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	Hal089002	A. BUILDING: _____ B. WING _____	05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

(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 conducted an annual survey and complaint investigation on 05/06/19 through 05/17/19.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to maintain an environment free of hazards in the special care unit as evidenced by Resident #9's room having a bed bug infestation that was left untreated for 7 days and a broken window in resident room 209 that was not repaired for more than 6 weeks. The findings are: 1. Interviews with a personal care aide (PCA) on 05/07/19 at 4:48am and 5:05am revealed: -There was a bedbug infestation at the facility in the special care unit (SCU). -She found 2 bedbugs crawling on her about a month ago while she was working in the SCU. -She reported it to the medication aide (MA) on	D 079		

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duty but she could not recall which MA was working at that time.
-She had not seen any bedbugs in residents' rooms until this past Saturday night (5/04/19).
-Resident #9 came out of her room on Saturday night and said something was biting her.
-Another PCA went into Resident #9's room and discovered there were bedbugs in the room.
-The other PCA came and got her and they went into Resident #9's room together.
-They saw multiple bedbugs on Resident #9's pillows, sheets, and bedspread.
-They did not see any bedbugs on the mattress.
-They removed the bedding, bagged it, and washed it all in hot water and dried it.
-They checked Resident #9's arms for bedbug bites but they could not tell if there were any bites because the resident's arms always had bruises.
-The other PCA also checked the room next to Resident #9's room but the PCA did not see any bedbugs in that room.
-She thought the MA on duty reported the bedbugs to the Care Manager (CM).
-She did not know if anything had been done about the bedbugs.
-She had never seen any bedbugs on the assisted living (AL) side of the facility.

Interview with a second MA on 05/14/19 at 9:10am revealed:
-Resident #9 came out to the front desk on the SCU and said she was itching overnight on 05/04/19.
-She found three bed bugs on Resident #9's arm.
-She went and checked the resident's room and there were bed bugs "everywhere."
-There approximately 40 bed bugs on the sheet, the pillow and along the seams of the pillow.
-She knew they were bed bugs because she looked bed bugs up online that night.

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-She checked the seams of the mattress but did not find any bed bugs.
-She had read online that heat killed the bed bugs.
-She and the PCA removed the bed linens, pillows, stuffed animals and blankets and washed and dried them three times.
-She saw bed bug eggs on the sheet corners; she knew what they looked like from online images.
-It was hard to tell if Resident #9 had bite marks before 05/05/19.
-Resident #9 had dry skin with red spots and was always scratching before 05/05/19.
-She had administered medications to Resident #9 every morning and had never seen any bed bugs before 05/05/19.
-She was told the day shift (7:00am-3:00pm) on 05/05/19 cleaned Resident #9's clothing.

Interview with the CM on 05/08/19 at 3:17pm revealed:
-Staff had reported to her over the last weekend (05/05/19) that bed bugs were found in Resident #9's room.
-She could not remember which staff reported finding the bed bugs.
-The process for managing bed bugs in the facility was for staff to report to her and she reported to the Administrator.
-The Administrator would then put a work order in the computer and maintenance would come out to the facility and treat the room.
-Resident #9's room had not been treated for bed bugs as of 05/08/19 because the facility was waiting for the pest control company.
-Resident #9 was staying with a family member until the room had been treated for bed bugs.

Observations of Resident #9's room on 05/07/19 at 4:44am revealed:

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-The mattress was turned up on the box spring and leaned against the wall at the head of the bed.
-There were no linens on the mattress.
-There were personal items in the room such as a blanket on the recliner, throw pillows, plastic storage bins and clothing in the closet and drawers.
-None of the clothing, blanket or throw pillows were sealed in plastic bags.
-The recliner had fine white particles in the folds of the chair that resemble bed bug eggs.
-There was dirt and dust build up on and around the carpet on the floor.
-There was no resident in the room.

Observations of Resident #9's room on 05/09/19 from 12:35pm until 12:45pm revealed:
-There were small black specks resembling bed bug excrement around the call bell, electrical outlet, a picture hanger on the wall above the bed and around a small hole in the wall in the corner above the headboard.
-There were two small pale bed bugs next to the picture hanger and four small pale bed bugs on the headboard.
-There was a live bed bug where the wall meets the ceiling above the window.

Interview with the Administrator on 05/09/19 at 12:47pm revealed:
-Bed bug management at the facility was "a process and time frames were different."
-When staff found bed bugs in a resident's room, the staff sent photos of the bed bugs to her via cell phone.
-She sent the bed bug photos to her maintenance staff and he sent the photos to his supervisor and the pest control company.
-The pest control company would then come out

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and heat treat the room.
-She had a copy of the work order she put in for the bed bugs in Resident #9's room.
-She was not aware of the evidence of bed bugs on the walls in Resident #9's room.

Review of a computerized work order dated 05/06/19 revealed:
-There was documentation of a "Life safety" work order for bed bugs in Resident #9's room.
-The work order was from the Administrator and assigned to the canine handler.

Review of emails between the the Administrator, the Maintenance District Manager (MDM) and the canine Manager dated 05/07/19 and 05/08/19 revealed:
-On 05/07/19 at 10:43am, there was documentation an image was sent from the the Administrator to the MDM.
-On 05/07/19 at 10:46am, there was documentation the MDM forwarded the image to the canine Manager.
-On 05/07/19 at 10:57am, the canine Manager replied an inspection would be scheduled for after 05/08/19.
-On 05/08/19 at 8:54am, the MDM forwarded the canine Manager's reply to theAdministrator.

Interview with the maintenance staff on 05/09/19 at 5:07pm revealed:
-He had been notified by the Administrator on 05/05/19 about the bed bugs in Resident #9's room.
-He followed up with his supervisor on 05/06/19 to coordinate pest control treatment of the room.
-He closed off the room, so no one was able to enter the room.
-There was nothing else he could do to prevent the spread of the bed bugs.

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D 079	Continued From page 5 Observation on 05/13/19 at 11:30am revealed Resident #9's room was unchanged from observation on 05/07/19 at 4:44am; all personal belongings remaining un-bagged and in the room. Interview with a housekeeper on 05/14/19 at 1:15pm revealed: -He worked at the facility for a couple of weeks on the AL side. -He had not seen any bed bugs in the facility. -He was told by the Regional Clinical Director (RCD) to put the residents clothing in the dryer at 400 degrees Fahrenheit for one hour if bed bugs were found. -He was not sure how to clean a room after finding bed bugs -He knew the room needed to be wiped down; he did not know what chemicals to use. Interview with the Housekeeping Supervisor on 05/14/19 at 1:35pm revealed: -He had not seen any bed bugs while cleaning rooms on the SCU. -Housekeepers were responsible for spraying and cleaning any resident rooms where bed bugs were found daily until the pest control company came. -They used a spray with a chemical that was already mixed. -The resident's personal belongings were bagged up and taken to the laundry room where it was dried several times, washed and dried again. Interview with the Administrator on 05/15/19 at 2:55pm revealed: -Resident #9's room 203 suite A had been cleared out. -Resident #9's clothing was placed in plastic bags, sealed and taken outside and placed by the	D 079		

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D 079	Continued From page 6 storage unit. The family member was going to pick up Resident #9's clothing. -The family member said to throw away the recliner and any other furniture belonging to Resident #9. -The facility's headboard and bed frame were wiped down and sprayed with rubbing alcohol. -The room had been sealed off and was awaiting heat treatment by the pest control company. -The facility had started clearing Resident #9's room out on 05/12/19. -The last pieces of personal furniture were discarded on 05/14/19. -Resident #9 would return to the facility following the pest control treatment of the resident's room. -She had contacted the corporate office at the beginning of the week (05/13/19) to have the pest control company come out and treat for bed bugs. -The pest control company would not be available until the end of the week (05/17/19). -While the facility was waiting for the pest control treatment for bed bugs, staff were expected to bag clothing and linen immediately and place in the dryer. -Staff were expected to take the resident to shower, dress in a hospital gown and dry the removed clothes. -Staff were expected to wipe down furniture in the room and spray rubbing alcohol. -Staff were expected to check for bed bugs in the adjoining suite. -Follow up inspections for bed bugs were done by the canine inspector and/or pest control company. -She had spoken with the family members of the residents earlier in the week (05/13/19) related to the bed bugs.	D 079		

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Telephone interview with the MDM on 05/14/19 at 11:53am revealed:
-He was contacted about bed bugs at the facility on 05/08/19.
-Staff sent the location and pictures of the bed bugs that were found in the facility.
-He forwarded the information from the facility to the canine inspector.
-The canine inspector went out to the facility to identify which rooms bed bugs were active in.
-The canine inspector then emailed a report to him and the facility; then the pest control company was contacted to treat for the bed bugs.

Observation on 05/13/19 at 11:20am revealed there was a dog going room to room in the facility with the canine handler.

Interview with the canine handler on 05/13/19 at 11:30am revealed there were findings that he would put in his report to the Administrator.

Review of the canine inspection report dated 05/13/19 revealed:
-An inspection was completed on all areas of the facility including 60 rooms.
-Concerns were identified in Resident #9's room and another room.
-Next step were listed as notify pest control company and recheck in 30 days.
-There was documentation the facility's last treatment was on 04/08/19.

Telephone interview with a representative of the pest control company on 05/14/19 at 3:30pm revealed:
-A technician would go out to the facility and inspect for bed bugs and determine what type of treatment was needed (spray and/or heat).
-Canine inspection was also used to inspect for

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bed bug activity.
-Canine inspections were the most effective way of finding bed bug activity.
-The pest control company did not provide instructions on isolating, treating or preventing bed bugs.
-The pest control company would get out to treat the facility once contacted, as soon as possible.
-The facility had been treated for bed bugs seven times by the pest control company.
-The pest control company required permission from the facility to release past treatment information.
-The facility had not contacted the pest control company for a bed bug treatment for May 2019.

Interview with the pest control technician on 05/16/19 at 2:24pm revealed:
-He was at the facility to heat treat furniture from Resident #9's room.
-He was going to remove the wall receptacles and treat the wall spaces and general area of Resident #9's room.
-He did not inspect the entire facility, only rooms adjacent to the room of concern.
-He was notified yesterday by his Supervisor to treat for bed bugs at the facility.
-The company had a call center out of another state, so it was difficult to determine when the call originally came in before going to the Supervisor.
-The only instructions left with the facility were to keep the room closed off overnight with any staff or residents entering the following day.

Interview with the Administrator on 05/15/19 at 12:30pm revealed:
-The canine inspector contacted the pest control company on behalf of the facility.
-The canine inspector gives the pest control company information on where bed bug activity

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was found.
-She contacted the canine inspector to request contact with the pest control company for treatment of the bed bugs.
-The canine inspector told the Administrator he would try to get the pest control company to the facility by the end of the week.

Interview with the RCD on 05/14/19 at 4:50pm revealed the facility had a policy and procedure for bed bug management; the staff had not followed it.

Review of the facility's undated bed bug protocol revealed:
-Until bed bugs were confirmed the following step were to be followed for the safety and well-being of residents and to prevent the spread of bed bugs.
-Carefully remove bedding and clothing and place into bags and tie closed.
-Immediately carry bags to the laundry and place bag inside the dryer and dump items into the dryer...do not leave bags sitting in the laundry area.
-Remove bag and seal it inside another bag; carry the bag out of the facility to the dumpsters immediately.
-Do not move the resident or their belongings to another room.
-Suspected rooms must be cleaned thoroughly.
-Beds must be taken apart, vacuumed crack and crevice, cleaned thoroughly ...and isolated until pest control can treat.
-Pictures, purses, personal items including wheelchairs and walkers must be cleaned.
-Housekeeping must thoroughly vacuum and wipe down all surfaces to include baseboards, furniture (inside and out), beds, closets, pictures, and personal items daily.

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D 079	Continued From page 10 2. Review of documentation on a "Care Note" for Resident #16 dated 04/01/19 revealed: -Resident #16 "went into another resident's room and pulled the window up and looked out the window." - "When staff heard noise and approached the resident, the resident came from under the window and the window cracked." Observation on 05/08/19 at 2:47pm revealed: -There was a glass repair technician removing the lower window pane in resident room 209. -The window pain was fully covered with cardboard and black tape. Interview with a housekeeper on 05/08/19 at 2:47pm revealed he did not know what happened to the window in resident room 209. Interview with a personal care aide (PCA) on 05/08/19 at 2:47pm revealed: -She did not know how long the window had been broken or what happened. -The Administrator would know. Interview with a medication aide (MA) on 05/08/19 at 2:53pm revealed she thought a rock from the lawnmower hit the window last week, but she wasn't sure. Interview with the Care Manager (CM) on 05/08/19 at 3:12pm revealed she was not sure "off the top of her head" what happened and when to the window in resident room 209; the Administrator would know. Interview with the Administrator on 05/08/19 at 3:12pm revealed: -Resident #16 was seeking to get out of the	D 079		

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window in another's resident room (room 209) around the first of April 2019.
-The resident tried to lift the window and get out through the screen, but the window only opened about four inches.
-The staff found the resident at the window.
-She could not remember the details of which resident, which staff and when the incident occurred.
-She would have to check her paperwork and incident reports.

Upon request on 05/08/19 at 3:12pm, there was no incident report for the broken window and the attempted elopement by a resident.

Interview with a concerned citizen on 05/10/19 at 1:00pm revealed:
-Another resident had broken the window in room 209 over a month ago and they did not repair it until this week (05/06/19).
-The Care Manager (CM) had said Resident #16 was upset and wanted to go home so the resident" busted the window."
-The entire window was broken and had cardboard covering the opening.
-For the time the window had been broken, the CM had told her the facility was going to try to do the repair "in house as inexpensively as possible."

Interview with a PCA on 05/10/19 at 1:30pm revealed:
-The window in room 209 was broken over a month ago on 04/01/19 by Resident #16.
-When the PCA had checked on Resident #16, she was not in her room.
-The PCA found the resident in another room (209) at the window. The window was cracked.
-Resident #16 had pulled the window up and was

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trying to get her head and shoulders through the window.
-The resident refused to move away from the window, so she left the room to get the CM.
-When she and the CM came back into the room, the resident was still attempting to get out.
-She and the CM assisted the resident away from the window and the broken window fell out onto the ground.
-The maintenance staff covered the window with a piece of cardboard and covered the cardboard with clear plastic. The plastic and cardboard was taped by maintenance and the cardboard and tape remained on the window until repaired 2 days ago.

Interview with a PCA on the special care unit (SCU) on 05/14/19 at 10:10am revealed:
-Resident #16 was trying to get out of the facility and kicked the window out in room 209 last month (May 2019) but she did not remember the date.
-The resident had pulled the window up and could not get out.
- Another staff and she observed her with part of her body out of the window (her head and shoulders), but she got stuck.
-Maintenance tape cardboard over the window and the cardboard remained over the window until last week.

Interview with the Administrator on 05/14/19 at 3:45pm revealed:
-Resident #16 broke the window in room 209 and pushed the screen out and was observed with her head out of the window.
-Staff heard noise in room 209 and when they went in the room, Resident #16 had already broke the window and had her head out of the window.

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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 079	Continued From page 13 -The Administrator did not know why there was a delay in replacing the window. Interview with the maintenance staff on 05/16/19 at 3:13 pm revealed: -The window in room 209 was broken and kicked out around the 1st of last month (May 2019) by a resident who was trying to get out of the window. -He taped a temporary cover over the window which were cardboard and plastic covering taped to the window. -The window was replaced last week by a glass repair company. -The facility was responsible for contacting the glass company and scheduling replacement of the window. _____ The facility failAdministrator to maintain an environment free of hazards related to bed bugs and broken windows in resident rooms on the special care unit (SCU). The facility's failure to prevent the spread of bed begs for 7 days and prevent possible elopement and/or injury from an un-repaired broken window for more than 6 weeks was detrimental to the health, safety and well-being of residents on the SCU and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2019.	D 079		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to	D 113		

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	Hal089002	A. BUILDING: _____ B. WING _____	05/17/2019

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D 113	Continued From page 14	D 113		

provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure hot water temperatures were maintained between 100 - 116-degrees Fahrenheit (F) as evidenced by hot water temperatures lower than 100°F from five fixtures in the special care unit (SCU).

The findings are:

Observations on 05/07/19 in the SCU between 4:35am and 1:14pm revealed:
-At 4:35am, the hot water temperature at the bathroom sink in room 209 was 88 degrees F.
-At 4:40am, the hot water temperature at the bathroom sink in room 212 was 88 degrees F.
-At 4:45am, the hot water temperature at the bathroom shower in room 212 was 83 degrees F.
-At 1:11pm, the hot water temperature at the bathroom sink in room 207 was 83 degrees F.
-At 1:14pm, the hot water temperature at the shower in room 207 was 86 degrees F.

Interview with the Administrator on 05/07/19 at 1:40pm revealed:
-She was not aware the water temperatures at the fixtures on the SCU back hall were cold.
-The maintenance staff checked the hot water temperatures weekly and documented the

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D 113	Continued From page 15	D 113		

temperatures in a "Hot Water Log."
-She would contact the maintenance staff and he would follow-up and schedule a plumber to come to the facility to check the hot water heater.
-The staff had not reported cold water temperatures to the Administrator.

Interview with the resident in room 207 on 05/08/19 at 2:45pm revealed:
-The water temperature in the bathroom (the sink and the shower) was cold even if the water was running for several minutes.
-The water temperature needed to be "fixed".
-He did not know how long the water had been cold.
-The staff either assisted him with his showers in the big bathroom (Spa) or gave him a bed bath with water in a pan.

Interview with the residents in room 212 on 05/08/19 at 2:56pm revealed:
-The water temperature at the sink and shower was "off", it was cold
-They could not take a shower because the water was too cold.
-They complained of the cold water to the staff multiple times, but nothing had been done to fix the water.
-The water has been cold for a few weeks.
-The maintenance guy had been in their bathroom earlier today looking at the water.

Interview with a personal care aide (PCA) on 05/08/19 at 3:15pm revealed:
-The back hall of the special care unit had cold water at the sink and shower fixtures.
-The residents complained of cold water when bathing or using the water.
-The staff was instructed to give all bathes on the front hall in the spa.

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D 113	Continued From page 16 -She did not know how long the water temperatures on the back hall had been cold. Interview with the Administrator on 05/08/19 at 3:45pm revealed: -A licensed plumber checked the hot water heater on the SCU which provided hot water to the bathrooms on the back hall on the SCU on 5/07/19. -A part had to be replaced and was ordered by the plumber who would return and repair the hot water heater. -The water in the residents' bathrooms on the back hall in the SCU remained cold and staff have been directed to bathe the residents in the spa on the front hall in the SCU. Interview with the maintenance staff on 5/08/19 at 11:35am revealed: -A plumber checked the hot water heater (SCU back hall) on 5/07/19. The "motherboard" needed to be replaced. -The part was ordered and will be installed when the part was delivered to the plumber. -He did not know how long the water had been cold on the SCU back hall. -He randomly checked hot water temperatures on the SCU weekly. -He checked the hot water at the fixtures and the water temperature was cold (87 degrees F) at the bathroom sink in room 209 on 4/17/19. -He had not contacted a plumber but had planned to when he returned to the facility. -The Administrator informed him on 5/07/19 of the continued cold water temperatures on the SCU back hall. Review of the facility's "Weekly Water Temperature Checks" log revealed: -On 4/3/19 the hot water temperature at a	D 113		

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D 113	Continued From page 17 bathroom fixture in room 212 was 103 degrees F. -On 4/17/19, the hot water temperature at a bathroom fixture in room 209 was 87 degrees F. There was no documentation of hot water temperatures in room 207 or follow-up temperatures in rooms 212 or 209. Review of an invoice from a plumbing service dated 5/07/19 revealed: -The plumbing service was called by the facility to determine problems with tankless heaters. -Heater had a bad control board and the manufacturer was sending one to the plumber. -As soon as the control board arrived, the plumber would return to install.	D 113		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by:	D 167		

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Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management for 3 of 27 shifts sampled in April 2019 and May 2019.

The findings are:

Review of personnel records, resident census reports, staffing schedules, and time punch detail reports revealed:
-The facility had 3 shifts: first shift was 7:00am - 3:00pm, second shift was 3:00pm - 11:00pm, and third shift was 11:00pm - 7:00am.
-There were no staff on duty with CPR training on Saturday, 04/27/19, during third shift from 11:39pm - 6:59am.
-There were no staff on duty with CPR training on Friday, 05/03/19, during third shift from 11:15pm - 6:59am.
-There were no staff on duty with CPR training on Saturday, 05/04/19, during first shift from 7:00am - 8:29am.

1. Review of Staff A's personnel record revealed:
-Staff A was hired as a personal care aide (PCA) and medication aide (MA) on 06/15/17.
-There was no documentation of Staff A having training on cardio-pulmonary resuscitation (CPR).

Review of time punch detail reports and personnel records revealed:
-Staff A worked on third shift on 04/27/19.
-No other staff on duty with Staff A on 04/27/19 (from 11:39pm - 6:59am) had training on CPR.
-Staff A worked on third shift on 05/03/19.
-No other staff on duty with Staff A on 05/03/19 (from 11:15pm - 6:59am) had training on CPR.

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-Staff A worked on first shift on 05/04/19.
-No other staff on duty with Staff A on 05/04/19 (from 7:00am - 8:29am) had training on CPR.

Interview with the Regional Clinical Director (RCD) on 05/16/19 at 4:40pm revealed:
-She thought Staff A had CPR training but there was no documentation on file at the facility.
-Staff A told the RCD that she had CPR training at another facility in the past (did not know time frame).
-They were trying to contact the other facility to get a copy of Staff A's CPR training.

No further information was provided regarding CPR training for Staff A.

Refer to interview with the Administrator on 05/16/19 at 5:18pm.

Refer to interview with the RCD on 05/17/19 at 4:15pm.

2. Review of Staff C's personnel record revealed:
-Staff C was hired as a personal care aide (PCA) on 01/15/19.
-There was no documentation of Staff C having training on cardio-pulmonary resuscitation (CPR).

Review of time punch detail reports and personnel records revealed:
-Staff C worked on third shift on 04/27/19 until 2:24am.
-No other staff on duty with Staff C on 04/27/19 (from 11:39pm - 2:24am) had training on CPR.

Interview with the Regional Clinical Director (RCD) on 05/15/19 at 2:50pm revealed:
-Staff C no longer worked at the facility as of last week.

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D 167	Continued From page 20 -Staff C did not have CPR training. -Staff C was no longer employed by the facility and unavailable for interview. Refer to interview with the Administrator on 05/16/19 at 5:18pm. Refer to interview with the RCD on 05/17/19 at 4:15pm. 3. Review of Staff E's personnel record revealed: -Staff E was hired as a personal care aide (PCA) on 03/18/19. -There was no documentation of Staff E having training on cardio-pulmonary resuscitation (CPR). Review of time punch detail reports and personnel records revealed: -Staff E worked on third shift on 04/27/19. -No other staff on duty with Staff E on 04/27/19 (from 11:39pm - 6:59am) had training on CPR. -Staff E worked on third shift on 05/03/19. -No other staff on duty with Staff E on 05/03/19 (from 11:15pm - 6:59am) had training on CPR. Interview with the Regional Clinical Director (RCD) on 05/15/19 at 2:50pm revealed: -Staff E no longer worked at the facility. -Staff E did not have CPR training. Staff E was no longer employed by the facility and was unavailable for interview. Refer to interview with the Administrator on 05/16/19 at 5:18pm. Refer to interview with the RCD on 05/17/19 at 4:15pm. 4. Review of Staff F's personnel record revealed:	D 167		

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D 167	Continued From page 21 -Staff F was hired as a personal care aide (PCA) on 03/29/19. -There was no documentation of Staff F having training on cardio-pulmonary resuscitation (CPR). Interview with the Regional Clinical Director (RCD) on 05/15/19 at 2:50pm revealed Staff F did not have CPR training. Refer to interview with the Administrator on 05/16/19 at 5:18pm. Refer to interview with the RCD on 05/17/19 at 4:15pm. Interview with the Administrator on 05/16/19 at 5:18pm revealed: -When she worked as the Business Office Manager (BOM) prior to becoming the Administrator, she was trained that all medication aides (MAs) had to have cardio-pulmonary resuscitation (CPR) training. -No other staff were required to have CPR training because there should always be a MA on duty. -The CPR certificates were supposed to be kept in the personnel files. -The facility's previous BOM left employment with the facility on 04/26/19 and would have been responsible for making sure CPR training was completed by all MAs and kept on file. -She and the Care Manager (CM) were responsible for making the schedule and they always made sure a MA was on duty. -She thought the facility was covered with CPR training at all times because she thought all of the MAs had CPR training. -If there was only 1 MA on duty, the MA was not allowed to leave the premises while on break.	D 167		

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D 167	Continued From page 22 -If there were 2 MAs on duty, 1 MA could leave the premises for break as long as the other MA was on the premises. -She did not have a system in place to check the personnel files to assure CPR training was on file and up-to-date. Interview with the Regional Clinical Director (RCD) on 05/17/19 at 4:15pm revealed: -The BOM was responsible for assuring CPR training was on file for staff. -A new BOM just started working at the facility about a week ago and had not been trained yet on responsibilities with the personnel files, including CPR training. -She was unable to locate documentation of any other current staff having CPR training. -They planned to have CPR classes at the facility next week.	D 167		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census	D 188		

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D 188	Continued From page 23 or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure aide hours met the minimum requirements on 15 of 27 shifts for 9 days sampled in April 2019 and May 2019 resulting in inadequate staff to meet the supervision and personal care needs of residents. The findings are: Review of the facility's 2019 license for adult care	D 188		

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homes revealed:
-The facility was licensed for a capacity of 50, including 24 beds licensed as special care unit (SCU).
-The capacity for the assisted living (AL) side of the facility was 26.

Review of a resident census report dated 04/19/19 revealed the facility's in-house census on the AL side was 25 residents.

Review of the punch time detail report dated 04/19/19 revealed:
-There were 12.34 staff hours provided on first shift on the AL side, leaving the shift short staffed by 3.26 hours
-There were 15.25 staff hours provided on third shift on the AL side, leaving the shift short staffed by 0.35 hours.

Review of a resident census report dated 04/20/19 revealed the facility's in-house census on the AL side was 25 residents.

Review of the punch time detail report dated 04/20/19 revealed there were 6.32 staff hours provided on first shift on the AL side, leaving the shift short staffed by 1.28 hours.

Review of a resident census report dated 04/21/19 revealed the facility's in-house census on the AL side was 24 residents.

Review of the punch time detail report dated 04/21/19 revealed:
-There were 13.98 staff hours provided on first shift on the AL side, leaving the shift short staffed by 2.02 hours.
-There were 7.15 staff hours provided on third shift on the AL side, leaving the shift short staffed

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D 188	Continued From page 25 by 0.85 hours. Review of incident logs, progress notes, post fall reports and interviews revealed: -Resident #14 had a fall on first shift at 10:00am while the facility was short staffed. -[Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision]. Review of a resident census report dated 04/22/19 revealed the facility's in-house census on the AL side was 24 residents. Review of the punch time detail report dated 04/22/19 revealed there were 14.28 staff hours provided on first shift on the AL side, leaving the shift short staffed by 1.88 hours. Review of a resident census report dated 04/27/19 (Saturday) revealed the facility's in-house census was 25 residents. Review of the punch time detail report dated 04/27/19 (Saturday) revealed: -There were 13.5 staff hours provided on first shift on the AL side, leaving the shift short staffed by 2.5 hours. -There was one medication aide (MA) on duty for the facility for first shift; seven of the MA's hours were assigned to the AL side. -There was no punch time detail for a dietary aide. -There were two cooks on duty from 6:23am until 6:31pm. -There were 3.5 staff hours provided on third shift on the AL side, leaving the shift short staffed by 4.5 hours. -There was one MA on duty for the facility for third shift.	D 188		

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Review of a resident census report dated 04/28/19 revealed the facility's in-house census was 25 residents.

Review of the punch time detail report dated 04/28/19 (Sunday) revealed:
-There were 15 staff hours provided on first shift on the AL side, leaving the shift short staffed by 1 hour.
-There was one MA on duty for the facility on first shift.
-There was no punch time detail for a dietary aide.
-There were two cooks on duty from 6:25am until 6:15pm.

Interview with a second MA on 05/14/19 at 5:50pm revealed:
-When she was the only MA on duty in the facility, her time was spent running back and forth between the SCU and the AL side.
-She was never on just one side and probably spent a total of 50% if the shift on the SCU and 50% on the AL side.
-The Manager on Duty did not help with the care and supervision of residents; they were in the office.
-Staff felt burnt out and too tired to respond due to working many days in a row and short staffed.
-"It was like you see, but you don't see and you hear, but you don't hear."

Review of a resident census report dated 05/03/19 revealed the facility's in-house census on the AL side was 24 residents.

Review of the employee punch time cards dated 05/03/19 revealed:
-There were 14 staff hours provided on second shift on the AL side, leaving the shift short staffed

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by 2 hours.
-There were 7.08 staff hours provided on third shift on the AL side, leaving the shift short staffed by 0.92 hours.

Review of a resident census report dated 05/04/19 revealed the facility's in-house census was 24 residents.

Review of the punch time detail report for the AL side dated 05/04/19 revealed:
-There were 7 hours 55 minutes of staff hours provided on first shift on the AL side, leaving the shift short staffed by 8 hours 5 minutes.
-There was one PCA on duty for the facility for first shift.
-There were 13 hours 3 minutes of staff hours provided on second shift on the AL side, leaving the shift short staffed by 2 hours 57 minutes.
-There was one MA on duty for the facility for second shift and 1 PCA on duty for a partial shift.

Interview with the Administrator on 05/14/19 at 5:05pm revealed:
-She had enough staff on duty each shift every day to complete increased safety checks on residents with increased supervision needs.
-She was not aware of any shifts having one PCA for the SCU, one PCA for the AL side and one medication aide covering both the SCU and AL side.

Review of a resident census report for the AL side dated 05/05/19 revealed the facility's in-house census was 24 residents.

Review of the punch time detail report dated 05/05/19 revealed:
-There were 15 hours 23 minutes of staff hours provided on second shift on the AL side, leaving

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the shift short staffed by 37 minutes.
-There was one PCA on duty for the facility, two PCAs on duty for a partial shift and one MA on duty for a partial shift.
-There were 27 minutes of staff hours provided on third shift on the AL side, leaving the shift short staffed by 7 hrs 33 minutes.
-There was one MA on duty for the facility for second shift with 1 PCA on duty for a partial shift.

Confidential interview with a resident revealed:
-There was not enough staff at the facility.
-The resident needed help pulling up incontinence briefs but the resident did not ask for help because staff was too busy and it took too long for staff to come.
-Sometimes it took "2 days maybe" for staff to come and help.
-The resident had urinated on themselves "a few times" while waiting for staff to come.

Confidential interview with a resident revealed the resident had to bathe self at times because staff said they were coming to help but never came.

Confidential interview with a resident revealed:
-The resident had to wait a long time for staff to come to assist the resident with care.
-When the resident rang the call bell, the resident sometimes waited "an hour" before any staff came to assist the resident for toileting.

Confidential interview with a resident revealed:
-Her shower days were Tuesdays, Thursdays, and Saturdays
-It was hard to get a shower on Saturdays because of the facility being short staffed.

Confidential interview with a family member revealed the resident would use call bell, but no

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one would come or it would take too long and the resident would almost urinate on themselves.

Confidential interview with a family member revealed:
-The family member visited 7 days a week at various times and there was usually only 1 PCA on the AL side of the facility.
-The resident reported to the family member that the resident had to wait at least 30 minutes or longer when they called for help.

Interview with a PCA on 05/07/19 at 4:23am revealed:
-She had worked at the facility for 3 months and she usually worked on third shift.
-There were usually 4 staff on duty on third shift for the entire facility.
-There were usually 3 PCAs and 1 MA with 2 staff in the AL side and 2 staff in the SCU.
-The MA usually stayed on the AL side for most of the shift but gave medications in the SCU if needed.
-If "lucky" and fully staffed, there would be 5 staff on duty, but they recently had "a lot" of call outs or no shows.
-The facility management was aware, but she did not know if anything was being done.
-There was not enough staff to keep a check on all residents and make sure residents were dry and "not laying in urine".
-Staff usually got their jobs done but it was difficult and delayed due to being short staffed.
-She sometimes got residents up as early as 3:30am to give them a bath in order to have enough time to get all tasks completed during the shift.
-Staff also worked 12 hour shifts sometimes and double shifts to help with the shortage.

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D 188	Continued From page 30 Second interview with the Administrator on 05/17/19 at 3:44pm revealed: -She was responsible for making the staff schedule. -She used the "regulatory" staffing grid to determine staff need by resident census. -She or the CM would make calls to staff to cover short shifts. -If they were unable to find staff to work, then the lead Supervisor, CM or the Administrator covered the shift. -When she or the CM worked on the floor providing direct care, they "clocked in" on the time clock. -"Clocking in" meant working on the floor. -She provided oversight and monitoring of staff while working on the floor. -She usually came in at random times on all three shifts; "if staff were found sleeping they were terminated on the spot." The CM was not available for interview on 05/16/19 and 05/17/19.	D 188		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	D 269		

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews and record reviews, the facility failed to provide assistance for the personal care needs 7 of 8 sampled residents (#1, #2, #4, #5, #6, #8 and #15) who were unable to attend to themselves including incontinence care, toileting, bathing and dressing.

The findings are:

Confidential interview with a resident revealed "for the time that you all (survey team) are here, we might actually be treated right and might even get a bath."

1. Review of Resident #4's current FL-2 dated 03/06/19 revealed:
-Diagnoses included central demyelination of corpus collosum, hypomagnesia, candidiasis, hypoosmolality, hyponatremia, alcohol abuse, major depression, insomnia and hypertension.
-There was documentation Resident #4 was semi-ambulatory with the aide of a wheelchair.
-There was documentation Resident #4 needed assistance with bathing and dressing.

Review of Resident #4's current care plan dated 03/05/19 revealed:
-Resident #4 was ambulatory with a wheelchair and had no upper extremity limitations.
-Resident #4 needed staff supervision with transfers and eating.
-Resident #4 needed limited assistance with toileting, bathing and dressing.

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D 269	Continued From page 32 Review of Resident #4's current Licensed Health Professional Support (LHPS) evaluation dated 03/04/19 revealed: -Resident #4's LHPS tasks included transfer assistance and assistive devices. -Resident #4 self propelled her wheelchair and was able to bath and dress herself. -Resident #4 required staff assistance with transfers in and out of the shower. -Resident #4 had occasional urgency incontinence. Review of a charting note dated 03/08/19 at 10:06pm for Resident #4 revealed staff documented, "Some days she act as if she can't do anything, then other days she was fine." Telephone interview with a medication aide (MA) on 05/15/19 at 9:40pm revealed: -She had documented the charting note dated 03/08/19 for Resident #4. -The MAs were responsible for documenting what type of assistance a resident needed. -Resident #4 had returned to the facility after being gone for several months in the hospital and a rehabilitation center. -When Resident #4 returned she was different, and staff had to help the resident "get back to routine." -Getting back to the routine meant Resident #4 needed assistance because "she could hardly use her left arm." -Resident #4 needed assistance with bathing, toileting and pulling up her incontinence brief. -She did not know of any staff being demeaning or rude to Resident #4 about providing assistance. Interview with Resident #4 on 05/08/19 at 3:28pm revealed:	D 269		

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D 269	Continued From page 33 -She had been gone from the facility from September 2018 through March 2019. -She was seriously ill from a life threatening low level of sodium which caused her to have a metabolic brain injury. -She was independent with toileting, showering, dressing and ambulating prior to leaving the facility in September 2018. -She was hospitalized for several months and then in a rehabilitation center for several months. -She tried to keep herself clean but was not always able to manage on her own. -She was not able to raise and use her left arm, had limited strength in her legs and her balance was off. -She was usually able to transfer herself and used a wheelchair for ambulation. -Some days she had a hard time getting up from the recliner. -She would have to rock back and forth to get enough momentum to raise up from sitting. -Some days she needed help with bathing, dressing, getting out of the chair and cleaning after toileting. -It was "humiliating" to have to ask for assistance because of how staff treated her. -Staff had laughed at her and called her lazy behind her back. -One staff had handed her a wad of toilet paper and said "Here, I heard you can do it yourself," and then walked away without helping. -The incident had happened two or three weeks ago and she reported the staff to the Administrator. -She could not remember the staff's name. -She had gotten to the point where she did not ask for assistance with cleaing after having repeated episodes of diarrhea. -She developed an infection to her groin, rectum and buttocks because she was not able to clean	D 269		

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well enough by herself.
-She saw her primary care provider (PCP) last week (04/30/19) and he prescribed a cream because her bottom was "raw".
-Her bottom started feeling better yesterday (05/07/19).

Observation of Resident #4 on 05/08/19 at 4:10pm revealed:
-Resident #4 rocked back and forth in her recliner several times before being able to push up and stand.
-Resident #4's left arm was limp at her side and she had limited range of motion.
-Resident #4 was unable to use her left arm to assist with getting out of the chair.
-Resident #4 took several small shuffling steps to turn and transferred into the wheelchair.
-Resident #4 was unable to use her left arm to guide herself into sitting down in the wheelchair.
-Resident #4 sat down forcefully into the wheelchair on her bottom.

Interview with a personal care aide (PCA) on 05/10/19 at 11:43am revealed:
-Resident #4 had not always needed help; the resident was at the facility in 2018 and did not need assistance.
-Resident #4 needed assistance with wiping her bottom after she had a bowel movement.
-Resident #4 also needed help in the shower washing her back and feet and help getting her bottoms pulled up when getting dressed.

Interview with a second MA on 05/10/19 at 11:52am revealed:
-Resident #4 went between constipation and diarrhea due to pain medications and laxatives.
-Resident #4 needed assistance with cleaning after toileting.

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D 269	Continued From page 35 -Resident #4 was not able to reach her bottom and wipe herself well. -Resident #4 had experienced diarrhea recently and "got raw down there (bottom)" from not getting cleaned well. -Resident #4 would ask for assistance when she needed help; she helped Resident #4 herself when she was working. -Resident #4 had told her that some staff did not help her with cleaning after toileting. -She did not report the staff because Resident #4 did not name the staff. Review of a primary care provider order dated 04/30/19 revealed there was an order for Lotrisone cream (an antifungal) apply three times daily to erythematous (redness due to injury, infection or inflammation) rash in perirectal area and groin until resolved. Telephone interview with Resident #4's PCP on 05/15/19 at 9:55am revealed: -He did not see the excoriation (raw) and/or erythema (red) on Resident #4's bottom. -Resident #4 did not want him to see the area for privacy. -He prescribed an ointment to treat the area empirically because Resident #4 reported having diarrhea and rectal burning. -He did not know of any issue with staff not assisting Resident #4 with cleaning after toileting. Interview with the Administrator on 05/09/19 at 4:45pm revealed: -She did not know Resident #4 had felt so humiliated and developed a rash due to not wanting to ask for help. -Staff were expected to provide care according to the residents' needs.	D 269		

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D 269	Continued From page 36 Refer to interview with a medication aide (MA) on 05/08/19 at 3:02pm. Refer to telephone interview with a second MA on 05/15/19 at 9:40pm. Refer to interview with the Care Manager (CM) on 05/07/19 at 7:41am. Refer to interview with the Administrator on 05/08/19 at 4:40pm. Refer to second interview with the Administrator on 05/17/19 at 3:44pm. 2. Review of Resident #8's current FL-2 dated 01/22/19 revealed: -Diagnoses included Alzheimer's dementia, osteoarthritis, Lewy body dementia, vitamin B12 deficiency, gastro-esophageal reflux disease and peripheral edema. -Resident #8 was constantly confused, ambulatory and wandered. -Resident #8 needed assistance with bathing and dressing. Review of Resident #8's current care plan dated 08/27/18 revealed: -Resident #8 was always disoriented with significant memory loss and needed to be redirected. -Resident #8 had bladder incontinence and required limited assistance with toileting, bathing and dressing. Review of Resident #8's current Licensed Health Professional Support (LHPS) evaluation dated 04/05/19 revealed: -Resident #4's LHPS tasks included use of assistive devices for ambulation.	D 269		

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-There was no documentation of Resident #8's ability to complete activities of daily living (ADLs).
-There was no documentation of ADL assistance required for Resident #8.

Observations on 05/07/19 from 6:18am until 6:33am revealed:
-There was a urine odor at the entrance of Resident #8's room.
-A personal care aide (PCA) entered Resident #8's room at 6:18am and began waking the resident.
-There was a brown stain on the recliner in Resident #8's room.
-When Resident #8 stood from the bed there was an area of wetness approximately the size of a large watermelon.
-The PCA took Resident #8 to the bathroom and removed the incontinence brief.
-The incontinence brief was saturated with urine.

Interview with the PCA on 05/07/19 at 6:30am revealed:
-Resident #8 would get up at night and would sometimes think the recliner or the foot stool was the toilet.
-Resident #8 wore an incontinence brief, but the resident used the bathroom sometimes.

Second interview with the PCA on 05/07/19 at 5:32am revealed:
-The 2nd shift completed their last rounds at 11:00pm to make sure residents were clean and dry; second shift was 3:00pm to 11:00pm and third shift was 11:00pm to 7:00am.
-The 3rd shift staff checked residents on the special care unit (SCU) every two hours by "just looking in the room."
-The 3rd shift did not check residents for incontinence or need for changing until 5:00am

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when the PCAs started getting residents up for the day.
-They did not check and change all residents on the SCU for incontinence before the end of the 3rd shift, just the eight they responsible for getting bathed and dressed.

Interview with a second PCA on 05/07/19 at 5:09am revealed:
-She had been working at the facility for two weeks.
-There were 22 residents on the SCU and two additional residents were out of the facility.
-She did not know how often residents on the SCU were checked for incontinence; she did not know which residents were incontinent.

Review of Resident #8's activities of daily living (ADL) record dated 03/25/19 through 05/08/19 revealed:
-There was an entry for hygiene after toileting/incontinence.
-There were 8 of 45 days where there was documentation of assistance being provided between 1:00am and 5:00am.

Interview with a concerned citizen on 05/10/19 at 1:00pm revealed:
-Resident #8 was not cleaned the way she was supposed to be.
-She visited Resident #8 every week and took her out to the hair salon once a month.
-Resident #8's hair had been oily and unwashed; her scalp had a thick build up oil and dandruff that was still there after washing.

Interview with a third PCA on 05/17/19 at 3:15pm revealed:
-Resident #8 was able to go to the bathroom on her own.

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-Resident #8 needed staff assistance with cleaning after toileting.
-Resident #8 wore incontinence briefs.
-Staff also showered Resident #8 and assisted with dressing and meals.

Interview with a medication aide (MA) on 05/17/19 at 3:25pm revealed:
-Resident #8 was incontinent and needed assistance with incontinence care.
-Over the last couple of months, Resident #8 had been "worsening with fussing and resisting care."
-Resident #8 got agitated and aggressive when staff tried to help her.

Telephone interview with Resident #8's primary care provider (PCP) on 05/15/19 at 3:28pm revealed:
-He last saw Resident #8's on 05/04/19.
-Resident #8 was still dressed in her pajamas; her hair was not particularly clean.
-Staff had reported Resident #8 had been refusing personal care assistance, was aggressive and struck staff.

Based on observations, interviews and record reviews, it was determined Resident #8 was not interviewable.

Refer to interview with a medication aide (MA) on 05/08/19 at 3:02pm.

Refer to telephone interview with a second MA on 05/15/19 at 9:40pm.

Refer to interview with the Care Manager (CM) on 05/07/19 at 7:41am.

Refer to interview with the Administrator on 05/08/19 at 4:40pm.

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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 269	Continued From page 40 Refer to second interview with the Administrator on 05/17/19 at 3:44pm. 3. Review of Resident #2's current FL-2 dated 02/05/19 revealed: -Diagnoses included Alzheimer's disease, high blood pressure, Vitamin D deficiency, and pre-renal disease. -The resident was constantly disoriented. -The resident was semi-ambulatory but assistive device used was not documented. -The resident required assistance with bathing, dressing, and feeding. -The resident was incontinent of bladder and bowel. Review of Resident #2's current assessment and care plan dated 02/12/19 revealed: -The resident was ambulatory with a wheelchair. -The resident had daily incontinence of bladder and bowel. -The resident was totally dependent for bathing, grooming, and toileting. -The resident required limited assistance with dressing, transferring and ambulation. Interview with a personal care aide (PCA) on 05/07/19 at 4:23am revealed: -There were usually 4 staff on duty on third shift, 3 PCAs and 1 medication aide (MA). -She was the only PCA currently working on the assisted living (AL) side and the MA was on the AL side. -There were 7 residents on the AL side that required 2-hour incontinence checks. -There was not enough staff to keep the residents checked every 2 hours and make sure they were dry and "not laying in urine". -She usually started her incontinence checks	D 269		

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around 1:00am depending on if any residents had pulled their call bells and she was busy assisting a resident.
-If she was bathing a resident, it could take a while (10 minutes or longer) to respond to a call bell.
-It was "stressful" trying to get all of the care done and there was sometimes a delay in providing incontinence care because there was not enough staff.

Interview with the same PCA on 05/07/19 at 5:15am revealed:
-Resident #2 was on the day shift bath list so she was just going to change her and get her dressed.
-Resident #2 required assistance with all activities of daily living.

Observation of Resident #2 on 05/07/19 at 5:15am revealed:
-There was strong odor of feces and urine.
-Resident #2 was lying in bed with pajamas on and she was lying on top of an incontinence pad.
-The PCA removed the resident's pajama bottoms.
-The PCA assisted the resident to the shower in the resident's private bathroom.
-The incontinence pad was dry.
-The resident's incontinence brief sagged while the resident walked with assistance to the bathroom.
-The resident was wearing two incontinence briefs.
-When the PCA removed the incontinence briefs, there was a large bowel movement and both briefs were saturated with urine.
-The PCA undressed the resident in the bathroom and gave her a shower.
-The bowel movement was stuck to the resident's

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skin and was difficult to clean.
-There was no skin breakdown or irritation on Resident #2.
-At 5:28am, the PCA got the resident out of the shower and assisted the resident with walking back to her bed.
-The PCA finished dressing the resident, assisted the resident to the wheelchair, and left the room at 5:46am.

Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable.

Interview with the same PCA on 05/07/19 from 5:15am - 5:46am revealed:
-She bathed Resident #2 because the resident had "messed up" her incontinence briefs.
-She thought she had last checked the resident around 3:00am (not sure of time) and the resident had two incontinence briefs on at that time.
-She did not know why they put two incontinence briefs on Resident #2.
-She put two incontinence briefs on the resident because that was they way staff on other shifts did it.

Interview with a second PCA on 05/08/19 at 5:35pm revealed:
-The residents that required assistance with incontinence care usually wore two incontinence briefs for "extra protection" so if they wet before the next change it would not go through and leak.
-Resident #2 had always worn two incontinence briefs because she required assistance with incontinence care.
-Resident #2 did not have any skin breakdown.

Interview with a MA / supervisor on 05/08/19 at 5:35pm revealed:

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-Resident #2 should wear only one incontinence brief.
-Staff had been told (within the last 2 months) not to put two incontinence briefs on residents.
-She had not had a chance to check behind the PCAs to see if they were still putting two briefs on residents.
-The residents should not have two briefs on because it could cause skin breakdown.

Interview with the Care Manager (CM) on 05/07/19 at 2:05pm revealed:
-She was not aware staff were putting two incontinence briefs on Resident #2.
-Staff were not supposed to put two incontinence briefs on the residents.
-Staff were supposed to do incontinence rounds every 2 hours.

Telephone interview with Resident #2's primary care provider (PCP) on 05/15/19 at 10:44am revealed:
-He was not aware staff were putting two incontinence briefs at time on Resident #2.
-There was a potential for the resident to develop skin issues such as redness and irritation if left in urine or feces.
-He was not aware of any skin issues with Resident #2.

Refer to interview with a medication aide (MA) on 05/08/19 at 3:02pm.

Refer to telephone interview with a second MA on 05/15/19 at 9:40pm.

Refer to interview with the Care Manager (CM) on 05/07/19 at 7:41am.

Refer to interview with the Administrator on

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D 269	Continued From page 44 05/08/19 at 4:40pm. Refer to second interview with the Administrator on 05/17/19 at 3:44pm. 4. Review of Resident #6's current FL-2 dated 07/13/18 revealed: -Diagnoses included dementia, hypertension, chronic anxiety, hyperlipidemia, and glaucoma. -The resident was intermittently disoriented. -The resident was semi-ambulatory but assistive device used was not documented. -The resident's sight was functionally limited. -The resident required assistance with bathing, dressing, and feeding. -The resident was continent of bowel and bladder. Review of Resident #6's current assessment and care plan dated 12/27/18 revealed: -The resident was ambulatory with a wheelchair. -The resident was continent of bladder and bowel. -The resident required extensive assistance with bathing, grooming, dressing, and toileting. -The resident required limited assistance with eating, transferring, and ambulation. Interview with a personal care aide (PCA) on 05/07/19 at 4:23am revealed: -There were usually 4 staff on duty on third shift, 3 PCAs and 1 medication aide (MA). -She was the only PCA currently working on the assisted living (AL) side and the MA was on the AL side. -There were 7 residents on the AL side that required 2-hour incontinence checks. -There was not enough staff to keep the residents checked every 2 hours and make sure they were dry and "not laying in urine".	D 269		

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D 269	Continued From page 45 -She usually started her incontinence checks around 1:00am depending on if any residents had pulled their call bells and she was busy assisting a resident. -If she was bathing a resident, it could take a while (10 minutes or longer) to respond to a call bell. -It was "stressful" trying to get all of the care done and there was sometimes a delay in providing incontinence care because there was not enough staff. Observation of Resident #6 on 05/07/19 from 5:52am - 6:24am revealed: -Resident #6 was lying in bed, wearing pajamas, and had an incontinence pad underneath her. -The incontinence pad was dry. -The PCA assisted the resident to the wheelchair and pushed her to the suite bathroom. -The door to the suite and the bathroom were left open. -The PCA unclothed the resident in the bathroom with the door open. -The resident was wearing two incontinence briefs and both were saturated with urine. -There was a very strong odor of urine. -Resident #6's skin had no breakdown or irritation. -The PCA assisted the resident with dressing and transferring back to the wheelchair. -The PCA pushed the resident back to her bedroom and left the room at 6:24am. Interview with the same PCA on 05/07/19 from 5:52am - 6:24am revealed: -Resident #6 was wearing two incontinence briefs because that was the resident's request. -Resident #6 needed assistance with bathing, dressing, transferring, ambulation, and toileting. -She could not recall when she last checked	D 269		

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D 269	Continued From page 46 Resident #6 for incontinence care on this shift. Interviews with Resident #6 on 05/07/19 at 6:13am and 05/13/19 at 11:43am revealed: -She wore two incontinence briefs because she had to wait for staff to assist her and she did not want to wet her bed or clothes. -Sometimes she waited "about an hour" for staff to come and assist her because there was not enough staff. -The resident was legally blind and could only see shadows so she needed assistance. -Staff checked on her about every 2 hours during the day but staff did not check on her during the night. A third interview with Resident #6 on 05/15/19 at 4:10pm revealed she did not use the call bell at night anymore because staff "won't come". Interview with a second PCA on 05/08/19 at 5:35pm revealed: -The residents that required assistance with incontinence care usually wore two incontinence briefs for "extra protection" so if they wet before the next change it would not go through and leak. -Resident #6 "liked" to wear two incontinence briefs. -Resident #6 did not have any skin breakdown. Interview with a MA / supervisor on 05/08/19 at 5:35pm revealed: -Staff had been told (within the last 2 months) not to put two incontinence briefs on residents. -She had not had a chance to check behind the PCAs to see if they were still putting two briefs on residents. -The residents could not have two briefs on because it could cause skin breakdown. -Resident #6 might be wearing two incontinence	D 269		

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briefs because she was a "heavy wetter" and the resident had requested to wear two briefs.
-Resident #6 did not have any skin breakdown.

Interview with the Care Manager (CM) on 05/07/19 at 2:05pm revealed:
-She was not aware staff were putting two incontinence briefs on Resident #6.
-Staff were not supposed to put two incontinence briefs on the residents.
-Staff were supposed to do incontinence rounds every 2 hours.

Telephone interview with Resident #6's primary care provider (PCP) on 05/15/19 at 10:44am revealed:
-He was not aware staff were putting two incontinence briefs at time on Resident #6.
-There was a potential for the resident to develop skin issues such as redness and irritation if left in urine or feces.
-He was not aware of any skin issues with Resident #6.

Refer to interview with a medication aide (MA) on 05/08/19 at 3:02pm.

Refer to telephone interview with a second MA on 05/15/19 at 9:40pm.

Refer to interview with the Care Manager (CM) on 05/07/19 at 7:41am.

Refer to interview with the Administrator on 05/08/19 at 4:40pm.

Refer to second interview with the Administrator on 05/17/19 at 3:44pm.

5. Review of Resident #15's current FL-2 dated

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D 269	Continued From page 48 07/18/18 revealed: -Diagnoses included atrial fibrillation, hypertension, chronic renal insufficiency, hyperlipidemia, chronic back pain, arthritis bilateral knees, lumbar spondylosis, and degenerative joint disease. -The resident was ambulatory with a walker. -The resident required assistance with bathing and dressing. -The resident was incontinent of bladder. Review of Resident #15's current assessment and care plan dated 08/27/18 revealed: -The resident was ambulatory with an aide or device (type not specified). -The resident was occasionally incontinent of bladder and bowel. -The resident required extensive assistance with bathing, grooming, and dressing. -The resident required limited assistance with toileting and transferring. -The resident required supervision with ambulation. Interview with a personal care aide (PCA) on 05/07/19 at 4:38am revealed: -Resident #15 got upset over the weekend because she liked to get up and get bathed and dressed at 4:00am. -There was about a 45-minute delay over the weekend in assisting the resident. -She was on her way to Resident #15's room now to get her up. Observation of Resident #15 on 05/07/19 at 4:41am revealed: -Resident #15 was lying in bed with her night clothes on. -The PCA provided standby assist to the resident with transfer from bed to wheelchair.	D 269		

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-The PCA pushed the resident from her room to the shared suite bathroom.
-The PCA assisted the resident with transferring from wheelchair to the toilet.
-The PCA removed the resident's clothing and bathed the resident with water, soap, and a washcloth while the resident was sitting on the toilet without clothes on.
-The PCA assisted the resident with standing so the PCA could wash the resident's private area and helped the resident put on clean incontinence briefs and clothing.
-The PCA assisted the resident back to her bedroom, made the resident's bed, and then left the room.

Interviews with Resident #15 on 05/07/19 at 1:10pm and 05/13/19 at 11:28am revealed:
-She needed assistance with bathing and she usually got a sink bath every day since she did not take showers.
-Staff were supposed to get her up at 4:00am every day to bathe and dress her.
-She asked them to come at 4:00am otherwise she would have to wait for staff.
-Staff did not get her up at 4:00am anymore and it had been around 6:00am lately when staff came.
-She had to bathe and dress herself on at least two occasions because staff were either late or never came to assist her.
-Staff told her they were the only ones on duty and they had to assist residents in the special care unit (SCU).
-It was difficult to bathe and dress herself because she could not reach her back and she had a hard time trying to put on her socks.

Telephone interview with Resident #15's family member on 05/15/19 at 7:38pm revealed:
-Resident #15 needed assistance with bathing

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and dressing.
-The resident refused to bathe in a shower or tub so she was supposed to get a sponge bath every morning.
-There had been a "few times" the resident missed her bath in the mornings.
-The most recent time was about a week ago on a Sunday.
-There was one time last year the resident missed her bath because staff was new and did not know the bath schedule.

Interview with a MA / supervisor on 05/08/19 at 5:35pm revealed:
-Resident #15 should not bathe herself because she was at risk for falls.
-She was not aware Resident #15 had to bathe herself without staff assistance.
-The facility had been short staffed and that may have caused a delay in providing care to the resident.

Refer to interview with a medication aide (MA) on 05/08/19 at 3:02pm.

Refer to telephone interview with a second MA on 05/15/19 at 9:40pm.

Refer to interview with the Care Manager (CM) on 05/07/19 at 7:41am.

Refer to interview with the Administrator on 05/08/19 at 4:40pm.

Refer to second interview with the Administrator on 05/17/19 at 3:44pm.

6. Review of Resident #1's FL-2 dated 10/17/18 revealed diagnoses included Alzheimer's Disease, unspecified dementia, right hip joint

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replacement, hypertension, depression, anxiety, osteoarthritis.

Review of Resident #1's care plan dated 12/19/18 revealed:
-The resident ambulated with the use of a device (walker).
-The resident was disoriented at times, forgetful and needed reminders.
-The resident required limited assistance with bathing and dressing.

Observation made on 05/07/19, in the special care unit (SCU), at 4:37am revealed:
-Resident #1 was in her room asleep in a recliner with her feet elevated.
-The resident was fully dressed in a pair of pants, a pullover blouse and socks.

Interview with the 3rd shift PCA on 05/07/19 at 4:57am revealed;
-Some residents slept in their "street clothes".
-Second shift staff were responsible for getting the residents ready for bed, including changing into bed clothes.
-Resident #1 slept in her recliner and sometimes slept in her clothes. The resident maybe "cold natured".
-She never attempted to assist the resident with changing into her bed clothes.

Interview with Resident #1 on 05/07/19 at 1:55pm revealed:
-The staff assisted her with her bath and changing clothes.
-She slept in her clothes at times because her clothes were warm at night.
-She would sleep in her pajamas if they were warm and the staff helped her change.
-She did not remember if she slept in her

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pajamas or her clothes last night or any other night.

Observation made on 05/07/19 at 1:55pm revealed:
-Resident #1 was in the SCU living room area with other residents.
-The resident was dressed in the same pair of pants, the same pullover blouse.

Interview with two of Resident #1's family members on 5/09/19 at 6:50pm revealed:
-They expected the staff to assist the resident with her personal care, which included bathing, dressing and changing into bed clothes at night.
-Even though the resident slept in her recliner, she should not sleep in her clothes she had worn all day.

Refer to interview with a medication aide (MA) on 05/08/19 at 3:02pm.

Refer to telephone interview with a second MA on 05/15/19 at 9:40pm.

Refer to interview with the Care Manager (CM) on 05/07/19 at 7:41am.

Refer to interview with the Administrator on 05/08/19 at 4:40pm.

Refer to second interview with the Administrator on 05/17/19 at 3:44pm.

7. Review of Resident #5's FL-2 dated 3/6/19 revealed diagnoses of cirrhosis, hypertension, esophageal varices, osteoarthritis, dementia with confusion, and bipolar.

Review of the resident's care plan dated 6/19/18

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revealed the resident required limited assistance with bathing, dressing and grooming.

Interview with Resident #5 on 05/15/19 at 2:10pm revealed;
-Staff usually spend about 15 minutes assisting with her bath/shower which included shampooing hair, washing her back and towel drying.
-The resident only received a shower one time a week but wanted to shower at least two times a week.
-A PCA told the resident if she had the time, she would assist the resident with more showers.
-The resident kept herself clean by using pre-moistened wipes.

Interview with a PCA on 05/16/19 at 5:59pm revealed:
-She tried to give Resident #5 a shower at least 1 time a week.
-All the resident's would get more showers/bathes but we usually work short and if she was the only PCA on the floor, she could not give showers 3 times a week.

Refer to interview with a medication aide (MA) on 05/08/19 at 3:02pm.

Refer to telephone interview with a second MA on 05/15/19 at 9:40pm.

Refer to interview with a medication aide (MA) on 05/08/19 at 3:02pm.

Refer to telephone interview with a second MA on 05/15/19 at 9:40pm.

Refer to interview with the Care Manager (CM) on 05/07/19 at 7:41am.

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D 269	Continued From page 54 Refer to interview with the Administrator on 05/08/19 at 4:40pm. Refer to second interview with the Administrator on 05/17/19 at 3:44pm. Interview with a medication aide (MA) on 05/08/19 at 3:02pm revealed: -The PCAs entered the activities of daily living (ADLs) they completed on the computer throughout the shift. -The MA printed, reviewed and signed the ADL report and gave the report to the Administrator. -Upon review the MA had to follow up with any area that did not have 100% documentation. Telephone interview with a second MA on 05/15/19 at 9:40pm revealed: -Bathes were done too early on some bathing days for 3rd shift. -On the new computer documentation system, staff had to document activities of daily living (ADL) tasks within a certain time frame -Staff would rush to get done because they did not want to be late documenting. Interview with the Care Manager (CM) on 05/07/19 at 7:41am revealed: -PCAs were expected to monitor for incontinence care needs every two hours for all incontinent residents on the SCU and the AL side. -Most residents on the SCU required some type of incontinence care. -The 3rd shift was responsible for bathing and dressing eight residents between 5:00am and 7:00am. -Residents were bathed every day and received a shower three times a week. Interview with the Administrator on 05/08/19 at	D 269		

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D 269	Continued From page 55 4:40pm revealed: -It was not the facility's process to not perform incontinence checks between 11:00pm and 5:00am. -If a resident needed assistance then staff should be helping. -Staff were expected to offer toileting assistance and perform incontinence checks on all residents in the facility every two hours on every shift. Second interview with the Administrator on 05/17/19 at 3:44pm revealed: -Staff documented completed assistance tasks on the computer. -She monitored staff compliance with providing assistance with toileting and bathing four hours at a time on all shifts. -Staff were expected to provide incontinence care and bathing assistance to residents. -She monitored staff providing assistance by sitting on the special care unit (SCU) for 20 minutes at random times on all shifts. -She observed the staff checking incontinent residents. -The last time she monitored for incontinence care was one week ago. The facility failed to provide personal care assistance such as incontinence care, toileting, bathing and dressing for 7 of 8 sampled residents. The facility's failure to provide residents with personal care assistance resulted in Resident #4 developing a rash on the buttocks and groin area requiring a medicated ointment for one week before improvement and placed Resident #2 and Resident #6 at risk for skin breakdown. The facility's failure resulted in substantial risk of serious neglect and physical harm and constitutes a Type A2 Violation.	D 269		

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D 269	Continued From page 56 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/10/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 16, 2019.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews, observations, and record reviews, the facility failed to assure supervision was provided to 3 of 11 sampled residents (#1, #14, #16) including two residents who wandered out of the special care unit unsupervised into a service hall and kitchen (#1, #16) and a resident with 29 falls in 6 months resulitng in injuries and visits to the emergency room (#14). The findings are: 1.Review of Resident #1's FL-2 dated 10/17/18	D 270		

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revealed diagnoses included Alzheimer's Disease, unspecified dementia, right hip joint replacement, hypertension, depression, anxiety, osteoarthritis.

Review of Resident #1's care plan dated 12/19/18 revealed:
-The resident had a history of wandering and ambulated with the use of a device (walker).
-The resident was disoriented at times, forgetful and needed reminders.

Review of Resident #1's care plan dated 12/19/18 revealed:
-The resident had a history of wandering and ambulated with the use of a device (walker).
-The resident was disoriented at times, forgetful and needed reminders.

a.Observation made on 05/07/19 at 4:37am revealed;
-The resident was asleep in a recliner in her bedroom with her feet elevated.
-There were massive dark purplish facial bruises covering the right half of the resident's face which included her right forehead, under her right eye, her right chin, under her left eye, and on her left brow above the left eye.

Interview with the third shift PCA on 5/7/19 at 4:57am revealed:
-On 5/03/19 around 5:00am, another PCA found the resident on the floor in her room.
-The resident's face was bruised and the resident complained of knee pain.
-The resident was transported to the ER for evaluation and came back to the facility.
-She did not know how long the resident was on the floor.
-The resident's supervision did not change, the

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third shift staff checked on the resident every two hours.
-All residents on the SCU was checked every 2 hours when in bed.
-The resident fell one more time since 05/03/19. She fell again on 5/6/19 (3rd shift).
-The resident was found on the floor on 05/03/19 on third shift. and complained of pain of her "bad" right knee which had blisters from the previous fall. The resident was not sent to the ER.
-She thought the fall was reported to the MA but was not sure.

Interview with Resident #1 on 05/07/19 at 1:55pm revealed:
-The resident fell while getting out of her recliner to go to the bathroom 3 or 4 nights ago.
-She did not use her walker and fell and hit the right side of her face, nose and right knee.
-She was transported to the ER but there were no fractures, just bruises on her face and a blister on her knee.
-She fell one more time about 1-2 days ago but there were no injuries.

Interview with two of Resident #1's family members on 05/09/19 at 6:50pm revealed:
-A staff called him at 5:45am last week on 05/03/19 and reported the resident had fallen and she was found lying on the floor.
-She was bruised and had a "goose egg" on her head.
-The staff did not know how long the resident was on the floor.
-The staff stated they checked on the resident every 2 hours.
-The staff should check on her more often and assist her with getting up and using her walker.
-The family members were not aware of any subsequent falls since 05/03/19

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D 270	Continued From page 59 Interview with a third shift MA on 5/14/19 at 9:20am revealed; -She was working the morning the resident fell on 05/03/19. -She was found by the PCA and the resident was sent to the ER. -The PCAs should check all the residents every 30 minutes on the SCU. Review of an Event Report (incident report) dated 05/03/19 revealed: -On 05/03/19 at 5:15am the resident had an unwitnessed fall in her bedroom. -The resident complained of pain. There was bruising of the right forehead, and complained of pain to her back, eye and forehead. -The resident was transported to the local ER. Review of an ER visit summary dated 05/03/19 revealed: -Resident #1 was transported to the ER because of an accidental fall. -The resident was diagnosed with periorbital contusion of the right eye, contusion of the right knee, and contusion of the lower right leg. -Discharge instructions to use Tylenol as needed for pain. User a U-shaped walker at all times for walking to help prevent further falls. b. Observation made on 05/07/19 at 10:05am revealed: -The entrance door from the SCU patio to the service hall was unlocked. -The door on the right, which was an entrance into the kitchen from the service hall was unlocked and the dietary staff was in the kitchen preparing a meal. -The door on the left end of the service hall which was an entrance to the SCU dining room had a	D 270		

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key pad.

Interview with a dietary aide on 05/07/19 at 10:15am revealed:
-She was a server and assisted with delivering meals from the kitchen to the special care unit (SCU).
-The hallway was a service hall used by kitchen staff to deliver meals to the SCU.
-Resident #1 had wandered into the kitchen through the door from the service hall recently, but she did not remember the date.
-The residents, from the SCU, entered the service hall from the secured outside patio on the SCU.
-The door from the patio into the service hall did not have a lock.
-Residents had made their way to the kitchen several times or got stuck in the hallway.
-On average, kitchen staff found a resident in the hallway or kitchen twice a week.
-The kitchen door was locked at night.

Interview with a personal care aide (PCA) on 05/07/19 at 1:29pm revealed:
-Residents could go out to the enclosed patio throughout the day.
-The staff "kept an eye on" residents while they were outside in the enclosed patio area.
-The staff watched the residents out on the patio from inside the common area/dining room through the windows.
-Kitchen staff had brought residents back to the special care unit (SCU) from the service hall.
-The kitchen staff would see the residents in the service hallway and bring the residents back to the SCU.
-The kitchen door was usually locked.
-She did not know if the exit door from the SCU dining room to the enclosed patio was supposed

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D 270	Continued From page 61 to be locked. Interview with the Executive Director (ED) on 05/08/19 at 4:40pm revealed: -Staff were expected to accompany residents to the secured patio and supervise residents while outside on patio. -Staff were expected to do "look in" checks every 30 minutes for all residents. -If a resident was "out of sight" then staff knew to check the service hall. -Staff did not document 30 minute checks on residents. -Residents should never walk into the service hall unsupervised. -She was aware the door the entrance door into the service hall from the SCU patio did not lock. -The door did not have a lock when the building was constructed. Observation on 05/08/19 at 2:40pm revealed: -There were two residents outside on the enclosed patio area. -There were no staff outside with the residents. -There two personal care aides (PCAs) in the common area with seven residents. Interview with the facility's cook on 05/16/19 at 10:00am revealed: -About 3-4 months ago, the cook was preparing lunch and a large pot of soup was cooking on the stove. -The cook (who was working alone) left the facility while on her break (about 30 minutes). -When she returned, Resident #1 was standing next to the stove over the pot of soup. She had turned the stove off. -The cook eased up to her to keep from startling the resident and took her back to the SCU. -The staff did not know she was off the unit; they	D 270		

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had not missed her.
-The dietary staff have complained about the service hall to the Executive Director (ED).
-The kitchen door which entered the service hall was kept unlocked while the dietary staff was on duty and preparing meals.
-If the door was locked, the residents who entered the service hall from the SCU patio just wandered in the service hallway until the dietary staff saw them and accompanied them back to the SCU.
-Multiple residents from the SCU walked in the kitchen from the service hall and were often found standing near the stove with the burners and the oven on and food cooking.
-The dietary staff recently started taking those residents to the ED office instead of back to the SCU because there was nothing being done to supervise the residents on the patio and they come and go through the service hall as they pleased.
-The ED did nothing different and resident's continued to walk in the service hall and in the kitchen.
-The SCU staff were always sitting at the nurse's station and not supervising the residents in the commons area or on the patio.
-The cook only worked part-time (1-2 a week) and the last time she observed a resident in the service hallway/kitchen was about one month ago.

Interview with a PCA on 5/16/19 at 5:59pm revealed:
-Resident #1 has wondered into the kitchen from the service hall several times before the staff realized she was gone.
-She did not know the last time the resident wandered into the kitchen but the wandering had occurred since January or February 2019.

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-The staff knew where the resident wandered into the service hall from the secured patio.
-The dietary staff always brought the resident back to the SCU.
-There were residents who occasionally walked into the service hall, but the dietary staff brought them back.
-She was aware the door to the service hall from the patio was not lockable.
-When the residents were outside in the patio area, the SCU staff was able to watch them from the dining room windows, and not go outside with the residents.

Interview with the Executive Director (ED) on 05/17/19 at 5:15pm revealed:
-She was Resident #1 routinely opened the door to the service hall and entered the kitchen unsupervised.
-The cook had repeatedly brought the resident either back to the SCU or to her office from the kitchen.
Resident #1 was on 30-minute supervisory checks and she was unaware the resident continued to wander into the kitchen.

2. Review of Resident #16's FL-2 dated 12/28/18 revealed diagnoses included vascular dementia with behavioral disturbances, and schizoaffective disorder.

Review of Resident #16's care plan revealed:
-The resident had a history of wandering and ambulated independently.
-The resident was disoriented at times, forgetful and needed reminders.

Observation made on 05/07/19 at 10:05am revealed:
-The entrance door from the SCU patio to the

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service hall was unlocked.
-The door on the right, which was an entrance into the kitchen from the service hall was unlocked and the dietary staff was in the kitchen preparing a meal.
-The door on the left end of the service hall which was an entrance to the SCU dining room had a key pad.

Interview with a dietary aide on 05/07/19 at 10:15am revealed:
-She was a server and assisted with delivering meals from the kitchen to the SCU.
-The hallway was a service hall used by kitchen staff to deliver meals to the SCU.
-The residents, from the SCU, entered the service hall from the secured outside patio on the SCU.
-The door from the patio into the service hall did not have a lock.
-Residents had made their way to the kitchen several times or got stuck in the hallway.
-On average, kitchen staff found a resident in the hallway or kitchen twice a week.
-The kitchen door was locked at night.

Interview with a personal care aide (PCA) on 05/07/19 at 1:29pm revealed:
-Residents could go out to the enclosed patio throughout the day.
-The staff "kept an eye on" residents while they were outside in the enclosed patio area.
-The staff watched the residents out on the patio from inside the common area/dining room through the windows.
-Kitchen staff had brought residents back to the special care unit (SCU) from the service hall.
-The kitchen staff would see the residents in the service hallway and bring the residents back to the SCU.

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-The kitchen door was usually locked.
-She did not know if the exit door from the SCU dining room to the enclosed patio was supposed to be locked.

Observation on 05/08/19 at 2:40pm revealed:
-There were two residents outside on the enclosed patio area.
-There were no staff outside with the residents.
-There two personal care aides (PCAs) in the common area with seven residents.

Interview with the Executive Director (ED) on 05/08/19 at 4:40pm revealed:
-Staff were expected to accompany residents to the secured patio and supervise residents while outside on patio.
-Staff were expected to do "look in" checks every 30 minutes for all residents.
-If a resident was "out of sight" then staff knew to check the service hall.
-Staff did not document 30 minute checks on residents.
-Residents should never walk into the service hall unsupervised.
-She was aware the door the entrance door into the service hall from the SCU patio did not lock.
-The door did not have a lock when the building was constructed.

Interview with the facility's cook on 5/16/19 at 10:00am revealed:
-Resident #16 wandered through into the service hall door repeatedly.
-The kitchen staff always watched her because she would try to escape from the building.
-She would try to open the exit door (in the service hall) if she could not get in the kitchen.
-The cook would take the resident back to the special care unit (SCU) or to the Administrator's

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office.
-The dietary staff have complained about the service hall to the Executive Director (ED).
-The kitchen door which entered the service hall was kept unlocked while the dietary staff was on duty and preparing meals.
-If the door was locked, the residents who entered the service hall from the SCU patio just wandered in the service hallway until the dietary staff saw them and accompanied them back to the SCU.
-Multiple residents from the SCU walked in the kitchen from the service hall and were often found standing near the stove with the burners and the oven on and food cooking.
-The dietary staff recently started taking those residents to the ED office instead of back to the SCU because there was nothing being done to supervise the residents on the patio and they come and go through the service hall as they pleased.
-The ED did nothing different and resident's continued to walk in the service hall and in the kitchen.
-The SCU staff were always sitting at the nurse's station and not supervising the residents in the commons area or on the patio.
-The cook only worked part-time (1-2 a week) and the last time she observed a resident in the service hallway/kitchen was about one month ago.

Interview with a personal care aide (PCA) on 5/16/19 at 5:59pm revealed:
-Resident #16 had wandered into the kitchen repeatedly from the service hall before the staff realized she was gone.
-The staff knew the resident wandered into the service hall from the secured patio.
-The dietary staff always brought the resident

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back to the SCU.
-There were residents who occasionally walked into the service hall, but the dietary staff brought them back.
-She was aware the door to the service hall from the patio was not lockable.
-When the residents were outside in the patio area, the SCU staff was able to watch them from the dining room windows, and not go outside with the residents.

Interview with the Executive Director (ED) on 05/17/19 at 5:15pm revealed:
-She knew Resident #16 routinely opened the door to the service hall and entered the kitchen unsupervised because the service door (from the secured patio) did not lock.
-The cook had repeatedly brought the resident either back to the SCU or to her office from the kitchen.
Resident #16 was on 30 minute supervisory checks and she was unaware the resident continued to wander into the kitchen.

3. Review of the facility's Falls Management Program revealed:
-It was the policy of the facility for residents to be monitored and identified for risk of falls.
-Fall Risk Assessments were completed for all residents admitted to the facility.
-Staff would receive training on Fall Prevention Awareness.
-Staff would complete an incident report in its entirety for any fall.
-Staff would complete the 72 Hour Follow Up on resident falls to investigate possible circumstances contributing to the fall and document observations for 72 hours after the fall.
-The 72 Hour Follow Up included vital signs initially and every shift for 72 hours and

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assessment of possible risk / contribution factors for falls.
-If a resident had 2 falls within a 4 weeks period, the physician was to be contacted requesting an order for physical therapy (PT) evaluation or other treatment / interventions.
-The resident was to be placed in Hot Box / Alert Charting for 72 hours for follow up and monitoring.
-The Healthcare Quality Assurance Team would review incident reports on a monthly basis.

Review of Resident #14's current FL-2 dated 02/26/19 revealed:
-Diagnoses included Huntington's disease and migraines. (Huntington's disease is a genetic disorder that causes uncontrolled movement of the arms, legs, head, face, and upper body.)
-The resident was semi-ambulatory with a wheelchair.
-The resident's speech was slurred.
-The resident required assistance with bathing and dressing.
-The resident had scars on her elbow.
-The resident was occasionally incontinent of bowel and bladder.

Review of Resident #14's current assessment and care plan dated 02/12/19 revealed:
-The resident was ambulatory with a wheelchair.
-The resident had Huntington's disease and was unsteady.
-The resident had limited range of motion in her upper extremities.
-The resident had occasional incontinence of bowel and bladder.
-The resident was oriented and her memory was adequate.
-The resident's speech was slurred.
-The resident was a fall risk and had to be

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monitored.
-The resident required extensive assistance with bathing, grooming, dressing, and toileting.
-The resident required limited assistance with transferring, ambulation, and eating.

Review of Resident #14's accident/injury reports, charting notes, and hospital records revealed:
-The resident had 29 falls from 11/04/18 - 05/14/19.
-The resident went to the emergency room (ER) for evaluation of injuries for 6 of the 29 falls.
-The resident's injuries included scalp hematoma, abrasions/lacerations to elbows, minor head injury, post-traumatic headache, pain and strain of neck muscle, bruising and knot on head, abrasion lower left ankle, scratch and bruise on left side of body, bruise on right hand, reddened area on back, and scratch on left side of face.

Interview with Resident #14 on 05/13/19 at 11:53am revealed:
-The resident had slurred speech and was difficult to understand.
-The resident had falls but she did not have any falls over the past weekend.
-The resident went to the hospital sometimes because of falls.
-When asked about the last time she fell, the resident's response could not be understood.

Review of Resident #14's charting note dated 11/04/18 at 7:41am revealed:
-The resident was found on the floor beside the closet on her bottom.
-There were no apparent injuries and her vital signs were good.
-The resident had a scratch and a bruise on her left side from an old fall.
-Staff would continue to monitor the resident

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throughout the shift.
-The primary care provider (PCP) and guardian were aware of the situation.

Review of Resident #14's accident/injury reports revealed there was no report completed for the resident's fall on 11/04/18.

Review of Resident #14's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 11/04/18.

Review of Resident #14's accident/injury report dated 11/07/18 at 6:20pm revealed:
-The resident was seen on the rocks, next to the sidewalk.
-The resident's wheelchair was sideways on the ground.
-The resident stated her wheelchair went backwards with her in it and she fell out.
-The resident had an abrasion (location not specified).
-The resident was taken to the ER.
-The resident was diagnosed with a minor head injury.
-Messages were left for the resident's PCP and guardian.

Review of Resident #14's charting note dated 11/07/18 at 7:13pm revealed:
-Resident #14 fell out of her wheelchair on the rocks while outside with another resident.
-The resident had a scratch on her lower left back.
-The resident stated she hit her head and she was sent to the ER.
-The PCP and guardian were contacted.

Review of Resident #14's hospital ER notes dated 11/07/18 revealed:

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D 270	Continued From page 71 -The resident was seen for a fall. -A head scan and an x-ray of the left ankle were done. -The resident was diagnosed with a minor head injury and an abrasion of the left ankle. Review of Resident #14's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 11/07/18. Review of Resident #14's charting note dated 11/16/18 at 10:43pm revealed: -The resident had fallen out of her wheelchair. -The resident later stated her head was hurting a little and she was given some Tylenol (for pain). -The resident's vital signs were taken again before the end of shift and the resident was "doing well". -Staff would continue to monitor the resident throughout the shift. Review of Resident #14's accident/injury reports revealed there was no report completed for the resident's fall on 11/16/18. Review of Resident #14's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 11/16/18. Review of Resident #14's accident/injury report dated 11/25/18 at 3:35pm revealed: -The resident was laying on the floor beside her bed. -The resident stated she was getting off the bed into the wheelchair when the wheelchair tipped backwards, and she landed on the floor. -No injuries were noted but the resident was sent to the ER. -Messages were left for the resident's PCP and guardian.	D 270		

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D 270	Continued From page 72 Review of Resident #14's hospital ER notes dated 11/25/18 revealed: -The resident was seen for a fall. -The resident fell out of the wheelchair, hit her head, and complained of pain to the right side of the neck and a headache. -Scans of the cervical spine and head were done. -No acute abnormalities were noted with either scan. -The resident was administered medication for the pain and sent back to the facility. Review of Resident #14's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 11/25/18. Review of a physician's order for Resident #14 dated 12/12/18 revealed an order for a lap buddy for the resident's wheelchair for safety and positioning. (A lap buddy is a cushion that fits snugly into the wheelchair frame about the lap that provides upper body support and posture assistance.) Review of Resident #14's accident/injury report dated 01/02/19 at 1:10pm revealed: -The resident was outside on the ground out of her wheelchair. -No injuries were present. -Messages were left for the resident's PCP and guardian. Review of Resident #14's charting note dated 01/02/19 at 3:29pm revealed: -The resident was outside and fell out of her wheelchair. -The resident had no injuries and was doing well at this time.	D 270		

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Review of Resident #14's accident/injury report dated 01/02/19 at 11:17pm revealed:
-The resident was laying on her left side beside the bed.
-The resident stated she rolled off the bed and hit her head.
-No injuries were noted but the resident was sent to the hospital.
-Messages were left for the resident's PCP and guardian.

Review of Resident #14's hospital ER notes dated 01/03/19 revealed:
-The resident was seen for a fall.
-Scans of the cervical spine and head were done.
-The resident was diagnosed with post-traumatic headache and strain of neck muscle.
-The resident was given orders for 3 new medications; a muscle relaxer, a pain medication, and a medication for nausea.

Review of Resident #14's charting note dated 01/03/19 at 12:21pm revealed the resident's guardian came and took the lap buddy back with her (no reason was specified).

Review of Resident #14's after visit summary with the neurologist dated 01/04/19 at 11:00am revealed:
-The resident was seen for a Huntington's disease and ataxia (impaired balance or coordination).
-The neurologist increased the dosage of a medication used to treat involuntary movements associated with Huntington's disease.
-The resident was to return to the neurologist in 6 months.

Review of Resident #14's accident/injury report dated 01/04/19 at 6:30pm revealed:

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D 270	Continued From page 74 -The resident was sitting in an upright position on the floor beside the bed. -No injuries were present. -Messages were left for the resident's PCP and guardian. Review of Resident #14's charting note dated 01/04/19 at 6:31pm revealed: -The resident was in her room and stated she slipped out of the wheelchair when trying to get on her bed. -The resident's vital signs were in normal range. -The resident's PCP and guardian were notified. -Staff would monitor her throughout the shift. Review of Resident #14's 72 hour fall follow-up report dated 01/04/19 revealed: -"Section B" for assessing the resident was blank including questions related to the resident's vital signs, wearing proper shoes, using an assistive device, or taking psychotropic medications. -The section for vital signs each shift was blank on 8 of 9 shifts from 01/04/19 - 01/06/19. Review of Resident #14's current PCP visit notes dated 01/08/19 revealed: -The resident was seen to be established as a new patient. -Staff reported the resident had a fall on 01/03/19 and was sent to the ER. -The resident was to be rechecked in one month. Review of Resident #14's accident/injury report dated 01/24/19 at 3:06pm revealed: -The resident rolled too far back and flipped over. -The resident was laying back on rocks in the wheelchair. -No injuries were present. -Messages were left for the resident's PCP and guardian.	D 270		

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D 270	Continued From page 75 Review of Resident #14's current PCP visit notes dated 02/05/19 revealed: -The resident was being seen for a routine follow-up visit. -The resident wanted to see the PCP to request something to keep her calm and something for a cough. -The PCP ordered medications for anxiety and cough. -There was no documentation regarding the resident's falls. Review of Resident #14's accident/injury report dated 02/18/19 at 12:49pm revealed: -The resident was in the wheelchair in the bathroom and slid out of the wheelchair and fell on the floor. -No injuries were present. -Messages were left for the resident's PCP and guardian. Review of Resident #14's charting note dated 02/18/19 at 1:16pm revealed: -The resident had "a fall today at 12:49pm". -The resident was in her wheelchair in the bathroom and slid out of the wheelchair and laid on the floor. -Staff would continue to monitor the resident throughout the shift. Review of Resident #14's accident/injury report dated 02/24/19 at 10:30pm revealed: -The resident was laying by the bed. -The resident stated she fell out of the bed while she was sleeping. -A cut reopened from an old cut on her right elbow. -Staff cleaned the cut and put some triple antibiotic ointment and a bandage on it.	D 270		

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D 270	Continued From page 76 -A message was left with the resident's guardian. -Staff spoke with the resident's PCP. Review of Resident #14's charting note dated 02/25/19 at 1:41am revealed: -The resident fell off her bed tonight while sleeping. -The resident stated she was "alright" but her right elbow was bleeding. -The resident reopened an old cut that was on her right elbow. -Staff did first aid on her elbow, called all responsible parties and notified them on what was going on with the resident. -The resident's vital signs were taken. -Staff would continue to monitor the resident's behaviors throughout that shift. Review of Resident #14's accident/injury report dated 02/25/19 at 12:21pm revealed: -The resident was laying on the floor on her back beside the bed. -The resident stated she fell off the bed. -No injuries were present. -A message was left with the resident's guardian. -Staff spoke with the resident's PCP. Review of Resident #14's charting note dated 02/25/19 at 1:44pm revealed: -The resident fell off her bed and was laying by her bed on the floor. -Staff would continue to monitor the resident throughout the shift. Review of Resident #14's accident/injury report dated 02/26/19 at 6:36am revealed: -The resident was laying on the floor. -The resident stated she tried to get in the wheelchair and fell out. -The resident had a laceration on her right elbow	D 270		

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and it was bandaged.
-Messages were left with the resident's PCP and guardian.

Review of Resident #14's current PCP visit notes dated 02/26/19 revealed:
-The resident was being seen for a follow-up visit.
-Care staff reported the resident had 3 falls in a row.
-All of the falls, she fell out of her bed trying to transfer to her wheelchair.
-No injuries noted from any of the falls.
-The resident stated she was okay and denied any pain.
-The PCP ordered physical therapy (PT) and occupational therapy (PT) evaluate and treat.

Review of Resident #14's charting note dated 02/26/19 at 10:33pm revealed:
-The resident fell getting in her wheelchair this morning.
-Vital signs were taken and the PCP and guardian were called.

Review of PT visit notes for Resident #14 revealed:
-The resident was admitted to PT services on 02/28/19.
-The resident was discharged from PT services on 03/28/19 due to lack of progress towards PT goals.

Review of an OT form for Resident #14 revealed:
-The resident was admitted to OT services on 03/01/19.
-The resident was discharged from OT services on 04/16/19 due to maximum rehabilitation potential being achieved.

Review of Resident #14's charting note dated

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D 270	Continued From page 78 03/01/19 at 8:50am revealed: -The resident fell out of her wheelchair this morning. -Vital signs were taken and were normal. -Voice messages were left for the resident's PCP and guardian. -Staff would continue to monitor the resident for the next 72 hours. Review of Resident #14's accident/injury reports revealed there was no report completed for the resident's fall on 03/01/19. Review of Resident #14's accident/injury report dated 03/07/19 at 10:15am revealed: -The resident was sitting in her wheelchair. -There was blood on the wall and air conditioner unit. -The resident stated she fell out of bed the night before and got back up on her own. -The resident had a laceration on her right elbow. -It was cleaned, ointment applied, and wrapped with gauze. -A message was left with the resident's guardian. -Staff spoke with the resident's PCP. Review of Resident #14's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 03/07/19. Review of Resident #14's accident/injury report dated 03/09/19 at 12:45pm revealed: -The resident was laying on the floor in the hallway. -The resident stated she fell out of the wheelchair. -No injuries were present. -Messages were left with the resident's PCP and guardian.	D 270		

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Review of Resident #14's charting note dated 03/09/19 at 4:02pm revealed:
-The resident fell out of her wheelchair this afternoon.
-No injuries were found, and vital signs were taken.
-The resident's PCP and guardian were notified.
-Staff would continue to monitor throughout shift.

Review of Resident #14's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 03/09/19.

Review of Resident #14's accident/injury report dated 03/13/19 at 6:28am revealed:
-The resident was sitting on the floor in the dining room.
-The resident stated she slipped out of her wheelchair.
-No injuries were present.
-Messages were left with the resident's PCP and guardian.

Review of Resident #14's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 03/13/19.

Review of Resident #14's accident/injury report dated 03/15/19 at 6:55pm revealed:
-The resident was laying on the floor next to her bed.
-The resident stated she rolled off the bed.
-No injuries were present.
-Messages were left with the resident's PCP and guardian.

Interview with a personal care aide (PCA) on 05/14/19 at 6:30pm revealed:
-Resident #14 needed assistance with showers and dressing.

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D 270	Continued From page 80 -Staff also assisted the resident with transferring if staff were in the room with her, otherwise the resident could transfer herself at times. -The residentcould toilet herself and would use the call bell if she needed help. -The resident was on 2-hour routine checks and no one had instructed staff to monitor the resident more frequently. -When the PCA worked, the resident fell about twice a week. -She thought the resident fell because the resident got in a hurry sometimes and the resident had involuntary movements. -She found the resident on the floor about 1 and ½ months ago (referring to 03/15/19) when the resident had fallen out of bed. -The resident did not have injuries or go to the hospital on that occasion. -She found the resident while doing routine 2-hour checks but she did not know how long the resident was on the floor. -She reported the fall to the medication aide (MA) on duty. -After a fall, a resident was checked every 30 minutes for 72 hours then back to routine 2-hour checks. Review of Resident #14's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 03/15/19. Review of Resident #14's accident/injury report dated 03/18/19 at 8:50am revealed: -The resident was sitting in her wheelchair. -The resident stated she fell out of the wheelchair while trying to put her shoes on. -No injuries were present. -Messages were left with the resident's PCP and guardian.	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 81 Review of Resident #14's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 03/18/19. Review of Resident #14's current PCP visit notes dated 03/20/19 revealed: -The resident was seen today for multiple falls. -The care staff reported the resident had falls about every day. -No injuries reported other than the "same spot" on her elbow. -The resident stated she was okay. -A number of these falls occurred when the resident had uncontrolled choreoathetoid movements (involuntary movements including irregular contractions, twisting, and writhing). -These tended to happen when the resident got out of bed. -The resident required positioning of the body in ways not feasible with an ordinary bed. -Pillows and wedges had been tried with no success. -The PCP ordered a concave mattress and a semi-electronic hospital bed. -The resident was to be rechecked in 2 weeks. Observation of Resident #14 on 05/14/19 at 2:10pm - 2:20pm revealed: -The resident was in her room sitting in a wheelchair. -The resident had a hospital bed and a concave mattress in her room. -The resident's arms, legs, and torso had near constant involuntary movements causing her body to jerk and her arms and legs to flail in random directions. -The resident could propel the wheelchair with her feet, but the wheelchair jerked and rolled uncontrollably in multiple directions because of the resident's sudden involuntary movements.	D 270		

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D 270	Continued From page 82 Review of Resident #14's accident/injury report dated 03/21/19 at 12:34am revealed: -The resident was sitting up on bathroom floor. -The resident stated she fell while pulling up her incontinence brief. -No injuries were present. -Messages were left with the resident's PCP and guardian. Review of Resident #14's charting note dated 03/21/19 at 12:35am revealed: -The resident fell in the bathroom. -The resident's vital signs were taken and were in normal range. -The resident's PCP and guardian were notified. Review of Resident #14's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 03/21/19. Review of a physician's order for Resident #14 dated 03/22/19 revealed an order for a semi-electric hospital bed and a concave mattress. Review of Resident #14's accident/injury report dated 03/28/19 at 6:49am revealed: -The resident was laying on the floor in the bathroom by her wheelchair. -The resident stated she fell trying to go to the bathroom. -No injuries were noted. -The resident's PCP and guardian were notified. Review of Resident #14's accident/injury report dated 03/30/19 at 11:26am revealed: -The resident lost her balance and fell while trying to use the bathroom. -No injuries were noted.	D 270		

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D 270	Continued From page 83 -The resident's PCP and guardian were notified. Review of Resident #14's accident/injury report dated 04/02/19 at 10:00am revealed: -The resident was laying on her back on the floor in her room, then she sat up. -The resident stated she fell. -No injuries were noted. -The resident's PCP and guardian were notified. Interview with a MA on 05/14/19 at 2:10pm revealed: -Resident #14's involuntary movements had gotten worse over the last year. -Staff helped the resident with bathing, dressing, and grooming. -The resident could stand holding onto something and she could transfer herself. -If staff pushed the resident in her wheelchair to her room, staff would assist the resident with transferring or toileting. -Resident #14 had "a lot" of falls because she tried to get up by herself and would not call for help. -She thought the resident had PT last month but she was discharged from PT services because she was "too far gone" to use a walker. -The resident had a hospital bed and she got a concave mattress around the end of last month or this month. -Resident #14 was monitored during routine checks every 2 hours, the same as the other residents. Review of Resident #14's accident/injury report dated 04/21/19 at 10:00am revealed: -The resident was sitting on the floor in her bedroom. -The resident did not state how she fell. -The resident already had a bruise on her right	D 270		

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hand but when she fell, "it made it bleed a little bit".
-The MA cleansed the bruise, put ointment on it, and bandaged it.
-The resident's PCP and guardian were notified.

Interview with a PCA on 05/14/19 at 5:21pm revealed:
-Resident #14 had falls but "not really" a lot of falls.
-Resident #14 needed assistance with bathing and dressing.
-Staff sometimes helped the resident with toileting "so she won't fall".
-Sometimes the resident did not call for help but she was supposed to call staff for assistance.
-All residents were on routine 2-hour checks, including Resident #14.
-There had been no instructions to monitor Resident #14 more frequently than every 2 hours.

Review of Resident #14's accident/injury report dated 05/02/19 at 1:55pm revealed:
-The resident was found on the floor on her right side with her hands under her head.
-The resident stated she was going to the bathroom and fell out of the wheelchair.
-The resident had a bump on the back of her head.
-The resident was taken to the ER.
-The resident's discharge diagnosis was scalp hematoma.
-The resident's PCP and guardian were notified.

Review of Resident #14's charting note dated 05/02/19 at 3:17pm revealed:
-The resident was found in her room on the floor.
-The resident stated she fell out of her wheelchair trying to go to the bathroom.
-The resident's vital signs were checked, and the

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resident was sent to the ER.

Review of Resident #14's hospital ER notes dated 05/02/19 revealed:
-The resident was seen for a fall.
-A head scan was done.
-The resident was diagnosed with a scalp hematoma.

Review of Resident #14's charting note dated 05/03/19 at 1:30pm revealed:
-The resident was found sitting on the floor in her room.
-The resident did not hit her head.
-The resident stated she was getting a cookie that fell on the floor.
-The resident's vital signs were taken.
-A message was left for the resident's guardian.
-Staff spoke with someone at the PCP's office and they would call back if there were any orders from the PCP.

Review of Resident #14's accident/injury reports revealed there was no report completed for the resident's fall on 05/03/19.

Review of Resident #14's charting note dated 05/05/19 at 10:20am revealed:
-The resident was found sitting on the floor in her bathroom and she was crying.
-The resident stated she hit her head on the toilet.
-The resident had a knot on the top of her head and a scratch on the left side of her face near her eye.
-The resident asked to go to the hospital.

Interview with a MA on 05/15/19 at 3:57pm (who wrote the charting note on 05/05/19) revealed:
-She usually worked on second shift from 3:00pm to 11:00pm.

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D 270	Continued From page 86 -Resident #14 tried to get up and down on her own but the resident needed assistance. -If the resident dropped something on the floor, the resident would try to pick it up, causing her to lean over in the chair and fall at times. -Resident #14 was on routine 2-hour monitoring checks until yesterday, when staff was told to start doing 30-minute checks on the resident. -She tried to keep Resident #14 in common areas to help monitor her more often. Review of Resident #14's accident/injury report dated 05/05/19 at 11:00am revealed: -The resident was laying on the floor in the bathroom. -The resident stated she hit her head on the toilet. -The resident had bruising and a bump and was sent to the ER. -The resident's PCP and guardian were notified. Review of Resident #14's hospital ER notes dated 05/05/19 revealed: -The resident was seen for a fall. -Scans of the head and spine were done. -The resident was diagnosed with abnormal coordination and history of Huntington's disease. -The resident was administered a pain medication. Review of Resident #14's current PCP visit notes dated 05/07/19 revealed: -The resident was being seen for multiple falls. -Care staff reported the resident had several falls. -The only injury obtained was a knot on the back of her head, which had resolved. -The resident stated she was "good" but she had been falling out of bed and she fell in the bathroom. -The plan was to recheck the resident in 4 weeks.	D 270		

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Review of Resident #14's accident/injury report dated 05/08/19 at 2:28pm revealed:
-The resident was sitting on the floor in the hallway.
-The resident stated she was trying to sit back in her wheelchair.
-No injuries were noted.
-A message was left for the resident's guardian.
-Information was relayed to the PCP's nurse.

Review of Resident #14's charting note dated 05/08/19 at 4:50pm revealed:
-The resident slid out of her wheelchair in the hallway.
-There were no injuries and vital signs were taken.

Review of Resident #14's charting note dated 05/08/19 at 9:50pm revealed:
-The resident saw the PCP on 05/07/19 for several falls.
-The PCP stated the resident needed to be placed somewhere else.
-Staff would continue to monitor.

Review of Resident #14's accident/injury report dated 05/09/19 at 12:30pm revealed:
-The resident was trying to pick up her shoe and fell in the dining room.
-The resident's PCP and guardian were not notified.

Review of Resident #14's accident/injury report dated 05/13/19 at 8:20am revealed:
-The resident was sitting on the floor in the hallway.
-The resident stated she was trying to get her shoe.
-The resident had "redness" on her back.
-The resident's PCP and guardian were notified.

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D 270	Continued From page 88 Review of Resident #14's charting note dated 05/13/19 at 9:47am revealed: -The resident was on the floor in the hallway. -The resident's vital signs were taken. -The resident's PCP and guardian were notified. Interview with a PCA on 05/14/19 at 5:35pm revealed: -Staff helped Resident #14 with bathing and dressing. -The resident sometimes tried to put her shoes on but would fall out of the wheelchair because of the resident's involuntary movements. -The resident tried to transfer and toilet herself but if staff where checking on her and the resident was in the bathroom, staff would assist her. -The resident was on routine 2-hour checks. -She thought Resident #14 may have been on 30-minute checks for 72 hours after a fall about a month ago but she was not sure. Interview with a PCA on 05/14/19 at 6:20pm revealed: -Resident #14 needed assistance with bathing and dressing. -The resident was not incontinent and she could go to the bathroom on her own. -Resident #14 could transfer herself but staff assisted because they were "afraid she was going to fall". -The resident called for assistance at times but not all of the time. -Most of the resident's falls were caused by the resident's involuntary movements while in the wheelchair. -Resident #14 was on 2-hour routine checks but she tried to check the resident more often because she needed assistance.	D 270		

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D 270	Continued From page 89 -If a resident fell, staff were supposed to do 30-minute checks for 72 hours after a fall then the resident went back on routine 2-hour checks. Review of Resident #14's current PCP visit notes dated 05/14/19 revealed: -The resident was being seen for multiple falls. -Care staff reported the resident had 5 falls in a week. -The resident had several abrasions of her elbows. -The PCP ordered a neurology consult for repeated falls. -The PCP ordered PT consult for evaluation of a specialized wheelchair to help control the resident's falls. Interview with the Care Manager (CM) on 05/13/19 at 4:20pm revealed: -Resident #14 had frequent falls. -One week she had 4 falls and one day she had 2 or 3 falls the same day. -Resident #14 tried to do things for herself instead of getting assistance. -Resident #14 could stand and walk some independently but she needed standby assistance at least. -The resident also slid out of her wheelchair and fell out of bed sometimes. -The resident got a concave mattress (could not recall when) and that helped some with falls from her bed. -The resident also had a lap buddy for her wheelchair but it did not work because the resident could remove it so the lap buddy was given to the resident's guardian (could not recall when). -The resident had PT and OT about a month ago but they were told PT and OT could not do anything else for the resident.	D 270		

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-There was not much improvement after the resident had PT/OT.
-Resident #14 was on routine 2-hour checks like the other residents.
-Staff should try to check on Resident #14 every time they walked by the resident's room.
-Resident #14's supervision checks had not been increased to her knowledge.
-If staff had done 30-minute checks, it would be documented.
-Staff should document vital signs and monitoring on each shift for 72 hours after each fall on the 72 hours falls follow-up report.

A second interview with the CM on 05/14/19 at 2:35pm revealed:
-Resident #14 got a new wheelchair last year but the resident broke it.
-The resident's guardian brought another wheelchair for the resident which was the one she currently used.
-The CM texted the resident's PCP yesterday about the possibility of getting the resident a specialty wheelchair because the Regional Clinical Director (RCD) had mentioned it to the CM.
-Resident #14 was on 2-hour incontinence checks.
-When staff walked by the resident's door, they "might" knock on the door and look in on the resident.
-Staff "just know" to check on Resident #14.
-Resident #14 tried to do for herself but she needed assistance.

Interview with the Administrator on 05/14/19 at 4:57pm revealed:
-If a resident had a fall, staff were supposed to get the MA so the MA could assess the situation and check the resident's vital signs.

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D 270	Continued From page 91 -If there was obvious pain, blood, or injury, emergency medical services (EMS) should be called. -If a resident hit their head but there was no knot or other obvious injury, staff should follow protocol of 72 hour reporting but they would not call EMS. -Staff were supposed to check vital signs and monitor pain status and pain on all 3 shifts for 72 hours after each fall. -If there was a change in a resident's status, the CM should be notified and the resident sent to the hospital. -Increased supervision meant more checks than the routine 2-hour checks with options for 1-hour or 30-minute checks. -All residents in the AL side of the facility including Resident #14 were on routine 2-hour checks. -She thought Resident #14 was put on hourly checks at one time but it had "been a while" and she could not recall when. -Staff did not document hourly checks because staff were entrusted to do the checks. -She could not recall if Resident #14 had ever been on 30-minute checks. -Resident #14 had a concave mattress, PT/OT, a lap buddy, and she was supervised while outside (could not recall when that started). -They had not tried a fall mat but had recently discussed in a management meeting (not sure date). -If a resident continued to fall, after 1-hour checks were being done, they would keep trying by monitoring more often such as 30-minute checks. -Resident #14 was currently on routine 2-hour checks. -She could not explain why Resident #14's supervision had not been increased even though the resident continued to fall.	D 270		

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D 270	Continued From page 92 Interview with the RCD on 05/14/19 at 4:55pm revealed: -The RCD, CM, and the resident's PCP had recently discussed (could not recall date) upgrading Resident #14 to a skilled nursing facility. -She was not sure how the resident would respond to that because this was the first facility the resident had resided in and it was the resident's home. -She was not sure the status of upgrading the resident; she would have to check with the CM. Telephone interview with Resident #14's current PCP on 05/15/19 at 10:23am revealed: -Resident #14 had a deterioration in functional status since January 2019 and was getting worse. -The resident's speech was more slurred and she was difficult to understand. -The resident's disease process (Huntington's disease) was "relatively aggressive". -He was aware Resident #14 had several falls but he was not sure if he was notified each time the resident fell. -He received a text from the CM yesterday (05/14/19) about the resident falling out of her wheelchair. -There was a care planning meeting for the resident about 6 weeks ago and staff reported the resident was falling on a daily basis. -A lot of the falls were related to the resident falling out of bed because the resident had a difficult time repositioning and moving around in bed. -They got a hospital bed with concave mattress and there had been a change in her wheelchair at some point (could not recall when). -He thought the resident's falls out of bed improved after they got the hospital bed and concave mattress.	D 270		

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-He thought most of the resident's falls now were out of the wheelchair.
-The resident was trying to maintain her independence and tried to do things for herself.
-The facility had not been able to lessen or improve the resident's falls.
-It was reasonable that more supervision may help the resident.
-He was currently thinking a skilled nursing facility would be able to "keep more eyes" on the resident and provide more supervision and that may decrease the resident's falls.
-He had discussed with the RCD but the RCD was concerned about the resident being moved because this facility was the resident's home.
-He was not sure if the facility had started looking for other placement for the resident.

Interview with the RCD on 05/16/19 at 12:40pm revealed they contacted the resident's guardian and the guardian was working on finding placement for the resident.

Telephone interview with Resident #14's Department of Social Services (DSS) guardian on 05/14/19 at 11:58am revealed:
-She was concerned because Resident #14 fell "a lot".
-The facility usually called her or left a voice message when the resident fell.
-She thought most of the time, the resident fell when the resident was going to the bathroom.
-She was not sure how often they assisted the resident to the bathroom.
-Staff told the guardian that the resident had been told to call staff when she needed to go to the bathroom.
-The resident needed assistance with bathing, dressing, and transferring.
-The resident could propel the wheelchair with

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her feet.
-She had seen the resident trying to stand up but the resident was "wobbly" when she did that.
-She had not seen the resident walk.
-The resident tried PT (could not recall when) but she was not sure how long the resident took PT.
-The resident felt more independent when she took PT and PT "maybe made her stronger" physically.
-A lap buddy was ordered and tried for the resident's falls because they thought it would help.
-The resident could remove the lap buddy and when the resident got a different wheelchair, the lap buddy no longer fit.
-The resident got a wider wheelchair (between November and December 2018) so she could lean back more and that "helped a lot".
-She did not know how often staff checked on or monitored the resident.
-The resident continued to have multiple falls and the guardian felt the resident needed a higher level of care because of the falls.
-She was currently looking for a skilled facility to move the resident.

A third interview with the CM on 05/16/19 at 11:55am revealed:
-They just started 30-minute supervision checks on Resident #14 on 05/14/19 as part of the facility's plan of protection.
-Staff were documenting the 30-minute checks on a spreadsheet that was kept at the nurses' station.

Review of a "Increased Supervision - Every 30 Minute Checks" form for Resident #14 revealed staff started documenting 30-minute checks on the resident on 05/14/19 at 6:30pm.

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D 270	Continued From page 95 The facility failed to provide adequate supervision for 3 of 11 sampled residents resulting in one resident (#14) sustaining 29 falls in 6 months resulting in injuries and emergency room visits; and another resident (#1) wandering away from the SCU unsupervised into a service hall and into the facility's kitchen near a hot stove with a large pot of soup cooking. The facility's failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/19 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 16, 2019.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to respond to incidents immediately and in accordance with the facility's established policy and procedures for 1 of 5 residents	D 271		

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sampled (#1) who fell in the facility.

The findings are:

Review of the facility's Falls Management Program revealed:
-It was the policy of the facility for residents to be monitored and identified for risk of falls.
-Fall Risk Assessments were completed for all residents admitted to the facility.
-Staff would receive training on Fall Prevention Awareness.
-Staff would complete an incident report in its entirety for any fall.
-Staff would complete the 72 Hour Follow Up on resident falls to investigate possible circumstances contributing to the fall and document observations for 72 hours after the fall.
-The 72 Hour Follow Up included vital signs initially and every shift for 72 hours and assessment of possible risk / contribution factors for falls.
-If a resident had 2 falls within a 4 weeks period, the physician was to be contacted requesting an order for physical therapy (PT) evaluation or other treatment / interventions.
-The resident was to be placed in Hot Box / Alert Charting for 72 hours for follow up and monitoring.
-The Healthcare Quality Assurance Team would review incident reports on a monthly basis.

Review of Resident #1's FL-2 dated 10/17/18 revealed diagnoses included Alzheimer's Disease, unspecified dementia, right hip joint replacement, hypertension, depression, anxiety, osteoarthritis.

Interview with a 3rd shift personal care aide (PCA) on 05/07/19 at 4:57am revealed:

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-She worked at the facility for about 1½ months.
-Resident #1 had two falls since she had been employed at the facility.
-The resident was found by another PCA after she had fallen on floor and had hit her head on 3rd shift last Friday (5/03/19). The resident was transported to the local emergency room (ER).
-The resident fell one more time after the 5/03/19 (on 3rd shift). The fall occurred yesterday (5/06/19).
-She found Resident #1 on the floor on her knees.
-The resident complained of knee pain of her bad knee (right knee).
-She assisted the resident up into her chair and reminded the resident to use her walker.
-All resident falls were required to be reported to the medication aides (MA) who assessed the resident for injuries.
-She did not remember if she had reported the fall to the fall to the MA, but she may have reported it.

Interview with another 3rd shift PCA on 05/07/19 at 5:05am revealed she was aware of Resident #1's second fall but was not sure it was reported to the MA.

Interview with Resident #1 on 5/07/19 at 1:55pm revealed:
-She had fallen about 4 nights ago while getting out of bed.
-She hit her right knee and the right side of her face.
-She fell 1 or 2 nights ago, but did not remember what happened orhow she fell.
-She hit her right knee again and the knee remained painful.

Observation of Resident #1's right knee on

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D 271	Continued From page 98 05/07/19 at 2:00pm revealed a dark bruise covering the knee and a blister, the size of a half dollar, filled with clear fluid. Interview with a 3rd shift MA on 05/14/19 at 9:20am revealed: -She was aware of Resident #1's fall on 3rd shift, on 05/03/19, but she was not aware of another fall since then. -Staff had not reported a second fall. -When a resident fell, whether injuries or not, staff should always report the fall to the MA and an accident/incident report would be completed after the resident was assessed for injuries. The fall would have beem reported the the resident's primary care provider (PCP). Interview with the Administrator on 05/14/19 at 3:45pm revealed: -She was not aware of Resident #1 sustaining a second fall this month (May 2019). -The resident or staff had not reported a second fall. -All falls should be reported to the MA or Care Manager (CM), who would assess the resident for injuries. -The falls were documented on an incident report and reported to the resident's primary care physician (PCP). The resident would be sent to the emergency room (ER) if necessary. Interview with the CM on 05/14/19 at 5:50pm revealed: -She was not aware Resident #1 had fallen again since 05/03/19. -There was not an incident report documenting a second fall. -She expected staff to report all falls. -The PCAs should report resident falls/incidents to the MA or CM and the MA/CM would assess	D 271		

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D 271	Continued From page 99 the resident for injuries and report the fall to the resident's PCP or send the resident to the ER. Review of an Event Report (incident report) dated 05/03/19 revealed: -On 05/03/19 at 5:15am the resident had an unwitnessed fall in her bedroom. -The resident complained of pain. There were bruising of the right forehead, and complained of pain to her back, eye and forehead. -The resident was transported to the local ER. There was no documentation of a second fall on 05/03/19 in Resident #1's records.	D 271		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Type A1 VIOLATION Based on observations, interviews, and record reviews the facility failed to assure referral and follow up for routine and acute health care needs for 6 of 10 sampled residents (#2, #3, #4, #6, #10, and #17) as evidenced by failing to obtain routine and weekly lab work (#2, #10); report a resident heart rate of 38 to the physician (#6);	D 273		

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obtain a pressure release cushion for a resident's wheelchair and a referral to podiatry (#3); obtain a stool culture as ordered due to diarrhea and to follow up with the PCP for a recheck visit after a fall and unsteady gait (#2); report a fall with injury and emergency department visit to the physician (#17); and assure a resident received ordered testing (#4).

1. Review of Resident #10's current FL-2 dated 10/29/18 revealed:
-Diagnoses included congestive heart failure, atrial fibrillation, chronic anticoagulation therapy, hypertension, and diabetes mellitus.
-There was documentation to obtain a prothrombin time and international normalized ratio (PT/INR) weekly until stable then monthly as needed. (PT/INR are blood tests to measure the speed blood coagulates and used to determine safe dosing of Coumadin. Coumadin is a medication that slows coagulation to prevent clots).
-There was an order for Coumadin 1 milligram (mg) take two tablets daily.
-There was an order for Coumadin 5mg take one tablet daily. "Take 5mg with 1mg to equal 7.5mg daily".
-There was an order for Coumadin 7.5mg daily.

Review of Resident #10's resident register revealed an admission date of 11/01/18.

Review of Resident #10's subsequent orders dated 11/15/18 revealed there was an order for Coumadin 2.5 mg take three tablets (7.5mg) daily (check PT/INR every week).

Review of an additional subsequent order for Resident #10 dated 11/17/18 revealed:
-There was an order for Coumadin 7.5mg daily.

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D 273	Continued From page 101 -There was an order to check the PT/INR weekly. Review of Resident #10's Licensed Health Professional Support (LHPS) dated 11/13/18 revealed there was documentation to obtain a "PT/INR weekly, staff does not perform". Review of Resident #10's 11/07/18 - 11/30/18 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Coumadin 5mg daily. "Take 5mg with 1mg to equal 7.5mg". The origination date was 11/08/18. -There was documentation Coumadin 5mg "take 5mg with 1mg to equal 7.5mg" was administered from 11/09/18 - 11/10/18 and 11/12/18 at 5:00 pm. -There was an electronic entry for Coumadin 2.5mg take 3 tablets (7.5mg) daily. Check PT/INR every week. The origination dated was 11/11/18. -There was documentation Coumadin 7.5mg was administered from 11/11/18 - 11/30/18 at 5:00 pm. -There was an electronic entry for Coumadin 7.5mg daily. Check PT/INR weekly. The origination date was 11/10/18. -There was documentation Coumadin 7.5mg was administered 11/10/18 at 5:00 pm. Review of Resident #10's December 2018 eMAR revealed: -There was an electronic entry for Coumadin 2.5mg take 3 tablets (7.5mg) daily. Check PT/INR weekly. -There was documentation Coumadin 7.5mg was administered 12/01/18 - 12/05/18 at 5:00 pm. Review of the facility's transportation log for November and December 2018 revealed there was no documentation Resident #10 was transported to a medical facility for lab work.	D 273		

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D 273	Continued From page 102 Review of Resident #10's charting and care notes, physician notes and orders, and Emergency Department (ED) notes revealed there were no PT/INR's obtained from 11/07/18 - 12/06/18 other than 11/29/18 when the resident went to the ED for diabetic polyneuropathy and 12/06/18 when the Resident was admitted to the hospital for a hemorrhagic stroke. Review of Resident #10's Emergency Medical Services (EMS) patient care notes dated 12/06/18 revealed: -Staff reported when coming on shift at 7:00 am Resident #10 was slouching to the side and unable to walk like normal. -"Last night's staff said they noticed him slouching but was fine when I left here at 7 pm." -Upon EMS arrival he was found sitting in a recliner, alert but confused, and difficulty controlling his right arm and leg. -His stroke screen was positive. -His fingerstick blood sugar was 48. Review of Resident #10's Emergency Department (ED) record dated 12/06/18 revealed: -He presented to the ED with right sided weakness at 8:42 am. -He was treated in the ED 12/05/18 for a fall and complained of right hip pain. -He reported he may have fallen again the night of 12/05/18 but was able to get back into bed. -There was a prothrombin time (PT) result of 59.4 (A blood test to determine the effectiveness of Coumadin. The normal reference range is 9.1 - 11.1 seconds). -There was an international normalized ratio (INR) result of 6.2 (A blood test that measures how fast blood clots and is used to determine safe dosing of Coumadin. The normal	D 273		

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therapeutic range is 2.0 - 3.0).
-He was diagnosed with an acute left thalamic intraparenchymal hemorrhage (a bleed in the brain).
-His mental status declined, and he was intubated (a tube placed in the lungs to secure the airway in respiratory failure).
-He had a "high probability of life-threatening deterioration in conditions at the initial presentation or during the ED course related to intercranial hemorrhage".
-He was transferred by air ambulance to neurosurgery at a higher-level hospital.

Review of Resident #10's higher-level hospital records from 12/06/18 - 12/30/18 revealed:
-He was given KCentra in the ED (a medication to urgently reverse the effects of Coumadin) on 12/06/18.
-He developed aspiration pneumonia on 12/11/18.
-He received a tracheostomy (incision to trachea for breathing tube placement) on 12/21/18.
-He received a percutaneous gastrostomy tube (a tube in the stomach for feedings and medications) on 12/21/18.
-His condition continued to decline.
-He was made a do not resuscitate [DNR (no life-saving mechanisms)] on 12/28/18.
-He was placed on comfort care only on 12/28/18.
-His time of death was 12/30/18 at 11:57 pm.

Interview with a medication aide (MA) on 05/16/19 at 5:00 pm revealed:
-She was working as a personal care aide (PCA) on 12/06/18.
-She was doing rounds before breakfast and Resident #10 was sitting in his recliner.
-Resident #10 looked as if he was having a stroke.
-Resident #10 was drooping, leaning to the side, "

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D 273	Continued From page 104 ...looked funny to me ...speech may have been slurred". -She notified the MA. She could not remember who the MA was. -The morning of 12/06/18 was the first time she had seen Resident #10 in that condition. Interview with the Administrator on 05/17/19 at 2:45 pm revealed: -The facility would take residents to the local hospital for labs. -Whoever received the lab order would complete a hospital lab requisition. -The lab requisition was signed by the Primary Care Provider (PCP) then they would call the hospital lab to schedule the lab work. -The lab appointment information would be documented in the charting notes. -Labs were done weekly, no specific day. -When the resident was taken to the hospital for labs a copy of the lab requisition would be filed in the resident's facility chart. -There was a transportation log that was used to document when residents were taken for medical appointments. -Resident #10's PT/INR results should be filed in his facility chart. Interview with the Regional Clinical Director on 05/17/19 at 3:05 pm revealed: -The Care Manager (CM) was responsible for transcribing lab orders onto the hospital lab requisition. -The PCP would sign the lab requisition manually or electronically. -The CM was responsible for faxing the lab requisition to the hospital or calling to schedule the ordered labs. -They were in the process of obtaining Resident #10's PT/INR results.	D 273		

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D 273	Continued From page 105 -She expected residents to be taken for labs as ordered. Telephone interview with a representative for the facility's contracted pharmacy on 05/17/19 at 4:00 pm revealed: -The pharmacy had received a medication list with three different orders for Coumadin on 11/8/18. -The pharmacy had to call Resident #10's PCP to clarify the correct order for Coumadin. -The order was for Coumadin 7.5mg daily. -They dispensed 70 tablets of Coumadin 2.5mg tablets on 11/10/18 with instruction to take 3 tablets daily to equal 7.5 mg daily. Telephone interview with a nurse for Resident #10's PCP on 05/17/19 at 4:15 pm reveled: -He was on Coumadin because of atrial fibrillation (a-fib) (irregular contraction of the heart that allows the blood to pool in the heart and can contribute to blood clots). -The PT/INR was ordered weekly to monitor the coumadin levels to have a therapeutic control. -The therapeutic range for the INR was between 2.0 - 3.0. -Resident #10 was seen in the ED on 11/29/18 and had an INR of 3.9. -The blood was "a little thin" with an INR of 3.9. -The PCP probably would have adjusted down the Coumadin level. She could not say to what dose. -Resident #10 was seen in the ED on 12/06/18 and had an INR of 6.2. -The blood was very thin with an INR of 6.2. -There were no other PT/INR's obtained for Resident #10 between 11/07/18 - 12/06/18. -There was no documentation the facility had notified Resident #10's PCP that the PT/INR's were not obtained.	D 273		

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Telephone interview with a physician who worked with Resident #10's PCP on 05/17/19 at 4:30 pm revealed:
-They normally tried to keep the INR between 2.0 - 3.0.
-The higher the INR the higher the risk of bleeding.
-She expected the PT/INR's to be done as ordered.
-Resident #10's thin blood could make him more prone to bleeding.
-PT/INR's are done weekly to monitor the blood and prevent a combination of things such as gastrointestinal bleeding, hemorrhagic strokes, and hematomas with falls.

A second interview with the ED on 05/17/19 at 5:18pm revealed:
-She was not aware Resident #10's INR lab work had not been done as ordered.
-The Care Manager (CM) was responsible for ensuring lab work was obtained as ordered.

The CM was not available for interview on 05/16/19 or 05/17/19.

Attempted interview with a MA on 05/16/19 at 8:30 pm was unsuccessful.

Attempted interview with Resident #6's PCP on 05/17/19 at 4:15 pm was unsuccessful.

2. Review of #6's current FL-2 dated 07/13/18 revealed:
-Diagnoses included hypertension, dementia, chronic anxiety, hyperlipidemia, and glaucoma.
-There was an order for Amlodipine 10 milligrams (mg) at bedtime (a medication used to lower blood pressure that could also lower the heart

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rate).
-There was an order for Losartan Potassium 100mg daily (a medication used to lower blood pressure that could also lower the heart rate).

Review of Resident #6's subsequent orders dated 01/02/19 revealed:
-There was an order for Amlodipine 10 milligrams (mg) at bedtime.
-There was an order for Losartan Potassium 100mg daily.

Observation of Resident #6 on 05/09/19 at 9:07 am revealed:
-She was laying in her bed.
-She was alert, cooperative, and conversed appropriately.
-The medication aide (MA) assessed her left radial pulse.
-The MA returned to the medication cart and proceeded to the next resident for medication administration.

Interview with the MA on 05/09/19 at 09:08 am revealed Resident #6's pulse was 38 beats per minute (bpm).

Review of Resident #6's physician notes dated 01/08/19 revealed:
-She was being seen for visual hallucinations.
-There was an order for a weekly heart rate (HR).
-There were HR parameters to call if HR greater than (>) 140 or less than (<) 50.

Review of Resident #6's 05/01/19 - 05/09/19 electronic medication administration record (eMAR) revealed:
-The resident was receiving two medications to lower blood pressure that may also lower HR.
-There was an electronic entry to call for pulse <

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D 273	Continued From page 108 50. -There was no documentation the resident had a HR of 38 on 05/09/19. -There was documentation the resident had a HR of 98 at 8:00 am on 05/09/19. -There was documentation the HR of 98 at 8:00am on 05/09/19 was "late administration: charted late ..." at 9:55am on 05/09/19. Review of Resident #6's progress and care notes revealed there was no documentation informing the residents Primary Care Provider (PCP) of a pulse of 38 bpm. A second interview with the MA on 05/09/19 at 10:35 am revealed: -A HR of 38 was "too low". -She did not realize Resident #6's HR was low because she was distracted. -She was distracted because she did not "feel good" and was "nervous" because she had "a lot" of things to do on her medication pass. -She did not know if Resident #6 had HR parameters. -She should have notified the resident's PCP she had a pulse of 38. -She did not know if the facility had a policy for HR's. -She would recheck Resident #6's HR and if still low "..38 ..." she would call the PCP. Interview with the care manager (CM) on 05/09/19 at 11:15 am revealed: -She expected the PCP to be notified of a HR of 38 within 5 to 10 minutes of obtaining. -She expected the HR to be rechecked within 15 - 20 minutes. -Resident #6's PCP had HR parameters to be notified for HR's > 140 or < 50.	D 273		

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Interview with the Administrator on 05/09/19 at 5:55 pm revealed:
-Resident #6 had HR parameters in the electronic medication administration record (eMAR).
-The MA should have looked at the parameters on the eMAR and notified the PCP " ...right away" for a HR of 38.

Telephone interview with Resident #6's PCP on 05/15/19 at 4:34 pm revealed:
-He expected the weekly HR to be obtained for Resident #6 as ordered.
-A HR of 38 was not good and was life-threatening.
-He had not been notified of a HR of 38 for Resident #6.
-He expected to be notified as soon as possible.
-If he had of been notified of a HR of 38 he would have had the CM or supervisor recheck the HR then assess based on the new HR.

3. Review of Resident #3's current FL-2 dated 02/07/19 revealed:
-Diagnoses included type 2 diabetes mellitus, infection and inflammatory reaction to left hip, acquired absence of left upper limb above elbow, hypertension, atherosclerotic heart disease, history of falling, history of healed traumatic fracture.
-He was semi-ambulatory.
-He had a right hip wound.
-Wound care to the right hip was ordered.
-He was incontinent of bowel and bladder.

Review of Resident #3's Resident Register revealed an admission date of 02/07/19.

a. Review of Resident #3's physicians order dated 05/03/19 revealed an order for a pressure relief cushion for the resident's wheelchair (a

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cushion that decreases the amount of sitting pressure by air cells that increase and decrease in air volume).

Observation of Resident #3's wheelchair on 05/15/19 at 2:20 pm revealed:
-There was a light blue foam cushion in the wheelchair.
-The cushion did not fit fully in the wheelchair seat.
-There was approximately a two-inch gap from each side of the cushion to the wheelchair.
-There was approximately a three-inch gap from the end of the cushion to the end of the wheelchair seat where the resident's legs rested.
-The cushion position was not fixed in the wheelchair.

Interview with Resident #3's family member on 05/10/19 at 11:50 pm revealed:
-Resident #3 could not walk.
-Resident #3 spent a lot of time in the wheelchair.
-The left back thigh wound was new and had developed since he had been at the facility.
-He thought the wound was caused from the resident sitting in the wheelchair.

Interview with Resident #3 on 05/14/19 at 10:35 am revealed he needed assistance with transfers, bathing, and dressing.

Interview with the care manager (CM) on 05/14/19 at 4:45 pm revealed:
-The pressure relief cushion for Resident #3 had not been ordered.
-She had tried to order the pressure relief cushion but the durable medical equipment (DME) company did not carry the pressure relief cushion.
-The DME company only carried gel cushions.

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-The DME company told her the prescription needed to be written for a gel cushion.
-She did not know when she tried to order the ROHO cushion.
-She did not contact Resident #3's wound care provider to inform them the ROHO cushion had not been ordered.
-The facility transporter was to contact Resident #3's wound care provider because it was easier for her to contact the provider when transporting residents.
-The transporter was unable to contact the provider.

Interview with the Administrator on 05/14/19 at 4:53 pm revealed:
-She expected the pressure relief cushion for Resident #3 to have been ordered.
-She expected the provider to have been informed immediately if there was a delay with ordering the pressure relief cushion.
-If a different order was required she expected the CM to have contacted the provider immediately.
-She did not expect any delays in ordering any DME.

Interview with Resident #3's home health registered nurse (HHRN) on 05/15/19 at 2:19 pm revealed:
-The resident had a wound to the back of his left thigh that developed after admission to the facility.
-The resident would scoot forward in his wheelchair.
-The wheelchair cushion would slide towards the back of the wheelchair.
-The back of the resident's leg would hit the front of the wheelchair seat.
-She thought the resident's wound on the back of

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his left thigh was caused by the wheelchair.
-The wound on the back of the resident's left thigh would heal but would possibly reoccur because of the back of the leg resting on the front of the wheelchair seat.
-The pressure relief cushion would fit in the wheelchair wider than Resident #6's current cushion.
-There would be no gaps between the pressure relief cushion and the wheelchair.

Telephone interview with a nurse for Resident #3's wound care provider on 05/15/19 at 3:35 pm revealed:
-The pressure relief cushion was ordered 05/03/19 because Resident #3 spent a lot of time in the wheelchair.
-The pressure relief cushion would help to improve Resident #3's pressure ulcer.
-The pressure relief cushion would help to decrease development of new pressure ulcers.
-Without the pressure relief cushion Resident #3 could have an increase in the stage or worsening of the pressure ulcer.
-She expected the facility to initiate orders the same day as received.
-She expected the provider be notified within one to two days maximum if there were any problems getting the pressure relief cushion for Resident #3.
-There was no contact from anyone regarding the pressure relief cushion for Resident #3 until 05/14/19 by the HHRN.

Telephone interview with a second nurse for Resident #3's wound care provider on 05/16/19 at 12:52 pm revealed:
-The care manager (CM) called either 05/14/19 or 05/15/19 regarding the need for and delay of the pressure relief cushion for Resident #3.

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D 273	Continued From page 113 -There was no contact regarding the pressure relief cushion for Resident #3 before the CM called. Attempted interview with Resident #3's wound care physician on 05/15/19 at 12:52 pm was unsuccessful. b. Observation of Resident #3's toenails on both feet on 05/08/19 at 5:00 pm revealed: -His toenails on both feet were thick, yellow, discolored, and jagged. -The right 2nd - 5th toenails extended beyond the tips of his toes from approximately 0.5 - 1 millimeters (mm). -The left 3rd - 5th toenails extended beyond the tips of his toes for approximately 0.5 - 1mm. -There were ridges in the right and left 1st - 5th toenails. -The skin to both feet, toes, and cuticles were dry, thin, and flaking. -When his socks were removed flakes of skin fell from his socks and feet. Interview with Resident #3 on 05/08/19 at 5:00 pm revealed: -He had not had his toenails cut since he had been at the facility. -His family member used to bring him to have his toenails cut. -He was going to ask his family member to take him to have his nails cut. -His toenails did not bother him. Interview with a personal care aide (PCA) on 05/14/19 at 10:40 am revealed: -She had never provided nail care to Resident #3. -She had never bathed Resident #3. Interview with a medication aide (MA) on	D 273		

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D 273	Continued From page 114 05/14/19 at 10:45 am revealed: -She did not know if Resident #3 saw a podiatrist. -There was no documentation in Resident #3's charting notes that he saw a podiatrist. -The care manager (CM) would know if Resident #3 saw a podiatrist. -She did not know anything about Resident #3's toenails. Interview with a second PCA on 05/14/19 at 10:55 am revealed: -PCA's were not allowed to trim the toenails of a diabetic resident. -She did not perform any nailcare to diabetic residents. -The MA would perform nailcare to diabetic residents. -She had never bathed Resident #3 Interview with the Administrator on 05/14/19 at 1:00 pm revealed: -There was a facility podiatrist that was available to see the residents. -She did not know Resident #3's toenails were thick, yellow, and long. -Residents had to have a referral from their Primary Care Provider (PCP) before they could see the podiatrist. -The care manager (CM) was responsible for scheduling residents to see the podiatrist. -She expected Resident #3 to already have seen the podiatrist because he was a diabetic with thick, yellow, discolored, and jagged toenails. Interview with the CM on 05/14/19 at 1:28 pm revealed: -Resident #3 had not seen a podiatrist. -Resident #3 did not need a referral from his PCP to see the podiatrist. -She did not know Resident #3 needed to see a	D 273		

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podiatrist.
-She would schedule Resident #3 to see the facility podiatrist.
-The PCAs and MAs were not allowed to do nail care to diabetic residents.

Interview with Resident #3's PCP on 05/14/19 at 4:00 pm revealed:
-She Resident #3 once on 03/15/19 for a right hip wound.
-She had referred Resident #3 to the wound care center on 03/15/19.
-Resident #3 did not have a return appointment scheduled.
-She could not answer any questions related to Resident #3 other than for the right hip wound because she had not seen him for anything else.

4. Review of Resident #17's current FL-2 dated 01/22/19 revealed:
-Diagnoses included vascular dementia, generalized anxiety, depression and malnutrition.
-There was documentation Resident #17 was constantly disoriented.

Review of an accident/incident report dated 05/06/19 at 11:38am revealed:
-Resident #17 was found sitting on the floor in the common area in the special care unit (SCU) on 05/05/19 at 10:00am.
-No injury was noted and the resident's primary care provider (PCP) and Guardian were notified.
-There was documentation Resident #17 was to have vital signs checked and monitoring for bruises, mental status change, condition change, pain or other injuries every shift for 72 hours.

Interview with a personal care aide (PCA) on 05/14/19 at 1:48pm revealed:
-On 05/05/19, Resident #17 did not "fall-fall," the

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resident got up from the chair in the common area and lost her balance.
-The wheelchair "kind of caught" Resident #17.
-Resident #17's arm caught the arm of the wheelchair and the resident's side "kind of hit" the foot rest that was turned outward.
-Resident #17 did not fall hard.
-She asked Resident #17 if she was hurt and checked the resident; she said she was not hurt.
-She reported the fall to the medication aide (MA) on 05/05/19, but she could not remember which MA.
-Resident #17 did not complain of any pain until two days later.

Observation on 05/07/19 at 5:48am revealed:
-Resident #17 was sitting on the edge of her bed facing the window.
-Resident #17 told the PCA, "I'm hurting on my side," pointing to her left side near the rib cage.
-The PCA said she would tell the MA.

Observation on 05/08/19 at 5:07pm revealed Resident #17 was returning to the facility on a ambulance stretcher.

Interview with the Administrator on 05/08/19 at 5:07pm revealed Resident #17 was sent to the hospital because her stomach was hurting.

Review of hospital records dated 05/08/19 for Resident #17 revealed:
-She was seen in the emergency room (ER) fall of unknown mechanism and left side pain.
-She was diagnosed with left rib fractures and acute cystitis.

Review of a charting note dated 05/07/19 at 1:01pm for Resident #17 revealed staff documented leaving a message for the resident's

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primary care provider (PCP) regarding concern for the resident having a breathing issue.

Review of charting notes dated 05/08/19 for Resident #17 revealed:
-At 10:49am, the Care Manager (CM) documented staff reported finding Resident #17 sitting on the floor in the common area with no apparent injuries.
-At 7:51pm, the CM documented Resident #17 was complaining of stomach pain and wheezing badly.
-Resident #17's PCP was notified and told the CM to send the resident to the ER.
-Resident #17 returned to the facility with a closed left rib fracture.

Interview with a medication aide (MA) on 05/14/19 at 9:10am revealed:
-She did not remember hearing anything about Resident #17 falling on 05/05/19; there was no 72 hour monitoring on the electronic medication administration record (eMAR).
-The first she knew about Resident #17 experiencing a fall was when the resident complained of pain on her side.
-She had given Resident #17 ibuprofen for the pain; she did not remember what day that was.
-Incidents and accidents were not always reported by outgoing staff to the next shift.
-Sometimes she might find out about a resident falling the next day, and sometimes not at all.

Review of Resident #17's May 2019 eMAR revealed:
-There was an entry for Fall Prevention Program.
-There was documentation of vital signs every shift 05/06/19 through 05/09/19.
-There was an entry for Monitor status for 72 hours for bruising, change in mental

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status/condition, pain or other injuries related to fall.
-Staff documented left side pain on the 11:00pm to 7:00am shift on 05/06/19.
-There was an entry for ibuprofen 600mg every four hours as needed for pain.
-There was documentation ibuprofen was administered on 05/06/19 at 6:08am and 05/07/19 at 6:21am for left side pain.

Attempted second interview with the MA on 05/16/19 at 10:13am was unsuccessful.

Interview with a second MA on 05/14/19 at 1:53pm revealed:
-She worked 1st shift on 05/07/19.
-She had not been told by the prior shift MA Resident #17 was complaining of left sided pain earlier that morning.

Second interview with the second MA on 05/14/19 at 5:20pm revealed:
-Residents were placed on 72 hour monitoring after each fall.
-The MAs were responsible for checking resident's vital signs and for any new pain or complaints.
-The MA had to document every shift on the resident's condition.
-The 72 hour monitoring was automatically entered on the eMAR and came up on the screen each shift.

Interview with a third MA on 05/14/19 at 12:42pm revealed:
-On 05/08/19, a PCA came and told her Resident #17's stomach was hurting and she was breathing funny.
-She went and checked Resident #17; the resident pointed to her left side.

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-She called the PCP who said to send Resident #17 to the ER.
-She did not know Resident #17 had complained of left sided pain on 05/06/19 and 05/07/19.
-MAs reported off to the oncoming shift, but if a MA was off for a day or two there was no way to know what happened those days.
-There was no communication book to review.

Telephone interview with Resident #17's Guardian on 05/14/19 at 12:10pm revealed:
-Resident #17 had not been having any falls.
-Monday of last week (05/06/19) she received a voicemail from staff saying Resident #17 had fallen.
-The staff said they checked Resident #17's vital signs and she was okay so they did not need to send her to the ER.
-Staff had not said Resident #17 was hurting anywhere.
-She had not been called about Resident #17 being sent to the ER on 05/08/19 and diagnosed with rib fractures.

Telephone interview with Resident #17's PCP on 05/15/19 at 9:55am revealed:
-He did not have a record of being notified for Resident #17's fall on 05/05/19 or complaints of pain after the fall on 05/06/19 and 05/07/19.
-Resident #17 was first seen for a fall on 05/14/19.

Second telephone interview with Resident #17's PCP on 05/15/19 at 3:28pm revealed:
-He was at the facility every Tuesday to see residents.
-The CM was able to add residents to the weekly schedule for falls, hospital follow up and other acute needs.
-The normal protocol was for staff to notify him

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within one hour of an event, incident or acute changes in a resident's condition.
-There was a medical provider on call 24 hours a day from his office.

Interview with the CM on 05/14/19 at 2:00pm revealed:
-The MA who was on duty 05/05/19 reported Resident #17 did not fall.
-The MA said Resident #17 was going to fall, but staff caught her and slid her to the floor.
-The MAs had not reported giving pain medication to Resident #17 on 05/06/19 and 05/07/19 for left sided pain.
-The MAs did not usually report administering pain medication unless three consecutive doses had been given.
-Once a resident had required three consecutive doses she would follow up with the PCP.
-The purpose of 72 hour monitoring after a fall was to monitor for new pain and changes in condition.
-Staff "should have had the common sense to report the pain and we could have gone from there."
-She would have contacted the PCP about Resident #17's left sided pain.

Interview with the Administrator on 05/14/19 at 2:15pm revealed:
-She did not know Resident #17 had complained of left sided pain each morning after falling 05/05/19 and then returning from the emergency room on 05/08/19 with rib fractures.
-She did not know the PCP had not been contacted 05/06/19 or 05/07/19 about Resident #17's left side pain.
-The MA should have notified the CM and administered the pain medication.
-The 72 hour monitoring was specifically to

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TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

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monitor for pain; if the pain continued after 72 hours then the CM would have contacted the PCP.
-Staff would be educated to call the PCP immediately or send the resident to the ER when there was new pain after a fall.

5. Review of Resident #4's current FL-2 dated 03/06/19 revealed:
-Diagnoses included central demyelination of corpus collosum, hypomagnesia, candidiasis, hypoosmolality, hyponatremia, alcohol abuse, major depression, insomnia and hypertension.

a. Review of a primary care provider (PCP) visit note dated 04/02/19 for Resident #4 revealed there was an order for bilateral breast mammogram.

Interview with Resident #4 on 05/16/19 at 3:35pm revealed:
-She had a mass in her left breast last year and was supposed to have a follow up mammogram in September 2018.
-She was seriously ill and hospitalized with other medical issues in September 2018 and then when to a rehabilitation facility for several months.
-She never had the follow up from September 2018, so her PCP ordered the mammogram.
-She had not had a mammogram since before September 2018.

Interview with the transportation staff on 05/16/19 at 3:20pm revealed:
-The day after she got the order for the mammogram for Resident #4 she contacted a local provider to schedule the test.
-She did not remember the exact date in April 2019.
-The local provider said Resident #4 had already

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had a mammogram in March 2019.
-The local provider said the insurance company would only pay for a mammogram every six months.
-She did not have access to Resident #4's electronic record.
-She told the Care Manager (CM) that she could not schedule the mammogram for Resident #4.
-The CM was responsible for getting referral orders to her, then she scheduled the appointment, took the resident to the appointment and brought the visit form back to the CM.
-If there were any issues with scheduling appointments or taking residents to appointments she let the CM know.

Telephone interview with Resident #4's PCP on 05/15/19 at 9:55am revealed:
-He had ordered a mammogram on 04/02/19 for Resident #4 because she had prior female issues that needed follow up.
-He did not recall seeing that the mammogram had been done.

b. Review of a primary care provider (PCP) visit note dated 04/02/19 for Resident #4 revealed there was an order for a pelvic ultrasound for history of a mass on the resident's right fallopian tube.

Interview with Resident #4 on 05/16/19 at 3:35pm revealed:
-While she was hospitalized in September 2018 they found a mass on her right fallopian tube.
-She was re-hospitalized with a serious illness and did not have any follow up for the fallopian tube mass.
-Her PCP ordered a pelvic ultrasound to finally get some follow up on that.

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D 273	Continued From page 123 Interview with the transportation staff on 05/16/19 at 3:20pm revealed she did not know anything about scheduling a pelvic ultrasound for Resident #4. Telephone interview with Resident #4's PCP on 05/15/19 at 9:55am revealed: -He had ordered a pelvic ultrasound on 04/02/19 for Resident #4 because she had prior female issues that needed follow up. -He did not recall seeing that the pelvic ultrasound had been done. Telephone interview with a medication aide (MA) on 05/15/19 at 9:40pm revealed she did not know who was responsible for making referral appointments ordered by a resident's PCP. Interview with the Regional Clinical Director (RCD) on 05/10/19 at 1:45pm revealed: -The Care Manager (CM) was responsible for giving appointment referrals to the transportation staff. -The transportation staff was responsible for scheduling the appointment, documenting in the appointment in the scheduling book and entering the appointment in the computer. The CM was not available for interview on 05/16/19 and 05/17/19. Interview with the Administrator on 05/17/19 at 3:44pm revealed: -She did not know the PCP had ordered referrals for a mammogram and pelvic ultrasound on 04/02/19 for Resident #4 that had not been scheduled. -The facility PCP sits down with the CM and goes over each resident seen each week. -The PCP gives all the orders to the CM.	D 273		

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-The CM was responsible for putting all PCP orders in the computer system.
-The CM was responsible for reviewing documentation of referral orders and appointments from the transportation staff each month.
-The transportation staff was responsible for documenting in the progress notes about resident appointments.
-The CM was responsible for reporting any issues with scheduling or keeping appointments to the PCP.

6. Review of Resident #2's current FL-2 dated 02/05/19 revealed:
-Diagnoses included Alzheimer's disease, high blood pressure, Vitamin D deficiency, and pre-renal disease.
-The resident was constantly disoriented.
-The resident was semi-ambulatory.
-The resident required assistance with bathing, dressing, and feeding.
-The resident was incontinent of bladder and bowel.

a. Review of Resident #2's charting note dated 02/06/19 at 4:39pm revealed:
-The resident had a few bowel movements but did not seem to be in any pain.
-Staff would continue to monitor throughout the shift.

Review of Resident #2's primary care provider (PCP) visit notes dated 02/12/19 revealed:
-Staff reported the resident had diarrhea for the past 3 days.
-The diarrhea had a white, slimy substance present.
-The PCP ordered a stool culture O & P (ova and parasite) difficile toxin. (O & P testing and difficile

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toxin testing are used to determine if there are infections in the intestines that could cause symptoms such as diarrhea.)

Review of Resident #2's charting notes, lab notes, and provider notes revealed no documentation the stool culture was done as ordered on 02/12/19.

Review of Resident #2's charting note dated 04/25/19 at 4:35pm revealed the resident was sent out to the hospital for loose stool with very foul odor.

Review of Resident #2's incident/accident report dated 04/25/19 at 4:47pm revealed:
-The resident was sent to the hospital for very loose stool and foul odor.
-No new medications were ordered.

Interview with a personal care aide (PCA) on 05/10/19 at 1:42pm revealed:
-Resident #2's diarrhea "comes and goes".
-Resident #2 last had diarrhea a couple of weeks ago.

Interview with the Care Manager (CM) on 05/09/19 at 5:45pm revealed she did not know if Resident #2's stool culture had been done but she would check on it.

Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable.

A second interview with the CM on 05/10/19 at 12:40pm revealed:
-She contacted the local hospital and there was no record of a stool culture being done for Resident #2.

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-The CM was responsible for setting up appointments including any labwork.
-The residents at the facility had to be taken to the local hospital for labwork to be completed or if stool samples were obtained, the samples were taken to the local hospital for testing.
-If a stool sample was needed, the PCAs would notify the MAs when a resident had a bowel movement and the MA was responsible for getting the sample.
-The facility staff would then take the sample to the lab at the local hospital for testing.
-Resident #2's stool culture ordered on 02/12/19 was not done because she overlooked the order.
-She was not aware of Resident #2 having any issues with diarrhea since she was seen in the emergency room on 04/25/19.
-She contacted Resident #2's PCP this morning (05/10/19) and he still wanted the resident to have a stool culture done.

A third interview with the CM on 05/13/19 at 4:10pm revealed:
-A stool sample was collected for Resident #2's stool culture over the weekend (05/11/19 or 05/12/19).
-She would file a copy of the results in the resident's record when received.

Telephone interview with Resident #2's PCP on 05/15/19 at 10:00am revealed:
-He ordered a stool culture for Resident #2 in February 2019 because she was having diarrhea and he was concerned the resident might have a Clostridium difficile infection. (Clostridium difficile can infect the intestines causing diarrhea.)
-He was not aware the stool culture had not been done until facility staff notified him last week.
-He had them to get the stool culture done last week and it came back negative.

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D 273	Continued From page 127 Review of Resident #2's labwork dated 05/11/19 revealed the resident's stool sample was negative for Clostridium difficile toxin. b. Review of Resident #2's incident/accident report dated 03/13/19 at 8:10am revealed: -The resident was sitting on the floor in front of her bedroom door. -The resident had a skin tear on her lower left leg that was cleaned and bandaged. -The resident's family was notified and a message was left for the primary care provider (PCP). Review of Resident #2's PCP visit notes dated 03/20/19 revealed: -The resident was being seen for a fall. -Staff reported the resident had a fall and obtained a small abrasion on her lower left leg. -There was an abrasion on her lower left leg with no redness or infection noted. -The PCP ordered for the resident to be rechecked in 4 weeks. Review of Resident #2's PCP visit notes revealed: -There was no documentation of a follow-up visit in 4 weeks after the visit on 03/20/19. -There was no documentation of any PCP visits after 03/20/19. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. Interview with the Care Manager (CM) on 05/10/19 at 12:40pm revealed: -She was responsible for making a list of residents to be seen by the PCP during the PCP's	D 273		

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weekly visits.
-Resident #2's last visit with the PCP was on 03/20/19.
-She had overlooked the PCP's note to have the resident follow-up in 4 weeks from the visit on 03/20/19.
-She would put Resident #2 on the list to be seen by the PCP on his next visit on Tuesday, 05/14/19.
-To her knowledge, Resident #2 had no falls since the fall in March 2019.

Telephone interview with Resident #2's PCP on 05/15/19 at 10:00am revealed:
-He tried to see most residents at the facility at least every 90 days routinely.
-He was at the facility seeing residents once a week.
-The CM would notify him of any residents that needed to be seen for acute needs.
-If there was a problem with a resident, he would note on the visit form for them to be rechecked in 4 weeks.
-He expected that resident to be put back on the list by the facility to be seen in 4 weeks as noted.
-Resident #2 should have been seen in 4 weeks after the visit on 03/20/19 to follow-up on her status after a fall.
-He saw Resident #2 yesterday (05/14/19) during his routine visits.
-He was not aware of the resident having anymore falls since March 2019.

c. Review of Resident #2's primary care provider (PCP) visit notes dated 01/08/19 revealed:
-The resident was seen today to establish as a new patient.
-The PCP ordered labwork for a CBC (complete blood count) and CMP (comprehensive metabolic panel) at next blood draw and every 4 months.

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D 273	Continued From page 129 Review of Resident #2's charting notes, lab notes, and provider notes revealed no documentation the CBC or CMP were done as ordered on 01/08/19. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. Interview with the Care Manager (CM) on 05/10/19 at 12:40pm revealed: -She contacted the local hospital and there was no record of CBC or CMP being done for Resident #2. -The CM was responsible for setting up appointments including any labwork. -The residents at the facility had to be taken to the local hospital for labwork to be completed. -When the CM received an order for labwork, she communicate with the facility's transporter to coordinate at time to take the resident to the hospital lab. -An appointment was not needed for the hospital lab so the transporter could take a resident without making an appointment. -Resident #2's CBC and CMP ordered on 02/12/19 were not done because she overlooked the order. -She contacted Resident #2's PCP this morning (05/10/19) and he told them to get the labwork done today, 05/10/19. A second interview with the CM on 05/13/19 at 4:10pm revealed: -Resident #2's labwork for the CBC and CMP was done on Friday, 05/10/19. -She would file a copy of the results in the resident's record when received.	D 273		

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D 273	Continued From page 130 Review of Resident #2's labwork revealed a CMP and CBC were completed on 05/10/19. Telephone interview with Resident #2's PCP on 05/15/19 at 10:00am revealed: -Resident #2 was established as a new patient during the visit in January 2019. -He routinely ordered CBC and CMP for all new patients to establish a baseline and then every 4 months. -He was not aware Resident #2's CBC and CMP had not been completed as ordered in January 2019 until the facility staff notified him last week. -He had them to get the labwork done last week and he would recheck the CMP in 4 weeks as he wanted to monitor the resident's response to a potassium supplement he discontinued. The facility failed to assure PT/INR levels were obtained weekly for 4 weeks for a resident who was on Coumadin 7.5mg daily for atrial fibrillation, had a blood sugar of 48, was admitted to the hospital with a hemorrhagic stroke, was intubated, given medication to reverse a high INR level of 6.2, developed aspiration pneumonia, received a tracheostomy and gastric tube, and died. The facility also failed to report to the primary care provider that a resident fell, developed new left side pain for 2 consecutive days after the fall who went to the emergency department 3 days after the fall and was diagnosed with a left rib fracture; and failed to ensure a resident have a mammogram and pelvic ultrasound that had been ordered for 45 days. This failure resulted in death, serious physical harm, and neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/10/19 with	D 273		

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D 273	Continued From page 131 revision on 05/14/19. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 15, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure orders were implemented for 2 of 10 sampled residents (#4, #6) for a daily postural vital signs (#4); and daily blood pressure and heart rate checks (#6). 1. Review of #6's current FL-2 dated 07/13/18 revealed: -Diagnoses included hypertension, dementia, chronic anxiety, hyperlipidemia, and glaucoma. -There was an order for Amlodipine 10 milligrams (mg) at bedtime (Amlodipine is a medication used to treat high blood pressure by relaxing the blood	D 276		

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vessels which could lower the heart rate).
-There was an order for Losartan Potassium 100mg daily (Losartan Potassium is a medication used to treat high blood pressure by relaxing the blood vessels which could lower the heart rate).

Review of Resident #6's subsequent orders dated 01/02/19 revealed:
-There was an order for Amlodipine 10 milligrams (mg) at bedtime.
-There was an order for Losartan Potassium 100mg daily.

Review of Resident #6's physician notes dated 01/08/19 revealed:
-She was having visual hallucinations.
-There was an order for weekly blood pressure (BP) and heart rate (HR).
-There were BP parameters to call if systolic blood pressure (SBP) greater than 220 or less than 90, or diastolic blood pressure (DBP) greater than 110.
-There were HR parameters to call if HR greater than 140 or less than 50.

Review of Resident #6's January 2019 - April 2019 electronic medication administration record (eMAR) revealed:
-The resident was receiving two medications to lower blood pressure that may also lower HR.
-There was no documentation that revealed Resident #6's BP or HR was obtained.

Review of Resident #6's monthly weight and vital signs log for January 2019 - April 2019 revealed the resident's weekly BP and HR were not obtained.

Review of Resident #6's charting notes revealed:
-There was a handwritten entry on 01/18/19

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regarding foot and nail care.
-There was a handwritten entry on 03/29/19 regarding foot and nail care.
-There was no documentation that revealed Resident #6's BP or HR heart rate was obtained.

Interview with the care manager (CM) on 05/09/19 at 5:39 pm revealed:
-She was responsible for printing physician notes, reviewing for orders, and faxing to pharmacy to be entered on the eMAR.
-She would attach the fax confirmation to the notes or orders faxed to pharmacy until pharmacy entered the orders on the eMAR.
-She also had access to enter orders on the eMAR.
-She thought she faxed Resident #6's 01/08/19 physician notes with the order for weekly BPs and HRs to the pharmacy.
-She did not know why the order for weekly BP and HR did not populate on the eMAR's.

Interview with the Administrator on 05/09/19 at 5:55 pm revealed:
-The CM was responsible for reviewing physician notes for orders.
-The CM would fax orders to the pharmacy and the pharmacy would put the orders on the eMAR.
-The CM also could enter orders on the eMAR.
-She expected the CM to enter orders on the eMAR if not entered by pharmacy.
-She did not know there were 01/08/19 orders for Resident #6's BP and HR to be obtained weekly.

Telephone interview with Resident #6's PCP on 05/15/19 at 4:34 pm revealed:
-He did not see a diagnosis of hypertension for Resident #6.
-He did not know why he ordered a weekly BP and HR on Resident #6.

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-He ordered weekly BP checks if he was concerned about a resident's BP.
-He did not know Resident #6 had not had weekly BP's and HR's obtained.
-He expected the weekly BPs and HRs for Resident #6 to have been obtained as ordered.

2. Review of Resident #4's current FL-2 dated 03/06/19 revealed:
-Diagnoses included central demyelination of corpus collosum, hypomagnesia, candidiasis, hypoosmolality, hyponatremia, alcohol abuse, major depression, insomnia and hypertension.

Review of a primary care provider (PCP) visit note dated 03/20/19 reveal an order for postural vital signs daily for two weeks. (Postural vital signs are a check of heart rate and blood pressure while lying down, sitting up and then standing consecutively.)

Review of a PCP order dated 03/26/19 revealed an order for postural vital signs daily for one week.

Review of Resident #4's March and April 2019 electronic medication administration record (eMAR) revealed there was no entry for postural vital signs.

Upon request on 05/14/19, documentation of postural vital signs for Resident #4 were not available for review.

Interview with Resident #4 on 05/16/19 at 3:35pm revealed:
-Three months ago, her PCP ordered blood pressures while laying, sitting and standing.
-Staff did not do blood pressure checks except once right before the PCP returned for the next

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D 276	Continued From page 135 visit. Telephone interview with Resident #4's PCP on 05/15/19 at 9:55am revealed: -He had ordered postural vital signs because Resident #4 was experiencing balancing issues when she stood. -He did not recall seeing any vital signs results. -Getting vital signs results was a common problem at the facility. The Care Manager (CM) was not available for interview on 05/16/19 and 05/17/19. Interview with the Administrator on 05/17/19 at 3:44pm revealed: -She did not know there was a PCP order for postural vital signs on 03/20/19 and 03/26/19, and the postural vital signs were not documented for Resident #4. -The facility PCP sits down with the CM and goes over each resident seen each week. -The PCP gives all the orders to the CM. -The CM was responsible for putting all PCP orders in the computer system.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 4 residents	D 310		

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sampled (#2) with an order for a regular chopped meats diet who coughed during a lunch meal while eating food that was not chopped as ordered.

The findings are:

Review of Resident #2's current FL-2 dated 02/05/19 revealed:
-Diagnoses included Alzheimer's disease, high blood pressure, Vitamin D deficiency, and pre-renal disease.
-The resident was constantly disoriented.
-The resident required assistance with feeding.
-There was an order for a regular chopped meats diet.

Review of the facility's diet list dated 02/28/19 revealed Resident #2 was listed as a ground meats diet.

Review of the weekly menu for lunch on 05/10/19 revealed:
-There was no column labeled for regular - no chopped meats diet.
-The lunch meal included: cornmeal breaded catfish, cream coleslaw, cucumber tomato salad, baked roll, beverage choice, and assorted cookies.

Observations during the lunch meal on 05/10/19 from 12:05pm until 12:24pm revealed:
-Resident #2 was seated in the dining room at 12:05pm and served a plate of a whole piece of baked fish, coleslaw, cut green beans and a biscuit.
-There was a personal care aide (PCA) seated next to Resident #2 assisting the resident with eating the meal.
-The PCA used a spoon to break apart the baked

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fish and assisted Resident #2 with eating teaspoon sized pieces of the fish.
-The PCA assisted Resident #2 with eating one to one and half inch pieces of green beans.
-At 12:15pm, Resident #2 coughed twice while chewing food.
-The PCA continued to assist Resident #2 with eating teaspoon sized pieces of the baked fish and green beans that were one to one and half inch in length.
-Resident #2 finished eating the lunch meal at 12:24pm with no further coughing.

Interview with the PCA on 05/10/19 at 12:43pm revealed:
-A chopped diet meant to make the food small enough, so the resident could eat the food.
-Resident #2 was able to chew food.
-Coughing during the meal was normal for Resident #2.
-The medication aides (MAs) knew Resident #2 coughed while eating meals because the MAs were usually in the dining room during the meals.

Interview with a second PCA on 05/10/19 at 12:31pm revealed:
-Resident #2 was not on a therapeutic diet; the resident was not ordered to have chopped or ground food.
-Resident #2 "ate everything," and was able to chew the food.
-She had never paid attention to it before, but Resident #2 did cough regularly while eating meals.

Interview with a MA on 05/10/19 at 12:44pm revealed:
-She had never noticed Resident #2 coughing while eating a meal.
-She did not know the process for diet orders,

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chopped food and ground food.
-She thought the kitchen staff would chop or ground a resident's food if that was the order.

Interview with the Dietary Manager/Cook on 05/10/19 at 12:38pm revealed the PCAs chopped up Resident #2's food when they assisted the resident with eating.

Interview with the Care Manager (CM) on 05/10/19 at 12:50pm revealed:
-The primary care provider (PCP) completed the diet order sheet for the resident and then she gave the diet order sheet to the kitchen staff.
-The kitchen staff followed the diet order written by the PCP.
-A chopped diet meant the food was big enough to pick up with a utensil (spoon or fork), but small enough so as not to choke.
-If a resident experienced coughing while eating, she expected staff to attend to the resident immediately.
-Tending to the resident meant checking the resident's mouth to make sure there was no food there and standing the resident up because that helped food to go down.
-PCAs were expected to report any incidents of residents coughing while eating to the MA.

Interview with Resident #2's family member on 05/09/19 at 12:55pm revealed:
-Resident #2's PCP told the family member he had ordered the resident's food to be chopped.
-Resident #2 was missing several teeth and it took the resident a long time to chew her food.
-The resident's food was not being chopped.
-Staff were cutting the resident's food with a knife, but not always in small pieces.
-She had asked the kitchen staff several times about it and she was told the facility did not have

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D 310	Continued From page 139 the proper equipment to chop the food. -She was not aware of the resident coughing or choking while eating. Telephone interview with Resident #2's PCP on 05/15/19 at 10:00am revealed: -Resident #2 was ordered a chopped meats diet due to bad dentition. -He was not aware Resident #2 was not being served a chopped diet. -He was not aware Resident #2 had been coughing while eating. -Anytime a resident coughed while eating, there was a potential risk of aspiration pneumonia. -He would expect to be notified if Resident #2 coughed while eating due to possible risk of aspiration. Interview with the Administrator on 05/17/19 at 3:44pm revealed: -The CM was responsible for entering diet orders into the computer system. -She printed the diet order report every month and gave a copy to the kitchen staff. -She did not know the diet orders in Resident #2's chart and on the diet order report did not match. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the	D 312		

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assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to provide assistance with eating two observed meals in a manner that maintained Resident #21's dignity and respect by staff standing over the resident during each meal.

The findings are:

Review of Resident #21's current FL-2 dated 12/08/18 revealed:
-Diagnoses included vascular dementia, frontal temporal lobe degeneration, hypothyroidism, osteoporosis and back pain.
-Resident #21 was constantly disoriented.
-Resident #21 required assistance with eating meals.

Review of Resident #21's current care plan dated 03/05/19 revealed the resident was totally dependent on staff for assistance with eating meals and did not verbally communicate.

Review of a diet order sheet dated 01/08/19 for Resident #21 revealed there was an order for a regular diet.

Observations during the dinner meal on 05/08/19 from 5:30pm until 5:53pm revealed:
-A personal care aide (PCA) was assisting Resident #21 with eating a plate of baked lasagna, mixed vegetables and a dinner roll.
-Resident #21 was seated in a high back wheelchair.
-The PCA stood at the side of the wheelchair over Resident #21 while assisting the resident with

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D 312	Continued From page 141 eating. Observations during the dinner meal on 05/13/19 from 5:38pm until 5:45pm revealed: -A PCA was assisting Resident #21 with eating while the resident was seated in a high back wheelchair. -The PCA stood at the side of the wheelchair over Resident #21 while assisting the resident with eating. Interview with the PCA on 05/13/19 at 5:45pm revealed: -She did not want a chair to sit and assist Resident #21 with eating her meal. -In response to feeding the resident at eye level, she said, "I'm fine." -Resident #21 was "okay with standing over her." -It was up to the PCA assisting the resident with eating if they wanted to sit down or stand. Interview with the Executive Director (ED) on 05/17/19 at 3:44pm revealed: -She did not know staff were standing to assist Resident #21 with eating meals. -Staff were expected to sit down at eye level to assist residents with eating meals. -Staff standing over a resident was intimidating and disrespectful. Based on observations, interviews and record reviews, it was determined Resident #21 was not interviewable.	D 312		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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D 358	Continued From page 142 preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policy for 2 of 11 residents (#18, #19) observed during the medication passes including errors with a vitamin D supplement (#18, #19); and for 3 of 10 sampled residents (#3, #2, #4) including errors with a diuretic (#3), medications used to treat low potassium, treat and prevent acid reflux, and treat and prevent stomach ulcers (#2), and a medication to treat chronic obstructive pulmonary disease and asthma (#4). The findings are: 1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 27 opportunities during the 6:00 am, and 7:00 am medication passes on 05/07/19; 9:00 am and 11:00 am medication passes on 05/09/19; and	D 358		

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D 358	Continued From page 143 8:00 am and 9:00 am medication passes on 05/10/19. a. Review of Resident #18's current FL-2 dated 01/23/19 revealed diagnoses included Alzheimer's dementia, muscle weakness, dysphagia, iron deficiency anemia, thyroid disorder, history of femur fracture, lack of coordination, and abnormal gait and mobility. Review of Resident #18's physician order dated 01/23/19 revealed an order for Vitamin D3 1,000 units every day (Vitamin D 3 is a vitamin supplement that helps the body absorb calcium and phosphorus and is used to treat and prevent bone disorders). Observation of the 8:00 am medication pass on 05/10/19 revealed Vitamin D3 1000 units was not administered to Resident #18. Review of Resident #18's 05/01/19 - 05/10/19 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 1,000 units take 1 tablet daily. -Vitamin D3 had a discontinue date of 05/01/19. -Vitamin D3 was documented as administered on 05/01/19. -Vitamin D3 was not documented as administered from 05/02/19 - 05/10/19. -There was no reason documented why Vitamin D3 was not administered from 05/02/19 - 05/10/19. Review of a physician order dated 04/22/19 revealed: -There was an order to discontinue Theragram (a multivitamin). -There was a handwritten yellow post- it type note	D 358		

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attached to the order which read to discontinue "Vitamin D3".
-Resident #18's name was handwritten on the post it note.

Review of Resident #18's physicians orders revealed there was no order to discontinue Vitamin D3 1000 units daily.

Interview with the Care Manager (CM) on 05/10/19 at 12:20 pm revealed:
-She called Resident #18's primary care provider (PCP) to clarify the 04/22/19 physician order to discontinue theragram.
-Resident #18's PCP told her the Vitamin D3 should have been discontinued also.
-She received a verbal order to discontinue Vitamin D3 for Resident #18.
-She did not write a verbal order to discontinue Vitamin D3 for Resident #18.
-She could not remember when she received the verbal order to discontinue Vitamin D3.
-Verbal orders were to be been written when received.
-She would call Resident #18's PCP for clarification.

Telephone interview with a pharmacist for the facility's contracted pharmacy on 05/10/19 at 12:25 pm revealed:
-The pharmacy had not received a discontinue order for Resident #18's Vitamin D3.
-In reviewing the eMAR there was not a discontinue date for the Vitamin D3.
-The pharmacy did receive a discontinuation order for a multivitamin on 04/22/19.

Interview with the Regional Clinical Director (RCD) on 05/10/19 at 1:45 pm revealed:
-The physician order dated 04/22/19 for Resident

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#18 was to discontinue theragram not Vitamin D3.
-The CM spoke with Resident #18's PCP (as she pointed at the post it note) and was told to discontinue the Vitamin D3.
-There was no verbal order written to discontinue the Vitamin D3 for Resident #18.
-The CM would contact Resident #18's PCP for clarification.
-She expected verbal orders to be written when obtained and given or faxed to the provider to sign.

Interview with the Executive Director (ED) on 05/09/19 at 5:55 pm revealed:
-At the end of each shift the medication aides (MAs) pulled a medication administration compliance report to check for missed medication administration to residents.
-If missed medication administration was discovered the PCP, and CM or ED would be notified.
-Cart audits were done where orders were pulled and compared to the eMAR and medications in the medication cart.

Telephone interview with Resident #18's PCP on 05/10/19 at 4:48 pm revealed:
-The CM had called her requesting an order to discontinue Resident #18's Vitamin D3.
-The CM told her another provider wanted the Vitamin D3 discontinued.
-She did not give the order to discontinue the Vitamin D3 because she did not write the order for Resident #18.
-Another provider for Resident #18 at her office wrote the order for Vitamin D3 and would not be back to the facility until 05/22/19.
-Vitamin D3 deficiency could worsen and cause a decrease in the metabolism and bone health in

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the elderly.
-She expected the facility to follow orders as written.
-If a provider gave orders to discontinue a medication that was ordered by another provider, she expected the facility to call the ordering provider for clarification instead of discontinuing the order.

b. Review of Resident #19's current FL-2 dated 07/13/18 revealed diagnoses included hypertension, heart murmur, depression, dementia in chronic schizophrenia.

Review of Resident #19's physician orders dated 01/02/19 revealed an order for Vitamin D3 400 units take 2 tablets (800 units) daily.(Vitamin D 3 is a vitamin supplement that helps the body absorb calcium and phosphorus and is used to treat and prevent bone disorders).

Observation of the 11:00 am medication pass on 05/19/19 revealed:
-The medication aide (MA) prepared one Vitamin D3 400 unit tablet into Resident #19's medication cup.
-Resident #19 was administered one Vitamin D3 400 unit tablet.

Interview with the MA on 05/10/19 at 1:56 pm revealed:
-Resident #19 should have been administered two Vitamin D3 400 units tablets.
-She did not look at the directions on the medication card or on the eMAR for Resident #19's Vitamin D3.
-She "just overlooked" the order for two tablets of Vitamin D3 for Resident #19 and administered one tablet instead of two tablets.
-She normally would read the medication

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directions on the medication card and eMAR.
-She would tell the Care Manager (CM) or the Executive Director (ED) Resident #19 was not administered the correct dose of Vitamin D3.
-She was not sure if she would notify Resident #19's primary care provider (PCP) of the incorrect dose of Vitamin D3.

Interview with the CM on 05/09/19 at 1:07 pm revealed:
-She expected the MA to inform the CM or ED as soon as a medication error was noted.
-She expected the MA to administer medications as ordered.
-She would inform Resident #19's PCP the resident did not receive the correct dose of Vitamin D3.

Interview with the ED on 05/09/19 at 5:55 pm revealed:
-She expected the MA's to review the eMAR and compare the eMAR to the medication card three times before administering medication to the residents to ensure the correct resident, medication, dose, route, and time was administered.
-She expected the MA to notify the PCP, and CM or ED of medication errors.
-At the end of each shift the MA's pulled a medication administration compliance report to check for missed medication administration to residents.
-If missed medication administration was discovered the PCP, and CM or ED would be notified.
-Cart audits were done where orders were pulled and compared to the eMAR and medications in the medication cart.

Telephone interview with Resident #19's PCP on

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D 358	Continued From page 148 05/15/19 at 4:40 pm revealed Vitamin D3 was ordered for Resident #19 due to previously documented low Vitamin D levels. 2. Review of Resident #3's current FL-2 dated 02/07/19 revealed: -Diagnoses included type 2 diabetes mellitus, infection and inflammatory reaction to left hip, acquired absence of left upper limb above elbow, hypertension, atherosclerotic heart disease, history of falling, history of healed traumatic fracture. Review of an electronic order dated 03/15/19 for Resident #3 revealed: -There was an order for Lasix 20mg take 1/2 tablet daily for 10 days. (Lasix is a diuretic used to high blood pressure). -The quantity was 10 tablets. Review of one of Resident #3's March 2019 electronic Medication Administration Records (eMARs) revealed: -There was an entry for Lasix 20 milligrams (mg) take "1/2 tablet" daily for 10 days. -There was documentation Lasix was administered from 03/16/19 - 03/31/19. Review of Resident #3's April 2019 eMAR revealed: -There was an entry for Lasix 20mg take "1/2 tablet" daily for 10 days. -There was documentation Lasix was administered from 04/01/19 - 04/30/19. Review of Resident #3's May 2019 eMAR revealed: -There was an entry for Lasix 20mg take "1/2 tablet" daily for 10 days. -There was documentation Lasix was	D 358		

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administered on 05/01/19.

Review of Resident #3's medications on hand on 04/29/19 revealed there was no Lasix available for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/14/19 at 12:30 pm revealed:
-Resident #3 did not have a current order for Lasix on file at the pharmacy.
-They had never filled an order for Lasix for Resident #3 since his admission date of 02/07/19.

Telephone interview with a representative of Resident #3's previous pharmacy on 05/14/19 at 12:42 pm revealed:
-Resident #3's had an order for Lasix 20 milligrams (mg) take 1/2 tablet daily (10mg) for 10 days.
-The pharmacy dispensed ten Lasix 20mg tablets for Resident #3 on 03/15/19.
-The facility picked up Resident #3's Lasix prescription on 03/15/19.

A second telephone interview with another representative of Resident #3's previous pharmacy on 05/17/19 at 3:32 pm revealed:
-Ten whole tablets of Lasix 20mg tablets were dispensed for Resident #3 on 03/15/19.
-The Primary Care Provider (PCP) wrote an order to dispense ten tablets.

Interview with the Care Manager (CM) on 05/14/19 at 12:50 pm revealed:
-She remembered entering the Lasix order on the eMAR for Resident #3.
-She entered Resident #3's start and end date for Lasix.
-The start date was "03/18/19" which was the

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date the medication arrived from the pharmacy.
-She should have entered Resident #3's Lasix stop date for 03/28/19.
-She entered a stop date of 05/01/19 for Resident #3's Lasix instead of 03/28/19.
-She did not remember if she notified Resident #3's PCP of the extra days Lasix was administered to Resident #3 past the ordered 10 days.
-The MA would not have known to stop the Lasix on 03/28/19 for Resident #3 because of the end date on the eMAR being 05/01/19.

Interview with the Executive Director (ED) on 05/14/19 at 1:00 pm revealed:
-She expected the MA's to follow orders as written.
-It was unacceptable Resident #3 was administered Lasix for more days than it was ordered.
-She did not know where the extra Lasix would have come from .
-The CM should have entered the end date for Resident #3's Lasix as 03/28/19 which was 10 days from the start date of 03/18/19.
-Resident #3's son brought the Lasix to the facility.
-The CM would transcribe medication orders on the eMAR when outside facilities provided resident medications.
-The MA would not have known to stop the Lasix on 03/28/19 because the end date on the eMAR was 05/01/19.

Telephone interview with Resident #3's current PCP on 05/14/19 at 4:00 pm revealed:
-Should could not answer any question related to Resident #3's Lasix order because she did not order the Lasix.
-Resident #3 saw a previous provider that

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ordered the Lasix and no longer worked at the PCP office.

3. Review of Resident #2's current FL-2 dated 02/05/19 revealed diagnoses included Alzheimer's disease, high blood pressure, Vitamin D deficiency, and pre-renal disease.

a. Review of Resident #2's current FL-2 dated 02/05/19 revealed an order for Potassium Chloride Liquid 20mEq/15ml take 10mEq (7.5ml) once a day, dilute in 6 ounces of water or juice. (Potassium Chloride is used to treat low potassium levels. Potassium Chloride Liquid should be diluted before taking to prevent mouth, throat, and stomach irritation.)

Review of Resident #2's March 2019 - May 2019 electronic medication administration records (eMARs) revealed:
-There was an entry on each eMAR for Potassium Chloride 10mEq/15ml Liquid take 7.5ml (10mEq) by mouth every day - dilute in 6 ounces of water or juice.
-Potassium Chloride Liquid was documented as administered daily at 7:00am from 03/01/19 - 05/14/19.

Observation of Resident #2's medications on hand on 05/09/19 at 4:25pm revealed:
-There were 2 bottles of Potassium Chloride Liquid on hand.
-There was a 30ml bottle dispensed on 04/14/19 that was unused and still contained 30ml (a 4-day supply).
-There was a 30ml bottle dispensed on 05/07/19 that was unused and still contained 30ml (a 4-day supply).

Interview with a medication aide (MA) on

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D 358	Continued From page 152 05/09/19 at 4:25pm revealed: -She had not administered Potassium Chloride Liquid to Resident #2 because it was scheduled to be administered at 7:00am and she thought the third shift MAs were supposed to administer it. -There was no other supply of Potassium Chloride Liquid on hand for Resident #2. -Resident #2 did not usually refuse medications to her knowledge. Interview with the Care Manager (CM) on 05/09/19 at 5:45pm revealed: -She did not know why the pharmacy would have sent a 4-day supply of Potassium Chloride Liquid for Resident #2 instead of a month's supply. -The MAs were supposed to administer the Potassium Chloride as ordered. -She did not know why the supplies of Potassium Chloride Liquid on hand had not been administered to the resident. -She would check with the MAs and the pharmacy. -She would notify Resident #2's primary care provider (PCP) the Potassium Chloride Liquid had not been administered as ordered. A second interview with the CM on 05/13/19 at 4:12pm revealed: -She sometimes administered medications to the residents. -She had administered the Potassium Chloride Liquid to Resident #2 but could not recall the last time. -She usually mixed the Potassium Chloride Liquid in water and gave it to the resident to drink when she administered her medications or when the resident was eating breakfast. -The MAs were supposed to follow instructions and mix the Potassium Chloride Liquid in water or juice for administration.	D 358		

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-The resident usually drank all of it and had not refused it to her knowledge.
-She notified Resident #2's PCP on Friday, 05/10/19, about the Potassium Chloride Liquid not being administered as ordered.
-Labwork was drawn on 05/10/19 to check the resident's potassium level.

A second observation of Resident #2's medications on hand on 05/13/19 at 5:55pm revealed:
-The 2 bottles of Potassium Chloride Liquid that were dispensed on 04/14/19 and 05/07/19 were still on hand.
-Both of the bottles still contained 30ml of 30ml and none had been used.
-There was no other supply of Potassium Chloride Liquid on hand for Resident #2.

A third interview with the CM on 05/13/19 at 5:55pm revealed:
-She was not aware staff had not administered any Potassium Chloride Liquid from 05/09/19 - 05/13/19.
-The MAs were supposed to administer the Potassium Chloride as ordered.
-She would check with the third shift MAs because they would be responsible for administering it since it was scheduled for 7:00am.

Interview with a second MA on 05/14/19 at 9:25am revealed:
-She administered Resident #2's Potassium Chloride Liquid every morning before third shift ended at 7:00am.
-She last administered Potassium Chloride Liquid from a large white bottle on Friday, 05/10/19.
-There was a "little" liquid left in the white bottle after that last dose she administered.

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D 358	Continued From page 154 -After that, she was off for 3 days. -The white bottle was not in the medication cart anymore and she gave a dose that morning (on 05/14/19) from the small 30ml bottle in the cart. -That was the first time she had used the small brown bottle. -When she administered the Potassium Chloride Liquid, she administered it to the resident without diluting it. -She had not noticed the instructions on the eMAR and medication label to mix and dilute the Potassium Chloride with water or juice. -The resident would swallow the medication and did not complain or grimace when taking it. -The resident had dementia and she had not refused the Potassium Chloride to her knowledge. Telephone interview with a third MA on 05/15/19 at 10:05pm revealed: -She usually worked on third shift and she did not remember ever administering Potassium Chloride Liquid to Resident #2. -She recalled seeing a white or brown bottle in the cart for Resident #2 but she could not recall when she saw it. -She could not recall if Potassium Chloride Liquid was "popping" up on the eMAR. -She could not explain why she documented the Potassium Chloride Liquid as administered on the eMAR when she never administered any. -Sometimes it was "too much" with one MA administering medications for the whole facility. -When MAs went back and forth between the special care unit (SCU) and the assisted living (AL), "something will be missed." Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed:	D 358		

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D 358	Continued From page 155 -Liquid medications were not on a cycle fill and had to be reordered by the facility for refills to be dispensed. -There was 473ml (a 63-day supply) of Resident #2's Potassium Chloride Liquid dispensed on 12/05/18. -The facility did not request another refill until 04/14/19, over 4 months later. -There was 30ml (a 4-day supply) dispensed on 04/14/19. -The facility did not request another refill until 05/07/19, over 3 weeks later. -There was 30ml (a 4-day supply) dispensed on 05/07/19. -The facility did not request another refill until 05/13/19, 6 days later. -There was 225ml (a 30-day supply) dispensed on 05/13/19 (delivered on 05/14/19). -She was not sure why a 4-day supply was sent on 2 occasions unless the quantity dispensed was keyed into the system incorrectly. -No Potassium Chloride Liquid had been dispensed by the back-up pharmacy because any back-up request had to be processed through the contracted pharmacy. A third observation of Resident #2's medications on hand on 05/15/19 at 3:35pm revealed: -There were 3 bottles of Potassium Chloride Liquid on hand. -The 30ml bottle dispensed on 04/14/19 had not been used and still contained 30ml (a 4-day supply). -The 30ml bottle dispensed on 05/07/19 had 15ml (a 2-day supply) remaining. -There was a 225ml bottle dispensed on 05/13/19 that had not been used and still contained 225ml (a 30-day supply). Interview with a fourth MA on 05/15/19 at 3:35pm	D 358		

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revealed:
-She had never administered Potassium Chloride Liquid to Resident #2 because she usually worked first shift and it was not administered on that shift.
-The MAs were responsible for ordering medications and they were supposed to fax any refill requests to the pharmacy.
-When liquid medications got "low" (usually half of the bottle), the MAs were supposed to reorder them.

Observations, interviews, and record reviews regarding Resident #2's Potassium Chloride Liquid revealed:
-There were 758ml dispensed from 12/05/18 - 05/15/19, which was a 101-day supply (for a 162-day time period).
-There were 488ml (a 65-day supply) used during the 162-day time period, only about 40% of the amount required if administered as ordered at 7.5ml per day.

Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable.

Telephone interview with Resident #2's PCP on 05/15/19 at 10:00am revealed:
-Resident #2 was ordered Potassium Chloride Liquid prior to establishing care with him in January 2019.
-Potassium Chloride Liquid tasted "awful" and should be diluted for administration as ordered.
-He was "surprised" the resident was would take it without it being diluted because of the taste.
-Facility staff notified the PCP last week that the resident had not received Potassium Chloride as ordered.
-He had the resident's potassium level checked

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last week and it was 4.0 (within normal range.)
-He saw the resident for a visit yesterday (05/14/19) and decided to discontinue the Potassium Chloride Liquid and try the resident without it to see how her levels ranged.
-He planned to recheck the resident's potassium level in 4 weeks.

Review of Resident #2's labwork dated 05/10/19 revealed the resident's potassium level was 4.0, within normal limits (reference range 3.4 - 4.4).

Review of Resident #2's physician's order dated 05/14/19 revealed an order to discontinue Potassium Chloride.

b. Review of Resident #2's current FL-2 dated 02/05/19 revealed an order for Omeprazole 20mg 1 capsule twice daily. (Omeprazole is used to treat and prevent acid reflux.)

Review of Resident #2's pharmacy recommendation dated 04/05/19 revealed:
-The pharmacist recommended to decrease Omeprazole to once a day due to high dose use was associated with Vitamin B12 deficiency, low magnesium levels, increased incidence of Clostridium difficile infections and pneumonia.
-The primary care provider (PCP) accepted the recommendation and signed the order to decrease Omeprazole 20mg to once a day on 04/30/19.

Review of Resident #2's April 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Omeprazole 20mg 1 capsule twice daily scheduled for administration at 7:00am and 7:00pm.
-Omeprazole was documented as administered

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twice daily from 04/01/19 - 04/30/19.
-The order dated 04/30/19 to decrease Omeprazole 20mg to once daily was not listed on the eMAR.

Review of Resident #2's May 2019 (eMAR) revealed:
-There was an entry for Omeprazole 20mg 1 capsule twice daily scheduled for administration at 8:00am and 8:00pm.
-Omeprazole was documented as administered twice daily from 05/01/19 - 05/08/19.
-The order dated 04/30/19 to decrease Omeprazole 20mg to once daily was not listed on the eMAR.
-The resident continued to be administered Omeprazole 20mg twice daily instead of once daily as ordered on 04/30/19.

Interview with a medication aide (MA) on 05/09/19 at 4:25pm revealed:
-Resident #2's Omeprazole was administered twice a day because that was how it "popped" on the eMAR.
-She was not aware the order for Omeprazole changed on 04/30/19.

Interview with the Care Manager (CM) on 05/09/19 at 5:35pm revealed:
-She was responsible for faxing any orders from pharmacy recommendations to the pharmacy.
-She could not recall if she faxed Resident #2's order dated 04/30/19 to decrease the Omeprazole to the pharmacy.
-Most of the time, the pharmacy entered any new orders or order changes onto the eMAR.
-Since the facility changed to a new eMAR system on 03/25/19, the CM was the only staff at the facility who could enter orders into the eMAR system.

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D 358	Continued From page 159 -She did not know why Resident #2's order for Omeprazole 20mg once a day was not entered into the eMAR system. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed: -The most current order the pharmacy had on file for Resident #2's Omeprazole was dated 01/02/19 with instructions for twice a day. -The pharmacy never received the order dated 04/30/19 to decrease the Omeprazole to once daily. Telephone interview with Resident #2's PCP on 05/15/19 at 10:00am revealed: -He was not aware Resident #2's Omeprazole dosage had not been decreased to once a day as ordered on 04/30/19. -He expected the facility to implement the order as written. -He was concerned that prolonged use of high doses of Omeprazole could cause issues such as low magnesium and it could interfere with bone health. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. c. Review of Resident #2's current FL-2 dated 02/05/19 revealed an order for Carafate 1gm/10ml Oral Suspension, take 10ml (1gm) with meals and at bedtime. (Carafate Oral Suspension is used to treat and prevent stomach ulcers.) Review of Resident #2's March 2019 electronic medication administration record (eMAR) revealed:	D 358		

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D 358	Continued From page 160 -There was an entry for Carafate 1gm/10ml Oral Suspension, take 10ml (1gm) with meals and at bedtime with scheduled administration times of 7:00am, 12:00pm, 5:00pm, and 8:00pm. -Carafate was documented as administered 4 times a day from 03/01/19 - 03/31/19 for a total of 124 doses (or 1,240ml). Review of Resident #2's April 2019 eMAR revealed: -There was an entry for Carafate 1gm/10ml Oral Suspension, take 10ml (1gm) with meals and at bedtime with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -Carafate was documented as administered 4 times a day from 04/01/19 - 04/30/19 for a total of 120 doses (or 1,200ml). Review of Resident #2's May 2019 eMAR revealed: -There was an entry for Carafate 1gm/10ml Oral Suspension, take 10ml (1gm) with meals and at bedtime with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -Carafate was documented as administered 4 times a day from 05/01/19 - 05/13/19 (5:00pm) for a total of 51 doses (or 510ml). Observation of Resident #2's medications on hand on 05/15/19 at 3:35pm revealed: -There were three 420ml bottles of Carafate Oral Suspension (total of 1,260ml) dispensed on 05/02/19. -Bottles 2 of 3 and 3 of 3 were unopened and each contained 420ml for a total of 840ml. -Bottle 1 of 3 contained approximately 300ml out of 420ml. -Approximately 120ml (a 3-day supply) had been used from the 1,260ml dispensed on 05/02/19.	D 358		

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Interview with a medication aide (MA) on 05/09/19 at 4:25pm revealed:
-Resident #2 usually took the Carafate Oral Suspension and did not refuse it when the MA was working.
-She did not know why there was an oversupply of Carafate Oral Suspension on hand.

Interview with a second MA on 05/15/19 at 3:35pm revealed:
-Resident #2 took Carafate Oral Suspension and did not refuse it when she was working.
-Resident #2 had not run out of Carafate Oral Suspension.
-The MAs were responsible for ordering medications and they were supposed to fax any refill requests to the pharmacy.
-When liquid medications got "low" (usually half of the bottle), the MAs were supposed to reorder them.

Interview with the Care Manager (CM) on 05/09/19 at 5:45pm revealed:
-She did not know why there was an oversupply of Carafate Oral Suspension on hand for Resident #2.
-Resident #2 did not refuse to take any medications to her knowledge.
-The MAs were supposed to administer the Carafate Oral Suspension as ordered.
-She would check with the MAs and the pharmacy about the Carafate Oral Suspension.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed:
-Liquid medications were not on a cycle fill and had to be reordered by the facility for refills to be dispensed.
-There were 420ml (a 10.5-day supply) of

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D 358	Continued From page 162 Resident #2's Carafate Oral Suspension dispensed on 01/02/19. -There were 420ml (a 10.5-day supply) dispensed on 01/16/19. -There were 420ml (a 10.5-day supply) dispensed on 01/27/19. -The facility did not request another supply until 02/27/19, 30 days later. -There were 1,260ml (a 31.5-day supply) dispensed on 02/27/19. -The facility did not request another supply until 05/02/19, over 2 months later. -There were 1,260ml (a 31-day supply) dispensed on 05/02/19. -No Carafate Oral Suspension had been requested or dispensed by the back-up pharmacy because any back-up requests were processed through the contracted pharmacy. Observations, interviews, and record reviews regarding Resident #2's Carafate Suspension: -There were 3,780ml of Carafate Oral Suspension dispensed from 01/01/19 - 05/15/19, which was a 94.5-day supply (for a 134-day time period). -There were approximately 2,640ml (a 66-day supply) used during the 134-day time period, only about half of the amount required if administered as ordered at 10ml 4 times a day. Telephone interview with Resident #2's primary care provider (PCP) on 05/15/19 at 10:00am revealed: -He was not aware Resident #2's Carafate Oral Suspension was not being administered as ordered. -He could evaluate the resident and if she was not having symptoms, he may stop the order for the Carafate.	D 358		

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D 358	Continued From page 163 Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. 4. Review of Resident #4's current FL-2 dated 03/06/19 revealed: -Diagnoses included central demyelination of corpus collosum, hypomagnesia, candidiasis, hypoosmolality, hyponatremia, alcohol abuse, major depression, insomnia and hypertension. -There was an order for an Ellipta inhaler one puff daily. (Ellipta is used to treat chronic obstructive pulmonary disease (COPD) and asthma). Review of Resident #4's March 2019 electronic medication administration record (eMAR) revealed: -There was an entry for an Ellipta inhaler one puff daily. -There was documentation the Ellipta inhaler was administered daily 03/01/19 through 03/31/19. Review of Resident #4's April 2019 eMAR revealed: -There was an entry for an Ellipta inhaler one puff daily. -There was documentation the Ellipta inhaler was administered daily 04/01/19 through 04/30/19. Review of Resident #4's May 2019 eMAR revealed: -There was an entry for an Ellipta inhaler one puff daily. -There was documentation the Ellipta inhaler was administered daily 05/01/19 through 05/06/19 and on 05/08/19. -There was documentation the Ellipta inhaler was not administered on 05/07/19 because the medication was not available.	D 358		

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D 358	Continued From page 164 Interview with Resident #4 on 05/16/19 at 3:35pm revealed: -She went four days "last week" without her Ellipta inhaler. -She had "really bad" COPD. -The Ellipta inhaler worked well at controlling her symptoms most of the time. -If she did not have the Ellipta inhaler then she had to use her Albuterol inhaler. (Albuterol is used to treat asthma symptoms.) -There were times she needed the Albuterol inhaler after taking the Ellipta inhaler. Observation of medications on hand for Resident #4 on 05/10/19 at 11:21am revealed: -There was no Ellipta inhaler on hand for the resident. -There was an Albuterol inhaler with a prescription label with Resident #4's name and instructions for two puffs every four hours as needed for shortness of breath. Interview with the medication aide (MA) on 05/11/19 at 11:21am revealed: -Resident #4's Ellipta inhaler was on order from the pharmacy. -She did not know when the inhaler had been ordered. -MAs were responsible for requesting medication refills when there was a one week supply remaining. -The MA would remove the sticker from the pharmacy label, place the sticker on the refill request sheet and fax the sheet to the pharmacy. Telephone interview with a MA on 05/15/19 at 9:40pm revealed: -Resident #4 had two inhalers in addition to the Ellipta, Spiriva and another in a "red box" that she gave the resident whenever the Ellipta was not	D 358		

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available. (Spiriva is used to treat COPD and asthma).
-Resident #4 would ask for one of the two inhalers if the Ellipta was not available.
-One of the other two inhalers was what she gave Resident #4 on 05/08/19.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/15/19 at 2:00pm revealed:
-The Ellipta inhaler for Resident #4 was originally ordered on 03/07/19.
-The pharmacy dispensed a 30 day supply of Ellipta for Resident #4 on 03/07/19 and 05/09/19.

Review of a Medication Release form dated 03/01/19 for Resident #4 revealed:
-The resident was admitted with one Ellipta inhaler on admission to the facility.
-There was no documentation of the number of doses.

Review of primary care provider orders for Resident #2 revealed:
-There was no order for Spiriva.
-There was an order for an Albuterol inhaler two puffs every four hours and needed (PRN) for shortness of breath (SOB)/wheezing dated 03/06/19.

Review of Resident #4's May 2019 eMAR revealed:
-There was an entry for an Albuterol inhaler two puffs every four hours PRN for SOB/wheezing.
-There was no documentation the Albuterol inhaler was administered on the morning of 05/08/19.
-There was documentation the Albuterol inhaler was administered on 05/03/19 at 4:17pm and 05/08/19 at 5:46pm.

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D 358	Continued From page 166 Review of charting notes dated 03/01/19 through 05/09/19 for Resident #4 revealed there was no documentation about the resident's Ellipta inhaler. Telephone interview with Resident #4's primary care provider (PCP) on 05/15/19 at 9:55am revealed: -The Ellipta inhaler was used to treat asthma and COPD. -The Ellipta inhaler should be used daily as prescribed because it was a controller medication. -A controller medication was used to keep symptoms from occurring verses a rescue medication (Albuterol) which was used to control symptoms that were present. -Not taking the Ellipta inhaler as prescribed could cause symptoms to arise. Interview with the Administrator on 05/17/19 at 3:44pm revealed: -She did not know Resident #4 had been without her Ellipta inhaler for four days and Albuterol was administered in place of Ellipta. -The MAs were responsible for reordering medications when they saw there was a week's supply left. -MAs faxed the refill request to the pharmacy. The facility failed to administer medications as ordered for 2 of 11 residents observed during the medication passes and 3 of 10 sampled residents for record review. Resident #3 was administered 10 additional doses (5 whole tablets) of Lasix 20mg 1/2 tablet daily without an order. Resident #2 was administered approximately 40% of the amount of Potassium Chloride Liquid needed for the dosage ordered from 12/05/18 - 05/15/19, putting the resident at risk for low potassium	D 358		

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D 358	Continued From page 167 levels. Resident #2 was administered approximately 50% of the amount of Carafate Oral Suspension needed for the dosage ordered from 01/01/19 - 05/15/19, putting the resident at risk for stomach ulcers. Resident #4's Ellipta inhaler was unavailable for administration for at least 4 days in May 2019, putting the resident at risk of exacerbation of breathing problems associated with asthma and chronic obstructive pulmonary disease. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/16/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 30, 2019.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	D 367		

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medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records were accurate for 2 of 5 residents sampled (#2, #4) including inaccurate documentation of a liquid potassium supplement (#2), an inhaler for chronic obstructive pulmonary disease (#4), and an inhaler for shortness of breath and wheezing (#4).

The findings are:

1. Review of Resident #2's current FL-2 dated 02/05/19 revealed:
-Diagnoses included Alzheimer's disease, high blood pressure, Vitamin D deficiency, and pre-renal disease.
-There was an order for Potassium Chloride Liquid 20mEq/15ml take 10mEq (7.5ml) once a day, dilute in 6 ounces of water or juice. (Potassium Chloride is used to treat low potassium levels.)

Review of Resident #2's March 2019 - May 2019 electronic medication administration records (eMARs) revealed:

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D 367	Continued From page 169 -There was an entry on each eMAR for Potassium Chloride 10mEq/15ml Liquid take 7.5ml (10mEq) by mouth every day - dilute in 6 ounces of water or juice. -Potassium Chloride Liquid was documented as administered daily at 7:00am from 03/01/19 - 05/14/19. Observation of Resident #2's medications on hand on 05/09/19 at 4:25pm revealed: -There were 2 bottles of Potassium Chloride Liquid on hand. -There was a 30ml bottle dispensed on 04/14/19 that had not been used and still contained 30ml (a 4-day supply). -There was a 30ml bottle dispensed on 05/07/19 that had not been used and still contained 30ml (a 4-day supply). Interview with a first shift medication aide (MA) on 05/09/19 at 4:25pm revealed: -She did not administer Potassium Chloride Liquid to Resident #2 because it was scheduled to be administered at 7:00am and third shift MAs were supposed to administer it. -She did not know why she documented administering Potassium Chloride Liquid on 3 occasions in April 2019 since she had not administered it. Interview with the Care Manager (CM) on 05/09/19 at 5:45pm revealed: -The MAs were not supposed to document a medication was administered on the eMAR if it was not administered. -She did not know why the the MAs documented the Potassium Chloride Liquid was administered on the eMAR when the medication was still on hand and had not been used.	D 367		

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D 367	Continued From page 170 A second observation of Resident #2's medications on hand on 05/13/19 at 5:55pm revealed: -The 2 bottles of Potassium Chloride Liquid that were dispensed on 04/14/19 and 05/07/19 were still on hand. -Both of the bottles still contained 30ml of 30ml and none had been used. -There was no other supply of Potassium Chloride Liquid on hand for Resident #2. A second interview with the CM on 05/13/19 at 5:55pm revealed: -She was not aware staff had not administered any Potassium Chloride Liquid from 05/09/19 - 05/13/19 but documented it as administered on the eMAR. -The MAs had been trained on how to document on the eMAR and they were not supposed to document a medication was administered if it was not administered. Interview with a second MA on 05/14/19 at 9:25am revealed: -She administered Resident #2's Potassium Chloride Liquid every morning before third shift ended at 7:00am. -She last administered Potassium Chloride Liquid that morning on 05/14/19. -She did not administer Potassium Chloride Liquid over the past weekend because she was off and did not work. -She had not noticed the instructions on the eMAR and medication label to mix and dilute the Potassium Chloride Liquid with water or juice. -Even though she initialed the eMAR that the Potassium Chloride Liquid was diluted and administered, she had not actually diluted it. Telephone interview with a third MA on 05/15/19	D 367		

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at 10:05pm revealed:
-She usually worked on third shift and she did not remember ever administering Potassium Chloride Liquid to Resident #2.
-She could not explain why she documented the Potassium Chloride Liquid as administered on the eMAR on 21 occasions from March 2019 - May 2019 when she never administered any.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed:
-There was 473ml (a 63-day supply) of Resident #2's Potassium Chloride Liquid dispensed on 12/05/18.
-There was 30ml (a 4-day supply) dispensed on 04/14/19.
-There was 30ml (a 4-day supply) dispensed on 05/07/19.
-There was 225ml (a 30-day supply) dispensed on 05/13/19 (delivered on 05/14/19).
-No Potassium Chloride Liquid had been dispensed by the back-up pharmacy because any back-up request had to be processed by the contracted pharmacy.

A third observation of Resident #2's medications on hand on 05/15/19 at 3:35pm revealed:
-There were 3 bottles of Potassium Chloride Liquid on hand.
-The 30ml bottle dispensed on 04/14/19 had not been used and still contained 30ml (a 4-day supply).
-The 30ml bottle dispensed on 05/07/19 had 15ml (a 2-day supply) remaining.
-There was a 225ml bottle dispensed on 05/13/19 that had not been used and still contained 225ml (a 30-day supply).

Observations, interviews, and record reviews

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regarding Resident #2's Potassium Chloride Liquid revealed:
-There were 758ml dispensed from 12/05/18 - 05/15/19, which was a 101-day supply (for a 162-day time period).
-There were 488ml (a 65-day supply) used during the 162-day time period, only about 40% of the amount required if administered as ordered at 7.5ml per day.
-The MAs had documented 562.5ml were administered from 03/01/19 - 05/14/19 but only 488ml were used from 12/05/18 - 05/14/19, rendering the eMARs inaccurate.

Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable.

2. Review of Resident #4's current FL-2 dated 03/06/19 revealed:
-Diagnoses included central demyelination of corpus collosum, hypomagnesia, candidiasis, hypoosmolality, hyponatremia, alcohol abuse, major depression, insomnia and hypertension.
-There was an order for an Ellipta inhaler one puff daily. (Ellipta is used to treat chronic obstructive pulmonary disease (COPD) and asthma).

Review of Resident #4's May 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for an Ellipta inhaler one puff daily.
-There was documentation the Ellipta inhaler was administered daily 05/01/19 through 05/06/19 and on 05/08/19.
-There was documentation the Ellipta inhaler was not administered on 05/07/19 because the medication was not available.

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Interview with Resident #4 on 05/16/19 at 3:35pm revealed:
-She went four days "last week" without her Ellipta inhaler.
-She had "really bad" COPD.
-If she did not have the Ellipta inhaler then she had to use her albuterol inhaler.
-There were times she needed the albuterol inhaler even after taking the Ellipta inhaler.

Observation of medications on hand for Resident #4 on 05/10/19 at 11:21am revealed:
-There was no Ellipta inhaler on hand for the resident.
-There was an albuterol inhaler with a prescription label with Resident #4's name and instructions for two puffs every four hours as needed for shortness of breath.

Interview with the medication aide (MA) on 05/11/19 at 11:21am revealed Resident #4's Ellipta inhaler was on order from the pharmacy.

Telephone interview with a MA on 05/15/19 at 9:40pm revealed:
-Resident #4 had two inhalers in addition to the Ellipta, "Spiriva" and another in a "red box" that she gave the resident whenever the Ellipta was not available. (Spiriva is used to treat COPD and asthma).
-Resident #4 would ask for one of the two inhalers if the Ellipta was not available.
-One of the other two inhalers was what she gave Resident #4 on 05/08/19.

Review of primary care provider orders for Resident #2 revealed:
-There was no order for Spiriva.
-There was an order for an albuterol inhaler two puffs every four hours and needed (PRN) for

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D 367	Continued From page 174 shortness of breath (SOB)/wheezing dated 03/06/19. Review of Resident #4's May 2019 eMAR revealed: -There was an entry for an albuterol inhaler two puffs every four hours PRN for SOB/wheezing. -There was no documentation the albuterol inhaler was administered on the morning of 05/08/19. -There was documentation the albuterol inhaler was administered on 05/03/19 at 4:17pm and 05/08/19 at 5:46pm. Review of charting notes dated 03/01/19 through 05/09/19 for Resident #4 revealed there was no documentation about the resident's Ellipta inhaler. Interview with the Administrator on 05/17/19 at 3:44pm revealed: -MAs were expected to document on the eMAR when a medication was not available. -MAs were expected to document in the progress notes what they did about any medication that was not available. -MAs were expected to document administering PRN medications when they administered PRN medications.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.	D 392		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to assure there was a readily retrievable record documenting the receipt, administration and disposition of controlled substances including Oxycodone, Oxycontin and alprazolam in the resident's record for accurate reconciliation for 1 of 6 sampled residents (#4).

The findings are:

Review of Resident #4's current FL-2 dated 03/06/19 revealed diagnoses included central demyelination of corpus collosum, hypomagnesia, candidiasis, hypoosmolality, hyponatremia, alcohol abuse, major depression, insomnia and hypertension.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 03/01/19.

a. Review of Resident #4's current FL-2 dated 03/06/19 revealed there was an order Oxycodone 5mg every six hours as needed (PRN). (Oxycodone is a controlled substance used to treat pain.)

Review of a primary care provider (PCP) order dated 03/20/19 revealed an order to discontinue Oxycodone 5mg.

Telephone interview with the Pharmacist with the facility's contracted pharmacy on 05/15/19 at

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2:00pm revealed:
-The pharmacy did not have an order for Oxycodone 5mg tablets for Resident #4 dated 03/01/19 through 03/31/19.
-There were no returns to the pharmacy of Oxycodone 5mg.

Review of a Medication Release form dated 03/01/19 for Resident #4 revealed there were 106 Oxycodone 5mg tablets released to the facility at the time the resident was admitted.

Review of Resident #4's March 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone 5mg every six hours PRN.
-There was documentation 40 Oxycodone 5mg tablets were administered from 03/01/19 at 6:42pm through 03/03/19/19 at 6:15am.

Observation of medications on hand for Resident #4 on 05/10/19 at 11:21am revealed there were no Oxycodone 5mg tablets.

Review of an controlled substance "Inventory Report" dated 03/24/19 revealed there was no entry for Oxycodone 5mg tablets for Resident #4.

Upon request on 05/09/19, there was no controlled substance record available for review for Oxycodone 5mg for Resident #4.

Interview with the Regional Clinical Director (RCD) on 05/17/19 at 4:00pm revealed she unable to get an electronic record for Oxycodone 5mg for Resident #4.

Based on review of Resident #4's 03/01/19 Medication release form, March 2019 eMAR and

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controlled substance records; and interview with the facility's contracted pharmacy's Pharmacist, there was insufficient documentation to accurately reconcile the record for Oxycodone 5mg leaving 66 Oxycodone 5mg tablets unaccounted for.

Refer to interview with a medication aide (MA) on 05/10/19 at 11:21am.

Refer to interview with the Regional Clinical Director (RCD) on 05/17/19 at 4:00pm.

Refer to telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/15/19 at 2:00pm.

Refer to interview with the Administrator on 05/17/19 at 3:44pm.

b. Review of a primary care provider (PCP) visit note dated 03/06/19 revealed an order for Oxycodone 10mg every six hours as needed (PRN). (Oxycodone is a controlled substance used to treat pain.)

Review of a PCP order dated 03/13/19 revealed an order for Oxycodone 10mg every six hours PRN.

Review of a PCP order dated 03/26/19 revealed an order for Oxycodone 10mg at 6:00am, 12:00pm and 6:00pm.

Review of a PCP order dated 04/02/19 for Resident #4 revealed an order for Oxycodone 10mg every six hours scheduled.

Telephone interview with the Pharmacist with the facility's contracted pharmacy on 05/15/19 at

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D 392	Continued From page 178 2:00pm revealed: -The original order for Oxycodone 10 mg was dated 03/06/19. -The original order for Oxycodone 10mg was for 120 tablets, but it was not covered by Resident #4's insurance. -The pharmacy dispensed 20 tablets of Oxycodone 10mg on 03/12/19, 100 tablets on 04/16/19 and 120 tablets on 05/11/19. -There were no returns to the pharmacy of Oxycodone 10mg. Review of Resident #4's March 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone 10mg every six hours PRN pain. -There was documentation 26 Oxycodone 10mg tablets were administered PRN from 03/19/19 at 11:45am through 03/27/19 at 12:16pm. -There was an entry for Oxycodone 10mg three times daily. -There was documentation 13 Oxycodone 10mg tablets were administered from 03/27/19 at 6:00pm through 03/31/19 at 6:00pm. Review of an controlled substance "Inventory Report" dated 03/24/19 revealed: -There were 63 Oxycodone 10mg tablets documented as remaining for Resident #4. -The report did not document the original delivery date and amount delivered. Review of a Controlled Substance Report for Resident #4 dated 03/01/19 through 03/31/19 revealed: -The documentation for Oxycodone did not specify the dosage of the tablets (5mg or 10mg). -There was no documentation of receipt, administration and disposition of Oxycodone prior	D 392		

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to 03/25/19.
-There was documentation 63 Oxycodone tablets were received on 03/25/19 at 12:49am.
-There were eight tablets of Oxycodone documented as being administered on the controlled substance report between 03/25/19 at 7:24am and 03/27/19 at 12:16pm.
-There was documentation of the following in order: one tablet administered on 03/25/19 at 7:24am, one tablet wasted/dropped at 5:44pm, one tablet administered on 03/26/19 at 2:05pm, two tablets wasted (given/working with new system) on 03/26/19 at 8:24pm, one tablet administered on 03/26/19 at 8:48pm, one wasted (given/working with new system) on 03/27/19 at 9:22am and one tablet administered on 03/27/19 at 12:16pm.

Review of Resident #4's March 2019 eMARs revealed on 03/25/19, Oxycodone 10mg was administered at 7:24am, 4:13pm and 10:35pm; on 03/26/19 at 2:05pm and 8:48pm; and on 03/27/19 at 12:16pm for a total of six tablets.

The Care Manager (CM) and medication aide (MA) who documented the discrepancies from 03/25/19 through 03/27/19 were not available for interview on 05/16/19 and 05/17/19.

Attempted telephone interview on 05/16/19 at 9:41pm with a second MA who documented a discrepancy on 03/37/19 at 9:22am was unsuccessful.

Review of Resident #4's April 2019 eMAR revealed:
-There was an entry for Oxycodone 10mg three times daily at 6:00am, 12:00pm and 6:00pm.
-There was documentation 10 Oxycodone 10mg tablets were administered every six hours daily

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from 04/01/19 at 6:00am through 04/04/19 at 6:00am.
-There was an entry for Oxycodone 10mg every six hours at 12:00am, 6:00am, 12:00pm and 6:00pm.
-There was documentation 104 Oxycodone 10mg tablets were administered three times daily from 04/04/19 at 12:00pm through 04/30/19 at 6:00pm.

Review of Resident #4's May 2019 eMAR revealed:
-There was an entry for Oxycodone 10mg every six hours at 12:00am, 6:00am, 12:00pm and 6:00pm.
-There was documentation a total of 35 Oxycodone 10mg tablets were administered from 05/01/19 at 12:00am through 05/09/19 at 12:00pm.

Review of a Controlled Substance Report for Resident #4 dated 04/01/19 through 05/09/19 revealed:
-The documentation for Oxycodone did not specify the dosage of the tablets (5mg or 10mg).
-There was documentation 20 Oxycodone tablets were received on 04/04/19 at 11:07am.
-On 04/10/19 at 3:52pm, a MA and the CM documented two Oxycodone tablets were wasted.
-The MA and CM documented the reason was the medication was already prepped but was discontinued.
-The MA and the CM documented in the comment section "system issues, medication given."
-There was documentation 100 Oxycodone tablets were received on 04/17/19 at 2:54pm.
-On 05/09/19 at 12:13pm there were 10 Oxycodone tablets remaining.

Attempted interview on 05/16/19 at 9:41pm with

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the MA who documented the 04/10/19 waste of two Oxycodone tablets was unsuccessful.

Observation of medications on hand for Resident #4 on 05/10/19 at 11:21am revealed:
-There was a bubble pack with a pharmacy label which had Resident #4's name and instructions for Oxycodone 10mg every six hours.
-The pharmacy label indicated 120 tablets were dispensed on 04/16/19, and there were 6 tablets remaining.

Interview with Resident #4 on 05/16/19 at 3:35pm revealed:
-She was taking 10mg of Oxycodone prior to coming to the facility in March 2019.
-She did not know why the prior facility sent Oxycodone 5mg tablets.
-At the prior facility, sometimes she was given two 5mg tablets of Oxycodone if there were no 10mg tablets.

Second interview with Resident #4 on 05/17/19 at 3:04pm revealed:
-She could not recall running out of Oxycodone since March 2019.
-She came to the facility in March 2019 with a "bunch" of Oxycodone tablets.
-She did not know if the Oxycodone was 5mg, 10mg, or both.

Telephone interview with Resident #4's PCP on 05/15/19 at 9:55am revealed:
-The Oxycodone was used for chronic pain management.
-He did not know of any requests for prescription refills that were out of the ordinary for Resident #4.
-He did not know of any missed dosages of pain medication for Resident #4.

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D 392	Continued From page 182 Based on review of Resident #4's 03/01/19 Medication release form, March, April and May 2019 eMARs and controlled substance records; and interview with the facility's contracted pharmacy's Pharmacist, there was insufficient documentation to accurately reconcile the record for Oxycodone 10mg. Discrepancies included where the 63 tablets documented as received on 03/25/19 on the Controlled Substance Report came from; a discrepancy of two Oxycodone 10mg tablets between the March 2019 eMAR and Controlled Substance report dated from 03/25/19 at 7:24am and 03/27/19 at 12:16pm; and a total of 179 Oxycodone 10mg tablets were documented as administered between 03/19/19 and 05/09/19, but there were only 120 tablets dispensed from the facility's contracted pharmacy. Refer to interview with a medication aide (MA) on 05/10/19 at 11:21am. Refer to interview with the Regional Clinical Director (RCD) on 05/17/19 at 4:00pm. Refer to telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/15/19 at 2:00pm. Refer to interview with the Administrator on 05/17/19 at 3:44pm. c. Review of a primary care provider (PCP) order dated 03/06/19 revealed an order for Oxycontin 10mg every 12 hours. (Oxycontin is a controlled substance used to treat chronic pain.) Review of a PCP order dated 03/20/19 revealed an order to discontinue Oxycontin.	D 392		

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D 392	Continued From page 183 Telephone interview with the Pharmacist on 05/15/19 at 2:00pm revealed: -The pharmacy dispensed 10 tablets of Oxycontin 10mg on 03/12/19. -The original order was for 60 tablets, but it was not covered by Resident #4's insurance. -There were no returns to the pharmacy of Oxycontin 10mg for Resident #4. Review of Resident #4's March 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycontin 10mg twice daily. -There was documentation 10 doses of Oxycontin were administered and an additional 5 doses were refused. Review of an controlled substances "Inventory Report" dated 03/24/19 revealed there was no documentation for Oxycontin for Resident #4. Review of a Controlled Substance Report for Resident #4 dated 03/01/19 through 05/09/19 revealed there was no documentation for Oxycontin. Interview with the Regional Clinical Director (RCD) on 05/17/19 at 4:00pm revealed she unable to get an electronic record for Oxycontin 10mg for Resident #4. Observation of medications on hand for Resident #4 on 05/10/19 at 11:21am revealed there was no Oxycontin 10mg tablets. Interview with Resident #4 on 05/17/19 at 3:04pm revealed: -She had taken the Oxycontin for one week	D 392		

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because she could not tolerate the medication.
-She had been unable to sleep and the Oxycontin did not control her pain.

Telephone interview with Resident #4's PCP on 05/15/19 at 9:55am revealed:
-He tried to change Resident to Oxycontin for better pain control.
-Oxycontin was a long acting medication verses Oxycodone which was short acting.
-Resident #17 did not tolerate the Oxycontin due to insomnia and jitters, so he discontinued the Oxycontin.

Based on review of Resident #4's 03/01/19 Medication release form, March 2019 eMARs and controlled substance records; and interview with the facility's contracted pharmacy's Pharmacist, there was no Controlled Substance Record for Oxycontin for Resident #4 and 10 tablets were documented as dispensed, but 15 tablets were documented as administered or refused on the eMAR.

Refer to interview with a medication aide (MA) on 05/10/19 at 11:21am.

Refer to interview with the Regional Clinical Director (RCD) on 05/17/19 at 4:00pm.

Refer to telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/15/19 at 2:00pm.

Refer to interview with the Administrator on 05/17/19 at 3:44pm.

d. Review of Resident #4's current FL-2 dated 03/06/19 revealed there was an order alprazolam 0.25mg twice daily. (Alprazolam is a

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D 392	Continued From page 185 controlled substance used to treat anxiety.) Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/17/19 at 2:54pm revealed the pharmacy dispensed alprazolam 0.25mg 10 tablets on 04/02/19 and 04/07/19; and 60 tablets on 04/09/19 and 05/10/19. Review of a Medication Release form dated 03/01/19 for Resident #4 revealed there were 62 alprazolam 0.25mg tablets released to the facility at the time the resident was admitted. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/15/19 at 2:00pm revealed there were no returns to the pharmacy of alprazolam 0.25mg. Review of Resident #4's March 2019 electronic medication administration records (eMARs) revealed: -There was an entry for alprazolam 0.25mg twice daily at 7:00am and 7:00pm. -There was documentation a total of 61 alprazolam 0.25mg tablets were administered from 03/01/19 at 7:00pm through 03/31/19 at 7:00pm. Review of an Inventory Report dated 03/24/19 for Resident #4 revealed: -There were 16 alprazolam 0.25mg tablets remaining. -The report did not document original delivery date and amount delivered. Review of Resident #4's April 2019 eMAR revealed: -There was an entry for alprazolam 0.25mg twice daily at 7:00am and 7:00pm.	D 392		

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D 392	Continued From page 186 -There was documentation a total of 57 alprazolam 0.25mg tablets were administered from 04/01/19 at 7:00am through 04/301/19 at 7:00pm. -There was documentation no doses were administered on 04/03/19 at 7:00am, 04/07/19 at 7:00pm and 04/08/19 at 7:00am. -There was documentation alprazolam 0.25mg was administered on 04/02/19 at 7:00am and 7:00pm, and 04/07/19 at 7:00am. Review of Resident #4's May 2019 eMAR revealed: -There was an entry for alprazolam 0.25mg twice daily at 7:00am and 7:00pm. -There was documentation a total of 17 alprazolam 0.25mg tablets were administered from 05/01/19 at 7:00am through 05/09/19 at 7:00am. Review of a Controlled Substance Report dated 03/01/19 through 05/09/19 revealed: -The documentation for alprazolam did not specify dosage of tablets. -There was documentation 16 alprazolam tablets were received on 03/25/19 at 12:49am. -There were 16 alprazolam tablets documented as administered between 03/25/19 at 7:19am and 04/01/19 at 6:45pm; the remaining count was zero. -There was documentation one alprazolam tablet was administered on 04/02/19 at 6:43am leaving a remaining count of negative one. -There was documentation one alprazolam tablet was received on 04/02/19 at 11:16am leaving a remaining count of zero. -There was documentation one alprazolam tablet was administered on 04/02/19 at 7:01pm leaving a remaining count of negative one. -There was documentation one alprazolam tablet	D 392		

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D 392	Continued From page 187 was received on 04/02/19 at 11:31pm leaving a remaining count of zero. -There was documentation 10 alprazolam tablets were received on 04/03/19 at 9:09pm. -There were 9 alprazolam tablets documented as administered and one tablet documented as wasted between 04/03/19 at 3:47pm and 04/06/19 at 6:05pm. -There was documentation two alprazolam tablets were administered on 04/06/19 at 6:05pm and 04/06/19 at 6:06pm leaving a remaining count of negative one. -There was documentation one alprazolam tablet was administered on 04/07/19 at 6:28am leaving a remaining count of negative two. -There was documentation two alprazolam tablets were received on 04/08/19 at 10:07am leaving a remaining count of zero. -There was documentation 10 alprazolam tablets were received on 04/08/19 at 3:35pm. -There was documentation 60 alprazolam tablets were received on 04/10/19 at 10:24am. -On 04/18/19 at 6:22pm, staff documented administering one alprazolam tablet. -On 04/18/19 at 6:25pm, staff documented administering one alprazolam tablet. -There were no discrepancies in the count documented 04/19/19 at 6:20am through 05/09/19 at 6:17am. -On 05/09/19 at 6:17am there were 7 alprazolam tablets remaining. Observation of medications on hand for Resident #4 on 05/10/19 at 11:21am revealed: -There was a bubble pack with a pharmacy label which had Resident #4's name and instructions for alprazolam 0.25mg twice daily. -The pharmacy label indicated 60 tablets were dispensed on 04/09/19 and there were 5 tablets remaining.	D 392		

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D 392	Continued From page 188 Interview with Resident #4 on 05/17/19 at 3:04pm revealed: -She could not recall running out of alprazolam since March 2019. -She came back to the facility in March 2019 with a "bunch" of alprazolam tablets. Telephone interview with a medication aide (MA) on 05/15/19 at 9:40pm revealed: -Regarding Resident #4's alprazolam on 04/02/19, medications were delivered to the facility at 2:00am. -The 3rd shift MA had to enter the amount delivered on the electronic medication administration record. -MAs were responsible for reordering medication when the number of tablets was down to seven. -She had never borrowed a controlled drug from one resident for another resident. -If she documented a medication was given, then the medication was given. -Residents knew what medications they were supposed to get. -If a resident did not get the medication, the resident would come and ask about the medication. Interview with a second MA on 05/16/19 at 5:52pm revealed: -Regarding the negative balance documented on the Controlled Substance Report for Resident #4's alprazolam, she did not know how the electronic controlled drug record would record a negative number. -"Even when we (MAs) try to put negative zero it (the computer system) won't take it." -She had not tried to enter a negative number, but other MAs had. -The MAs counted the number of tablets and	D 392		

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entered the amount at shift change.
-The computer system would either take the number or not.
-The MAs could not see the remaining balance when entering the counts.
-On 04/18/19, she may have entered administering alprazolam twice but only gave it once.
-Sometimes the computer system would show error and she would have to enter it again.
-The count was not affected because she probably had to call the Care Manager (CM).
-If there was a note, she did not know where the note would be.

Second interview with a MA on 05/17/19 at 3:25pm revealed:
-The CM entered all the order information for controlled drugs.
-The dose and frequency came up on the computer screen when the MA administered or counted the medication.

The CM was not available for interview on 05/16/19 and 05/17/19.

Interview with the Administrator on 05/17/19 at 3:44pm revealed:
-She did not know what happened on 04/02/19 with documenting negative balances and deliveries of 1 or 2 tablets of alprazolam.
-On 04/18/19 those were system issues from where staff kept "clicking off" on administering alprazolam.

Based on review of Resident #4's 03/01/19 Medication release form, March, April and May 2019 eMARs and controlled substance records, and interview with the facility's contracted pharmacy's Pharmacist, there was insufficient

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documentation to accurately reconcile the record for alprazolam 0.25mg. The discrepancies included no Controlled Substance Record for 03/01/19 through 03/24/19, discrepancies between the eMAR and the Controlled Substance Record with documentation of three tablets on 04/02/19 and 04/07/19, two tablets were administered within one to three minutes of each other on 04/06/19 and 04/18/19 with no subsequent discrepancy in the count and 142 tablets were dispensed from the facility's contracted pharmacy with documentation of 135 having been administered.

Refer to interview with a medication aide (MA) on 05/10/19 at 11:21am.

Refer to interview with the Regional Clinical Director (RCD) on 05/17/19 at 4:00pm.

Refer to telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/15/19 at 2:00pm.

Refer to interview with the Administrator on 05/17/19 at 3:44pm.

Interview with a medication aide (MA) on 05/10/19 at 11:21am revealed:
-MAs counted controlled drugs at the change of each shift.
-One MA counted and a second MA entered the number onto the computer system.
-If the number entered was wrong, then the MAs would have to recount.
-On the third count the system would not allow any further attempts and the MA would have to call the Care Manager (CM) or the Administrator.
-The MA usually called the CM or the Administrator after the second attempt to resolve

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D 392	Continued From page 191 the problem. Interview with the Regional Clinical Director (RCD) on 05/17/19 at 4:00pm revealed: -The facility had switched electronic medication administration record (eMAR) systems on 03/25/19. -The Inventory Report was the only report for controlled drug records she was able to retrieve for Resident #4 for dates prior to 03/25/19. -The amount on the "Inventory Report" was the amount transferred to the Controlled Substance Report when the electronic record system was changed. Interview with the Administrator on 05/17/19 at 3:44pm revealed: -Medications were delivered on the 3rd shift. -The MAs were responsible for counting controlled drugs on receipt and immediately entering the amount in the computer system. -There had to be a second MA to sign off on the received amount entered, so either the Administrator or the CM would sign off on the computer system. -Whenever there were system issues, the MA had to call her or the CM. -She and the CM were able to remotely see the whole computer system. -Two MAs were responsible for counting controlled drugs every shift change. -One MA counted the controlled drugs, the second MA entered the amount into the computer and both MAs sign off on the computer. -Controlled drug counts were monitored daily by the CM through the review of online tracking reports. _____ The facility failed to have an accurate accounting of the receipt, administration and disposition of	D 392		

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D 392	Continued From page 192 controlled substances including Oxycodone, Oxycontin and alprazolam available in Resident #4's record. The facility's failure to assure an accurate accounting of controlled substances allowed for an unmonitored opportunities for potential drug diversion and risk of medication errors which was detrimental to the health, safety and welfare of residents in the facility and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/16/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2019.	D 392		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5 day requirements for 3 of 3 sampled residents (#8, #11 and #12) sustaining physical abuse and	D 438		

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injuries of unknown origin.

The findings are:

1. Review of Resident #11's current FL-2 dated 02/05/19 revealed diagnoses included gait dysfunction, dementia, hypertension, lower extremity edema, constipation, hyperlipidemia, anemia and depression.

Review of Resident #11's Resident Register revealed the resident was admitted to the facility 09/3016 and discharged 02/15/19 for a change in the level of care to a skilled nursing facility.

Review of an accident/injury report dated 02/05/19 at 6:10am for Resident #11 revealed:
-Resident #11 was found sitting on the floor by her bed.
-Resident #11 had bruising to her left forehead, left shoulder and left chest.

Telephone interview with a personal care aide (PCA) on 05/16/19 at 10:01pm revealed:
-It was about 5:00am on 02/05/19 when she walked by Resident #11's room and found Resident #11 on the floor near the foot of her bed.
-The Care Manager (CM) and the Administrator asked her what happened to Resident #11 a week later (02/12/19).
-She did not see anyone handle Resident #11 roughly or physically abuse her.

Attempted telephone interview on 05/16/19 at 9:35pm with the MA who completed the incident and accident report dated 02/05/19 at 6:10am was unsuccessful.

Review of an accident/injury report dated 02/05/19 at 10:15pm for Resident #11 revealed:

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D 438	Continued From page 194 -Resident #11's knees were swollen. -Resident #11 was sent to the emergency room (ER) and admitted to the hospital. Telephone interview with a PCA on 05/16/19 at 11:00pm revealed: -The evening of 02/05/19, Resident #11 was sent to the ER. -Resident #11 was moaning in pain when she helped her to bed that night and her legs were swollen. -Resident #11 had bruises under her eye, on her arm and her legs. -She worked with Resident #11 the evening before she fell (02/04/19), and the resident did not have any bruises. Review of Resident #4's February 2019 Activities of Daily Living (ADL) Log revealed Staff C, PCA documented providing ADL assistance for the resident on 02/04/19 from 3:00pm until 11:00pm. Attempted telephone interview with Staff C on 05/16/19 at 9:43pm was unsuccessful. Review of Resident #11's hospital records dated 02/05/19 through 02/15/19 revealed: -Resident #11 presented to the ER with extensive bruising over her body in various stages of healing. -There were black and white photos of bruises to Resident #11's upper front left arm, left shoulder, left chest from breast to clavicle, left forehead and bilateral shins dated 02/05/19. -Resident #11 was diagnosed with a urinary tract infection, acute kidney injury and anemia with guaiac positive stools. -There was documentation the hospital Case Manager was working with Adult Protective Services (APS) for a safe discharge plan; the	D 438		

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D 438	Continued From page 195 facility was not a safe discharge plan. Telephone interview with the hospital Nurse Practitioner (NP) on 05/16/19 at 4:04pm revealed: -Resident #11 had multiple bruises in different stages of healing. -Resident #11 had bruises just above the left eyebrow, the left eye, left cheek, left shoulder, left upper arm and scattered on her lower extremities. -Resident #11 also had scattered skin tears on her lower extremities. -The bruises on Resident #11's left arm, shoulder, chest and cheek were a deep dark purple color. -The bruise above Resident #11's left eye was black and blue. -The oldest bruises were on Resident #11's legs, the newest was above the resident's eye and the shoulder and chest bruises were "in between (being the newest and the oldest)". -The staff at the facility were unable to tell the Case Manager at the hospital where the bruises came from. -The staff did not know the bruise that went from Resident #11's left elbow to her shoulder was even there. -The bruise on Resident #11's forehead could have been from a fall. -The bruises on Resident #11's chest, arm and shoulder did not appear to come from a fall. Telephone interview with the hospital Case Manager on 05/16/19 at 4:49pm revealed she did not have a record of who she spoke to at the facility, the date or details of the conversation. Telephone interview with Resident #11's family member on 05/15/19 at 7:25pm revealed: -Resident #11 was sent to the hospital for bruises on her arms and chest.	D 438		

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D 438	Continued From page 196 -After Resident #11 was hospitalized on 02/05/19, an investigation was done. -APS was involved, and it was determined a new employee hit Resident #11. -She did not remember the details of who had done the investigation and what exactly had happened. -An investigation was done because Resident #11 had bruises found when she went to the hospital that were not consistent with a fall. Interviews with three staff between 05/15/19 at 9:40pm and 05/17/19 at 3:15pm revealed: -The staff had "heard" from other staff that a staff "beat up" or handled Resident #11 roughly, causing the bruises on the resident's arm and chest. -The staff did not know the name of the staff who caused the bruises to Resident #11's arm and chest. -Resident #11's bruises did not look like they came from a fall. Interview with the Department of Social Services (DSS) representative on 05/16/19 at 11:40am revealed: -She and her Supervisor discussed the concerns of the hospital with the Administrator and former Administrator several times in February 2019. -There were discrepancies between what the hospital said about the bruises and what the Administrator and former Administrator said about the bruises on Resident #11. -The APS representative would have more information. Telephone interview with the APS representative on 05/17/19 at 11:56am revealed: -She had seen the bruises on Resident #11 while she was hospitalized 02/05/19 - 02/15/19.	D 438		

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D 438	Continued From page 197 -Resident #11 had a large purple bruise that went from her hairline to her eyelid; a blue/purple bruise on her left chest just below the collar bone that looked like a fist imprint; and large bruises on both shins with one being purple and the other red. -There was concern that a fall did not match the bruises Resident #11 had. -Staff reported not knowing what happened to Resident #11. Interview with the Regional Clinical Director (RCD) on 05/16/19 at 10:19am revealed: -Resident #11's injuries were not the result of abuse. -Resident #11 fell and sustained the bruises. -The Administrator reported to her that someone in the hospital said Resident #11 was abused. Interview with the current Administrator on 05/16/19 at 10:19am revealed: -She had just started as the Administrator in training the week of 02/04/19. -The hospital staff did not specifically say Resident #11 had been abused. -She had "gathered" there was a suspicion of abuse because the hospital stopped giving the facility updates when staff called the hospital. -She had not completed an initial report for the Health Care Personnel Registry (HCPR) for Resident #11. -She had not conducted an investigation into the cause of Resident #11's bruises. -She did not know anything about an investigation being done and the staff being terminated. -She did not know the extent of Resident #11's injuries. -She had not received a report from the hospital. -She had never suspected Resident #11's injuries were the result of physical abuse.	D 438		

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-None of the staff mentioned Resident #11 being "beat up" by a staff.
-No one told her there were allegations of abuse.

Interview with the former Administrator on 05/16/19 at 10:44am revealed:
-She was the Administrator at the time Resident #11 was injured (02/05/19).
-There were two incident and accident reports completed for Resident #11 on 02/05/19; one for the fall and a second for her knees being swollen.
-That was why an initial report for the HCPR for injury of unknown origin was not done.
-She was never notified by anyone from the hospital that there were suspicions of abuse.
-No staff was terminated because of Resident #11's injuries.
-Resident #11 had bruises on her head, chest and shoulder from falling off the bed and hitting the night stand.
-She knew this because the 1st shift staff reported that was what happened.
-The 3rd shift staff reported the fall was unwitnessed.
-The 3rd shift staff reported Resident #11 was found tangled in her blanket on the floor.
-There was no report of any physical abuse toward Resident #11 from staff.

Based on observations, interviews and record reviews, it was determined Resident #11 was not interviewable.

Refer to interview with the Administrator on 05/17/19 at 3:44pm.

2. Review of Resident #8's current FL-2 dated 01/22/19 revealed diagnoses included Alzheimer's dementia, osteoarthritis, Lewy body dementia, vitamin B12 deficiency,

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D 438	Continued From page 199 gastro-esophageal reflux disease and peripheral edema. Interview with a concerned citizen on 05/10/19 at 1:00pm revealed: -Resident #8 had large bruises on her arms in the past and no one knew how she got the bruises. -Resident #8's family member visited on 05/05/19 and found the resident crying and difficult to console. -The family member noticed bruises on both of Resident #8's hands. -A staff had reported to the family member Resident #8 had slapped a staff. -Resident #8 would have episodes of crying but had never been "ugly" or acted out before. -She visited Resident #8 on 05/06/19 and had seen the bruises on the resident's hands. -She was concerned because the bruises looked as if someone had grabbed Resident #8 by her wrists. -She spoke with the Care Manager (CM) about the bruises on 05/06/19. Review of a Health Care Personnel Registry (HCPR) 24 Hour/Initial Report dated 05/10/19 for Resident #8 revealed: -There were allegations of abuse which occurred on 05/09/19; the facility became aware of on 05/10/19 at 7:30am. -Staff C was taking Resident #8's clothes off at the front desk when another staff told Staff C to stop. -Staff C lead Resident #8 to her room by the resident's hands "roughly". -Staff C yelled loudly at Resident #8. -Resident #8 had bruises on both hands. -Resident #8 had a bruise on her right hand on "yesterday (05/09/19)".	D 438		

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D 438	Continued From page 200	D 438		

Review of a Body Evaluation & Observation sheet dated 05/10/19 at 7:04am for Resident #8 revealed the CM documented the resident had medium/large dark spots on both hands.

The CM was not available for interview on 05/16/19 and 05/17/19.

Telephone interviews with Resident #8's family member on 05/15/19 at 11:36am and 8:24pm revealed:
-On Sunday 05/05/19, he found two large bruises, one on each of Resident #8's hands in the same spot as if thumbs had been squeezed down on her hands.
-He had taken pictures of the bruises on 05/05/19.
-He talked with the staff working that day (05/05/19) about the bruises and did not get a call back until Friday (05/10/19).
-He got a call from a staff on 05/10/19 at 10:30am about the bruises; no one knew what happened.
-He could not remember which staff had called him on 05/10/19.
-The staff said there had been another incident on 05/09/19 where staff had found a bump and a bruise on Resident #8's hands.
-He got a call from the Regional Clinical Director (RCD) on 05/10/19.
-The RCD said the bruises were different on 05/10/19 from the bruises noted on 05/05/19, and the employee who was responsible was" let go".
-He never got the story of what happened on 05/05/19.
-He had spoken with the Administrator on 05/12/19 about the bruises on Resident #8's hands on 05/05/19 and 05/09/19.
-The Administrator reported having to follow a 5 day suspension before terminating the staff.
-This was not the first time Resident #8 had

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bruises; he had chalked the others up to falls.
-He was now very concerned that incidents with staff being abusive had happened before.

Review of photos received from Resident #8's family member date stamped 05/05/19 at 6:52pm revealed:
-There was a half dollar sized oval shaped purple bruise on Resident #8's right hand below the wrist and next to the thumb area.
-There was a quarter sized round purple bruise on Resident #8's left hand below the wrist and next to the thumb area.

Observations of Resident #8 on 05/10/19 at 1:40pm revealed:
-There was a half dollar sized oval shaped purple bruise on the resident's right hand below the wrist and next to the thumb area.
-There was a lighter area of purple at the center of the bruise.
-There was a large irregularly shaped purple and red bruise on the resident's left hand below the wrist from the thumb to just under the second finger.

Interview with the RCD on 05/15/19 at 3:23pm revealed:
-She could not remember whether staff reported the bruises on Resident #8's hands or if she had seen the bruises first.
-After seeing the bruises on 05/10/19, she checked with staff and found out there was an incident at change of shift for 2nd into 3rd shift (11:00pm) on 05/09/19 witnessed by two staff.
-Staff C took Resident #8 to the bathroom and the resident returned with marks on her hands.
-She did not know about bruises or other incidents earlier in the week (05/05/19).

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Review of a HCPR 5 Day/Investigation Report dated 05/15/19 for Resident #8 revealed:
-The RCD spoke with Resident #8's family member (date not documented).
-The family member visited Resident #8 several weeks ago and the resident reported a staff was mean to her; the family member described Staff C.
-Resident #8 was very agitated the day the family member visited; the family member had never seen the resident like that before.
-Resident #8 was agitated when Staff C was around her and had slapped Staff C in the past.
-Resident #8 was not known to hit anyone before.
-The RCD questioned Staff C and Staff C did not deny the allegations.

Interview with the current Administrator on 05/17/19 at 3:44pm revealed:
-She did not see Resident #8 on 05/05/19.
-She saw a small bruise on one of Resident #8's hands on Monday or Tuesday (05/06/19 or 05/07/19).
-No one had reported any concerns about how Staff C treated Resident #8 before 05/09/19.
-There was no concern to submit an initial HCPR report prior to 05/10/19.

Based on observations, interviews and record reviews, it was determined Resident #8 was not interviewable.

Refer to interview with the Administrator on 05/17/19 at 3:44pm.

3. Review of Resident #12's current FL-2 dated 04/09/19 revealed diagnoses included vascular dementia, hypertension and decubitus ulcer.

Observation on 05/07/19 at 12:57pm revealed:

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D 438	Continued From page 203 -Resident #12 had a large bruise on his right arm from near the wrist to the mid-forearm area. -The bruise was red, irregularly shaped and approximately two inches wide by six inches in length. Interview with a personal care aide (PCA) on 05/07/19 at 12:59pm revealed: -She had noticed the bruise on Resident #12's arm, but she was not sure when. -She was "pretty sure" the medication aides (MAs) knew about the bruise because all the staff knew about the bruise. -The bruise was documented in the shower book on the skin check sheet. Interview with a MA on 05/08/19 at 5:56pm revealed: -The bruise on Resident #12's right forearm "just popped up," she did not know where it came from. -She reported the bruise to the Care Manager (CM), Administrator and Licensed Health Professional Support (LHPS) Registered Nurse (RN). -She could not remember the date she found and reported the bruise, but she had written a note about the bruise. Upon request on 05/09/19, charting notes from 03/17/19 through 05/09/19 for Resident #12 were not available for review. Second interview with the MA on 05/14/19 at 12:42pm revealed: -She documented the bruise on Resident #12's right forearm the day she found the bruise. -She must have been working as a PCA and documented on the shower check sheet rather than care notes.	D 438		

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D 438	Continued From page 204 Review of a shower assessment sheets dated 05/02/19 and 05/06/19 for Resident #12 revealed staff documented the resident had a bruise on his right forearm. Review of an incident report dated 05/09/19 at 7:33pm revealed: -Resident #12 had bruising on his lower right arm. -There was no documentation of how Resident #12 bruised his lower right arm. -The report was completed on 05/09/19 at 7:35pm by the CM. Telephone interview with Resident #12's primary care provider (PCP) on 05/15/19 at 3:28pm revealed: -He had seen Resident #12 on three occasions for bruises; the resident had fragile skin. -He had seen Resident #12 on 04/30/19, 05/07/19 and 05/14/19. -He did not know anything about an investigation into the cause of the bruise on Resident #12's right forearm. -On 05/14/19, the bruised area had a small laceration at the center and looked as if an infection had started. -He started Resident #12 on an antibiotic. Interview with the CM on 05/09/19 at 5:35pm revealed: -She had seen the "red spots" on Resident #12's arms after a staff had reported the "bruise" on 05/07/19. -She let the PCP know on 05/07/19 when the PCP was at the facility. -The PCP did not know what caused the bruise on Resident #12's right forearm. -She had asked several staff about the bruise; the staff did not know where the bruise came from.	D 438		

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D 438	Continued From page 205 -When a PCA found a bruise on a resident and did not where the bruise came from, the PCA reported it to the MA. -The MA reported to her or directly to the Administrator. -She reported all bruises of unknown origin to the Administrator so a Health Care Personnel Registry (HCPR) report could be done by the Administrator. -She had not reported the bruise on Resident #12's right forearm to the Administrator. -She did not know if a MA had reported the bruise to the Administrator and if a HCPR report had been done. Interview with the Administrator on 05/09/19 at 6:30pm revealed: -She had seen the bruise on Resident #12's right forearm earlier in the week (05/07/19). -She had not sent a HCPR report because the PCP had seen Resident #12 and said the bruising was from aging. Based on observations, interviews and record reviews, it was determined Resident #12 was not interviewable. Refer to interview with the Administrator on 05/17/19 at 3:44pm. Interview with the Administrator on 05/17/19 at 3:44pm revealed: -Staff were expected and knew to report any instances of verbal or physical abuse to the Care Manager (CM) and/or Administrator. -Staff would be written up for not reporting. -If there were any suspicions of abuse, neglect or exploitation of resident it was reported to the HCPR. -She was responsible for completing reports to	D 438		

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D 438	Continued From page 206 the HCPR. The facility failed to complete an initial report within 24 hours, investigate and complete an investigation report within 5 days for 3 of 3 sampled residents with bruises of unknown origin (#8, #11 and #12) and accusations of physical abuse (#8 and #11). The facility's failure placed residents at substantial risk of serious injury and abuse because of delayed or absent reporting and investigating which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/16/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 16, 2019.	D 438		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 465		

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D 465	Continued From page 207 Based on observations, interviews and record reviews, the facility failed to assure there was enough staff present on the special care unit and attentive to meet the personal care, supervision and health care needs of the residents for 14 of 27 sampled shifts. The findings are: Review of a resident census report dated 04/19/19 (Friday) revealed the facility's in-house census on the special care unit (SCU) was 24 residents, which required at least 24 hours of staff duty on first shift. Review of the punch time detail report dated 04/19/19 (Friday) revealed there were 17.08 staff hours provided on first shift, leaving the shift short staffed by 6.52 hours. Review of a resident census report dated 04/20/19 (Saturday) revealed the facility's in-house census on the SCU was 24 residents, which required at least 24 hours of staff duty on first and second shift. Review of the punch time detail report dated 04/20/19 (Sunday) revealed: -There were 14.52 staff hours provided on first shift, leaving the shift short staffed by 9.08 hours. -There were 13.02 staff hours provided on second shift, leaving the shift short staffed by 10.58 hours. Review of a resident census report dated 04/21/19 (Sunday) revealed the facility's in-house census on the SCU was 23 residents, which required at least 18.4 hours of staff duty on third shift.	D 465		

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D 465	Continued From page 208 Review of the punch time detail report dated 04/21/19 (Sunday) revealed there were 13.52 staff hours provided on third shift, leaving the shift short staffed by 5.22 hours. Review of a resident census report dated 04/22/19 (Monday and a Holiday) revealed the facility's in-house census on the SCU was 23 residents, which required at least 18.4 hours of staff duty on third shift. Review of the punch time detail report dated 04/22/19 (Monday and a Holiday) revealed there were 21.78 staff hours provided on third shift, leaving the shift short staffed by 1.22 hours. Review of a resident census report dated 04/27/19 (Saturday) revealed the SCU's in-house census was 24 residents, which required at least 24 hours of staff duty on first shift and at least 19.2 hours on third shift. Review of the punch time detail report dated 04/27/19 (Saturday) revealed: -There were 21 staff hours provided on first shift, leaving the shift short staffed by 3 hours. -There was one medication aide (MA) on duty for the facility for first shift; all of the MA's hours were assigned to the SCU. -There was no punch time detail for a dietary aide. -There were two cooks on duty from 6:23am until 6:31pm. -There were 22 staff hours provided on second shift, leaving the shift short staffed by 2 hours. -There was one MA in the facility from 5:09pm until 10:47pm; all of the MA's hours were assigned to the SCU. -One personal care aide (PCA) punched out for a	D 465		

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meal break at 10:00pm and punched in after the break at 12:02am for a total of two consecutive hours.

Interview on 05/15/19 at 5:58pm with the MA who worked 04/27/19 second shift revealed:
-She normally "ran back and forth" between the SCU and the assisted living (AL) side.
-There was no management in the facility when they were short of staff on weekends.
-Short staffing for 1st and 2nd shift meant having two PCAs on the SCU, one PCA on the AL side and one MA for the building.
-There always had to be three staff on the SCU, so she would have to send the PCA from the AL side to the SCU while she worked alone passing medications on the AL side.
-Then she would go the SCU to pass medications and send one of the PCAs to the AL side.
-Residents did not get the proper care and supervision because there was not enough time.
-Staff were also responsible for completing "all of the paperwork" and covering meal breaks.
-When she worked she was responsible for 50 residents and three to four staff.

Review of a resident census report dated 04/28/19 (Sunday) revealed the SCU's in-house census was 24 residents, which required at least 24 hours of staff duty on first shift and at least 19.2 hours on third shift.

Review of the punch time detail report dated 04/28/19 (Sunday) revealed:
-There were 16.25 staff hours provided on first shift, leaving the shift short staffed by 7.75 hours.
-There was one MA in the facility for first shift.
-There was no punch time detail for a dietary aide.
-There were two cooks on duty from 6:25am until

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6:15pm.
-There were 15 staff hours provided on second shift, leaving the shift short staffed by 9 hours.
-There was one MA in the facility from 4:30pm until 11:00pm; all of the MA's hours were assigned to the SCU.
-One PCA punched out for a meal break at 6:22pm and punched in after the break at 7:57pm for a total of 1.5 consecutive hours.

Interview with a PCA on 05/07/19 at 1:29pm revealed:
-Staff were able to take naps during their shift, just not in the building.
-Staff had to take a nap in their car on their lunch break.
-If the shift was short of staff, then staff could not go out to their car and take a nap on their lunch break.
-The facility was 24-hour care, staff could not sleep while on duty because a resident might get up an fall.

Interview with the Administrator on 05/08/19 at 2:15pm revealed:
-Staff were allowed to take a two-hour break if they worked 12 or more hours, their was enough staff to cover the break and the break was not during times such as the medication pass.
-Whether or not staff could take a two-hour break was determined and scheduled by the Care Manager (CM).

Review of a resident census report dated 05/03/19 (Friday) revealed the facility's in-house census on the SCU was 23 residents, which required at least 23 hours of staff duty on first and second shifts.

Review of the punch time detail report dated

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D 465	Continued From page 211 05/03/19 (Friday) revealed: -There were 22.65 staff hours provided on first shift, leaving the shift short staffed by 1.35 hours. -There were 22.92 staff hours provided on second shift, leaving the shift short staffed by 1.08 hours. Review of a resident census report dated 05/04/19 revealed the facility's in-house census was 23 residents, which required at least 18.44 hours of staff duty on third shift. Review of the punch time detail report dated 05/04/19 revealed: -There were 8 hours 29 minutes of staff hours provided on third shift, leaving the shift short staffed by 10 hours. -There was one PCA on duty for the facility SCU for third shift Review of a resident census report dated 05/05/19 revealed the facility's in-house census was 23 residents, which required at least 23 hours of staff duty on second shift and 18.44 hours of staff duty on third shift. Review of the punch time detail report dated 05/05/19 revealed: -There were16 hours 28 minutes of staff hours provided on third shift, leaving the shift short staffed by 1 hour 32 minutes. -There was one MA on duty for the facility for third shift and 1 PCA on duty for third shift. Interview with a 3rd shift personal care aide (PCA) on 05/07/19 at 4:57am revealed: -A resident fell on third shift on Monday (5/06/19). -She found the resident on the floor on her knees. -The resident complained of knee pain of her bad knee.	D 465		

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D 465	Continued From page 212 -She assisted the resident up into her chair and reminded the resident to use her walker. -She was the only PCA working on the SCU. [Refer to Tag 271, 10A NCAC 13F .0901(c) Supervision] Review of a resident's accident/incident report dated 05/05/19 and May 2019 electronic medication administration record (eMAR) revealed: -The resident fell on 05/05/19 and complained of new left side pain at 6:08am on 05/06/19 (end of 3rd shift on 05/05/19). -The resident's primary care provider was not notified of the resident's new pain following a fall in the previous 24 hours. -On 05/08/19 the resident went to the emergency room and was diagnosed with left rib fractures. -[Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care]. Interview with a second PCA on 05/07/19 at 4:10am revealed: -There were two PCAs working on the SCU for 3rd shift on 05/06/19. -There was one MA working in the building. -The MA worked on both the SCU and the AL side for 3rd shift on 05/06/19. -There were 22 residents in the SCU. -The facility had some issues with short staffed shifts because they could not keep staff especially for 3rd shift. -Shift times were 7:00am to 3:00pm for first shift, 3:00pm to 11:00pm for second shift and 11:00pm to 7:00am for third shift. Observations on the SCU during the facility tour	D 465		

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	Hal089002	A. BUILDING: _____ B. WING _____	05/17/2019

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D 465	Continued From page 213	D 465		

on 05/07/19 at 4:18am revealed:
-A PCA was sitting in a chair in the common area with her back towards the hallway and her feet up in the chair.
-The chair was covered with a blanket and the PCA had a sweatshirt over her shoulders.
-The PCA stood from the chair, rolled up the blanket and placed the sweatshirt and the blanket in the seat of the chair.
-The PCAs eyes were red and she appeared startled and disheveled.
-A second PCA was seated at the SCU front desk.

Interview with the PCA on 05/07/19 at 5:32am revealed:
-She was not sleeping at 4:18am on 05/07/19.
-The blanket was on the chair because residents urinated on the chairs.
-Her eyes were red because she was tired at 4:18am on 05/07/19.
-Staff did not sleep while working because management did "pop up" visits at night.

Interview with a fourth PCA on 05/07/19 at 5:09am revealed:
-She did not know what the other PCA was doing in the common area at 4:18am on 05/07/19.
-She had worked with the other PCA one other time and never seen her sleeping.

Interview on 05/07/19 at 5:43am with the MA on duty third shift on 05/06/19 revealed:
-She tried to check on the staff and residents in the SCU every two hours.
-She checked to make sure staff were doing rounds and completing daily tasks.
-How often she was able to check staff and residents on the SCU depended on how the night was going and what was going on in the facility.

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D 465	Continued From page 214 Second interview on 05/07/19 at 8:19am with the MA on duty third shift on 05/06/19 revealed: -What was going on in the facility meant, sometimes a resident would fall, someone might need her attention, medications might be delivered from the pharmacy and the shift might be short staffed. -There were usually more PCAs on the SCU, so she would spend "most" of her time on the AL side. -Daily tasks were tasks the PCAs were responsible to sign off on the computer. -The tasks were activities of daily living such as making sure residents were clean and dry, toileting, bathing, dressing, changing the bed and assisting with ambulation. -She did not know what the PCA on the SCU was doing at 4:18am on 05/07/19. -She had worked with the PCA before and never had any problems. -Third shift on the past two weekends (04/20/19 and 04/27/19), the facility had been short staffed because two PCAs were a no call/no show. Confidential interview with a former staff revealed: -She stopped working at the facility because there was not enough staff to take care of the residents. -Staff worked 13 to 14 hours a day for days in a row with no lunch break on both the SCU and AL side. -Staff were overwhelmed. -There was resident personal care that was not getting done. -There was not enough staff to check residents who needed increased supervision due to falls, exit seeking behavior and aggression toward other residents.	D 465		

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D 465	Continued From page 215 Interview with the Administrator on 05/14/19 at 5:05pm revealed: -She had enough staff on duty each shift every day to complete increased safety checks on residents with increased supervision needs. -She was not aware of any shifts having one PCA for the SCU, one PCA for the AL side and one medication aide covering both the SCU and AL side. [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care] Interview with the Care Manager (CM) on 05/07/19 at 7:41am revealed: -The PCA had talked to her on 05/07/19 before leaving at the end of her shift; the PCA said she was not sleeping. -She reported the incident to the Administrator on 05/07/19. Interview with the Administrator on 05/15/19 at 2:55pm revealed: -One of the PCAs who was working on 3rd shift on the SCU 05/06/19 quit. -The second PCA that was seen in the chair at 4:18am on 05/07/19 put her two week notice in. -The facility had changed all staff schedules to 12 hour shifts since 05/10/19. -The staff were a team and would get the work done. -Staff were not working too many consecutive 12 hour shifts. Interview with a fifth PCA on 05/16/19 at 5:15pm revealed: -Laundry was being finished from what the 1st shift staff had put in the washer and dryer before the end of their shift.	D 465		

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D 465	Continued From page 216 -The PCAs on the AL side folded the laundry and she was putting it away for the SCU residents. Interview with the Administrator on 05/17/19 at 3:44pm revealed: -The facility had dietary and housekeeping staff; PCAs only assisted with laundry. -Laundry was incorporated in housekeeping responsibilities; housekeepers were able to do the laundry but were not responsible for doing the laundry. -The PCAs were responsible for doing facility and residents' laundry. -She was responsible for making the staff schedule. -She used the "regulatory" staffing grid to determine staff need by resident census. -She or the CM would make calls to staff to cover short shifts. -If they were unable to find staff to work, then the lead Supervisor, CM or ED covered the shift. -It had been a "few months" since she worked on the floor to cover a shortage. -When she or the CM worked on the floor providing direct care, they "clocked in" on the time clock. -"Clocking in" meant working on the floor. -She provided oversight and monitoring of staff while working on the floor. The CM was not available for interview on 05/16/19 and 05/17/19. The facility failed to assure enough staff were present on the special care unit for 14 of 27 sampled shifts. The facility's failure resulted in a lack of personal care assistance with incontinence care and dressing, supervision with unwitnessed falls and residents wandering away from the facility and into the main kitchen, and a	D 465		

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D 465	Continued From page 217 failure to report symptoms of serious injury following a fall. This failure placed residents at substantial risk of serious neglect and physical harm which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/10/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 16, 2019.	D 465		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure residents were treated with respect, dignity, consideration, and right to privacy as related to staff leaving doors and window blinds open while providing incontinence and bathing care to residents (#2, #3, #6, #15); speaking and being disrespectful to residents (#4, #14); and failed to provide an acceptable bed at the facility for a resident whose room was infested with bedbugs (#9). The findings are: 1. Review of Resident #2's current FL-2 dated	D911		

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D911	Continued From page 218 02/05/19 revealed: -Diagnoses included Alzheimer's disease, high blood pressure, Vitamin D deficiency, and pre-renal disease. -The resident was constantly disoriented. -The resident was semi-ambulatory. -The resident required assistance with bathing, dressing, and feeding. -The resident was incontinent of bladder and bowel. Review of Resident #2's current assessment and care plan dated 02/12/19 revealed: -The resident was ambulatory with a wheelchair. -The resident had daily incontinence of bladder and bowel. -The resident was totally dependent for bathing, grooming, and toileting. -The resident required limited assistance with dressing, transferring and ambulation. Observation of Resident #2 on 05/07/19 at 5:15am on the assisted living (AL) side of the facility revealed: -The personal care aide (PCA) entered the resident's room and turned on the lights. -There was strong odor of feces and urine. -Resident #2 was lying in bed with pajamas on and she was lying on top of an incontinence pad. -The resident's bed was closest to the door and the resident did not currently have roommate. -The PCA did not close the door to the resident's bedroom. -The PCA did not close the window blinds in the resident's room leaving the resident visible from the front parking lot of the facility. -The PCA removed the resident's pajama bottoms. -At 5:18am, a male resident walked by Resident #2's room in the hallway and looked in the room.	D911		

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D911	Continued From page 219 -Resident #2 was lying on the bed wearing an incontinence brief, socks, and a t-shirt when the male resident looked in the room. -At 5:20am, a staff person walked by the room while the door was open and the resident was not fully clothed. -The PCA assisted the resident to the shower in the resident's private bathroom. -The PCA undressed the resident in the bathroom and gave her a shower without out ever closing the door to the bathroom or the resident's room for privacy. -At 5:28am, the PCA got the resident out of the shower and assisted the resident with walking back to her bed without clothing or a towel to cover the resident. -The resident was still wet on some areas of her skin and was not dried completely. -The PCA assisted the resident in sitting on the bed and the resident was not wearing any clothing. -The PCA stepped away to the resident's closet to gather clean clothing, leaving the resident naked on the bed with the door and window blinds still open. -The PCA returned to the resident and finished drying her with a washcloth. -The PCA then walked to the resident's bathroom and then the PCA left the resident's room, leaving the resident naked on the bed. -The door and window blinds were still open. -A car pulled in the parking lot and drove by the resident's window. -At 5:30am, the PCA walked back in the room, went to the bathroom and came back to the resident to apply deodorant. -At 5:31am, the PCA put on the resident's socks, an incontinence brief, jogging pants, shoes, and then a bra. -The incontinence brief and the jogging pants	D911		

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D911	Continued From page 220 were only pulled up to the resident's knees as the resident was still sitting on the bed. -At 5:34am, the same male resident walked up to the resident's door, waved at the PCA, and told the PCA "hey". -The PCA spoke back to the male resident and continued to assist Resident #2 with dressing. -The PCA did not try to cover Resident #2 or close the door to prevent the male resident from seeing Resident #2 exposed. -The PCA assisted the resident in standing to pull up incontinence briefs and pants and the same male resident came back to the door and spoke to the PCA again. -The PCA finished dressing the resident, assisted the resident to the wheelchair, and left the room at 5:46am. Interview with the PCA on 05/07/19 at 6:50am revealed: -She usually closed the residents' doors when she provided personal care. -She "just forgot" to close the door that morning (05/07/19) when she was providing care to Resident #2. -It had been a long, tiring weekend because they were short staffed and she forgot it. -She had not noticed Resident #2' blinds were open as well. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Confidential interview with staff revealed: -The staff had observed PCAs leave residents' doors open while providing personal care to residents. -The staff had observed it "sometimes" but could not specify how often.	D911		

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D911	Continued From page 221 Interview with the Care Manager (CM) on 05/07/19 at 2:05pm revealed: -Staff were supposed to close doors to residents' rooms and bathrooms when providing care for an "extra sense of privacy". -Staff should also close window blinds if providing care. -She was not aware staff were not closing doors or window blinds when providing care to residents. 2. Review of Resident #6's current FL-2 dated 07/13/18 revealed: -Diagnoses included dementia, hypertension, chronic anxiety, hyperlipidemia, and glaucoma. -The resident was intermittently disoriented. -The resident was semi-ambulatory. -The resident's sight was functionally limited. -The resident required assistance with bathing, dressing, and feeding. -The resident was continent of bowel and bladder. Review of Resident #6's current assessment and care plan dated 12/27/18 revealed: -The resident was ambulatory with a wheelchair. -The resident was continent of bladder and bowel. -The resident required extensive assistance with bathing, grooming, dressing, and toileting. -The resident required limited assistance with eating, transferring, and ambulation. Observation of Resident #6 on 05/07/19 from 5:52am - 6:24am on the assisted living (AL) side of the facility revealed: -The personal care aide (PCA) entered the resident's room and turned on the lights. -Resident #6 was lying in bed, wearing pajamas,	D911		

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D911	Continued From page 222	D911		

and had an incontinence pad underneath her.
-The PCA assisted the resident to the wheelchair and pushed her to the suite bathroom.
-The door to the suite and the bathroom were left open.
-The PCA unclothed the resident in the bathroom with the door open.
-There was a very strong odor of urine.
-The PCA had stepped out into the hall and announced she needed some body wash.
-At 6:00am, a male staff (did not provide personal care to residents) handed a bottle of body wash to the PCA while the door to the suite and bathroom were still open, leaving the unclothed resident visible.
-The resident was sitting naked on the toilet and the PCA bathed the resident with body wash, water, and a washcloth while the resident was sitting on the toilet.
-The PCA assisted the resident with dressing and transferring back to the wheelchair.
-The PCA pushed the resident back to her bedroom and left the room at 6:24am.

Interview with the PCA on 05/07/19 at 6:50am revealed:
-She usually closed the residents' doors when she provided personal care.
-She "just forgot" to close the door that morning (05/07/19) when she was providing care to Resident #6.
-It had been a long, tiring weekend because they were short staffed and she forgot it.

Interview with Resident #6 on 05/10/19 at 11:25am revealed:
-Staff assisted her with bathing and dressing.
-She thought staff kept the door closed when they provided care but she was not sure because she was blind and could only see shadows.

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D911	Continued From page 223 -She wanted the door closed for privacy. Confidential interview with staff revealed: -The staff had observed PCAs leave residents' doors open while providing personal care to residents. -The staff had observed it "sometimes" but could not specify how often. Interview with the Care Manager (CM) on 05/07/19 at 2:05pm revealed: -Staff were supposed to close doors to residents' rooms and bathrooms when providing care for an "extra sense of privacy". -Staff should also close window blinds if providing care. -She was not aware staff were not closing doors or window blinds when providing care to residents. 3. Review of Resident #15's current FL-2 dated 07/18/18 revealed: -Diagnoses included atrial fibrillation, hypertension, chronic renal insufficiency, hyperlipidemia, chronic back pain, arthritis bilateral knees, lumbar spondylosis, and degenerative joint disease. -The resident was ambulatory with a walker. -The resident required assistance with bathing and dressing. -The resident was incontinent of bladder. Review of Resident #15's current assessment and care plan dated 08/27/18 revealed: -The resident was ambulatory with an aide or device (type not specified). -The resident was occasionally incontinent of bladder and bowel. -The resident required extensive assistance with bathing, grooming, and dressing.	D911		

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D911	Continued From page 224	D911		

-The resident required limited assistance with toileting and transferring.
-The resident required supervision with ambulation.

Observation of Resident #15 on 05/07/19 at 4:41am on the assisted living (AL) side of the facility revealed:
-The personal care aide (PCA) entered the resident's room and turned on the lights.
-Resident #15 was lying in bed with her night clothes on.
-The PCA provided standby assistance to the resident with transfer from bed to wheelchair.
-The PCA pushed the resident from her room to the shared suite bathroom.
-The door to the suite and the door the bathroom were left open and visible from the hallway.
-The PCA assisted the resident with transfer from wheelchair to the toilet.
-The PCA removed the resident's clothing and bathed the resident with water, soap, and a washcloth while the resident was sitting on the toilet without clothes on.
-The PCA assisted the resident with standing so the PCA could wash the resident's private area and helped the resident put on clean incontinence briefs and clothing.
-Both doors remained open during the entire time the PCA was providing care to the resident.
-The PCA assisted the resident back to her bedroom, made the resident's bed, and then left the room.

Interview with the PCA on 05/07/19 at 6:50am revealed:
-She usually closed the residents' doors when she provided personal care.
-She "just forgot" to close the door that morning (05/07/19) when she was providing care to

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D911	Continued From page 225 Resident #15. -It had been a long, tiring weekend because they were short staffed and she forgot it. Interviews with Resident #15 on 05/07/19 at 1:10pm and 05/13/19 at 11:28am revealed: -She needed assistance with bathing; she usually got a sink bath every day since she did not take showers. -She could not recall if staff closed the door when they provided care to her, but she would like for them to close the door. Confidential interview with staff revealed: -The staff had observed PCAs leave residents' doors open while providing personal care to residents. -The staff had observed it "sometimes" but could not specify how often. Interview with the Care Manager (CM) on 05/07/19 at 2:05pm revealed: -Staff were supposed to close doors to residents' rooms and bathrooms when providing care for an "extra sense of privacy". -Staff should also close window blinds if providing care. -She was not aware staff were not closing doors or window blinds when providing care to residents. 4. Review of Resident #3's current FL-2 dated 02/07/19 revealed: -Diagnoses included type 2 diabetes mellitus, infection and inflammatory reaction to left hip, acquired absence of left upper limb above elbow, hypertension, atherosclerotic heart disease, history of falling, history of healed traumatic fracture. -The resident was semi-ambulatory.	D911		

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D911	Continued From page 226 -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing and dressing. Review of Resident #3's current assessment and care plan dated 02/08/19 revealed: -The resident was ambulatory with a wheelchair. -The resident had limited range of motion in upper extremities. -The resident was daily incontinence of bladder and bowel. -The resident was fully dependent with bathing, dressing, and grooming. -The resident required limited assistance with transferring and ambulation. Interview with the personal care aide (PCA) on 05/07/19 at 6:50am revealed: -She usually closed the residents' doors when she provided personal care. -She "just forgot" to close the doors that morning (05/07/19) when she provided care to three residents prior to 6:50am. -It had been a long, tiring weekend because they were short staffed and she forgot it. Observation of Resident #3 on 05/07/19 at 7:20am on the assisted living (AL) side of the facility revealed: -The same PCA entered the resident's room and turned on the lights. -The resident was lying in bed with incontinence brief only. -The PCA went in room and told the resident she was going to get him up. -The PCA left the room at 7:22am to get some gloves and came back to the room. -The PCA sat the resident up in bed. -The door to the resident's room and the suite	D911		

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was left open and visible from the hallway.
-The PCA put on the resident's socks, his pants up to his knees, and his slippers.
-The PCA left the resident sitting on the side of the bed while she went to his bathroom to get a washcloth to wipe his face.
-The resident was only wearing socks, pants to his knees and slipper while sitting on his bed with the doors still open and visible from the hallway.
-Staff and residents were passing by in the hallway.
-The PCA then washed the resident's face, stood him up, pulled up his pants, and transferred him to the wheelchair.

Interview with the same PCA on 05/07/19 at 7:43am revealed:
-She "forgot" to close Resident #3's door while providing care that morning (05/07/19).
-She had no other explanation for not closing the door.
-She should have closed the door.

Interview with Resident #3 on 05/10/19 at 11:35am revealed:
-He thought staff closed the door when providing care but he was not sure.
-He thought the door needed to be closed when providing care.

Confidential interview with staff revealed:
-The staff had observed PCAs leave residents' doors open while providing personal care to residents.
-The staff had observed it "sometimes" but could not specify how often.

Interview with the Care Manager (CM) on 05/07/19 at 2:05pm revealed:
-Staff were supposed to close doors to residents'

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rooms and bathrooms when providing care for an "extra sense of privacy".
-Staff should also close window blinds if providing care.
-She was not aware staff were not closing doors or window blinds when providing care to residents.

5. Review of Resident #14's current FL-2 dated 02/26/19 revealed diagnoses included Huntington disease (a disease that causes the nerve cells in the brain to break down causing uncontrolled movements).

Observation of on 05/16/19 at 11:28 am revealed:
-Resident #14 was sitting in a wheelchair on the Assisted Living (AL) hallway.
-Resident #14 had uncontrollable movements to her head, arms, trunk, and legs.
-There was a personal care aide (PCA) standing behind Resident #14 that leaned forward close to Resident #14's right ear.
-The PCA told Resident #14, "Stop. Be still. I don't know what I'm going to do with you".
-Resident #14 continued to have uncontrollable movements to her head, arms, trunk, and legs that were at a slower speed.

Interview with the PCA on 05/16/19 at 11:45 am revealed:
-Resident #14 could not control her movements.
-Resident #14 could control the speed of her movements.
-Resident #14 had "anxious" movements that were "fast when staff could not move fast enough".
-She told Resident #14 to "Stop. Be still. I don't know what I'm going to do with you" to get her to " ...calm down and be still so she wouldn't fall out of the wheelchair".

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-When she would tell Resident #14 to stop moving Resident #14 would slow her movements.

Interview with the Regional Clinical Director (RCD) on 05/16/19 at 6:30 pm revealed:
-The PCA should not have spoken to Resident #14 disrespectful.
-The way the PCA spoke with Resident #14 was unacceptable.

Based on observations, interviews, and record reveiws, it was determined Resident #14 was not interviewable.

6. Review of Resident #4's current FL-2 dated 03/06/19 revealed diagnoses included central demyelination of corpus collosum, hypomagnesia, candidiasis, hypoosmolality, hyponatremia, alcohol abuse, major depression, insomnia and hypertension.

Review of a charting note dated 03/08/19 at 10:06pm for Resident #4 revealed staff documented, "Some days she act as if she can't do anything, then other days she was fine."

Telephone interview with a medication aide (MA) on 05/15/19 at 9:40pm revealed:
-She had documented the note dated 03/08/19 for Resident #4.
-The MAs were responsible for documenting what type of assistance a resident needed.
-Resident #4 had returned to the facility after being gone for several months in the hospital and a rehabilitation center.
-When Resident #4 returned she was different, and staff had to help the resident "get back to routine."
-Getting back to the routine meant Resident #4 needed assistance because "she could hardly

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use her left arm."
-Resident #4 needed assistance with bathing, toileting and pulling up her incontinence brief.
-She did not know of any staff being demeaning or rude to Resident #4 about helping.

Interview with Resident #4 on 05/08/19 at 3:28pm revealed:
-She had been gone from the facility from September 2018 through March 2019.
-She was seriously ill from a life threatening low level of sodium which caused her to have a metabolic brain injury.
-She tried to keep herself clean but was not always able to manage on her own.
-She was not able to raise and use her left arm, had limited strength in her legs and her balance was off.
-She was usually able to transfer herself and used a wheelchair for ambulation.
-Some days she had a hard time getting up from the recliner.
-She would have to rock back and forth to get enough momentum to raise up from sitting.
-Some days she needed help with bathing, dressing, getting out of the chair and cleaning after toileting.
-It was "humiliating" to have to ask for assistance.
-Staff had laughed at her and called her lazy behind her back.
-One staff had handed her a wad of toilet paper and said "Here, I heard you can do it yourself," and then walked away without helping.
-The incident had happened two or three weeks ago and she reported the staff to the Administrator.
-The staff had called in for work last weekend (05/04/19 and 05/05/19) and was supposedly fired, but the staff was at work on 3rd shift last night (05/07/19).

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D911	Continued From page 231 -She could not remember the staff's name. -She had gotten to the point where she did not want to ask for assistance. -She developed an infection to her groin, rectum and buttocks because she was not able to clean well enough by herself. -She had seen her primary care provider (PCP) last week (04/30/19) and he prescribed a cream because her bottom was "raw". -Her bottom only started feeling better yesterday (05/07/19). Observation of Resident #4 on 05/08/19 at 4:10pm revealed: -Resident #4 rocked back and forth in her recliner several times before being able to push up and stand. -Resident #4's left arm was weak and had limited range of motion. -Resident #4 was unable to use her left arm to assist with getting out of the chair. -Resident #4 took several small shuffling steps to turn and transfer into the wheelchair. -Resident #4 was unable to use her left arm to guide herself into sitting down in the wheelchair. -Resident #4 plopped down into the wheelchair on her bottom. Interview with a personal care aide (PCA) on 05/10/19 at 11:43am revealed: -Resident #4 had not always needed help; she was at the facility in 2018 and did not need assistance. -Resident #4 was "alright," the resident needed assistance with wiping her bottom after she had a bowel movement. -Resident #4 also needed help in the shower washing her back and feet and help getting her bottoms pulled up when getting dressed.	D911		

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D911	Continued From page 232 Interview with a second MA on 05/10/19 at 11:52am revealed: -Resident #4 went between constipation and diarrhea due to pain medications and laxatives. -Resident #4 needed assistance with cleaning after toileting. -Resident #4 was not able to reach her bottom and wipe herself well. -Resident #4 had experienced diarrhea recently and "got raw down there (bottom)" from not getting cleaned well. -Resident #4 would ask for assistance when she needed help; she helped Resident #4 herself when she was working. -Resident #4 had told her that some staff had told the resident that providing assistance with cleaning after toileting was not on her care plan and did not help her. -She did not report the staff because Resident #4 did not name the staff. Telephone interview with Resident #4's PCP on 05/15/19 at 9:55am revealed: -He did not see the excoriation (raw) and/or erythema (red) on Resident #4's bottom. -Resident #4 did not want him to see the area for privacy. -He prescribed an ointment to treat the area empirically because Resident #4 reported having diarrhea and rectal burning. -He did not know of any issue with staff not assisting Resident #4 with cleaning after toileting. Interview with the Administrator on 05/09/19 at 4:45pm revealed: -She did not know Resident #4 had felt so humiliated and developed a rash due to not wanting to ask for help. -Staff were expected to provide care according to the residents' needs.	D911		

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7. Review of Resident #9's current FL-2 dated 01/23/19 revealed diagnoses included vascular dementia, chronic atrial fibrillation, type II diabetes mellitus, hyperlipidemia, depression with anxiety, gout, hypertension and hypothyroidism.

Review of a charting note dated 05/05/19 at 3:36pm for Resident #9 revealed staff documented the resident's room had bed bugs; the resident refused to go to another room and went home with a family member.

Telephone interview with Resident #9's family member on 05/09/19 at 9:58am revealed:
-Resident #9 left the facility on 05/05/19 and was staying with another family member because of bed bugs in her room at the facility.
-The bed bugs were all over Resident #9's recliner.
-Resident #9 had bed bug bites on the back of her neck and arms.
-The facility was supposed to have another room for Resident #9.
-The room the facility offered to move Resident #9 had a toilet that was running continuously and did not flush.
-The headboard on the bed was falling.
-The family member was waiting for the facility to "get it together."
-This was the 3rd time the facility had bed bugs since October 2018.
-The family members had to make changes to make sure Resident #9 was safe and cared for while away from the facility.

Interview with Resident #9's second family member on 05/09/19 at 11:44am revealed:
-He had picked up Resident #9 from the facility on 05/05/19.

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-When he arrived at the facility, he had seen a bed bug crawling on Resident #9's neck.
-The back of Resident #9's neck was "ate up" from bed bug bites and there were bite marks "all up and down her arms."
-Another family member had to shower Resident #9 before the resident left the facility.
-He had brought new clothing for Resident #9 to wear.

Interview with a medication aide (MA) on 05/14/19 at 9:10am revealed:
-Resident #9 came out to the front desk on the special care unit (SCU) and said she was itching overnight on 05/04/19.
-She found three bed bugs on Resident #9's arm which she removed.
-She went and checked the resident's room and there were bed bugs "everywhere."
-There approximately 40 bed bugs on the sheet, the pillow and along the seams of the pillow.
-She removed the bed linens from Resident #9's bed and put them in the dryer.
-She kept Resident #9 out of her room for the remainder of that shift.
-She was told the day shift (7:00am-3:00pm) on 05/05/19 cleaned Resident #9's clothing.

Interview with the Care Manager (CM) on 05/08/19 at 3:17pm revealed:
-Staff had reported to her over the last weekend (05/05/19) that bed bugs were found in Resident #9's room.
-She could not remember which staff reported finding the bed bugs.
-The process for managing bed bugs in the facility was for staff to report to her and she reported to the Administrator.
-The Administrator would then put a work order in the computer and maintenance would come out

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to the facility and treat the room.
-Resident #9's room had not been treated for bed bugs as of 05/08/19 because the facility was waiting for the pest control company.
-Resident #9 was staying with a family member until the room had been treated for bed bugs.

Observations of Resident #9's room on 05/07/19 at 4:44am revealed:
-The mattress was turned up on the box spring and leaned against the wall at the head of the bed.
-There were no linens on the mattress.
-There were personal items in the room such as a blanket on the recliner, throw pillows, plastic storage bins and clothing in the closet and drawers.
-None of the clothing, blanket or throw pillows were sealed in plastic bags.
-The recliner had fine white particles in the folds of the chair that resemble bed bug eggs.
-There was dirt and dust build up on and around the carpet on the floor.
-There was no resident in the room.

Observations of Resident #9's room on 05/09/19 from 12:35pm until 12:45pm revealed:
-There were small black specks resembling bed bug excrement around the call bell, electrical outlet, a picture hanger on the wall above the bed and around a small hole in the wall in the corner above the headboard.
-There were two small pale bed bugs next to the picture hanger and four small pale bed bugs on the headboard.
-There was a live bed bug where the wall meets the ceiling above the window.

Interview with the Administrator on 05/09/19 at 12:47pm revealed:

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D911	Continued From page 236 -Bed bug management at the facility was "a process and time frames were different." -When staff found bed bugs in a resident's room, the staff sent photos of the bed bugs to her via cell phone. -She sent the bed bug photos to her maintenance staff and he sent the photos to his supervisor and the pest control company. -The pest control company would then come out and heat treat the room. -She did not know when the pest control company would be at the facility. Interview with the Administrator on 05/09/19 at 4:50pm revealed: -She had offered a room for Resident #9 at the beginning of the week (05/06/19). -Resident #9's family member declined the room because the room was not equal to the room the resident had. -Resident #9 was in a semi-private suite where the rooms were separated by a wall and had individual doors. -The room offered was also semi-private, but did not have a separating wall or individual doors. -The roommate in the room offered made other residents and family members uncomfortable; the roommate was not aggressive and mostly walked around the SCU. -Resident #9's family member decided to keep the resident with the family member until her room on the SCU was treated for bed bugs. Observation on 05/13/19 at 11:30am revealed Resident #9's room was unchanged from observation on 05/07/19 at 4:44am; all personal belongings remaining un-bagged and in the room. Interview with the Administrator on 05/15/19 at 2:55pm revealed:	D911		

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D911	Continued From page 237 -The facility had started clearing Resident #9's room out on 05/12/19. -Resident #9's room had been cleared out. -Resident #9's clothing was placed in plastic bags, sealed and taken outside and placed by the storage unit. The family member was going to pick up Resident #9's clothing. -The family member said to throw away the recliner and any other furniture belonging to Resident #9. -The facility's headboard and bed frame were wiped down and sprayed with rubbing alcohol. -The room had been sealed off and was awaiting heat treatment by the pest control company. -The last pieces of personal furniture were discarded on 05/14/19. -Resident #9 would return to the facility following the pest control treatment of the resident's room. -She had contacted the corporate office at the beginning of the week (05/13/19) to have the pest control company come out and treat for bed bugs. -The pest control company would not be available until the end of the week 05/17/19). -She had spoken with the family member of the Resident #9 earlier in the week (05/13/19) related to the bed bugs. Based on observations, interviews and record reviews, it was determined Resident #9 was not interviewable. _____ The facility failed to treat at least 7 residents with respect, dignity, consideration, and right to privacy by leaving doors and window blinds open when providing personal care assistance to Resident #2, Resident #3, Resident #6, and Resident #15 resulting in residents who were unclothed being exposed to other residents and	D911		

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D911	Continued From page 238 staff. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/09/19 and 05/10/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2019.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration, controlled substances and housekeeping and furnishings. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to maintain an environment free of hazards in the special care	D912		

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unit as evidenced by Resident #9's room having a bed bug infestation that was left untreated for 7 days and a broken window in resident room 209 that was not repaired for more than 6 weeks. [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policy for 2 of 11 residents (#18, #19) observed during the medication passes including errors with a vitamin D supplement (#18, #19); and for 3 of 10 sampled residents (#3, #2, #4) including errors with a diuretic (#3), medications used to treat low potassium, treat and prevent acid reflux, and treat and prevent stomach ulcers (#2), and a medication to treat chronic obstructive pulmonary disease and asthma (#4) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

3. Based on observations, interviews and record reviews, the facility failed to assure there was a readily retrievable record documenting the receipt, administration and disposition of controlled substances including Oxycodone, Oxycontin and alprazolam in the resident's record for accurate reconciliation for 1 of 6 sampled residents (#4) [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].

4. Based on observations, record reviews, and interviews, the facility failed to assure residents were treated with respect, dignity, consideration, and right to privacy as related to staff leaving doors and window blinds open while providing incontinence and bathing care to residents (#2,

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D912	Continued From page 240 #3, #6, #15); speaking and being disrespectful to residents (#4, #14); and failed to provide an acceptable bed at the facility for a resident whose room was infested with bedbugs (#9) [Refer to Tag 911 G.S.131D-21(1) Residents' Rights (Type B 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: TYPE A2 VIOLATION I. Based on observations, interviews and record reviews, the facility failed to assure 2 residents (#8 and #11) were free of physical abuse as evidenced by bruises occurring on Resident #8's hands following incidents between Resident #8 and Staff C where Staff C handled Resident #8 roughly; and bruises inconsistent with fall found on admission to the hospital for Resident #11. The findings are: 1. Review of Resident #11's current FL-2 dated 02/05/19 revealed: -Diagnoses included gait dysfunction, dementia, hypertension, lower extremity edema, constipation, hyperlipidemia, anemia and depression. -Resident #11 was constantly disoriented, non-ambulatory and required a wheelchair for mobility.	D914		

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D914	Continued From page 241 Review of Resident #11's Resident Register revealed the resident was admitted to the facility 09/3016 and discharged 02/15/19 for a change in the level of care. Review of a charting note for Resident #11 dated 02/05/19 at 9:00am revealed: -The Care Manager (CM) documented Resident #11 was found sitting on the floor by her bed with bruising over her left eye and the front of her left shoulder. -Resident #11's primary care provider (PCP) was contacted and gave instructions to monitor the resident every 15 minutes for changes. -The PCP would see Resident #11 on 02/05/19. Review of an accident/injury report dated 02/05/19 at 6:10am for Resident #11 revealed: -Resident #11 was found sitting on the floor by her bed. -Resident #11 had bruising to her left forehead, left shoulder and left chest. -No first aide was done, and the resident was not sent to the emergency room (ER). -Staff spoke with Resident #11's primary care provider (PCP) at 7:26am. Telephone interview with a personal care aide (PCA) on 05/16/19 at 10:01pm revealed: -She was working 3rd shift on 02/05/19 on the assisted living (AL) side. -She was late getting to work that night. -She first checked on Resident #11 just after midnight; the resident was sleeping. -She then left the facility for her lunch break. -She returned to start getting residents up for the day. -It was about 5:00am and she walked by Resident #11's room.	D914		

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D914	Continued From page 242 -She found Resident #11 on the floor near the foot of her bed. -Resident #11's bed was near the window and her wheelchair was at the foot of the bed toward the wall. -She left Resident #11 sitting on the floor and went to the medication aide (MA). -The MA got Resident #11 up and sat her on the end of her bed. -She did not assist with getting Resident #11 up from the floor. -She was off work for a day or two and when she returned other staff were saying someone "beat up" Resident #11. -She did not see any bruises on Resident #11 while she was sitting on the floor. -The CM and the Administrator asked her what happened to Resident #11 a week later (02/12/19). -She did not see anyone handle Resident #11 roughly or physically abuse her. -Resident #11 did not talk, she was in a wheelchair and needed help to get up. Attempted telephone interview on 05/16/19 at 9:35pm with the MA who completed the incident and accident report dated 02/05/19 at 6:10am was unsuccessful. Review of a charting note for Resident #11 dated 02/05/19 at 7:00pm revealed: -The CM documented Resident #11 was seen by her PCP and diagnosed with contusion of the left forehead, fall from slipping, trip or stumble and left shoulder pain. -The PCP ordered a mobile x-ray of Resident #11's left shoulder and scheduled a follow up visit for two weeks. Telephone interview with Resident #11's PCP on	D914		

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D914	Continued From page 243 05/15/19 at 3:28pm revealed: -He had been notified Resident #11 had fell on 02/05/19 and had left shoulder pain and a hematoma on her left forehead. -He had seen Resident #11 on 02/05/19; the resident had a bruise that went from her shoulder to halfway down her arm. -He ordered a mobile x-ray of Resident #11's left shoulder. -Resident #11 was scheduled for a follow up visit in 2 weeks. -He "did not note anything suspicious at that time." Review of a charting note for Resident #11 dated 02/05/19 at 11:30pm revealed staff documented Resident #11 was sent to the hospital for swollen knees. Review of a second accident/injury report dated 02/05/19 at 10:15pm for Resident #11 revealed: -Resident #11's knees were swollen. -Resident #11 was sent to the ER and admitted to the hospital. Telephone interview with a second PCA on 05/16/19 at 11:00pm revealed: -The night Resident #11 fell (02/04/19 into 02/05/19) she was working on the special care unit (SCU) and did not see the resident. -The next evening she came to work and Resident #11 was sent to the emergency room (ER). -Resident #11 was moaning in pain when she helped her to bed that night and her legs were swollen. -Resident #11 had bruises under her eye, on her arm and her legs. -Staff working on 02/05/19 said Resident #11 fell; she did not remember which staff.	D914		

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D914	Continued From page 244 -She worked at the facility for a year and had not known Resident #11 to fall. -The bruises on Resident #11 looked as if someone had hurt her. -She worked with Resident #11 the night before she fell, and the resident did not have any bruises. -She did not know who could have done that to Resident #11; she did not know who was working that night. -Resident #11 was not difficult, she did not walk by herself and needed staff to help with ambulation. Review of Resident #11's February 2019 Activities of Daily Living (ADL) Log revealed Staff C documented providing ADL assistance for the resident on 02/04/19 from 3:00pm until 11:00pm. Attempted telephone interview with Staff C on 05/16/19 at 9:43pm was unsuccessful. Review of Resident #11's hospital records dated 02/05/19 through 02/15/19 revealed: -Resident #11 presented to the ER with extensive bruising over her body in various stages of healing. -There were black and white photos of bruises to Resident #11's upper front left arm, left shoulder, left chest from breast to clavicle, left forehead and bilateral shins dated 02/05/19. -Resident #11 was diagnosed with a urinary tract infection, acute kidney injury and anemia. -There was documentation the hospital Case Manager was working with Adult Protective Services (APS) for a safe discharge plan; the facility was not a safe discharge plan. Telephone interview with the hospital Nurse Practitioner (NP) on 05/16/19 at 4:04pm revealed:	D914		

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-Resident #11 had multiple bruises in different stages of healing.
-Resident #11 had bruises just above the left eyebrow, the left eye, left cheek, left shoulder, left upper arm and scattered on her lower extremities.
-Resident #11 also had scattered skin tears on her lower extremities.
-The bruises on Resident #11's left arm, shoulder, chest and cheek were a deep dark purple color.
-The bruise above Resident #11's left eye was black and blue.
-The oldest bruises were on Resident #11's legs, the newest bruise was above the resident's eye and the shoulder and chest bruises were "in between".
-The staff at the facility were unable to tell the Case Manager at the hospital where the bruises came from.
-The staff did not know the bruise that went from Resident #11's left elbow to her shoulder was even there.
-The bruise on Resident #11's forehead could have been from a fall.
-The bruises on Resident #11's chest, arm and shoulder did not appear to come from a fall.
-Resident #11 was initially combative, however the longer she stayed in the hospital, the calmer she became.

Telephone interview with the hospital Case Manager on 05/16/19 at 4:49pm revealed she did not have a record of who she spoke to at the facility or the date.

Telephone interview with Resident #11's family member on 05/15/19 at 7:25pm revealed:
-Resident #11 was a difficult person with dementia.
-Resident #11 was combative and would hit

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people.
-Resident #11 was sent to the hospital on 02/05/19 for bruises on her arms and chest.
-After Resident #11 was hospitalized on 02/05/19, an investigation was done.
-An investigation was done because Resident #11 had bruises found when she went to the hospital that were not consistent with a fall.
-She did not remember the details of who had done the investigation and what exactly had happened.
-The APS was involved, and it was a new employee that hit Resident #11.

Confidential interview with a resident revealed:
-The whole left side of Resident #11's face was black and blue.
-Someone said the bruise was from a fall.
-Then Resident #11 had more bruising on the same side.
-Staff kept saying it was from falls.
-The Activity Director told residents it was being investigated.
-No one ever came around asking any questions about what happened to Resident #11.
-Resident #11 was in a wheelchair and never walked.

Confidential interview with a concerned citizen revealed:
-The concerned citizen was at the facility a few months ago and had seen Resident #11 with "God awful bruising on her face."
-Resident #11 had bruises all over her face and looked like a racoon.
-The concerned citizen could not understand how a resident could have injuries like that from a fall.

Telephone interview with a third PCA on 05/16/19 at 9:29pm revealed:

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-She had worked with Resident #11 the day before she went to the hospital (02/04/19).
-Resident #11 did not have any bruises on her on 02/04/19.
-She had heard from other staff in February 2019 Resident #11 went to the hospital and had bruises.
-She did not know what happened to Resident #11.

Interviews with three staff between 05/15/19 at 9:40pm and 05/17/19 at 3:15pm revealed:
-The staff had heard from other staff that a staff "beat up" or handled Resident #11 roughly causing the bruises on the resident's arm and chest.
-Resident #11's bruises did not look like they came from a fall.

Interview with the Department of Social Services (DSS) representative on 05/16/19 at 11:40am revealed:
-She and her Supervisor discussed the concerns of the hospital with the current Administrator and former Administrator several times.
-There were discrepancies between what the hospital said about the bruises and what the current Administrator and former Administrator said about the bruises on Resident #11.

Telephone interview with the APS representative on 05/17/19 at 11:56am revealed:
-She had seen the bruises on Resident #11 while she was hospitalized 02/05/19 - 02/15/19.
-Resident #11 had a large purple bruise that went from her hairline to her eyelid; a blue/purple bruise on her left chest just below the collar bone that looked like a fist imprint; and large bruises on both shins with one being purple and the other red.

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-There was concern that a fall did not match the bruises Resident #11 had.
-She initiated her investigation on 02/13/19.
-Staff reported they did not know what happened to Resident #11.

Interview with the Regional Clinical Director (RCD) on 05/16/19 at 10:19am revealed:
-The Administrator reported to her that someone in the hospital said Resident #11 was abused.
-Resident #11's injuries were not the result of abuse.
-Resident #11 fell and sustained bruises which were worsened by gravity.

Interview with the current Administrator on 05/16/19 at 10:19am revealed:
-She had just started as the Administrator in training the week of 02/04/19.
-The hospital staff did not specifically say Resident #11 had been abused.
-She had gathered there was a suspicion of abuse because the hospital stopped giving the facility updates when staff called the hospital.
-She had not conducted an investigation into the cause of Resident #11's bruises.
-She did not know anything about an investigation being done and the staff being terminated.
-She did not know the extent of Resident #11's injuries.
-She had not received a report from the hospital.
-She had never suspected Resident #11's injuries were the result of physical abuse.
-None of the staff mentioned Resident #11 being "beat up" by a staff.
-No one told her there were allegations of abuse.

Interview with the former Administrator on 05/16/19 at 10:44am revealed:
-She was the Administrator at the time Resident

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#11 was injured (02/05/19).
-There were two incident and accident reports completed for Resident #11 on 02/05/19; one for the fall and a second for her knees being swollen.
-She was never notified by anyone from the hospital that there were suspicions of abuse.
-No staff was terminated because of Resident #11's injuries.
-Resident #11 had bruises on her head, chest and shoulder from falling off the bed and hitting the night stand.
-She knew this because the 1st shift staff reported that was what happened.
-The 3rd shift staff reported the fall was unwitnessed.
-The 3rd shift staff reported Resident #11 was found tangled in her blanket on the floor.
-There was no report of any physical abuse toward Resident #11 from staff.

Interview with the current Administrator on 05/17/19 at 3:44pm revealed:
-When she saw Resident #11 on 02/05/19, it looked like Resident #11 fell.
-No one reported suspecting physical abuse.
-APS came to the facility but she was not the Administrator then.

Based on observations, interviews and record reviews, it was determined Resident #11 was not interviewable.

Refer to interview with the Administrator on 05/17/19 at 3:44pm.

2. Review of Resident #8's current FL-2 dated 01/22/19 revealed:
-Diagnoses included Alzheimer's dementia, osteoarthritis, levy body dementia, vitamin B12 deficiency, gastro-esophageal reflux disease and

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peripheral edema.
-There was documentation Resident #8 was constantly confused, ambulatory and wandered.

Interview with a concerned citizen on 05/10/19 at 1:00pm revealed:
-Resident #8 had large bruises on her arms in the past and no one knew how she got the bruises.
-Resident #8's family member visited on 05/05/19 and found the resident crying and difficult to console.
-The family member noticed bruises on both of Resident #8's hands.
-A staff had reported to the family member Resident #8 had slapped a staff on 05/05/19.
-Resident #8 would have episodes of crying but had never been "ugly" or acted out before.
-She visited Resident #8 on 05/06/19 and had seen the bruises on the resident's hands.
-She was concerned because the bruises looked as if some had grabbed Resident #8 by her wrists.
-She spoke with the Care Manager (CM) about the bruises on 05/06/19.

Telephone interviews with Resident #8's family member on 05/15/19 at 11:36am and 8:24pm revealed:
-On Sunday 05/05/19, he had found two large bruises, one on each of Resident #8's hands in the same spot as if thumbs had been squeezed down on her hands.
-He had taken pictures of the bruises on 05/05/19.
-The bruises on Resident #8's hands were purple; it did not look like it happened that day or the day before (05/04//19 or 05/05/19).
-During the visit Resident #8 was "hysterical and inconsolable."
-He talked with the staff working that day

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(05/05/19) and did not get a call back until Friday (05/10/19).
-There was a staff working on 05/05/19 that said Resident #8 was in a bad mood and had slapped her (staff).
-Resident #8 had never slapped anyone, to the family's knowledge.
-Another staff working on 05/05/19 said she was not surprised Resident #8 slapped the staff because Resident #8 did not like the staff that was slapped.
-Something must have happened to make Resident #8 slap the staff.
-He did not know what the staffs' names were but he was able to describe the staff.
-He got a call from a staff on 05/10/19 at 10:30am about the bruises; no one knew what happened.
-He could not remember which staff had called him on 05/10/19.
-The staff said there had been another incident on 05/09/19 where staff had found a bump and a bruise on Resident #8's hands.
-He got a call from the Regional Clinical Director (RCD) on 05/10/19.
-The RCD said the bruises were different on 05/10/19 from the bruises noted on 05/05/19, and the employee who was responsible was let go.
-He never got the story of what happened on 05/05/19.
-He had spoken with the Administrator on 05/12/19 about the bruises on Resident #8's hands on 05/05/19 and 05/09/19.
-The Administrator reported having to follow a 5 day suspension before terminating the staff.
-The Administrator knew about the bruises on 05/05/19 and did not do anything until 05/10/19.
-This was not the first time Resident #8 had bruises; he had chalked the others up to falls.
-He was now very concerned that incidents with staff being abusive had happened before.

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D914	Continued From page 252 Review of photos received from Resident #8's family member date stamped 05/05/19 at 6:52pm revealed: -There was a half dollar sized oval shaped purple bruise on Resident #8's right hand below the wrist and next to the thumb area. -There was a quarter sized round purple bruise on Resident #8's left hand below the wrist and next to the thumb area. Observations of Resident #8 on 05/10/19 at 1:40pm revealed: -There was a half dollar sized oval shaped purple bruise on the resident's right hand below the wrist and next to the thumb area. -There was a lighter area of purple at the center of the bruise. -There was a large irregularly shaped purple and red bruise on the resident's left hand below the wrist from the thumb to just under the second finger. Review of charting notes dated 05/01/19 through 05/14/19 for Resident #8 revealed there was no documentation related to the bruises or change in status for Resident #8 on 05/01/19 through 05/07/19. Review of a Body Evaluation & Observation sheet dated 05/08/19 at 7:04am for Resident #8 revealed staff documented the resident had a bruise on her right hand. Interview with the RCD on 05/15/19 at 3:23pm revealed: -She could not remember whether staff reported the bruises on Resident #8's hands or if she had seen the bruises first. -After seeing the bruises on 05/10/19, she	D914		

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D914	Continued From page 253	D914		

checked with staff and found out there was an incident at change of shift for 2nd into 3rd shift (11:00pm) on 05/09/19.
-There were two staff who witnessed Resident #8 standing at the special care unit (SCU) front desk.
-Resident #8 had been incontinent of a bowel movement.
-Staff C began pulling Resident #8's pants down at the front desk.
-The two staff told Staff C she could not do that to a resident at the front desk.
-Staff C took Resident #8 to the bathroom and the resident returned with marks on her hands.
-She did not know about bruises or other incidents earlier in the week (05/05/19).

Telephone interview with Resident #8's primary care provider (PCP) on 05/15/19 at 3:28pm revealed:
-He could not say for sure whether or not staff contacted him regarding bruises on Resident #8's hands.
-He had been receiving an increased amount of calls and text messages from staff and the CM since 05/08/19.
-He had last seen Resident #8's on 05/04/19.
-Resident #8 was still dressed in her pajamas; her hair was not particularly clean.
-Staff had reported Resident #8 had been refusing personal care assistance, was aggressive and struck staff.

Interview with a personal care aide (PCA) on 05/16/19 at 5:15pm revealed:
-She worked 2nd shift on 05/05/19.
-Resident #8's family member did not talk to her about bruises on the resident's hands.
-She was with Staff C a couple of times when Staff C was assisting the resident with

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incontinence care.
-Staff C was not "rough" with Resident #8.
-Staff C would get loud when she talked to Resident #8.
-Staff C was only like that with Resident #8.
-She did not say anything to anyone about Staff C.
-She just "took over" in helping Resident #8.

Observations of Resident #8 on 05/16/19 at 5:15pm revealed there were no bruises on her waist and the bruises on her hands were fading to purple and yellow.

Review of a Health Care Personnel Registry (HCPR) 5 Day/Investigation Report dated 05/15/19 for Resident #8 revealed:
-Staff C was accused of taking Resident #8's clothes off at the front desk area on the SCU.
-Staff C lead Resident #8 to her room "roughly" by her hands and yelled loudly at the resident.
-Resident #8 had bruises on both hands on 05/10/19; there was a bruise on the right hand on 05/09/10.
-The RCD spoke with Resident #8's family member (date not documented).
-The family member visited Resident #8 several weeks ago and the resident reported a staff was mean to her; the family member described Staff C.
-Resident #8 was also very agitated the day the family member visited; the family member had never seen the resident like that before.
-Resident #8 was agitated when Staff C was around her and had slapped Staff C in the past.
-Resident #8 was not known to hit anyone before.
-The RCD questioned Staff C and Staff C did not deny the allegations.

Review of a PCA's hand-written witness

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statement for Resident #8 revealed:
-On 05/09/19 at 11:00pm, Staff C stopped at the front desk area in the SCU and started taking off Resident #8's pants.
-Staff C was going to provide incontinence care at the front desk because she did not want to take Resident #8 to her room.
-Another staff told Staff C to take Resident #8 to her room.
-Staff C was heard at the front desk yelling at Resident #8 in the resident room.
-Another staff went to check on Resident #8.

Telephone interview with a third PCA on 05/15/19 at 9:28pm revealed:
-She had witnessed the incident between Staff C and Resident #8 at the front desk on the SCU.
-She did not remember what day the incident occurred between Resident #8 and Staff C; it was either the beginning of the week 05/013/19) or the end of last week (05/10/19).
-Staff C was taking Resident #8 to get changed and took the resident by her hands.
-She did not see Resident #8 get bruised.
-She did not see any bruises on Resident #8's hands before.
-She had seen a bruise on Resident #8's waist; she could not remember which side.
-The bruise was purple and the size of a quarter.
-She could not remember the date she saw the bruise on Resident #8's waist.
-Staff C spoke roughly to residents.
-She had heard Staff C yell at Resident #8, "Stop it. Don't be doing that."
-Resident #8 had hit Staff C more than once.
-Resident #8 never hit anyone before or anyone else.
-Resident #8 was normally sweet and not violent.

Review of a second PCA's hand-written witness

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statement for Resident #8 revealed:
-On 05/09/19, Staff C was at the front desk on the SCU trying to "strip" Resident #8.
-Staff C was going to provide incontinence care at the front desk because she did not want to take Resident #8 to her room.
-She told Staff C to take Resident #8 to her room.
-Staff C was yelling at Resident #8 "so loud" she went to check on the resident.
-Staff C was being rough with Resident #8 so she stayed in the room to make sure Staff C did not hurt Resident #8.

Attempted telephone interview with the second witnessing staff on 05/17/19 at 2:08pm was unsuccessful.

Review of a Body Evaluation & Observation sheet dated 05/10/19 at 7:04am for Resident #8 revealed the CM documented the resident had medium/large dark spots on both hands.

The CM was not available for interview on 05/16/19 and 05/17/19.

Review of a corrective action form for Staff C dated 05/10/19 revealed the staff was suspended until an investigation was completed.

Interview with the ED on 05/17/19 at 3:44pm revealed:
-She did not see Resident #8 on 05/05/19.
-She saw a small bruise on one of Resident #8's hands on Monday or Tuesday (05/06/19 or 05/07/19).
-No one had reported any concerns about how Staff C treated Resident #8 before 05/09/19.

Based on observations, interviews and record reviews, it was determined Resident #8 was not

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D914	Continued From page 257 interviewable. Refer to interview with the Administrator on 05/17/19 at 3:44pm. Interview with the Administrator on 05/17/19 at 3:44pm revealed: -Staff were expected and knew to report any instances of verbal or physical abuse. -Staff were expected to do the "Three Time Approach" which was to walk away from a resident resisting or agitated and try again later three times. -The fourth time staff were to get someone else. The facility failed to protect Resident #8 and Resident #11 from potential physical abuse. The facility's failure resulted in multiple bruises on Resident #11 including a bruise to the chest resembling a fist which demonstrates substantial risk of abuse and serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/17/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 16, 2019. II. Based on observations, interviews and record reviews, the facility failed to provide assistance for the personal care needs 7 of 8 sampled residents (#1, #2, #4, #5, #6, #8 and #15) who were unable to attend to themselves including incontinence care, toileting, bathing and dressing [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)].	D914		

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D914	Continued From page 258 III. Based on interviews, observations, and record reviews, the facility failed to assure supervision was provided to 3 of 11 sampled residents (#1, #14, #16) including two residents who wandered out of the special care unit unsupervised into a service hall and kitchen (#1, #16) and a resident with 29 falls in 6 months resulting in injuries and visits to the emergency room (#14) [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. IV. Based on observations, interviews, and record reviews the facility failed to assure referral and follow up for routine and acute health care needs for 6 of 10 sampled residents (#2, #3, #4, #6, #10, and #17) as evidenced by failing to obtain routine and weekly lab work (#2, #10); report a resident heart rate of 38 to the physician (#6); obtain a pressure release cushion for a resident's wheelchair and a referral to podiatry (#3); obtain a stool culture as ordered due to diarrhea and to follow up with the PCP for a recheck visit after a fall and unsteady gait (#2); report a fall with injury and emergency department visit to the physician (#17); and assure a resident received ordered testing (#4) [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. V. Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5 day requirements for 3 of 3 sampled residents (#8, #11 and #12) sustaining physical abuse and injuries of unknown origin [Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)]. VI. Based on observations, interviews and record	D914		

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D914	Continued From page 259 reviews, the facility failed to assure there was enough staff present on the special care unit and attentive to meet the personal care, supervision and health care needs of the residents for 14 of 27 sampled shifts [Refer to Tag 465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A2 Violation)]. VII. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for supervision, health care, personal care and other staffing, personal care, health care personnel registry reporting, special care unit staffing, residents' rights, medication administration, controlled substances, housekeeping and furnishings, hot water requirements, training on cardio-pulmonary resuscitation, and nutrition and food service [Refer to Tag 980 G.S.131D-25 Implementation (Type A1 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the	D980		

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management, operations, and policies of the facility were implemented and rules were maintained for supervision, health care, personal care and other staffing, personal care, health care personnel registry reporting, special care unit staffing, residents' rights, medication administration, controlled substances, housekeeping and furnishings, hot water requirements, training on cardio-pulmonary resuscitation, and nutrition and food service.

The findings are:

Confidential interview with a family member revealed:
-The quality of care at the facility has dropped down to the floor.
-There had been four Administrators at the facility.
-Each of the Administrators would listen and smile but do nothing.

Confidential interview with a resident revealed "the lady that owned the placed cussed" at residents and residents did not like it.

Confidential interviews with a resident revealed:
-If resident complained about anything the Administrator would "punish" the resident.
-The resident already felt some staff mistreated residents and if they knew that a resident complained about them the staff would treat them even worse.

Confidential interview with a family member revealed:
-The staff were not sensitive to the needs of memory care residents.
-Staff treated residents like animals not people.

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D980	Continued From page 261 Interview with the Administrator on 05/07/19 at 5:15am revealed: -She was the interim Administrator because she was still on her probationary period. -She started as the Administrator in February 2019 and the probationary period was 180 days. -She got her Administrator's certificate in April 2019. -She worked at the facility Monday through Friday from 9:00am until 5:00pm every week. -She shared Manager on Duty responsibilities with the Care Manager (CM), Activity Director (AD), Transportation staff, lead Supervisor and Dietary Manager (DM). -A Manager on Duty was present in the facility for four hours every Saturday and Sunday. -The Regional Clinical Director (RCD) was usually at the facility every one to two weeks. -The Regional Director of Operations (RDO) was at the facility every month. -The Regional Protocol Registered Nurse (RN) was last at the facility on Friday (05/03/19). Interview with the Administrator on 05/17/19 at 3:44pm revealed: -She did interviews with the CM every two weeks on pay day. -She pulled up performance evaluation questions on the computer and went through the questions with the CM. -She was just learning to check resident records and PCP order to assure compliance. -She monitored staff compliance with providing assistance with toileting and bathing four hours at a time on all shifts. -One week she would monitor four hours on the evening shift, the next week four hours on the night shift and on the weekends, she did a walk through at 6:00am or 6:00pm. -She provided oversight and monitoring of staff	D980		

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while working on the floor.
-She usually came in at random times on all three shifts; if staff were found sleeping they were terminated on the spot.
-She monitored staff providing assistance by sitting on the special care unit (SCU) for 20 minutes checking incontinent residents.
-The last time she monitored for incontinence care was one week ago.

1. Based on observations, interviews and record reviews, the facility failed to maintain an environment free of hazards in the special care unit as evidenced by Resident #9's room having a bed bug infestation that was left untreated for 7 days and a broken window in resident room 209 that was not repaired for more than 6 weeks [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].

2. Based on observations, interviews and record reviews, the facility failed to assure hot water temperatures were maintained between 100 - 116-degrees Fahrenheit (F) as evidenced by hot water temperatures lower than 100°F from five fixtures in the special care unit (SCU) [Refer to Tag 113 10A NCAC 13F .0311(d) Other Requirements].

3. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management for 3 of 27 shifts sampled in April 2019 and May 2019 [Refer to Tag 167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation].

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D980	Continued From page 263 4. Based on observations, interviews, and record reviews, the facility failed to assure aide hours met the minimum requirements on 15 of 27 shifts for 9 days sampled in April 2019 and May 2019 resulting in inadequate staff to meet the supervision and personal care needs of residents [Refer to Tag 188 10A NCAC 13F .0604(e) Personal Care and Other Staffing]. 5. Based on record reviews and interviews, the facility failed to respond to incidents immediately and in accordance with the facility's established policy and procedures for 1 of 5 residents sampled (#1) who fell in the facility [Refer to Tag 271 10A NCAC 13F .0901(c) Personal Care and Supervision]. 6. Based on observations, interviews, and record reviews the facility failed to assure orders were implemented for 2 of 10 sampled residents (#4, #6) for a daily postural vital signs (#4); and daily blood pressure and heart rate checks (#6) [Refer to Tag 276 10A NCAC 13F .0902(c) Health Care]. 7. Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 4 residents sampled (#2) with an order for a regular chopped meats diet who coughed during a lunch meal while eating food that was not chopped as ordered [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service]. 8. Based on observations, interviews and record reviews, the facility failed to provide assistance with eating two observed meals in a manner that maintained Resident #21's dignity and respect by staff standing over the resident during each meal [Refer to Tag 312 10A NCAC 13F .0904(f)(2) Nutrition and Food Service].	D980		

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D980	Continued From page 264 9. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policy for 2 of 11 residents (#18, #19) observed during the medication passes including errors with a vitamin D supplement (#18, #19); and for 3 of 10 sampled residents (#3, #2, #4) including errors with a diuretic (#3), medications used to treat low potassium, treat and prevent acid reflux, and treat and prevent stomach ulcers (#2), and a medication to treat chronic obstructive pulmonary disease and asthma (#4) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 10. Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records were accurate for 2 of 5 residents sampled (#2, #4) including inaccurate documentation of a liquid potassium supplement (#2), an inhaler for chronic obstructive pulmonary disease (#4), and an inhaler for shortness of breath and wheezing (#4) [Refer to Tag 367 10A NCAC 13F .1004(j) Medication Administration]. 11. Based on observations, interviews and record reviews, the facility failed to assure there was a readily retrievable record documenting the receipt, administration and disposition of controlled substances including Oxycodone, Oxycontin and alprazolam in the resident's record for accurate reconciliation for 1 of 6 sampled residents (#4) [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)]. 12. Based on observations, record reviews, and interviews, the facility failed to assure residents	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Hal089002	A. BUILDING: _____ B. WING _____	05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

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D980	Continued From page 265 were treated with respect, dignity, consideration, and right to privacy as related to staff leaving doors and window blinds open while providing incontinence and bathing care to residents (#2, #3, #6, #15); speaking and being disrespectful to residents (#4, #14); and failed to provide an acceptable bed at the facility for a resident whose room was infested with bedbugs (#9) [Refer to Tag 911 G.S.131D-21(1) Residents' Rights (Type B Violation)]. 13. Based on observations, interviews and record reviews, the facility failed to assure 2 residents (#8 and #11) were free of physical abuse as evidenced by bruises occurring on Resident #8's hands following incidents between Resident #8 and Staff C where Staff C handled Resident #8 roughly; and bruises inconsistent with fall found on admission to the hospital for Resident #11 [Refer to Tag 914 G.S.131D-21(4) Residents' Rights (Type A2 Violation)]. The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing supervision, health care, personal care and other staffing, personal care, health care personnel registry reporting, special care unit staffing, residents' rights, medication administration, controlled substances, housekeeping and furnishings. The Administrator's failure to implement rules and regulations resulted in serious neglect and physical harm which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/16/19 for this violation.	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D980	Continued From page 266 THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 16, 2019.	D980		