

AUG 24 2015

PRINTED: 08/12/2015
FORM APPROVED

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 07/01/2015 |
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| NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549 | County: <i>Franklin</i> |
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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 000 | Initial Comments The Adult Care Licensure Section and the Franklin County Department of Social Services conducted a complaint investigation on June 24, 25, and 26, 2015 with an exit conference via telephone on July 1, 2015. | D 000 | | |
| D 050 | 10A NCAC 13F .0305(e) Physical Environment 10A NCAC 13F .0305 Physical Environment (e) The requirements for bathrooms and toilet rooms are: (1) Minimum bathroom and toilet facilities shall include a toilet and a hand lavatory for each 5 residents and a tub or shower for each 10 residents or portion thereof; (2) Entrance to the bathroom shall not be through a kitchen, another person's bedroom, or another bathroom; (3) Toilets and baths for staff and visitors shall be in accordance with the North Carolina State Building Code, Plumbing Code; (4) Bathrooms and toilets accessible to the physically handicapped shall be provided as required by Volume I-C, North Carolina State Building Code, Accessibility Code; (5) The bathrooms and toilet rooms shall be designed to provide privacy. Bathrooms and toilet rooms with two or more water closets (commodes) shall have privacy partitions or curtains for each water closet. Each tub or shower shall have privacy partitions or curtains; (6) Hand grips shall be installed at all commodes, tubs and showers used by or accessible to residents; (7) Each home shall have at least one bathroom opening off the corridor with: (A) a door of three feet minimum width; (B) a three feet by three feet roll-in shower designed to allow the staff to assist a resident in | D 050 | | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nicole Terry</i> | TITLE <i>owner</i> | (X6) DATE <i>8/14/15</i> |
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STATE FORM 8999 WJ111 If continuation sheet 1 of 53

This POC has been approved on 8/26/15 by *Linda F Blalock*

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STREET ADDRESS, CITY, STATE, ZIP CODE
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LOUISBURG, NC 27549**

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| D 050 | <p>Continued From page 1</p> <p>taking a shower without the staff getting wet; (C) a bathtub accessible on at least two sides; (D) a lavatory; and (E) a toilet. (8) If the tub and shower are in separate rooms, each room shall have a lavatory and a toilet; (9) Bathrooms and toilet rooms shall be located as conveniently as possible to the residents' bedrooms; (10) Resident toilet rooms and bathrooms shall not be utilized for storage or purposes other than those indicated in Item (4) of this Rule; (11) Toilets and baths shall be well lighted and mechanically ventilated at two cubic feet per minute. The mechanical ventilation requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation; (12) Non-skid surfacing or strips shall be installed in showers and bath areas; and (13) The floors of the bathrooms and toilet rooms shall have water-resistant covering.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents' privacy by providing full shower curtains and doors which could be shut and locked for 3 of 4 bathrooms.</p> <p>The findings are:</p> <p>Observations during the facility tour on 6/24/15 between 12:30 pm and 3:00 pm revealed: -3 of 4 shower curtains were cut off or damaged making privacy impossible. -3 of 4 door knobs to main bathroom doors were broken, loose or not working, preventing the doors from locking.</p> <p>Observation of the Men's Hall right side bathroom on 6/25/15 at 10:00 am revealed:</p> | D 050 | <p><i>All shower curtains will be replaced to ensure resident privacy. All bathroom door knobs will be repaired or replaced so that the door can be completely closed and locked when occupied. The housekeeping staff will inspect each bathroom daily.</i></p> | 7/26/19 |
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| D 050 | <p>Continued From page 2</p> <p>-Door knob was broken and would not latch or lock to ensure privacy.</p> <p>-The existing shower curtain was cut off and an uneven overall length of 24" remained hanging on the 6' high shower curtain rod.</p> <p>Observation of the second Men's Hall bathroom (across the hall from the other bathroom on the hall) on 6/25/15 at 10:20 am revealed:</p> <p>-The door could be closed, but not locked.</p> <p>-1/2 of the shower curtain was irregularly cut off to a length of approximately 3 feet long hanging on the shower curtain rod.</p> <p>-The other 1/2 half of the shower curtain was unfastened with torn shower ring holes, hanging down loosely with soap scum, mold and mildew scattered over the lower surface of the curtain.</p> <p>-The shower curtain could not ensure privacy in its current condition.</p> <p>Observation of the second bathroom on the right Women's Hall on 6/25/15 at 4:50 pm revealed:</p> <p>-There was a full size shower curtain with mold, mildew and soap scum at the bottom edges.</p> <p>-The door knob was broken and loose.</p> <p>Observation of the first bathroom on the right of the Women's Hall on 6/26/15 at 3:00 pm revealed:</p> <p>-The shower enclosure did not have a shower curtain.</p> <p>-The door knob had a loose screw sticking out of the striker plate 1/2" and the striker plate was loose.</p> <p>-The door could not be latched or locked for privacy.</p> <p>Interviews on 6/25/15 and 6/26/15 with two housekeepers revealed;</p> <p>-They were responsible for cleaning the facility.</p> | D 050 | | |

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| D 050 | <p>Continued From page 3</p> <ul style="list-style-type: none"> -They cleaned each bathroom daily and had to re-clean the bathrooms if asked to after resident use. -Neither housekeeper knew how long the curtains had been missing or cut. -One housekeeper said all the curtains were up last week, and they wash them periodically, but did not remember when they were last washed. -Neither housekeeper knew how long the door knobs had been broken. <p>Interview with the facility's Building Property Manager on 6/25/15 at 2:30 pm revealed:</p> <ul style="list-style-type: none"> -He was responsible for physical plant operations and building upkeep. -He did not schedule or provide supervision of the housekeeping staff. -He was aware of the broken door knobs and thought they had been fixed. -There was a resident who like to take the curtains down in the shower rooms and that must be why they are cut off or missing. <p>Interview with a resident on 6/26/15 at 3:00 pm revealed:</p> <ul style="list-style-type: none"> -The resident tried to use the bathroom that could be locked and would wait to be able to use that bathroom. -The other bathrooms can not be locked. -"Now we don't have shower curtains." -The shower curtains have been cut off or missing for about a month. -The resident had not said anything to management about the doors or shower curtains; thought they should be aware of the problem. <p>Interview with another resident on 6/26/15 at 4:00 pm revealed:</p> <ul style="list-style-type: none"> -She used the second bathroom because the door could be shut and it had a curtain. | D 050 | | |

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| D 050 | Continued From page 4 -Some of the other women use the first bathroom, but people walk into that bathroom because the door cannot be locked. -She thought all of the bathrooms had shower curtains, but was not sure. | D 050 | | |
| D 077 | <p>10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain a North Carolina division of Environmental health approved sanitation classification of 85 or above at all times.</p> <p>The findings are:</p> <p>Observations upon entrance to the facility on 6/24/15 at 12:30 pm revealed a sanitation rating of 90.0 completed on 6/17/15 was posted next to the entrance for the dining room for the "Essex Caf."</p> <p>Interview with the kitchen Supervisor/cook on 6/24/15 at 1:30 pm revealed:</p> | D 077 | <p><i>Currently the facility has a score of 84.5. Franklin County Department of Health has been contacted for a follow up inspection. All equipment will be cleaned, repaired or replaced. The building manager will supervise all repairs.</i></p> | 7/26/19 |

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| D 077 | <p>Continued From page 5</p> <ul style="list-style-type: none"> -The 90.0 sanitation score posted in the lobby was for the kitchen inspection completed last week (6/17/15). -He did not know where the facility inspection report was. -The inspection done last week was not a reinspection. <p>Telephone interview on 6/25/15 at 8:00 am with the Environmental Health Specialist responsible for the county sanitation inspections revealed:</p> <ul style="list-style-type: none"> -The facility was inspected on 1/21/15. -The resultant score was 84.5. -The facility had not called to schedule a re-visit/re-inspection since first done. <p>Review of the 1/21/15 Health Inspection Report for the facility obtained from the Environmental Health Specialist revealed:</p> <ul style="list-style-type: none"> -A score of 84.5 -Demerits issued included crack floor coverings, walls and ceilings needed repairs, multiple bathrooms needing soap and hand drying device, furniture not in good repair, and handwashing signs were not posted. <p>Observations made during the facility tour on 6/24/15 between 12:30 pm and 3:00 pm revealed:</p> <ul style="list-style-type: none"> -All common bathrooms had soap scum, mold and mildew on the shower tiles rising 12" to 15". -3 of 4 shower curtains were cut off or damaged making privacy impossible. -1 shower curtain had significant mold and mildew. -Multiple tiles, floor molding and shower to tile thresholds were loose or missing. -3 of 4 door knobs to main bathroom doors were broken, loose or not working, preventing the doors from locking. -Two dining room chairs needed missing back | D 077 | | |

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| D 077 | <p>Continued From page 6</p> <p>bracing dowels replaced.</p> <ul style="list-style-type: none"> -One shower chair had a missing front left wheel. -Multiple wet, used towels were still in the bathrooms. -Scattered disposable gloves were left on surfaces and floor, which appeared to have been used. -Wall to floor junctions throughout the building had at least 1/2" of dirt buildup especially at doorways. <p>Interview with a resident on 6/26/15 at 3:00 pm revealed:</p> <ul style="list-style-type: none"> -The resident tried to use the bathroom that could be locked and would wait to be able to use that bathroom. -The other bathrooms can not be locked. -"Now we don't have shower curtains." -The shower curtains have been cut off or missing for about a month. -The resident had not said anything to management about the doors or shower curtains; thought they should be aware of the problem. <p>Interview with the facility's Building Property Manager on 6/24/15 at 3:30 pm revealed:</p> <ul style="list-style-type: none"> -He was responsible for the general building maintenance. -He was not aware the inspection posted was not for the facility. -He believed someone threw away the previous posting and replaced it with the inspection done on 6/7/15. -He had forgotten what the score was for the facility inspection. -He was aware there were two inspections done during the year. <p>[Refer to Tag 0050, 10A NCAC 13F.0305(e) Physical Environment and Tag 0079, 10A NCAC</p> | D 077 | | |

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| D 077 | Continued From page 7 13F.0306(a)(5) Housekeeping] | D 077 | | |
| D 079 | <p>10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure floors and walls in the bathrooms and showers were clean and free from all obstructions and hazards for 4 of 4 bathroom.</p> <p>The findings are:</p> <p>Observations during the facility tour on 6/24/15 between 12:30 pm and 3:00 pm revealed: -All common bathrooms had soap scum, mold and mildew on the shower tiles rising 12" to 15". -3 of 4 shower curtains were cut off or damaged -1 shower curtain had significant mold and mildew. -Multiple wall tiles, floor molding and shower-to-tile thresholds were loose or missing. -Two dining room chairs needed missing back brace dowels replaced. -One shower chair had a missing front left wheel. -Multiple wet, used towels were still in the bathrooms hanging or on the floor. -Scattered disposable gloves were left on</p> | D 079 | <p><i>All bathrooms will be sanitized on a daily basis and deep cleaned at least once a week by the housekeeping staff. A cleaning schedule has been distributed. The administrator will review the bathroom after each deep cleaning.</i></p> | <p><i>TKL/A</i></p> |

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| D 079 | <p>Continued From page 8</p> <p>surfaces and floor, which appeared to have been used.</p> <p>-Wall to floor junctions throughout the building had at least 1/2" of dirt buildup especially at doorways.</p> <p>Observation of the Men's Hall right side bathroom on 6/25/15 at 10:00 am revealed:</p> <p>-Soap scum, mold and mildew was present on the bottom three tiles of the shower surround (approximately 15 inches from floor).</p> <p>-The concrete painted shower floor had eroded and peeled.</p> <p>-There was no non-slip strips or applique to prevent slippage.</p> <p>-The towel bar beside the shower was missing.</p> <p>Observation of the second Men's Hall bathroom (across the hall from the other bathroom on the hall) on 6/25/15 at 10:20 am revealed:</p> <p>-The sink faucet could not be shut off, but dripped constantly.</p> <p>-The lower end of the right panel of the window curtains had brown splotchy stains.</p> <p>-The towel bar had used wet towels draped across the bar.</p> <p>-The other 1/2 half of the shower curtain was unfastened with torn shower ring holes, hanging down loosely with soap scum, mold and mildew scattered over the lower surface of the curtain.</p> <p>-There were no non-slip strips or appliques to prevent slips on the concrete shower floor.</p> <p>-There were 4 and 1/2 tiles missing from the floor to the the shower to the door molding.</p> <p>-A 6' piece of plastic floor transition strip was loose along the junction of the shower floor and the room floor and only connected at the end of the 6'.</p> <p>-The floor tile was separated from the bottom of the tub by 1"</p> | D 079 | | |

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| D 079 | <p>Continued From page 9</p> <p>-The tub to floor molding was missing.</p> <p>Observation of the second bathroom on the right Women's Hall on 6/25/15 at 4:50 pm revealed:</p> <ul style="list-style-type: none"> -Concrete shower surface had eroded with peeling paint. -No non-slip strips or applique on the surface of shower floor. -Soap scum, mold and mildew covered the lower 2 feet of shower enclosure wall tiles. -An extra large shower chair had a missing left front wheel. -The shower chair's back support net had soap scum, mold and mildew in the netting. -There was a full size shower curtain with mold, mildew and soap scum at the bottom edges. -The door knob was broken and loose. <p>Observation of the first bathroom on the right of the Women's Hall on 6/26/15 at 3:00 pm revealed:</p> <ul style="list-style-type: none"> -There were puddles of water on the floor outside of the shower flooring. -The shower/handheld nozzle was hanging down from the spout and dripping fresh water. -There were 6-8 used disposable gloves scattered over the surface of the floor. -The shower enclosure did not have a shower curtain. -The shower enclosure concrete floor was eroding with missing paint and no non-slip strips or appliques. -The door knob had a loose screw sticking out of the striker plate 1/2" and the striker plate was loose. -The door could not be latched or locked for privacy. <p>Interviews on 6/25/15 and 6/26/15 with two housekeepers revealed;</p> | D 079 | | |

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| D 079 | Continued From page 10 -They were responsible for cleaning the facility. -They cleaned each bathroom daily and had to re-clean the bathrooms if asked to after resident use. -One housekeeper said all the curtains were up last week, and they wash them periodically, but did not remember when they were last washed. -Neither housekeeper knew how long the door knobs had been broken. Interview with the facility's Building Property Manager on 6/25/15 at 2:30 pm revealed: -He was responsible for physical plant operations and building upkeep. -He did not schedule or provide supervision of the housekeeping staff. -He was aware of the broken door knobs and thought they had been fixed many times. -He stated there was a resident who like to take the curtains down in the shower rooms and that must be why they are cut off or missing. | D 079 | | |
| D 105 | 10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record review and interviews, the facility failed to assure the safe and continued operating condition for 2 of 4 central air conditioners for more than 30 days. | D 105 | | |

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| NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549 |
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| D 105 | <p>Continued From page 11</p> <p>The findings are:</p> <p>The facility is licensed for 56 beds and the current census on 6/24/15 was 20 residents with one resident in the hospital.</p> <p>Observation of the facility during an entrance tour on 6/24/15 at 12:30 pm revealed:</p> <ul style="list-style-type: none"> -The facility had two halls for resident rooms; the right hand hall known as the Men's Hall and the left hand hall, known as the Women's Hall. -The lobby ambient temperature appeared comfortable upon entrance. -An operating floor fan was situated at the corner of the right hall and was blowing air towards the lobby. -The ambient temperature rose remarkably after turning the corner to go down the Men's Hall. -Four occupied resident rooms which were without fans or window air conditioners were stifling. -There was a wall mounted fan positioned half way down the Men's Hall, turned and blowing towards the lobby. -The hall thermostat had a display of 82 degrees F. -The central air conditioners (A/C) serving the Men's Hall were not heard operating. <p>Ambient temperature measurements taken on 6/24/15 between 1:00 pm and 2:15 pm on the Men's Hall with both infrared gun and a glass thermometer revealed:</p> <ul style="list-style-type: none"> -Temperatures measured on the Men's Hall ranged between 75.8 degrees Fahrenheit (F) [room with window air conditioner] and 84.8 degrees F [room without fan or air conditioner]. -5 rooms on the Men's Hall had temperature ranges from 82.4 degrees F to 84.8 degrees F and did not have window air conditioners. | D 105 | <p><i>The contract with the current HVAC repair company will continue. If a resident occupies a room where the HVAC unit is not working, the resident will be supplied a window A/C unit. The building manager will supervise the repair of the HVAC unit and distribution of A/C units.</i></p> | 7/26/15 |

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| D 105 | <p>Continued From page 12</p> <p>Observation of the air conditioners on 6/25/15 at 7:00 am revealed</p> <ul style="list-style-type: none"> -The first central air conditioner outside the window of room 134 serving the Men's hall had the component cover panel removed and lying on the ground. -There was a 3-5 gallon red gasoline plastic can beside the unit with two thin 4' x 4' boards leaning across the can onto the A/C unit. -No operating sound was heard. -The second A/C unit serving the Men's Hall had two cover panels removed; the electrical components and the fan/condenser/motor were all exposed to elements. <p>Interview with 5 residents at various times on 6/24/15 and 6/25/15 revealed:</p> <ul style="list-style-type: none"> -The A/C units had not worked in several weeks. -There were some rooms with fans and some rooms with window A/C units. -They all thought it was warm in the facility, but were sleeping well. <p>Interview with one resident on 6/26/15 at 3:00 pm revealed:</p> <ul style="list-style-type: none"> -The resident thought it was hot in the building. -Several of the residents were visibly "sweating" during the last few weeks. -The fans helped but it was still hot in the building. -The resident thought the central A/C had been not working for approximately one month. <p>Telephone interview on 06/26/15 at 3:48 p.m. with Resident #3 revealed:</p> <ul style="list-style-type: none"> -He no longer resided in the facility. -He was sent out to the hospital on 06/16/2015 because he was stressed out because the facility was hot. -He revealed the facility central air conditioning | D 105 | | |

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| D 105 | <p>Continued From page 13</p> <p>wasn't working properly and he did not have a fan in his room.</p> <p>Interview with the Building Property Manager on 6/25/15 at 2:20 pm and 6/26/15 at 6:00 pm revealed:</p> <ul style="list-style-type: none"> -He was responsible for the equipment operation in the facility. -He was aware the A/C had not been working for approximately one month. -He was aware he had submitted a Plan of Protection to the Construction Section of the Division of Health Service Regulation in which he planned to have the units operational by 6/25/15. -He reported he needed to order a part for the first unit and the second unit needed to be replaced and had gotten a quote, but thought it was too high and was looking to reduce the cost. -He had not ordered the part needed to repair A/C #3 yet. -He later stated he felt the building owners were responsible for the repairs and replacement of the A/C and he was negotiating with them. <p>Review of resident records revealed two residents required treatment for dehydration and weakness related to heat. One resident had moved and one resident was discharged from the hospital to a skilled nursing center on 6/26/15.</p> <p>[Refer to Tag 0338, 10A NCAC .0909 (Resident Rights).]</p> <p>The facility provided the following Plan of Protection on 6/26/15:</p> <ul style="list-style-type: none"> -All resident will be checked for proper hydration. -All resident will be given window A/C units immediately if their central units are not working. -All equipment will be checked and repaired in 30 days. | D 105 | | |

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| D 105 | Continued From page 14 | D 105 | | |
| | THE DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED July 26, 2015. | | | |
| D 206 | 10A NCAC 13F .0604 (2--b) Personal Care And Other Staff 10A NCAC 13F .0604 Personal Care And Other Staff The following describes the nature of the aide's duties, including allowances and limitations: (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure any assigned housekeeping tasks (resident laundry) by aides were limited to occasional, non-routine tasks between 7:00 am and 9:00 pm. The findings are: Review of the census provided by the facility for 06/24/2015 to 06/24/15 revealed there were 20 residents currently residing in the facility. Observations during initial tour of the facility on the afternoon of 06/24/2015 at 4:18 p.m. revealed: -One washing machine located behind a small | D 206 | <i>Housekeeping duties, PCA/CNA duties and med tech duties have been distributed to the staff. Staff and residents have been instructed on when to do resident laundry. The administrator will supervise.</i> | <i>7/19/15</i> |

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| D 206 | <p>Continued From page 15</p> <p>locked closet door across from the staff bathroom.</p> <p>-A laundry schedule posted with residents' names and which day of the week their laundry was to be done. On this paper is printed: "Residents laundry to be washed on the following days****", "Revised 05/05/15", and "If laundry is soiled please do not wait for laundry day**".</p> <p>-Two dryers in an unattached small building behind the facility.</p> <p>-The dryer on the left side was drying clothes.</p> <p>-The dryer on the right side had a bag of clothing on top of it.</p> <p>Observations on 06/25/2015 revealed:</p> <p>-The door to the laundry room was locked and was unable to determine if laundry was being done prior to lunch time.</p> <p>-At 7:25 a.m. dryer on the left was drying and a single towel was on top of the dryer and the dryer on the right was empty and there was a bag of clothing on top of it.</p> <p>-At 3.45 p.m., the door to the laundry room was opened by the PCA and washing machine appeared to be on the spin cycle.</p> <p>-At 4:45 pm the dryer on the left was drying and the towel on top of the dryer had been removed and the dryer on the right was not running and the clothes on top of it had been removed.</p> <p>Observations on 06/26/15 at 9:03 am revealed the dryer on the left was running.</p> <p>Interview with a resident while touring the facility on 06/24/2015 at 2:02 p.m. revealed:</p> <p>-The aides washed her clothes for her.</p> <p>-She received clean sheets every 2 days because she liked fresh sheets.</p> <p>-She was given a clean washcloth and a clean towel every morning.</p> | D 206 | | |
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| D 206 | <p>Continued From page 16</p> <p>Interviews with facility's Medication Aides(MAs) and Personal Care Aides(PCAs) revealed: -They work 12 hour shifts either 7 a.m. to 7 p.m. or 7 p.m. to 7 a.m. -There is one MA and one PCA on duty each shift prior to the census declining there was two PCAs on each shift.</p> <p>Interview with a MA on 06/24/2015 at 4:35 p.m. revealed: -The facility was usually staffed with two PCAs and one MA. -She worked as a MA, usually first shift from 7 a.m to 7 p.m. -The first and second shift PCAs usually did the resident laundry and bathing. -She occasionally did the resident laundry between medication passes if they needed help. -The PCAs did residents' personal laundry daily, starting around 9:00 am -She worked both shifts at the facility. -Laundry was done for residents by the PCAs on both shifts daily and bed linens and towels and washcloths done by a laundry service.</p> <p>Interview with another MA on 06/25/2015 at 7:45 a.m. revealed: -She has been employed since August 2014 and usually worked 7:00 p.m to 7:00 a.m. -Laundry was normally done in the evening by the PCAs. -She used to assist with the resident laundry when the census was up. -She started laundry as soon as she could, usually by 8:00 p.m.</p> <p>Interview on 6/25/2015 at 4:52 p.m. with a PCA revealed: -She worked 4 days a week and 4 hours per day</p> | D 206 | | |

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| D 206 | <p>Continued From page 17</p> <p>in the afternoon.</p> <ul style="list-style-type: none"> -The Administrator in Charge (AIC) gave her the work assignment for each day. -She worked yesterday and did a resident's laundry. -She washed, dried, and folded resident laundry and returned the clean clothes to resident's room. <p>Interviews conducted on 06/24/2015, 06/25/2015, and on 06/26/2015 with 4 other PCAs revealed:</p> <ul style="list-style-type: none"> -PCAs do laundry for residents on both first and second shifts. -There is a sheet posted in the laundry area indicating which residents have their laundry done on what day of the week. -Towels, washcloths, and sheets are sent out to a linen company. <p>Interview on 06/25/2015 at 3:48 p.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> -She only cleaned residents' rooms. -She did not do residents' laundry. <p>Interview with the AIC on 06/25/2015 at 8:15 a.m. revealed:</p> <ul style="list-style-type: none"> -Laundry for residents was done on both first and second shifts by the PCAs. -Towels, washcloths, and bed linens are laundered by a linen service. <p>Interview on 06/26/2015 at 10:31 a.m. with the facility's owner/licensee revealed:</p> <ul style="list-style-type: none"> -Bed linen, towels, and washcloths are washed by a linen service. -PCAs do laundry on both first and second shifts. -She was not aware of the rule prohibiting routine laundering by aides between the hours of 7 a.m. and 9 p.m. <p>Interview on 06/26/2015 at 11:10 a.m. with the</p> | D 206 | | |

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| D 206 | Continued From page 18 Building Property Manager revealed: -He was responsible for the physical operation of the building. -A linen service launders residents' bed sheets, pillowcases, towels, and washcloths. -Residents' laundry was done by the PCAs on both first and second shifts. -He was not aware routine laundry should not be done between the hours of 7 a.m. and 9 p.m. by the aides. | D 206 | | |
| D 300 | 10A NCAC 13F .0904(d)(3)(B) 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: (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. This Rule is not met as evidenced by: Based on interviews, observations and record reviews, the facility failed to assure that a citrus fruit or a single strength juice of which there is 100% of the recommended dietary allowance of Vitamin C in each six ounces of juice were served as listed on the facility menu. | D 300 | <i>The dietary staff has been reminded of the rule about fruit. The facility will stock canned, processed and fresh fruits to reflect the current menu. The dietary manager will take inventory of the stock with each weekly menu.</i> | <i>7/19/15</i> |

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| D 300 | <p>Continued From page 19</p> <p>The findings are:</p> <p>Observations of the food storage in the kitchen on 6/24/15 at 1:15 pm revealed:</p> <ul style="list-style-type: none"> -One gallon container of "Sunny D Original Citrus Punch" in the refrigerator. -Three 11.5 ounce frozen containers of "Passion Fruit cocktail." -One 11.5 ounce frozen container of "Strawberry Breeze Juice Concentrate." -Three 11.5 ounce frozen containers of "Orange-Pineapple fruit concentrate." -1/3 gallon of reconstituted "juice" unlabeled and undated. -4 Apples -An open bag of approximately 20 grapes, somewhat dried and wrinkled. -A medium sized watermelon. -No other fresh fruit was seen in storage or refrigerator. -There were no containers of canned or processed fruit. <p>Interview with the Kitchen Supervisor/Cook on 6/24/15 at 2:00 pm revealed:</p> <ul style="list-style-type: none"> -He was responsible for cooking and serving meals according to the "Regular Menu" posted in the kitchen. -He thought the Building/Kitchen Manager purchased the food, but wasn't sure. -The food arrived after he left for the day and was put up on the shelves, in the refrigerator or freezer when he returned the next day. -He usually had the correct food to cook and serve, or a suitable alternative. -He reported the Building Property Manager would go to a local market to get food needed to prepare the day's menu if he needed more food. <p>Review of the labels of the juice containers</p> | D 300 | | |

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| D 300 | <p>Continued From page 20</p> <p>revealed:</p> <ul style="list-style-type: none"> -The first two ingredients were Corn syrup and filtered water. -The third ingredient was a mixture of various juices such as orange, apple, pineapple, pear and grape. <p>Interview with a Dietary Aide on 6/24/15 at 2:00 pm revealed:</p> <ul style="list-style-type: none"> -She had worked at the facility since November 2014. -The 1/3 gallon of reconstituted "juice" mixed up in the refrigerator was "Passion Fruit" juice, and was served at breakfast this morning. -The frozen concentrate cans of juice are what was normally served to residents. <p>Review of the posted menu in the kitchen revealed:</p> <ul style="list-style-type: none"> -The menu is titled "Regular Menu". -Each day, a 1/2 cup serving of "100% Juice" is to be served at breakfast. -Additionally, 1/2 cup of fresh fruit is also to be served daily at breakfast. -The dinner menu also calls for a serving of fruit. <p>Review of the posted menu for Thursday, 6/25/15, for breakfast revealed two pancakes, one sausage link, 1/2 cup fresh fruit and 1/2 cup 100% juice were to be served.</p> <p>Observation of the 6/25/15 breakfast meal from 7:10 am to 7:20 am revealed one waffle, 1-1/2 sausage patty, coffee, 6 ounces of "Sunny D" juice, milk and water.</p> <p>Interview with the Property Building Manager on 6/25/15 at 2:20 pm revealed:</p> <ul style="list-style-type: none"> -He -He was responsible for purchasing all food | D 300 | | |

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| D 300 | Continued From page 21 stores. -He purchased all fruit and juices. -Wednesdays are the biggest food purchase and shopped at four different vendors. -There was 100% citrus juice in the freezer, but he had to hide it away, so it won't "get gone." Observation of the chest freezer in the kitchen on 6/25/15 at 3:00 pm revealed there were 5 cans of frozen orange juice concentrate labeled 100% orange juice buried underneath assorted frozen foods and not visible. Interviews with 6 residents on 6/25/15 at various times revealed: -They do not know what kind of juice they are served; sometimes orange or tropical fruit punch and sometimes no juice at all. -Occasionally they might be served fresh fruit, but cannot remember when they have been served an orange; think it had been a long time. | D 300 | | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure 3 of 4 sampled residents (Residents #5, #6 and #7) were served therapeutic diets (diabetic and low potassium/low phosphorus/high protein) as | D 310 | | | |

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| D 310 | <p>Continued From page 22</p> <p>ordered by their physician.</p> <p>The findings are:</p> <p>Interview with the Kitchen Supervisor/Cook on 6/24/15 at 1:15 pm revealed:</p> <ul style="list-style-type: none"> -There were 4 physician ordered therapeutic diets; 4 diabetic regular and 1 "low potassium, high protein and low phosphorus diet suitable for a dialysis patient." -He cooked as if everyone was a diabetic and followed the doctor's guideline given to the facility for the low potassium/low phosphorus/high protein diet. -The facility does not have a therapeutic menu to guide the staff in preparing the doctor ordered diets. -The Kitchen Supervisor adjusted the regular menu to fit the special diets. -They used to have Therapeutic Diet spreadsheet from a prior vendor, but do not used them now. -The Building Property Manager purchased all of the food for the menus. <p>Observations in the kitchen and review of the "Residents Standard Facility Diets" list on 6/24/15 at 1:15 pm revealed;</p> <ul style="list-style-type: none"> -The list was posted, documenting 30 residents' diets (current census was 20) and dated 6/12/15. -The list documented resident diets of regular, diabetic, cardiac, puree/2 gram sodium, and low potassium/high protein/low phosphorus diets. -One resident's (Resident #6) listed diet was Regular/double portions but should have been on a diabetic diet based on physician's orders. -One resident (Resident #1) was listed as diabetic/regular and should have been served a regular diet as ordered by the physician. <p>Interview with the Kitchen/Building Manager on</p> | D 310 | <p><i>The kitchen staff has been educated on diabetic and renal (therapeutic) diets. A review of how to properly prepare food using the recipes supplied by the dietitian has taken place. The dietary manager will review the residents needs and menu so that an educated decision can be made on any alterations if necessary.</i></p> | 7/19/15 |
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| NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549 |
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| D 310 | <p>Continued From page 23</p> <p>2/25/15 at 2:20 pm revealed: -He was responsible for the physical plant operation and managed the kitchen. -He ordered and purchased the food from several different vendors. -He was aware there were residents with physician ordered Therapeutic Diets and instructed staff to use the regular menu and adjust the menu for diabetics such as unsweetened beverages and sugar free desserts. -He updated the diet list periodically or when new orders for diets were received.</p> <p>Review of the facility's "Regular Menu" for the week revealed: -Was for the week of 6/21/15 to 6/27/15. -The menu was signed at the end of the menu after statement "Dietitian's Signature", dated 6/1/15 but there was no Registered Dietitian's number.</p> <p>A. Review of Resident #6's current FL-2 dated 1/24/15 revealed: -Diagnoses included Diverticulosis, Diabetes Mellitus Type II, and chronic pain. -A diet order for a low fat diet. -An order for Novolog Insulin before each meal (Novolog is a rapid acting insulin to reduce blood glucose level.)</p> <p>Review of an Encounter Note dated 5/5/15 by the treating Nurse Practitioner (NP) revealed: -HgA1C performed on 4/8/15 resulted at 8.6% [Normal range is 5.7-6.4%]. -Under the "Therapy" section, a "diabetic diet" was documented. -Under "Plan" section, a discussion regarding the resident's diet compliance for better control and the resident's agreement to "do a better job" controlling her diet was documented.</p> | D 310 | | |

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| D 310 | <p>Continued From page 24</p> <p>Review of the posted diet list in the kitchen revealed Resident #6 was to be served a regular/double portions diet.</p> <p>Observation of the breakfast meal served to Resident #6 on 6/25/15 at 7:10 am to 7:20 am revealed:</p> <ul style="list-style-type: none"> -The resident was served a waffle, 1-1/2 sausage patties, 2 ounces regular syrup, 6 ounces of Orange/Pineapple/Apple juice, coffee and artificial sweetener for sweetener. -She consumed 100% of food and beverage. <p>Review of the facility's regular menu posted in the kitchen, residents were to be served the following:</p> <ul style="list-style-type: none"> -2 pancakes -1 sausage link -1/2 cup (C) of fresh fruit -1/2 C of 100% Juice <p>Observation of the lunch meal on 6/25/15 at 12:20 pm to 12:40 pm revealed Resident #6 was served the following:</p> <ul style="list-style-type: none"> -4 ounce chicken breast, grilled -1-1/2 Tablespoons of gravy -1/2 C instant mashed potatoes -1 yeast roll -1/2 C of vegetable medley (broccoli, carrots, cauliflower) -6 ounces of 2% low fat milk -The resident was served the same portions as the rest of the residents in the dining room. -The resident consumed 100 % of the food and beverages. <p>Review of the posted Regular Menu in the kitchen revealed resident should be served 3 ounces chicken/creamy gravy, 1/2 C fresh mashed</p> | D 310 | | |

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| D 310 | <p>Continued From page 25</p> <p>potatoes, 1/2 C of mixed vegetables, 1 baked roll and 1/2 C apple cobbler.</p> <p>Interview with Resident #6 in the dining room at 7:30 am on 6/25/15 revealed: -She ate whatever the staff served. -She knew she was on a diabetic diet but with bigger portions. -She thought the food was okay and what the doctor ordered.</p> <p>Review of the June 2015 facility Blood Glucose Log revealed Resident #6's range of Fingerstick blood sugars (FSBS) ranged from 94-434.</p> <p>Because there was no Therapeutic Diet Spread sheet for staff guidance, it could not be determined the resident received the correct doctor ordered diet.</p> <p>Resident #6's diet was clarified on 6/26/15 by the NP to reflect a diabetic diet should be served, not the previous low fat or regular diet.</p> <p>B. Review of Resident #5's current FL-2 dated 5/6/15 revealed: -Diagnoses included Hypoglycemia, Type I diabetes, malnutrition, chronic kidney disease Stage 3, and diabetic neuropathy. -Diet order was for a diabetic with double portions.</p> <p>Review of the posted diet list in the kitchen revealed Resdient #5 was to be served a "diabetic regular/double portions at lunch" diet.</p> <p>Observation of the breakfast meal served on 6/25/15 at 7:10 am revealed: -The resident was served a waffle, 2 sausage patties, 2 ounces regular syrup, 6 ounces of</p> | D 310 | | |

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| D 310 | <p>Continued From page 26</p> <p>Orange/Pineapple/Apple juice from concentrate, coffee and artificial sweetener for sweetener. -He consumed 100% of food and beverage.</p> <p>Review of the facility's regular menu posted in the kitchen, residents were to be served the following: -2 pancakes -1 sausage link -1/2 cup (C) of fresh fruit -1/2 C of 100% Juice</p> <p>Observation of the lunch meal on 6/25/15 at 12:00 pm to 12:35 pm revealed Resident #5 was served the following: -4 ounce chicken breast, grilled -1-1/2 Tablespoons of gravy -1/2 C instant mashed potatoes -1 yeast roll -1/2 C of vegetable medley (broccoli, carrots, cauliflower) -water, milk and juice -The resident was served the same portions as the rest of the residents in the dining room. -The resident consumed 100 % of the food and only 2 ounces of water.</p> <p>Review of the posted Lunch Regular Menu in the kitchen revealed resident should be served 3 ounces chicken/creamy gravy, 1/2 C fresh mashed potatoes, 1/2 C of mixed vegetables, 1 baked roll and 1/2 C apple cobbler.</p> <p>Interview with Resident #5 on 6/25/15 at 6:50 am revealed: -He was dressed and ready for breakfast. -Fingerstick blood sugar (FSBS) had been taken this morning was 120. -He stated he was hungry most of the time and not very diet compliant because he got so hungry.</p> | D 310 | | |

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| D 310 | <p>Continued From page 27</p> <p>-His "sugar" was up and down a lot.</p> <p>Review of the June 2015 facility Blood Glucose log revealed Resident #5's FSBS ranged from 36 to 589.</p> <p>Because there was no Therapeutic Diet Spread sheet for staff guidance, it could not be determined the resident received the correct doctor ordered diet.</p> <p>C. Review of Resident #7's current FL-2 dated 6/16/15 revealed: -Diagnoses included acute metabolic encephalopathy, end stage renal disease requiring dialysis, dementia, and diabetes mellitus. -An order for Diabetic/Renal diet to be served.</p> <p>Review of a previous diet order dated 6/9/15 revealed Resident #7 was to receive a "low potassium, high protein, low phosphorus diet suitable for dialysis patients, see attached guidelines."</p> <p>Observation of the lunch meal on 6/25/15 at 12:00 pm to 12:35 pm revealed the resident was served the following: -4 ounce chicken breast, grilled -1-1/2 Tablespoons of gravy -1/2 C cooked greens -1 yeast roll -1/2 C of vegetable medley (broccoli, carrots, cauliflower) -8 ounces of regular sweetened lemonade. -The resident consumed 100 % of the food and beverage.</p> <p>Review of the posted Regular Menu in the kitchen revealed resident should be served 3 ounces</p> | D 310 | | |

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| D 310 | Continued From page 28 chicken/creamy gravy, 1/2 C fresh mashed potatoes, 1/2 C of mixed vegetables, 1 baked roll and 1/2 C apple cobbler. Interview with the Kitchen Supervisor/cook on 6/25/15 at 12:25 pm revealed: -He used the guideline sheets provided by the physician to prepare Resident #7's food. -He served cooked greens in place of mashed potatoes and gave lemonade instead of juice for the beverage according to the guidelines. Because there was no Therapeutic Diet Spread sheet for staff guidance, it could not be determined the resident received the correct doctor ordered diet. Interview with Resident #7 on 6/25/15 at 11:00 am revealed: -He usually ate most of his meals. -He ate what was served to him and did not usually snack. -He went to dialysis three times weekly and was usually tired afterwards. -Liked to eat in his room frequently and staff brought it to him. -Thought he was on a special diet because of dialysis, but did not know what it was called. | D 310 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: | D 338 | | |

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| D 338 | <p>Continued From page 29</p> <p>TYPE A1 VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect as evidenced by the failure to have safe and continued operating air conditioning or other means of cooling temperatures of resident rooms and areas contributing to generalized weakness for Resident #1, inpatient hospitalization for dehydration for Resident #2 and emergency room admission for heat related illness for Resident # 3.</p> <p>The findings are:</p> <p>Ambient temperature measurements taken on 6/24/15 between 1:00 pm and 2:15 pm with both infrared gun and a glass thermometer revealed:</p> <ul style="list-style-type: none"> -Temperatures ranged between 75.8 degrees Fahrenheit (F) in rooms with window air conditioners and 84.8 degrees F in rooms without window air conditioners. -5 rooms on the Men's Hall had temperature ranges from 82.4 degrees F to 84.8 degrees F and did not have window air conditioners. <p>Observation of the air conditioners on 6/25/15 at 7:00 am revealed</p> <ul style="list-style-type: none"> -The first central air conditioner outside the window of room 134 serving the Men's hall had the component cover panel removed and lying on the ground. -No operating sound was heard. -The second A/C unit serving the Men's Hall had two cover panels removed; the electrical components and the fan/condenser/motor were all exposed to the elements. <p>Review of the "Weather Underground" recorded</p> | D 338 | <p><i>The facility will follow the Declaration of Residents' Rights by ensuring that all residents have safe and continued operating air conditioning either via the HVAC unit or A/C window units. The building manager will supervise this right.</i></p> | 7/26/15 |

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| D 338 | <p>Continued From page 30</p> <p>online weather data for calendar days 6/18/15 to 6/26/15 revealed: -The high temperature range for the period was 80 degrees F to 93 degrees F. -There were 6 consecutive days with daytime temperatures above 89 degrees F.</p> <p>[Refer to Tag 0105, 10A NCAC 13F..0311(a)(Other Requirements).]</p> <p>A. Review of Resident #2's current FL-2 dated 6/4/15 revealed: -This was a hospital discharge FL-2 related to a fall and subsequent rib fractures incurred on 5/26/15. -Diagnoses included dementia, hypertension and chronic anemia. -Documentation the resident was constantly disoriented, non-ambulatory, blind and had slurred speech. -Documentation the resident was incontinent of urine and bowel. -Documentation the resident needed total assistance with bathing, feeding, dressing and was considered total care.</p> <p>Review of Resident #2's record revealed: -An incident report documenting a fall from his wheelchair on "5/24/15" prepared by the Administrator in Charge (AIC) with no injuries noted. -The facility's Resident Log note dated 5/26/15 documenting a fall in the bathroom without injury. -A physician visit note dated 5/26/15 documenting the Nurse Practitioner's evaluation of the resident while she was in the facility shortly after the fall which documented "Patient will be monitored closely over the next few days to determine if he has pain and bruising in the left sternum/axilla area."</p> | D 338 | | |

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| D 338 | <p>Continued From page 31</p> <ul style="list-style-type: none"> -The resident was sent to the emergency room on 5/29/15 and returned on 5/30/15 with a diagnoses of rib fractures and received an order for a narcotic pain medication. -The resident received narcotic pain medication from 5/30/15 through 6/6/15 and the order was discontinued on 6/9/15. -Documentation of a facility visit by the NP on 6/9/15 finding the resident pain free and more alert. -A facility Resident Log note of 6/18/15 stating the resident complained of "abd pain, v/s [vital signs] 77/54 [blood pressure], p=54 and T=97.5. EMS was called" and transported the resident to the nearby hospital. <p>Interview on 6/24/15 at 3:30 pm with a Medication Aide (MA) who was on duty when Resident #2 was transported to the hospital on 6/18/15 revealed:</p> <ul style="list-style-type: none"> -She had been employed by the facility since March 2015 as a MA. -She checked on Resident #2 early in the morning and found he complained of abdominal pain and was holding his "tummy, skin was clammy and his blood pressure was low." -"He just didn't look right." -She notified the AIC and call EMS for transportation. -She stated after the resident's fall earlier in the month, Resident #2 had not been as alert and stayed in bed more than usual. <p>Interview with another MA on 6/25/15 at 7:45 am revealed:</p> <ul style="list-style-type: none"> -She was not working the day Resident #2 was transported to the hospital. -In the past, Resident #2 required a lot of assistance and could stand and pivot to the toilet, but lately had stayed in bed in his room and had | D 338 | | |

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| D 338 | <p>Continued From page 32</p> <p>pain from the fall earlier.</p> <p>- "The resident slept a lot more because of the pain medication he was taking."</p> <p>- The resident did not have a window air conditioner or fan.</p> <p>Interview with the AIC on 6/25/15 8:10 am revealed:</p> <p>- The MA had reported her concerns to the AIC regarding Resident #2 and had brought the resident to the AIC's office for her to check on him around 9:00 am.</p> <p>- The AIC thought the resident was not as alert and his blood pressure was decreased and his pulse was down and she was alarmed.</p> <p>- She thought he had a fan in his room but was not sure.</p> <p>- The central air conditioning was not working on his hall.</p> <p>- Because of his complaints of pain, they called EMS for transportation to the local hospital.</p> <p>Interview with a Nursing Assistant (NA) on 6/25/15 at 4:52 pm revealed:</p> <p>- She remembered when the resident fell and the NP checked him out right after the fall.</p> <p>- The resident continued to complaint of pain in side and stomach and was sent to the hospital for tests.</p> <p>- After the resident returned from the hospital ER, he stayed mostly in his room on bed rest and needed total care.</p> <p>- She was not working the morning Resident #2 was transported to the hospital.</p> <p>- She did not remember if the resident's room had an air conditioner or fan; only that the Men's Hall rooms were hot and the central air conditioning did not work on the Men's Hall.</p> <p>Interview with a local Social Services worker for</p> | D 338 | | |

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| D 338 | <p>Continued From page 33</p> <p>adult placement on 6/25/15 at 10:00 am revealed: -She had been in the facility twice during the month observing and interviewing staff regarding Resident #2. -She visited with the the resident and observed his room on 6/1/15 and 6/2/15 and found the room's ambient temperature hot with no air conditioning or fan, with the window open and hot outside air circulating in the room. -She did not know who opened the window. -According to the Social Services Worker, the resident's skin felt hot but not sweaty. -She stated the NP took Resident #2's oral temperature on 6/2/15 and it was not elevated, "not a fever."</p> <p>Interview with a resident on 6/26/15 at 3:00 pm revealed he remembered Resident #2 had been sweating some the previous weeks before he went to the hospital.</p> <p>Review of the hospital admission history and physical findings on 6/18/15 revealed: -The resident was admitted on 6/18/15 with a primary diagnoses of dehydration (extreme loss of body fluids), acute kidney injury with hyperkalemia (elevated potassium), bradycardia (slowed pulse rate), hypotension (low blood pressure do to volume loss), and anemia. -The resident was unable to provide a history or chief complaint secondary to dementia. -The resident was not accompanied by staff or family. -Documentation by the attending physician "they [the facility] have no air conditioner right now . . . I think that could have caused his dehydration."</p> <p>Interview with the attending physician on 6/26/15 at 10:00 am revealed: -There was a "strong possibility the lack of air</p> | D 338 | | |

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| NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549 | | |
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| D 338 | <p>Continued From page 34</p> <p>conditioning could have caused his dehydration given his age and debility." -The laboratory test performed in the hospital confirmed the resident's kidney function was diminished. -The initial low blood pressure measurements were alleviated by the immediate rehydration. -Resident #2's chronic anemia did not contribute to the dehydration and the resident showed no evidence of respiratory distress. -The resident will be transferred to a local skilled nursing facility upon discharge.</p> <p>Observation and attempted interview with Resident #2 on 6/26/15 at 6:30 pm revealed: -He was residing in a local skilled nursing facility. -The resident did not know where he was, what day it was or how he got there.</p> <p>B. Review of Resident #1's current FL-2 dated 8/14/14 revealed: -He was admitted to the facility on 8/9/14. -Diagnoses included diabetes mellitus, hypertension, transient ischemic attack (TIA) and mood disorder.</p> <p>Review of a hospital emergency room visit for Resident #1 dated 5/4/15 revealed: -An admission date of 5/4/15 with a chief complaint of right sided weakness for one week with headache. -His blood pressure was 130/70. -There was no significant finding and was discharged back to the facility without new orders.</p> <p>Observation on 6/24/15 at 1:40 pm of Resident #1's room revealed: -There were two box fans pointed towards the head of each bed. -Resident #1's fan was running and his</p> | D 338 | | |

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| D 338 | <p>Continued From page 35</p> <p>roommate's fan was off.</p> <ul style="list-style-type: none"> -The ambient temperature measured with glass thermometer and infrared gun was 83.6 degrees Fahrenheit (F) for the wall and 84.6 degrees F for the ceiling. <p>Observations on 6/25/15 at 6:45 am of Resident #1 and his room revealed:</p> <ul style="list-style-type: none"> -The resident was awake and lying on his bed awake. -A box fan was sitting on a bedside table and blowing across the resident's upper torso and head. -Resident #1's roommate was lying in bed asleep with his box fan not running. -The window was opened, drapes pulled back and hot air was entering from outside. <p>The temperature reading registering on the hall thermostat was 80 degrees F on 6/25/15 at 6:45 am.</p> <p>Observations in the facility on 6/26/15 between 7:20 am and at 8:45 am revealed:</p> <ul style="list-style-type: none"> -Resident #1 was in his room standing at his bedside. -Resident #1's room was warm. -The window beside the resident's roommate's bed was open, warm air entering from outside. -The roommate's box fan was not operating. -The box fan for Resident #1 was blowing air across his bed. -Resident #1 walked using his walker approximately 20 feet in the hall and fell to his knees. -Ambient temperature in Resident #1's room measured with a glass thermometer measured 82 degrees F at 7:30 am -Staff was in the hall, assisted him up and into a wheelchair and took him into the dining room. | D 338 | | |

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| D 338 | <p>Continued From page 36</p> <p>-After breakfast, the resident was assisted to the lobby. -At 8:45 am, the resident was on his bed, awake and the fan was running, blowing air across his upper torso.</p> <p>Multiple interviews with Resident #1 between 7:45 am and 8:45 am on 6/26/15 revealed: -He stated he sometimes became weak; did not know why he became weak. -He did not think he got too hot. -He believed he slept ok; it was warm in his room all night. -The fan helped keep him cool. -He felt better after eating and being in the lobby, but thought he would stay in bed for a while.</p> <p>Interview with the treating Nurse Practitioner on 6/26/15 at 1:45 pm revealed: -Resident #1's numerous insulin changes and unstable blood glucose levels could contribute to his weakness. -The elevated temperature in the facility did not help Resident #1 and could have contributed to the weakness also.</p> <p>C. Review of Resident #3's FL-2 dated 10/28/14 revealed: -Diagnoses included: Generalized Anxiety Disorder (GAD), Cardiovascular Accident (CVA), Diabetes Mellitus, Hypertension, Manic bipolar, and schizophrenia. -Medications included: Lithium 300 mg take 2 tablets by mouth at bedtime (used to treat manic depression), Ativan 0.5 mg by mouth every night at bedtime as needed for anxiety, Abilify 20 mg by mouth daily (used to treat bipolar and schizophrenia), Tegretol XR 200 mg by mouth daily (used to treat seizures or mood disorders), Ativan 0.5 mg by mouth every 8 hours as needed</p> | D 338 | | |

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| D 338 | <p>Continued From page 37</p> <p>for anxiety or sleep. (Antipsychotic medications can interfere with the way the body regulates temperature. Individuals taking antipsychotics have an increased risk of heat-related illnesses. Extreme heat increases the risk of heat stroke for those who take antipsychotics.)</p> <p>Record review of Resident #3 revealed: -An order dated 05/22/2015 to start 150 mg of Lithium every morning along with his current dose. -An order for staff to make sure patient is well hydrated to prevent toxicity and obtain lithium labs within 1 month. -No documentation the Lithium lab had been collected. -Staff note of 06/16/2015 at 12:15 p.m. by the Supervisor revealed "resident in room lying across his bed in a leather coat in a deep sleep. Vital signs were temperature 98.6, pulse 98, respirations 24, blood pressure 102/68, oxygen saturation 97%. Nurse Practitioner in facility and called to assess resident." -Emergency physician record of 06/16/2015 revealed resident seen in Emergency Department for being unresponsive and "pt states he got too hot" and vitals signs are marked "normal." -Hospital lab of 06/16/15 revealed a Myoglobin, serum of 100 ng/ml High (normal range 28 -72) and CPK of 562 IU/L (normal range is 24 - 204). This test is used to diagnose heart attacks as enzymes levels rise when there is damage to a muscle such as the heart. -Hematology labs of 06/16/2015 revealed WBC (white blood count) of 15.0 thou/cmm High (normal 5.1 - 10.8). Elevated levels of WBC is indicative of inflammation, infection, intense exercise, or severe stress. -Diagnosis of Syncope listed on physician record</p> | D 338 | | |

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| D 338 | <p>Continued From page 38</p> <p>of 06/06/2015. Syncope is a loss or partial loss of consciousness which may be caused by various things such as dehydration causing a loss of blood volume.</p> <p>Interview on 6/26/2015 with the AIC revealed:</p> <ul style="list-style-type: none"> -An aide called her down to Resident #3's room because they were having difficulty waking the resident up. -The Resident #3 appeared to be in a deep sleep. -She took the resident's vital signs which "were good" and since the Nurse Practitioner was in the facility, she called her to assess the resident and called 911. -The resident's leather jacket was removed and cool moist towels were placed on the resident to cool him down. -The resident refused to go to the hospital via ambulance, so she took him in her car. -The resident was released from the hospital and back in the facility in a few hours with no new orders. -To ensure all residents stay hydrated, water is always available in the dining room. -She encourages residents to drink their entire cup of water when administering medications. <p>Telephone interview on 06/26/2015 at 4 p.m. with Resident #3's Nurse Practioner revealed:</p> <ul style="list-style-type: none"> -She was in the building on 06/16/2015 when Resident #3 was found unresponsive. -He was laying in his bed with a leather jacket on. -His vital signs were within normal range. -They called 911 and removed his leather jacket, and placed cool wet towels on his body to cool him down. -She stated he returned to the facility a few hours later with no new orders from the hospital. -She does not believe the resident was dehydrated or overheated, she feels the incident | D 338 | | | |

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| D 338 | <p>Continued From page 39</p> <p>was cause by his antipsychotic medications.</p> <p>Interview on 06/26/2015 at 4 p.m. with an Institutional Engineering surveyor with the Construction Section, Division of Health Service Regulation revealed:</p> <ul style="list-style-type: none"> - He was at the facility today (06/26/15) to follow-up on the operating condition of the HVAC -He was at the facility on 06/16/2015 for an inspection and found 3 of 4 of the facility's HVAC units were not working and the resident rooms and resident areas were "hot". - He noticed Resident #3 laying across his bed wearing a leather jacket. -He asked one of the staff if the resident was OK, because the resident had not moved since passing by earlier. - Staff was unable to rouse the resident by calling the resident's name and shaking the resident. He asked staff to call 911. -He helped the facility staff remove the resident's jacket and assisted applying wet towels to his forehead and neck. -He observed there was no perspirations on the skin of his midsection where his shirt had been pulled up. -Resident # 3 opened his eyes and was moaning and crying out that "he did not wish to die". -The Emergency Medical Technicians (EMTs) came and the resident refused to go to the hospital with the EMTs but agreed to go with a staff person. <p>Interviews with two Medication Aides revealed:</p> <ul style="list-style-type: none"> -The facility made available in the dinning room a "hydration station" with ice water and cups. -They encourage residents to drink all the water when they are administrating medications to them. | D 338 | | |

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| D 338 | <p>Continued From page 40</p> <p>Interviews with three Personal Care Aides revealed they encourage residents to stay hydrated by having them sit a lot in the dining area where the cups and water were available.</p> <p>Telephone interview on 06/26/2015 at 3:48 p.m. with Resident #3 revealed:</p> <ul style="list-style-type: none"> -He was sent out to the hospital on 06/16/2015 and he "was stressed out" and "almost died." -He had walked outside 3 times the morning of 06/16/2016. -It was hot outside and it was hot inside the facility as the air conditioner was not working and he did not have a fan. -He was not sure how long the air conditioner has been broken. -He was wearing a leather jacket because it "helped my arthritis." -He stated he was "alright" and residing in another facility. <hr/> <p>The facility provided a Plan of Protection on 6/26/15 as follows:</p> <ul style="list-style-type: none"> -All residents in room without working A/C units will be moved to rooms with working A/C or given working A/C units. -Hydration of resident will be monitored immediately. -All residents will be assessed for proper hydration. -The ALF will follow the existing construction Plan of Correction. -The units [A/C] will be repaired within 30 days from today (6/26/15). <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED July 26, 2013.</p> | D 338 | | |

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| D 358 | Continued From page 41 | 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: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 6 residents (#5) observed during the medication pass which included errors with the administration of Gabapentin (used to treat diabetic neuropathy) and Norvasc (used to treat high blood pressure) and 1 of 6 residents sampled (#1) with failure to administer Sliding Scale insulin (used to reduce blood glucose) as ordered.</p> <p>The findings are:</p> <p>A. The medication error rate was 6% as evidenced by the observation of 2 errors out of 31 opportunities during the medication passes on 06/25/15 and 6/26/15.</p> <p>1. Observation of medication passed on 06/26/2015 at 8:03 a.m. revealed Resident #5 received: -2 tablets of Gabapentin 300 mg.</p> | D 358 | <p><i>The facility will reduce the medication error rate by having the administrator and ATC both review all prescribing practitioners orders as well as residents' FL-2's upon their return from the hospital. Clarification of orders will be requested as needed.</i></p> | 7/19/15 |

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| D 358 | <p>Continued From page 42</p> <p>Review of Resident #5's FL-2 dated 05/06/2015 revealed: -Diagnoses included hypoglycemia, Type 1 Diabetes, depression, history of cardiovascular accident, Diabetic neuropathy. -A medication order for Gabapentin 300 mg , one capsule, twice daily.</p> <p>Review of Resident #5's Medication Administration Record (MAR) for the month of June revealed: -Documentation Resident #5 had been administered 2 capsules of Gabapentin 300 mg twice a day.</p> <p>Interview on 06/26/2015 at 11:27 a.m. with the Administrator in Charge (AIC), who had administered the medications to Resident #5 revealed: -She had not noticed the order for Gabapentin had changed when the resident returned to the facility on 05/06/2015 with a new FL-2. -She was responsible for reviewing new physician orders and FL-2s and is responsible for changing the MARs to reflect a new order. -She stated she normally reviews orders monthly.</p> <p>Telephone interview on 06/26/2015 at 3:20 p.m. with the pharmacist revealed they had not received a change order for Gabapentin; the order they had read: Gabapentin 300 mg, 2 tablets by mouth twice a day.</p> <p>Telephone interview on 06/26/2015 at 4 p.m. with Resident #5's Nurse Practitioner revealed: -Resident #5's Gabapentin order was 300 mg twice a day. -She had not been notified by the facility they were giving the resident double the dose per day. -She did not plan to change his order back 600</p> | D 358 | | |

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| D 358 | <p>Continued From page 43</p> <p>mg twice a day.</p> <p>2. Observation of medication pass on 06/26/2015 at 8:03 a.m. revealed Resident #5 received: -1 tablet Norvasc 2.5 mg.</p> <p>Review of Resident #5's FL-2 dated 05/06/2015 revealed: -Diagnoses included hypoglycemia, Type 1 Diabetes, depression, history of cardiovascular accident, Diabetic neuropathy. -An order for Norvasc 2.5 mg 1 tablet by mouth daily.</p> <p>Review of Resident #5's Medication Administration Record (MAR) for the month of June 2015 revealed: -Norvasc 2.5 mg was documented as given June 1 through June 10, 2015. -Resident #5's documented blood pressure ranged from 99/61 to 130/70 (normal blood pressure per the American Heart Association was considered to be 120/80).</p> <p>Review of Resident #5's record revealed a physician order dated 05/19/15 to discontinue Norvasc 2.5 mg by mouth daily.</p> <p>Interview on 06/26/2015 with the AIC who had administered the medications to Resident #5 revealed: -She had not seen the discontinued order for Norvasc 2.5 mg. -She is responsible for reviewing new physician orders and FL-2s and was responsible for changing the MARs. -It was her responsibility to fax orders to the pharmacy. -She stated she normally reviews all orders monthly.</p> | D 358 | | |

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| D 358 | <p>Continued From page 44</p> <p>Telephone interview on 06/26/15 at 3:20 p.m. with the pharmacist revealed they had not received a discontinue order for Resident #5's Norvasc.</p> <p>Telephone interview on 06/26/2015 at 4 p.m. with Resident #5's Nurse Practitioner revealed: -She had discontinued Resident's #5's Norvasc due to his blood pressure being low on 05/19/2015. -She was unaware the facility's staff had not discontinued the order and he had received a dose this morning. -She did not want the resident to take Norvasc.</p> <p>B. Review of Resident #1's current FL-2 dated 8/14/14 revealed: -Diagnoses included Diabetes Mellitus, stroke and hypertension. -An order for a regular diet. -Medication orders for Novolog Mix 70/30 Insulin twice daily (an injectable combination of short and longer acting insulin to reduce blood glucose level.)</p> <p>Review of the resident's record revealed subsequent physician orders as follows: -A 5/12/15 order for Novolog Sliding Scale Insulin (SSI) administration before meals and at bedtime using with the following parameters: 151-200 = 2 Units, 201-250 = 4 Units, 251-300 = 6 Units, 301-350 = 8 Units, 351-400 = 10 Units and if >400, call MD. -A change in the SSI parameters dated 6/11/15 to Novolog Flexpen 151-200 = 0 Units, 201-250 = 2 Units, 251-300 = 4 Units, 301-350 = 8 Units, 351-400 = 10 Units and >400 = 12 Units and call MD. -A 6/20/15 order to "D/C Novolog SSI" and start Novolin-R SSI based on Fingerstick Blood Sugar</p> | D 358 | | |

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| NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549 |
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| D 358 | <p>Continued From page 45</p> <p>(FSBS) before meals and at bedtime.</p> <p>-The 6/20/15 SSI administration parameters, based on FSBS before meals and at bedtime, for the Novolin-R were 151-200 = 0 Units, 201-300 = 2 Units, 301-350 = 4 Units, 351-400 = 5 Units and if >400 = 5 Units and call MD office.</p> <p>Review of the June 2015 Medication Administration Records (MAR) for Resident #1 revealed:</p> <p>-A transcription entry for SSI administration before meals and at bedtime with parameters as ordered on 5/12/15.</p> <p>-The 5/12/15 ordered SSI administration transcription documented Novolog insulin was given between June 1-20, 2015 with notation "D'cd 6/20/15.</p> <p>-A transcription entry for the 6/20/15 SSI administration parameters with documentation of insulin administration given between June 20-25, 2015.</p> <p>-Documentation of insulin doses of SSI administration were recorded on the reverse side of the MAR.</p> <p>-There was no transcription entry on the MAR for the SSI parameter order changes of 6/11/15.</p> <p>Review of the facility's "Blood Glucose Log" for June 1-11, 2015 revealed:</p> <p>-There were 44 FSBSs documented as obtained.</p> <p>-There were 29 documented FSBSs which required SSI administration.</p> <p>-Of the 29 opportunities, 19 opportunities were either the wrong dose administered or no documentation of insulin administration when required based on SSI parameters.</p> <p>-Examples of the errors or omissions included: 6/1/15, 7:00 am, FSBS = 153, 0 Units were documented; should have received 2 Units; 6/4/15, 4:30 pm, FSBS = 226, 0 Units were</p> | D 358 | | |

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| D 358 | <p>Continued From page 46</p> <p>documented, should have received 4 Units; and 6/6/15, 4:30 pm, FSBS = 317, 6 Units were documented as administered, should have received 8 Units.</p> <p>Review of the facility's "Blood Glucose Log" for June 12-20, 2015 revealed:</p> <ul style="list-style-type: none"> -There were 32 FSBSs documented as obtained. -There were 14 documented FSBS which required SSI administration according to the 6/11/15 physician's order. -Eleven of the 32 FSBSs had incorrectly documented SSI parameters administered and some examples are: 6/12/15 at 7:00 am, FSBS = 213, 4 Units were documented as administered and should have received 2 Units; 6/16/15 at 4:30 pm, FSBS = 275, 6 Units were documented as administered and should have received 4 Units; and 6/19/15 at 11:30 am, FSBS = 217, 4 Units were documented as administered and should have received 2 Units. -There were 7 of the 32 FSBSs where SSI should have been documented as administered and there was no documentation SSI had been given and some examples include: 6/12/15 at 8:00 pm, FSBS = 311, no SSI was documented as administered and should have received 8 Units; 6/17/15 at 7:00 am, FSBS = 203, no SSI was documented as administered and should have received 2 Units; and 6/19/15 at 8:00 pm, FSBS = 233, no SSI was documented as administered and should have received 2 Units. <p>Review of the facility "Blood Glucose Log" for June 21-26, 2015 revealed:</p> <ul style="list-style-type: none"> -There were 6 FSBS which required | D 358 | | |

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| D 358 | <p>Continued From page 47</p> <p>administration of SSI according to the ordered parameters.</p> <p>-There were 3 of the 6 FSBS where the SSI was required but there was no documentation of administration:</p> <p>6/21/15 at 8:00 pm, FSBS=234, no SSI was documented as administered and should have received 2 Units;</p> <p>6/23/15 at 8:00 pm, FSBS=285, no SSI was documented as administered and should have received 2 Units; and,</p> <p>6/25/15 at 8:00 pm, FSBS=273, no SSI was documented as administered and should have received 2 Units.</p> <p>Interview with Resident #1 on 6/26/15 at 11:00 am revealed:</p> <p>-He had been a diabetic for a while, but did not know how long.</p> <p>-He relied on the facility staff to administer his medications according the the physician's order.</p> <p>-He was not certain what type of insulin he was receiving but was "getting shots all of the time."</p> <p>-Resident #1 stated his blood sugar "goes up and down a lot."</p> <p>Interview with the Adminsitrator in Charge/Medication Aide (MA) on 6/25/15 at 8:10 am and 6/26/15 at 1:45 pm revealed:</p> <p>-She was responsible for transcribing all new order to the MARs and sending to pharmacy to dispense.</p> <p>-She was not aware the 6/11/15 order was not transcribed to the MAR.</p> <p>-She thought the 6/11/15 order was an error, but did not call the Nurse Practitioner (NP) to verify.</p> <p>-She reviewed all medications orders, faxed the pharmacy, obtained any clarifications and reviewed the MARs for omissions or errors.</p> <p>-She usually worked as a MA 2 or 3 times per</p> | D 358 | | |

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| D 358 | <p>Continued From page 48</p> <p>week.</p> <p>Interview with the prescribing NP on 6/26/15 at 2:00 pm revealed: -She had written the 6/11/15 SSI order and considered it a valid order. -She wrote the order in response to changing the insulin from Novolog to Novolin-R insulin because his blood sugar was not well controlled and the resident had "big swings" in the blood sugar level. -She was not aware the 6/20/15 SSI order had not been transcribed to the MAR and administered according to the parameters.</p> <p>Interview with the facility's pharmacy staff on 6/26/15 at 3:30 pm revealed: -The pharmacy did receive the 6/11/15 SSI order. -The order was not filled because the MA called and told them not to fill it; they would get the insulin at a local pharmacy instead.</p> <p>Observation of Resident #1's medication available for administration on 6/26/15 at 10 am revealed a vial of multidose Novolog 70/30 mix and a vial of multidose Novolin-R insulin.</p> <p>The facility provided the following Plan of Protection on 6/26/15: -All residents' records will be reviewed and clarification orders will be written if necessary. -There will be full communication and documentation with all parties involved. -The Administrator in Charge and the Administrator in Training will review the MARs, physician's orders and discharge papers as they come into the facility and weekly. -A Registered Nurse will oversee all medication administration and documentation twice monthly.</p> <p>CORRECTION DATE FOR THE TYPE B</p> | D 358 | | |

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| D 358 | Continued From page 49 VIOLATION SHALL NOT EXCEED July 19, 2015. | D 358 | | | |
| D 489 | 10A NCAC 13F .1602(c) Issuance of Rated Certificates 10A NCAC 13F .1602 ISSUANCE OF RATED CERTIFICATES (c) The certificate and any worksheet the Division used to calculate the rated certificate shall be displayed in a location visible to the public. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to display the current rated certificate and the worksheet the Division of Health Service Regulation used to calculate the rated certificate in a location visible to the public. The findings are: Observations on 6/24/15 at 1:00 pm revealed: -The posted Star rating certificate documented the facility had 3 Stars issued for the annual survey of 6/14/14. -No worksheet was posted showing the calculations for the 3 stars. Review of the online published Star ratings for this facility on 6/24/15 revealed: -The current Star rating certificate was issued 4/27/15 and documented zero stars from the 4/1/15 county monitoring report. -The Star rating certificate issued before the 4/27/15 was also for zero stars and was issued 3/15/15 for an investigation completed 2/1/15. | D 489 | <i>The certificates and any worksheets that have been issued to the facility will be posted in a location that is visible to the public. This will be supervised by the building manager as each new certificate and worksheet becomes available.</i> | <i>7/19/15</i> | |

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| D 489 | Continued From page 50 Interview with the Building Property Manager on 6/25/15 at 2:20 pm revealed: -He thought he had another rating certificate somewhere but had not put it up. -He thought he had the current rating certificate in a folder and would see that it was posted. Observation on 6/26/15 at 7:00 am revealed the current rating certificate of zero stars issued 4/27/15 and the worksheet were posted on the lobby wall. | D 489 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on 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 medication administration. The findings are: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 6 residents (#5) observed during the medication pass which included errors with the administration of Gabapentin (used to treat diabetic neuropathy) | D912 | <i>The facility will follow the Declaration of Residents' Rights and ensure that each resident receives care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations. The administrator will supervise to ensure that the staff is following the Declaration.</i> | <i>7/19/15</i> |

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| D912 | Continued From page 51 and Norvasc (used to treat high blood pressure) and 1 of 6 residents sampled (#1) with failure to administer Sliding Scale insulin (used to reduce blood glucose) as ordered. [Refer to Tag 0358, 10A NCAC 13F.1004(a) (Type B Violation).] | D912 | | |
| 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 observations, interviews and record reviews, the facility failed to assure residents were free of neglect related to safe and continued operating air conditioning or provisions to ensure safe interior temperatures in order to maintain residents' physical well being and comfort and free of heat related illnesses.</p> <p>The finding are:</p> <p>A. Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect as evidenced by the failure to have safe and continued operating air conditioning or other means of cooling temperatures of resident rooms and areas contributing to generalized weakness for Resident #1, inpatient hospitalization for dehydration for Resident #2 and emergency room admission for heat related illness for Resident # 3. [Refer to Tag 338, 10A NCAC 13F.0909 (Type A1 Violation).]</p> <p>B. Based on observations, record review and interviews, the facility failed to assure the safe</p> | D914 | <p><i>The facility will follow the Declaration of Residents' Rights and ensure that every resident will be free of mental and physical abuse, neglect and exploitation. The administrator will supervise to ensure that the staff is following the Declaration</i></p> | 7/19/15 |

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| D914 | Continued From page 52 and continued operating condition for 2 of 4 central air conditioners for more than 30 days. [Refer to Tag 105, 10A NCAC 13F.0311(a) (Type A2 Violation).] | D914 | | |

Shook, Linda

From: Blalock, Linda
Sent: Wednesday, August 26, 2015 10:06 AM
To: Pamela Nelms
Cc: Shook, Linda
Subject: Plan of Correction for Essex Manor Assisted Living from Survey of 7/1/15
Attachments: ESSEX MANOR AL FACILITY 2015-08-14 POC-WJ111 REVIEW-signed.pdf

Good morning:

I have attached the accepted Plan of Correction for the survey exit date of 7/1/15 for your information and review. Thank you and please contact me if you have any questions. The follow up has not been scheduled at this time. Linda

Linda F. Blalock, BSN
N.C. Department of Health and Human Services
Adult Care Licensure Section - Division of Health Service Regulation
Lexington Region - Home Based
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Courier Service: #03-23-11
Phone: 704-898-1047
Fax: 704-986-2204
linda.f.blalock@dhhs.nc.gov
www.ncdhhs.gov/dhsr/acls

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