STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

(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 Cabarrus County Department of Social Services conducted an annual survey on March 13-14, 2019.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, floor and fixtures in 5 of 5 common bath/shower areas, on the top hall, the bottom hall, and in a resident room, were kept clean and in good repair, as evidenced by stains and smears on the shower room floors, mold and mildew buildup around the baseboards, black mold and build-up in the inside of the shower and on the tile and toilet, feces on a toilet seat and a broken metal strip on the tub on the bottom hall; light fixtures plastic covers throughout both halls were split, jagged and cracked. The findings are: Observation during the facility tour on 03/13/19 at 9:30am revealed: -The floor plan divided the facility into two long halls identified by staff as the top hall and the	D 074		

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D 074	Continued From page 1	D 074		

bottom hall.
-Three common shower room/ bathroom were located on the top hall, and there were two shower rooms located on the bottom hall.
-The resident rooms were located on both the top and bottom halls.

Observation of the common shower room on the top hall near the end of the hall on 03/13/19 at 10:00am revealed:
-The toilet, baseboards and floor tiles had an accumulation of mold, mildew and dirt.
-There was a broken tile along the base of the tub which was pushed inward toward the center of the tub about 2 inches.
-Around the base of the toilet and on the tile was a thick black dirt build-up and black mold staining.
-Behind the door and around the baseboards was mold and mildew buildup.

Observation of another common shower room on the top hall on the right side of the hall on 03/13/19 at 10:15am revealed:
-There was black grout stains around the base of the toilet and on the tile.
-There was black mold and grout on the inside of the shower on the floor and on the sides of the shower.
-Behind the door and around the baseboards was black mold and mildew buildup.

Observation of the third common shower room on the top hall on the left side near the smoking area on 03/13/19 at 10:20am revealed:
-Brown staining and mold surrounded the base of the toilet and on the tile.

Observation of the top hall overhead light fixtures revealed:
-The overhead light fixtures consisted of a lighting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 074	Continued From page 2	D 074		

unit attached to the ceiling and composed of two long fluorescent bulbs with a plastic cover encasing the bulbs.
-Near the foyer the two overhead plastic light covers were cracked and missing small plastic pieces from several areas.
-There was another plastic light cover on the top hall that had the plastic broken, cracked down the middle and missing pieces of the plastic.

Observation of the bottom hall overhead plastic light covers revealed:
-The overhead light fixtures consisted of a lighting unit attached to the ceiling and composed of two long fluorescent bulbs with a plastic cover encasing the bulbs.
-Near the back of the bottom hall the overhead plastic light cover was cracked and missing a large piece of the plastic, there was a portion of the plastic hanging down about 2 inches.
-On the bottom hall near the kitchen area there were two overhead plastic light covers that were cracked and missing small plastic pieces from several areas, one the light fixtures the bulbs were not working.

Interview with the facility maintenance director on 03/13/19 at 2:10pm revealed:
-He was responsible for the maintenance of the facility.
-He did not know of the black build-up of mold and mildew around the baseboards, toilets and inside the shower in the common shower areas.
-The housekeeper was responsible for cleaning the facility.
-He did know in the bottom hall common bathroom the tile around the toilet had black grout build-up and dirt around the base of the toilet and on the tile.
-He had placed new tile on the top of the old

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	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 074	Continued From page 3	D 074		

black molded tile a few weeks ago, but the new tile did not stick and he had to pull it up.
-He knew the overhead plastic light fixtures were cracked, "We're doing a complete over-haul of the facility to fix everything."
-He had hoped to have everything done in about 8 months.

Interview with the housekeeper on 03/13/19 at 2:30pm revealed:
-She worked 5 hours each day, Monday through Friday.
-She was the only housekeeper.
-She did know there was dirt, grout, and mildew build up on the floors in the common bathrooms.
-The Administrator had purchased cleaning supplies to clean the grout and the mildew off the shower floor and around the toilets, but she did not have any left.
-She cleaned with bleach but needed something stronger to remove the black mold and mildew.
-She never told the Administrator she was out of the cleaner that had worked to remove the grout and mildew.

Interview with a resident on 03/13/19 at 4:00pm revealed:
-He noticed the black mildew on the shower floor in the common shower area on the top hall.
-He always wore shower shoes when he took a shower.
-"I am afraid of catching "athlete's foot or some kind of fungus
-The housekeeper cleans the bathroom floors every day.

Interview with the Administrator on 03/14/19 at 8:30am revealed:
-It was the responsibility of the housekeeper to assure the facility was maintained in a clean and

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THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 074	Continued From page 4	D 074		

safe manner.
-The housekeeper did not have a schedule to follow of areas to clean in the facility every day "she just cleaned the facility."
-The housekeeper cleaned the common bathrooms which included the floors sometimes two or three times daily, because the male residents "sometimes miss the toilet".
-This was an "on-going work in progress."
-She would follow up with the maintenance staff and the housekeeper regarding the identified issues.

Observation of hallway on bottom hall 03/13/19 at 2:40pm revealed:
-There were cracked/broken plastic casings around the overhead light fixtures.
-The vents/duct work in ceiling had a build-up of thick dust.

Interview with maintenance man on 03/13/19 at 2:50pm revealed he cleaned the overhead vents 1 or 2 times a week.

Interview with Administrator on 3/14/2019 at 9:33am revealed:
-There was an order to replace the plastic casing around light fixtures.
-Cleaning the bathrooms floors should be done on a daily basis.

Observation on 03/12/19 at 9:57am of another shower/tub/bathroom located on the bottom hall common revealed:
-The base of the toilet and the tile floor around the toilet was covered with black and brown debris.
-The same tub had 12 pieces of exposed tile, with jagged edges on the bottom outer edge on the

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	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 074	Continued From page 5 right side of the tub. The left side of the tub was covered by a metal strip, but the right side metal strip was missing. -There were brown stains on the tile floor near the bathtub, on the right side of the room. -There were multiple black and brown stains and debris on the floor. -The sink had multiple brown stains on the top and in the bowl. Interview on 03/14/19 at 10:00am with the housekeeper revealed: -The bathtub on the right side of the lower hall common bathroom was not used by residents. -She was not aware that the tiles were exposed on the side of the bathtub, and that the metal protective strip was missing. Interview on 03/14/19 at 10:30am with the facility maintenance director revealed: -He did not know that the tiles were broken and exposed on the side of the bathtub (on the right) in the lower hall bathroom. -He did not know the metal protective strip was missing on the same bathtub. -He did not know what happened to the protective metal strip that covered the tiles. -The residents did not use the bathtub on the right in the lower hall bathroom. Interview with the Administrator on 03/14/19 at 10:45am revealed She was not aware the 12 tiles were exposed on the bathtub (on right side of room), and that the metal protective strip was missing, in the lower hall bathroom.	D 074		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 6 (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to contact the primary care physician for the acute and routine health care needs of 1 of 5 sampled residents (Resident #2) related to delaying transport to the emergency room (ER) and refusals of finger stick blood sugars (FSBS) and sliding scale insulin (SSI) administration. The findings are: Review of Resident #2's current FL-2 dated 02/25/19 revealed diagnoses included hypertension, muscle weakness, and thyroid issues. Review of Resident #2's Resident Register revealed Resident #2 was admitted to the facility on 02/01/19. a. Review of Resident #2's primary physician office note dated 02/25/19 revealed: -A diagnoses that included coronary artery disease, hypertension, diabetes, cerebral vascular accident, Parkinson's, cataracts, and Cholelithiasis. -Resident #2 reported several incidents of uncontrolled diabetes with hyperglycemia (FSBS reported to the physician fromm 200 to 591 in Febuary and march 2019). -A plan for adding metformin (used for treating high blood sugars) to Resident #2's medication was documented.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 7	D 273		

Review of Resident #2's Care Notes revealed:
-On 03/12/19 Resident #2 was sitting on his toilet.
-The staff checked on him and he seemed stiff and very out of it.
-The medication aide (MA) had the Resident Care Director (RCD) and the Administrator check on Resident #2.
-The Administrator sent Resident #2 to the ER.
-Resident #2's physician and family were notified.

Review of Resident #2's Incident/Accident Reports dated 03/12/19 at 3:00pm revealed:
-Resident #2 was documented as being found "stiff confused and was not acting like his normal self".
-Resident #2 did not respond when spoken to.
-Resident #2's physician was notified at 4:00pm and a telephone order to send Resident #2 to the emergency room (ER).
-There were no injuries documented.
-The family was notified.

Telephone interview with Resident #2's family member on 03/13/19 at 2:56pm revealed:
-He visits Resident #2 every other day.
-He took Resident #2 to the have cataracts removed on 03/04/19.
-He brought Resident #2 back to the facility after the procedure and provided the discharge paperwork for the facility he was given.
-He visited Resident #2 again on 03/06/19 and Resident #2 was acting weaker than usual. He notified the Administrator.
-He visited Resident #2 on 03/08/19 and Resident #2 was weaker than before and not communicating like normal, and not responding to the conversation as he normally would.
-Resident #2 had declined since the procedure and he notified the Administrator again on

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 273	Continued From page 8	D 273		

03/08/19.
-The Administrator stated she would keep an eye on Resident #2 but did not see the need to notify the physician.
-The Administrator told him she would notify him over the weekend if Resident #2 was not doing well.
-On 03/12/19 he received a call from the RCD Resident #2 was sent to the ER.

Review of Resident #2's Emergency Management System (EMS) report dated 03/12/19 revealed:
-Resident #2 was transported to the ER for altered mental status.
-Resident #2 was slow to respond and weak.
-Resident #2's vital signs at 2:49pm were a blood pressure of 143/79, a heart rate of 85, an oxygen level of 96% on room air, a FSBS of 249 and a Glasgow coma scale (GCS), (the most common scoring system used to describe the level of consciousness, the score is rated between 3 and 15, with 3 being the worst and 15 being the best) of 12.
-Resident was awake and alert to surroundings but did not answer questions when asked.
-Resident #2 could slightly squeeze fingers and move feet on command but Resident #2 could not follow any other commands during the neurological assessment.

Review of the ER report dated 03/12/19 revealed:
-Resident #2 arrived at the ER at 3:26pm.
-The EMS reported per the facility staff Resident #2 was lethargic and no verbal response, altered mental status with an onset of yesterday.
-Resident #2's family member was with Resident #2 when evaluated by the ER physician.
-A physical exam was completed. Resident #2 was awake and nonverbal.

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	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 273	Continued From page 9	D 273		

-Intravenous fluids and medications were started to treat the hyperkalemia (high potassium).
-The admission diagnoses was altered mental status (AMS), sepsis, acute kidney injury, hypoglycemia, multisystem organ failure, abdominal pain, lactic acidosis, metabolic acidosis, leukocytosis, hyperkalemia and abnormal cardiac enzyme level.

Review of Resident #2's Eye Procedure Physician's note dated 03/04/19 revealed:
-A cataract removal was performed on 03/04/19.
-Because of Resident #2's medical history, topical anesthetic was used instead of the general anesthesia.
-After the procedure was performed Resident #2 was stable and taken to recovery.

Interview with a housekeeper on 03/13/19 at 9:00am revealed:
-Resident #2 was always up and out of his room and very socially active.
-Resident #2 was one of the fun residents because he always telling jokes.
-Because Resident #2 was always telling jokes, he made her smile more while working at the facility.

Interview with the RCD on 03/14/19 at 8:22am and 8:33am revealed:
-Resident #2 was always singing and laughing with the staff and other residents.
-Resident #2 used a rollator to get around the facility.
-She considered Resident #2 very active.
-She was out of the facility on 03/03/19 - 03/09/19 and returned to work on 03/11/19.
-On 03/11/19 Resident #2 was very quiet, which was not his normal behavior. Resident #2 was usually very social.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 273	Continued From page 10	D 273		

-On 03/11/19 Resident #2 had his shoes on the wrong feet and would forget his rollator.
-On 03/12/19 around 7:00am she received report from the night shift MA Resident #2 was confused and up all night at the Nurses desk.
-On 03/12/19 Resident #2 was worse than the day before in the fact he was found on the toilet by the staff. He was "stiff" and non-verbal.
-She and the Administrator checked on Resident #2 and found him to be unable to answer questions, pale and very "stiff".
-She called the physician and received a telephone order to send Resident #2 out to the ER for evaluation.

Telephone interview with Resident #2's physician on 03/14/19 at 9:08am revealed:
-Resident #2 was seen for the first and only time on 02/12/19 for the new resident visit.
-He did not know Resident #2 had an eye procedure on 03/04/19.
-The only call or communication made to him or his office was on 03/12/19 concerning Resident #2 Altered Mental Status (AMS) and requesting to send Resident #2 to the ER.
-He gave a verbal order to send Resident #2 to the ER.
-There was no communication in Resident #2's record related to any decline or a change of condition.
-He expected the facility staff to notify him of the change in Resident #2's condition especially since the routine lab work (CBC, BMP, UA, A1C) he ordered on 02/25/19 could not be completed until 03/11/19 by the home health agency.
-He would have had the Corporate Nurse at the facility draw them as soon as Resident #2 was reported having the change in condition to check for reasons in the significant change.
-He considered a change as confusion,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

(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 273	Continued From page 11	D 273		

weakness, Resident #2 not finishing his sentences and anything other than the normal mental status.
-He would not have been able to address the issue unless the facility would have notified him.

Interview with a medication aide (MA) on 03/14/19 at 9:17am revealed:
-Resident #2 was active in the facility.
-Resident #2 used a rollator to get around in the facility.
-Resident #2 "joked around" with the staff and other residents.
-Resident #2 was very "social" and participated in activities every day.
-She went looking for Resident #2 just after breakfast started because he did not show up for breakfast and found Resident #2 sitting on his toilet, pale, non-verbal and "stiff".
-Resident #2 was no able to answer any questions just "moan".
-She and the PCA helped Resident #2 to his bed. It was very difficult for the two of them to get him to his bed. Resident #2 was having difficulty bearing weight because he was so weak.
-She had the PCA get the RCD and the Administrator.
-Resident #2 was sent to the ER.
-She notified Resident #2's family and completed the Accident/Incident form.

A follow-up interview with the housekeeper on 03/14/19 at 10:10am revealed:
-She noticed Resident #2 was "getting bad" not as active and joking around like normal after his eye surgery on 03/04/19.
-Resident #2 complained of his eye hurting and would not leave the eye patch alone.
-Resident #2 ambulated using a walker to the dining room for his meals, but on 03/11/19 he did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 273	Continued From page 12	D 273		

not go to the dining room for lunch.
-On 03/11/19 Resident #2 stayed in bed most of day, the staff took his lunch meal into the room.
-"He was real bad on 03/12/19 when the MA sent him out."

Interview with the PCA on 03/14/19 at 10:22am revealed:
-Resident #2 was "acting funny" on 03/11/19.
-Resident #2 stayed in his room on 03/11/19.
-Resident #2 complained "his belly hurt."
-On 03/11/19 Resident #2 was not eating or using his walker.
-She and the MA knew Resident #2 was not "acting himself" on 03/11/19 after the shift report at 7:00am.

Interview with Resident #2's roommate on 03/14/19 at 10:35am revealed:
-After Resident #2 had his eye surgery "he started going downhill."
-Resident #2 would not leave the eye patch alone and would "mess with" his eye all the time.
-Resident #2 complained of his stomach hurting about 4 or 5 days after his eye surgery (03/04/19).
-Resident #2 stayed up all night one night walking around the room and getting in the cabinet drawers.
-The roommate often helped Resident #2 get out of bed.
-The roommate noticed Resident #2's grips were weak on the left side when he tried to assist him using the walker.
-Resident #2's hands were shaking at lunch (could not recall the date) and he spilled his tea.
-Resident #2's family came 3 or 4 times after his eye surgery on 03/04/19.
-"The staff knew" Resident #2 "was not doing well over the weekend."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

(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 273	Continued From page 13	D 273		

-The roommate told both the housekeeper and the MA Resident #2 was not doing well on Friday (03/08/19).
-Resident #2's family member spoke to the MA on Friday about Resident #2 not doing well because," I heard him".
-Resident #2 would sit on the toilet 10 or 12 hours trying to have a bowel movement and complained of "belly pain", On 03/12/19 "Every time I came into the room he was in the bathroom."
-On 03/12/19 "It took two staff to get [Resident #2] off the toilet and onto the bed."
-He was moaning and looking upward when they put him in bed, "I thought he was going to die."

Interview with the Administrator on 03/14/19 at 11:30am revealed:
-Resident #2 was very active at the facility and used a rollator to help with ambulation.
-Resident #2 "cuts up" with the staff.
-She spoke with Resident #2's family on 03/04/19 after Resident #2 returned from his procedure.
-Resident #2's family member also spoke with her on 03/08/19 about Resident #2 "not acting right".
-She did not think anything of it because he had a procedure done on 03/04/19 but if Resident #2 continued to have issues over the weekend she would notify him and the physician.
-On 03/10/19 she worked as a MA during first shift and Resident #2 was not his normal happy, joking self.
-She did not notify the physician any time after speaking with Resident #2's family because she did not see the need.
-On 03/11/19 the RCD reported to her Resident #2 was at the nurse's station all night Sunday night (03/10/19).
-She did not call the physician on 03/11/19 and did not know why the staff did not call the physician during 3rd shift on Sunday night.

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	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

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D 273	Continued From page 14	D 273		

-On 03/12/19 the PCA came and got her and the RCD because Resident #2 was found on his toilet unable to answer any questions and "stiff".
-The RCD called the physician on 03/12/19 and reported Resident #2 was not acting right and was pale, weak and not able to answer questions.
-A telephone order was given to send Resident #2 to ER for evaluation.
-The policy was to notify the physician with any changes in condition or accidents.
-She could not give an answer as to why the physician was not notified after she had spoken to Resident #2's family member or after Resident #2 was not acting like himself.

Follow-up interview with Resident #2's family member on 03/14/19 at 5:00pm revealed:
-Resident #2 was admitted to the hospital on 03/12/19 for sepsis, sepsis, acute kidney failure, high potassium and low blood sugar.
-The ER physician told him if Resident #2 was "seen even just 5 days earlier, it would have made a difference in the outcome" of Resident #2.
-As of right now Resident #2 may not live past this hospitalization.
-He expected the facility staff to notify the physician about Resident #2 not acting right after the procedure.
-Resident #2 declined rapidly after the procedure.

Review of Resident #2's lab results dated 03/12/19 revealed sepsis was diagnosed because the White Blood Count (WBC) was 23.2 (normal 3.6-10.4) and the Lactic Acid level, (when the oxygen level is low, carbohydrates break down for energy and makes lactic acid. Lactic acid levels gets higher when strenuous exercise or other conditions such as heart failure, a severe infection (sepsis), or shock lower the flow of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 273	Continued From page 15	D 273		

blood and oxygen throughout the body) was 42 (normal 0.4-2.2mmol/L).

Review of the History and Physical Disposition dated 03/12/19 at 10:46pm revealed:
-The physician had a conversation with Resident #2's family about the disposition of Resident #2.
-The physician spoke with Resident #2's family and told them, he "felt with multisystem organ failure, most likely he will pass away during the hospital stay because of the active issues at this point in time".

Review of Resident #2's Critical Care Consult dated 03/12/19 revealed:
-A broad spectrum antibiotic was used to treat the sepsis.
-The AMS was likely caused secondary to the sepsis.

b. Review of Resident #2's current FL-2 dated 02/25/19 revealed:
-An order to check the FSBS three times a day.
-An order for Novolog SSI three times a day as follows; 150-200 =2units, 201-250 = 4units, 251-300 = 6units, 301-350 = 8units, 351-400 = 10units, if the FSBS was greater than 400 give 12units and call the physician.

Review of Resident #2's February 2019 Medication Administration Record (MAR) revealed:
-An entry for FSBS three times a day.
-An entry for Novolog SSI three times a day as follows; 150-200 =2units, 201-250 = 4units, 251-300 = 6units, 301-350 = 8units, 351-400 = 10units, if the FSBS was greater than 400 give 12units and call the physician.
-There were 7 out of 81 opportunities for a FSBS check that were documented as refused.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 273	Continued From page 16	D 273		

-There were 27 out of 74 remaining opportunities for a FSBS check that were blank.
-There was no insulin documented as administered for the 34 opportunities that were blank or documented as refused.
-There was no documentation on the February 2019 MAR the physician was notified of the refusals of FSBS.

Review of Resident #2's March 2019 Medication Administration Record (MAR) revealed:
-An entry for FSBS three times a day.
-An entry for Novolog SSI three times a day as follows; 150-200 =2units, 201-250 = 4units, 251-300 = 6units, 301-350 = 8units, 351-400 = 10units, if the FSBS was greater than 400 give 12units and call the physician.
-There were 9 out of 36 opportunities for a FSBS check that were documented as refused.
-There were 5 out of 27 remaining opportunities for a FSBS check that were blank.
-There was no insulin documented as administered for the 14 opportunities that were blank or documented as refused.
-There was no documentation on the March 2019 MAR the physician was notified of the refusals of FSBS.

Review of Resident #2's Care Notes revealed there were no entries documented from 02/02/19 to 03/12/19 related to refusals of FSBS.

Review of the facility Medication/Treatment Refusal Report revealed there were no forms completed for the FSBS refusals from 02/02/19 to 03/12/19.

Telephone interview with Resident #2's physician on 03/14/19 at 9:08am revealed:
-Resident #2 was seen for the first and only time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

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THE COUNTRY HOME	2908 COUNTRY HOME ROAD CONCORD, NC 28025

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D 273	Continued From page 17	D 273		

on 02/12/19 for the new resident visit.
-He had no communication with the facility staff regarding Resident #2's FSBS refusals.
-There was no documentation in Resident #2's office record related to Resident #2's FSBS refusals.
-When he saw Resident #2 on 02/25/19 it was a new resident visit and the facility staff reported Resident #2 had high uncontrolled FSBS and because of the those high FSBS (200-400's) he ordered another medication to take on top of the insulin to treat the high FSBS's.
-The increased lactic acid levels could be caused by many factors.
-It is possible that the increased lactic acid levels were caused from Resident #2 taking the metformin.
-It is possible the sepsis caused the lactic acid level to increase.
-It was impossible for him to pinpoint the exact cause of the increased lactic acid levels in Resident #2 but did consider the addition of the Metformin a possible cause of the lactic acid level increase.
-He expected the facility to report the refusals of the FSBS to him because if Resident #2 was taking the SSI as directed it would have prevented the unnecessary additional medication that had a side effect that could cause a buildup of lactic acid and cause serious harm to Resident #2.

Interview with the MA on 03/14/19 at 9:17am revealed:
-Resident #2 refused his FSBS often and she would document the refusals on the back of the MAR.
-She did not report any refusals to the physician because there were to be 3 in a row and she only took the lunch FSBS.

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	HAL013050	A. BUILDING: _____ B. WING _____	R-C 03/14/2019

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D 273	Continued From page 18	D 273		

-The RCD was responsible for checking the MARs weekly for refusals, missed doses and blank entries and report to the physician when needed.

Interview with the RCD on 03/14/19 at 10:40am revealed:
-She did not know Resident #2 refused FSBS in February or March 2018.
-All refusals were documented on the MAR, Medication/Treatment Refusal Report, and the Care Notes.
-She reviewed the MARs weekly and she did not know how she missed Resident #2's refusals of the ordered FSBSs.
-The Medication/Treatment Refusal Reports were to be faxed to the physician after every refusal and a return fax on the further orders from the physician was to be put into place and the copy of the form was to be placed in to the resident's record after the new orders were received.
-She did not notify the physician because she did not know about the refusals.

Interview with the Administrator on 03/14/19 at 11:30am revealed:
-She did not know Resident #2 had refused FSBSs.
-The policy was for the MA to document the refusals on the back of the MAR.
-The RCD was responsible for reviewing all of the MAR's on a daily basis to check for refusals, missed medications and order parameter issues and complete the Medication/Treatment Refusal Report and fax that to the physician every time.
-A form that was seen by the physician was signed by the physician and faxed back to the facility with new ordered if indicated.
-She did not know why the form was not completed and faxed to the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 19 The facility failed to notify the medical provider for Resident #2 and delayed transport to the emergency room (ER) which resulted in a hospital stay and a diagnosis of multisystem organ failure and the serious harm and failure to report refusal of finger stick blood sugars (FSBS) and SSI administration which lead to the order for an unnecessary medication with serious life threatening side effects that contributed to the hospital stay, which resulted in serious physical harm and neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/14/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 13, 2019.	D 273		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care referral and follow-up.	D912		

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D912	Continued From page 20 The findings are: 1. Based on interviews and record reviews, the facility failed to contact the primary care physician for the acute and routine health care needs of 1 of 5 sampled residents (Resident #2) related to delaying transport to the emergency room (ER) and refusals of finger stick blood sugars (FSBS) and sliding scale insulin (SSI) administration. [Refer to Tag 273, 10A NCAC 13F .0902 (b)Health Care. (Type A1 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights 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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents are free of neglect in compliance with federal and state laws and rules and regulations related to health care referral and follow-up. The findings are: 1. Based on interviews and record reviews, the facility failed to contact the primary care physician for the acute and routine health care needs of 1 of 5 sampled residents (Resident #2) related to delaying transport to the emergency room (ER) and refusals of finger stick blood sugars (FSBS) and sliding scale insulin (SSI) administration.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	Continued From page 21 [Refer to Tag 273, 10A NCAC 13F .0902 (b)Health Care. (Type A1 Violation)].	D914		