappropriate behaviors and wanderered.</p> <p>-Resident #8 was semi-ambulatory and uses a walker.</p> <p>-Resident #8 was incontinent of bladder and continent of bowel.</p> <p>-Resident #8 required personal care assistance with bathing, feeding, and dressing.</p> <p>-Review of Resident #8's record revealed resident was admitted to the Special Care Unit on 5/18/13.</p> <p>Review of Resident #8's care plan dated 10/12/14 revealed:</p> <p>-Resident's #8 was sometimes disoriented.</p> <p>-Resident #8's memory was forgetful-needs requiring reminders.</p> <p>-Resident #8 had occasional incontinence with bowel and bladder.</p> <p>-Resident #8 was independent with eating, ambulation, and transferring.</p> <p>-Resident #8 needed supervision with toileting, dressing, and grooming/personal hygiene.</p> <p>-Resident #8 needed limited assistance with bathing.</p> <p>Review of Resident #8's record revealed no quarterly care plans had been completed since the care plan dated 10/12/14.</p> <p>Refer to interview with the Interim Executive Director on 4/10/15 at 12:15 p.m.</p>	D 464		

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D 464	<p>Continued From page 97</p> <p>4. Review of Resident #9's FL-2 dated 8/5/14 revealed: -Diagnoses included: frontal-temporal dementia, hypertension, spinal stenosis/chronic pain, depression, tardive dyskinesia, and crohn's disease. -Resident #9 was constantly disoriented. -Resident #9 was identified as a wanderer. -Resident #9 was occasionally incontinent of bowel and bladder. -Resident #9 required personal care assistance with bathing.</p> <p>Review of Resident #9's care plan dated 6/18/14 revealed: -Resident #9's bowel and bladder were normal. -Resident #9 was oriented. -Resident #9's memory was forgetful-needs requiring reminders. -Resident #9 was independent with eating, toileting, ambulation/locomotion, dressing, grooming/personal hygiene, and transferring. -Resident #9 needed limited assistance with bathing.</p> <p>Review of Resident #9's record revealed no quarterly care plans had been completed since care plan dated 6/18/14.</p> <p>Refer to interview with the Interim Executive Director on 4/10/15 at 12:15 p.m.</p> <hr/> <p>Interview with Interim Executive Director on 4/10/15 at 12:15 p.m. revealed the Health Services Director was responsible for completing care plans for the special care unit.</p>	D 464		

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D 464	<p>Continued From page 98</p> <p>Subsequent interview with Interim Executive Director on 4/10/15 at 12:30 p.m. revealed: -The Health Services Director informed Executive Director via telephone call, she had not completed quarterly care plans in the Special Care Unit. -Care plans in the special care unit were completed annually unless the resident's status/condition changed, and when resident comes back from the hospital.</p> <p>Interview with Interim Executive Director and Health Services Director on 4/10/15 at 12:45 p.m. via telephone call revealed the Health Services Director reports the resident profiles are done quarterly for care plans and they should be up to date in all the resident records.</p> <p>Review of resident records on the Memory Care Unit with Interim Executive Director revealed no quarterly resident profiles or care plans had been done.</p>	D 464		
D 465	<p>10A NCAC 13F .1308(a) Special Care Unit Staff</p> <p>10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.</p> <p>This Rule is not met as evidenced by:</p>	D 465		

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D 465	<p>Continued From page 99</p> <p>TYPE A2 VIOLATION</p> <p>Based on observation, interview and record review, the facility failed to assure minimum staffing requirements were met and failed to assure sufficient staffing to meet the needs of the 35 residents residing in the Special Care Unit (SCU) from 4/01/15 through 4/14/15. The findings are:</p> <p>Review of the current posted staff schedule revealed:</p> <ul style="list-style-type: none"> - The staff schedule did not match the staff who were currently working. - Multiple changes on the schedule each day to reflect call outs. - Empty staff assignments on the schedule. <p>Observation of the facility on various dates and times 4/7/15 through 4/14/15 revealed:</p> <ul style="list-style-type: none"> - Staff were not working where they were assigned according to the schedule. - Staff had been moved around to accommodate call outs. <p>Interview with the Interim Executive Director on 4/8/15 at 5:50pm revealed:</p> <ul style="list-style-type: none"> - The memory care unit is on the second floor of the facility. - The memory care unit is U-shaped with resident rooms on 2 of the 3 halls, the small memory care and the big memory care, and the middle or adjoining hall has the activity room, dining room, TV room and nurse's station. - The second floor also has assisted living, referred to as the cottage, which is on one hall and shares another hall with the small memory care. - The memory care unit was to be staffed with 2 medication aides and 5 personal care 	D 465		

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D 465	<p>Continued From page 100</p> <p>assistants (PCAs) on first and second shift, with 1 of the medication aides and 1 of the personal care aides also staffing the cottage.</p> <ul style="list-style-type: none"> - The memory care should be staffed with 2 medication aides (MAs) and 2 PCAs on the third shift, with 1 of the medication aides and 1 of the personal care aides also staffing the cottage. - She was unable to provide documentation to show what staff or how many staff had been on duty in the facility at any given time. <p>Interview with the Director for the Memory Care Unit on 4/7/2015 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> - She started employment at the facility 1 week ago. - She had contacted most of the families of the residents on the Memory Care Unit and had identified complaints from the families regarding the number of staff available to provide care for the residents on the Small Memory Care (MC) hall (14 residents) and the Large Memory Care hall (21 residents). - Nine new staff were in the process of being screened to hire for the Memory Care Unit, including 4 Medication Aides. - Prior to her hire the staff working the Memory Care Unit did not have resident assignments and there was no accountability for the care provided or the whereabouts of staff during the day. - She started a sign-in and sign-out policy for the staff on the Memory Care Unit, so staff could be accounted for at all times and she could assure adequate coverage for their needs. - She was unable to provide documentation to show what staff or how many staff had been on duty in the facility at any given time. <p>Interview with medication aide (MA), Staff H, on 4/8/2015 at 4:30 p.m. revealed:</p> <ul style="list-style-type: none"> - There have been times when only 2 staff 	D 465		

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D 465	<p>Continued From page 101</p> <p>have been on duty for the Memory Care Unit and cottage.</p> <p>Interview with a Personal Care Aide (PCA), Staff M, on 4/7/15 at 12:40 p.m. revealed:</p> <ul style="list-style-type: none"> - The PCA was assigned to work on the cottage but was asked to sit with residents on the big memory care hall while memory care residents ate. With the PCA being on the big memory care hall there were no staff on the floor in the cottage. - The PCA was asked often to leave hall to help somewhere else in the building. <p>Interview with MA, Staff I, on the Memory Care Unit on 4/7/2015 at 1:45 p.m. revealed:</p> <ul style="list-style-type: none"> - "The residents are neglected." - There were 2 PCAs on the big memory care hall and there needed to be 3 for approximately 21 residents. - "The residents are not toileted like they should be." - She had difficulty giving medications on time. <p>Interview with PCA, Staff N, on the Memory Care Unit on 4/7/2015 at 2:00 p.m. revealed:</p> <ul style="list-style-type: none"> - There are 14 residents on the small MC hall, and only 3 of those residents require minimal assistance with Activities of Daily Living (ADL's). - Care was compromised for the other 11 residents she was responsible for because she was unable to toilet all of them every 2 hours. - The Medication Aide assigned to the small MC hall could provide minimal resident care assistance because she was assigned to pass medications to 14 residents in the cottage. - She was not always able to get the silverware, water and tea out on the dining room table before the meals. - The PCAs were responsible for placing the 	D 465		

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D 465	<p>Continued From page 102</p> <p>silverware and putting the drinks on the dining room table before the meal, making sure all the residents came to the dining room, were transferred into their chairs, were served, assisted, and fed as needed.</p> <ul style="list-style-type: none"> - "It is so much." <p>Interview with a MA, Staff J, on 4/8/2015 at 8:30 a.m. revealed:</p> <ul style="list-style-type: none"> - Staffing has been short for the Memory Care Unit and resident care has been affected. - She could not assist in personal care to all of the residents requiring personal care assistance. - She rushes in passing medications out and has had difficulty getting medications to residents on time. <p>Interview with a PCA, Staff O, on 4/8/15 at 10:30 a.m. revealed:</p> <ul style="list-style-type: none"> - The facility has a lot of callouts and when this happens a staff is moved around and usually someone has to float. - Memory care usually has 3 personal care aides which is not enough as it is hard to supervise the residents and get personal care done. - Staffing has been an issue for over a year. - With the "state" being in the building today there is more staff on the hall today. <p>Interview with a MA, Staff K, on 4/8/15 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> - The facility does not have enough staff. - There are usually 3 personal care aides and 2 medication aides in the memory care unit with one of the medication aides working the small memory care hall and the cottage. - It is hard to give medications in an appropriate timeframe when passing medications on the small memory care hall and the cottage. 	D 465		

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D 465	<p>Continued From page 103</p> <ul style="list-style-type: none"> - The MA reported not being able to assist with resident personal care due to constantly giving medications, calling families, and taking calls from doctor offices. - Management is aware of staffing being understaffed. <p>Observation on 4/8/2015 at 11:00 a.m. revealed the MA for the small memory care hall and the cottage, finished passing her 9:00 a.m. medications at 10:55 a.m.</p> <p>Interview with MA passing medications for the small memory care hall and the cottage on 4/8/2015 at 11:05am revealed she passed 9:00 a.m. medications to 5 residents in the cottage from 10:00 a.m. to 11:00 a.m.</p> <p>Interview with PCA, Staff P, on 4/8/15 at 12:45pm revealed:</p> <ul style="list-style-type: none"> - She works the first shift on assisted living, but gets pulled to work memory care or float one hallway of the first floor and the cottage, if there is a call out. - The facility was usually understaffed, but today they are full staffed. <p>Confidential family interview revealed the facility does not have enough staff in the memory care unit as the family member has helped staff pass out beverages during meals.</p> <p>Refer to 10A NCAC 13F .0901(a) Personal Care and Supervision.</p> <p>Refer to 10A NCAC 13F .0901(b) Personal Care and Supervision.</p> <p>_____</p> <p>Review of the facility's plan of protection dated</p>	D 465		

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D 465	Continued From page 104 4/10/2015 revealed: - We signed a Health Care agreement with a staffing agency to maintain staffing ratios. - We will begin immediately the evening of April 10, 2015. - Recruiting is ongoing and interviewing. - Eight care staff are being interviewed on Saturday. - We will continue using the staffing agency until all staff positions are filled. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 14, 2015.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision	D 468		

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D 468	<p>Continued From page 105</p> <p>within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.</p> <p>(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 3 of 3 sampled staff (Staff B, D, and E) assigned to perform duties in the special care unit received 6 hours of orientation training within the first week of employment and 20 hours of training within six months of employment. The findings are:</p> <p>1. Review of staff D's personnel record revealed:</p> <ul style="list-style-type: none"> - Staff D was hired on 3/19/15 as a personal care assistant. - There was no documentation to indicate staff D completed six hours of orientation on the nature and needs of the resident in a special care unit. - No documentation to show Staff D had completed any orientation on the nature and needs of the resident in a special care unit. <p>Observation on 4/10/15 at 4:45pm revealed, Staff D was working in the memory care unit.</p> <p>Interview with Staff D on 4/10/15 at 4:45pm revealed:</p> <ul style="list-style-type: none"> - She came in to work today because the facility was short staffed. - She normally worked the night shift on the 	D 468		

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D 468	<p>Continued From page 106</p> <p>memory care unit.</p> <p>Interview with the Interim Executive Director on 4/10/15 at 5:45pm revealed:</p> <ul style="list-style-type: none"> - She called Staff D in to work in the assisted living. - She was not aware Staff D was working in memory care that day. <p>Review of the Memory Care schedule from March 29, 2015 through April 11, 2015 revealed:</p> <ul style="list-style-type: none"> - Staff D was on the schedule to work 9 shifts. - She was scheduled to work as an aide on third shift in the memory care unit. <p>Refer to interview with Interim Executive Director on 4/14/15 at 6:00pm.</p> <p>2. Review of Staff E's personnel records revealed:</p> <ul style="list-style-type: none"> - Staff E ' s hire date was 11/05/13 - Staff E was hired as a medication aide. - There were no documentation of the required 20 hour SCU training. <p>Observations made on 4/10/15 (2nd shift) revealed Staff E was at the medication cart preparing and administering medications to residents on the memory care unit.</p> <p>Interview with the interim Executive Director on 4/14/15 at revealed Staff E had no record of the required 20 hour SCU training in her personnel record.</p> <p>Staff E was not available for interview on 4/14/15.</p> <p>Refer to interview with Interim Executive Director on 4/14/15 at 6:00pm.</p>	D 468		

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D 468	<p>Continued From page 107</p> <p>3. Review of Staff B's personnel record revealed: -Staff B was hired as a Medication Aide (MA)/Supervisor on 4/25/08. -Staff B had completed six hour training on nature and needs of the residents within the first week of employment. -Staff B had 4 of 20 hours of training specific to the population being served (dementia/Alzheimer's) within 6 months of employment. Interview with Staff B on 4/14/15 at 11:25am revealed: -She had some training on dementia during orientation after being hired by facility. -She had some training on dementia since employment but not sure of number of hours. -She could not recall having training about dementia within the last year of employment at facility.</p> <p>Interview with Interim Executive Director on 4/14/15 at 6:00pm revealed four of the required 20 hours of training specific to the population being served (dementia/Alzheimer's) within 6 months of employment was found in Staff B's personnel record.</p> <p>Refer to interview with Interim Executive Director on 4/14/15 at 6:00pm.</p> <p>_____ Interview with Interim Executive Director on 4/14/15 at 6:00pm revealed: -The business manager was responsible for personnel records to be in compliance with requirements but at the end of the day the responsibility lies on the Executive Director. -Previous business manager was not doing quality assurance to ensure compliance with staff</p>	D 468		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/14/2015
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NAME OF PROVIDER OR SUPPLIER PACIFICA SENIOR LIVING WILMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 2744 S 17TH STREET WILMINGTON, NC 28412
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D 468	Continued From page 108 training.	D 468		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with the rules and regulations as related to other requirements (hot water temperatures) and medication administration. The findings are:</p> <p>1. Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures for 8 of 10 fixtures located in 4 rooms used by 7 residents of the second floor rear hallway were maintained between 100 degrees Fahrenheit (F) and 116 degrees F, with water temperatures ranging from 120 to 134 degrees F. [Refer to Tag D113 10A NCAC 13F .0311(d) Other Requirements (Type A2 Violation)]</p> <p>2. Based on interviews, observations and record review, the facility failed to assure medications and treatments were administered as ordered for 4 of 9 sampled residents (#1, 5, 10 and 11). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]</p>	D912		

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D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on interview, observation, and record review the facility failed to assure residents were free from neglect as related to management, staffing, health care and personal care and supervision. The findings are:</p> <p>1. Based on observation, and interview, the Administrator and Manager failed to assure that all required duties were carried out in the facility related to the rule areas of housekeeping and furnishings, other requirements (hot water), test for tuberculosis, staffing, providing personal care and supervision, health care, nutrition and food service, resident rights, medication administration, reporting of accidents and incidents, special care unit resident profile and care plan, special care unit staff orientation and training, adult care home medication aides training and competency. [Refer to tag D176 10A NCAC 13F .0601 Management of Facilities (Type A1 Violation)]</p> <p>2. Based on observation, interview and record review, the facility failed to assure minimum staffing requirements were met and failed to assure sufficient staffing to meet the needs of the 55 residents residing in the assisted living. [Refer to Tag D201 10A NCAC 13F .0604 Personal Care And Other Staffing (Type A2 Violation)]</p> <p>3. Based on observations, record review and interviews, it was determined that the facility failed to provide appropriate personal care for 2</p>	D914		

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D914	<p>Continued From page 110</p> <p>of 3 residents in the sample, one requiring toileting assistance (Resident # 3) and one needing assistance to dining room for meals (Resident # 8). [Refer to Tag D269 10 NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)]</p> <p>4. Based on observation, interview and record review, the facility failed to provide supervision of residents according to their assessed needs for 4 of 7 sampled residents who sustained repeated observed and unobserved falls (Residents #2, #5, #6,) with injury and one resident who eloped (Resident #7). [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]</p> <p>5. Based on observation, interview and record review, the facility failed to assure referral and follow-up to meet the acute needs for 2 of 7 sampled residents; one who fell and hit her head (Resident #2) and one with skin excoriation and an open wound (Resident #3). [Refer to Tag D273 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)]</p> <p>6. Based on observation, interview and record review, the facility failed to assure minimum staffing requirements were met and failed to assure sufficient staffing to meet the needs of the 35 residents residing in the Special Care Unit (SCU). [Refer to Tag D465 10A NCAC 13F .1308 Special Care Unit Staff (Type A2 Violation)]</p>	D914		
D935	<p>G.S. § 131D-4.5B(b) ACH Medication Aides; Training and Competency</p> <p>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency</p>	D935		

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D935	<p>Continued From page 111</p> <p>Evaluation Requirements.</p> <p>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:</p> <p>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ol style="list-style-type: none"> a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <ol style="list-style-type: none"> a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: <ol style="list-style-type: none"> 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. 	D935		

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D935	<p>Continued From page 112</p> <p>This Rule is not met as evidenced by: Based on observations, interview and record review, the facility failed to assure all medication Aides (MA) hired after 10/01/13 received required 5 hour, 10 hour or 15 hour medication aide training or verified 24 month employment as a MA for 1 of 3 sampled MA's (Staff E) The findings are:</p> <p>Review of Staff E's personnel records revealed:</p> <ul style="list-style-type: none"> - Staff E hire date was 11/05/13 - Staff E was hired as a medication aide. - There were no documentation of the required "employment verification" or the 5 hour, 10 hour or 15 hour medication training for medications hired after 10/01/13. <p>Observation made on 4/10/15 (2nd shift) revealed the following:</p> <ul style="list-style-type: none"> - Staff E was working on the memory care unit as a MA. - Staff E was at the medication cart preparing and administering medications to residents on the memory care unit. <p>Review of Resident #1's medication administration record (January 2015) revealed:</p> <ul style="list-style-type: none"> - Staff E's name and initial on medication staff "name legion". - On 01/26/15, Staff E documented (initialed) 9:00am medications were administered to Resident #1. <p>Interview with the interim Executive Director on 4/14/15 at revealed:</p> <ul style="list-style-type: none"> - Staff E had no record of medication aide training or verified employment as a MA for the last 24 months. 	D935		

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D935	<p>Continued From page 113</p> <ul style="list-style-type: none"> - The business manager was responsible for personnel records to be in compliance with requirements but at the end of the day the responsibility lies on the Executive Director. - The previous business manager was not doing quality assurance to ensure compliance. - The interim Exexecutive Director had only been employed at the facility since 2/24/15 and was not aware Staff E did not have the required medication aide training or verified emploment history. <p>Staff E was not available for interview on 4/14/15.</p>	D935		