STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT HOPE MILLS	7051 ROCKFISH ROAD FAYETTEVILLE, NC 28306

(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 initial survey and a complaint investigation on June 5-6, 2019 and June 10-12, 2019. The complaint investigation was initiated by the Cumberland County Department of Social Services on March 28, 2019 and May 24, 2019.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record review and interviews, the	D 164		

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facility failed to assure 1 of 4 medication aides sampled (Staff C) received training on the care of diabetic residents prior to preforming fingerstick blood sugars and the administration of insulin.

The findings are:

Review of Staff C's personnel record revealed:
-The date of hire was 03/05/19 as a medication aide (MA).
-There was no documentation of training on the care of a diabetic resident.
-There was no documentation of a medication clinical skills competency validation signed by a Registered Nurse (RN) or Pharmacist.

Review of a resident's June 2019 electronic Medication Administration Record (eMAR) revealed:
-Staff C documented administering insulin at 6:00am on 06/01/19, 06/02/19, 06/03/19, 06/04/19, 06/05/19, 06/06/19, 06/07/19 and 06/11/19.
-Staff C administered between 2 units and 10 units of insulin.

Telephone interview with Staff C on 06/13/19 at 12:34pm revealed:
-She had worked full time in the facility as a MA/nursing assistant (NA)
since 03/05/19.
-She could not recall receiving any diabetic training while employed at the facility.
-She took the medication aide training on 06/13/19.
-Staff C spent the majority of her time at the facility on the medication cart.
-Staff C was unaware of completing a medications skills checklist.
-She had not completed a check list for the facility

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D 164	Continued From page 2 since being hired. Interview with the Executive Director/Administraor on 06/12/19 at 12:30pm revealed: -Staff C was hired as a MA. -Staff C did not have documentation of a completed training on the care of diabetic residents before administering insulin.	D 164		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure the residents' physicians certified their care by signing and dating care plans within 15 days of assessment for 5 of 5 sampled residents (#1, #2, #3, #4, #5). The findings are: 1. Review of Resident #1's current FL-2 dated 01/03/19 revealed: -Diagnoses included hypertension, hypothyroid, osteoarthritis, chronic low back pain, anxiety, depression and insomnia.	D 263		

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D 263	Continued From page 3 -The resident was ambulatory and continent of bowel and bladder. Review of Resident #1's Resident Register revealed an admission date not documented. Interview with the Executive Director/Administrator (ED/Administrator) on 06/07/19 at 10:20am revealed Resident #1 was admitted to the facility on 02/04/19. Review of Resident #1's care plan dated 02/04/19 revealed: -It was not signed by the Primary Care Provider (PCP). -It was not signed by the ED/Administrator. -It was not signed by a Registered Nurse (RN). Review of Resident #1's subsequent care plan dated 03/07/19 revealed: -It was not signed by the Primary Care Provider (PCP). -It was not signed by the ED/Administrator. -It was not signed by a Registered Nurse (RN). Interview with a MA on 06/11/19 at 9:25am revealed Resident #1 did not require assistance with ambulating, toileting, bathing, dressing, grooming and transfers. Interview with a nursing assistant (NA) on 06/11/19 at 8:30am revealed Resident #1 was assisted with showers on shower days. Interview with Resident #1 on 06/05/19 at 1:15pm revealed: -She did not need help with bathing, toileting, dressing or ambulation. -Some staff would come in and help lay out my clothes.	D 263		

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D 263	Continued From page 4 -Staff would help her if she needed the help, but she did not need much help. Observation of Resident #1 on 06/05/19 at 1:15pm revealed Resident #1 was walking down the hallway and in her room without assistance. Refer to interview with the facility's PCP on 06/11/19 at 2:50pm. Refer to interview with the Health Care Coordinator (HCC) on 06/11/19 at 5:20pm. Refer to interview with the ED/Administrator on 06/11/19 at 5:30pm. 2. Review of Resident #2's current FL-2 dated 02/01/19 revealed: -Diagnoses included diabetes mellitus, hypertension, asthma, carpal tunnel syndrome, left ankle and foot acute osteomyelitis, muscle weakness, unsteadiness on feet, and repeated falls. -There was documentation the resident was intermittently disoriented, semi-ambulatory, incontinent of bowel and bladder, and required assistance from staff for dressing, Review of Resident #2's Resident Register revealed: -There was an admission date of 02/08/19. -The resident was forgetful and needed reminders. -The resident required assistance from staff for dressing, bathing, nail care, ambulation, transfers, toileting, and grooming. -There was documentation the resident fell "a lot". Review of Resident #2's care plan dated 02/12/19 revealed:	D 263		

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D 263	Continued From page 5 -It was not signed by the Primary Care Provider (PCP). -The ED/Admnistrator signature was dated 03/22/19. Review of Resident #2's subsequent care plan dated 03/11/19 revealed: -It was not signed by the PCP. -The ED/Administrator's signature was dated 06/05/19. -The Health Care Coordinator's signature was dated 06/05/19. Observation of Resident #2 on 06/12/19 at 9:35am revealed: -She was pushed in a wheelchair to her bathroom. -A Licensed Practical Nurse (LPN) was assisting her while sitting in the wheelchair to remove a hospital gown. -A Medication Aide (MA) removed her shoes. -The LPN and the MA assisted Resident #2 to stand from the wheelchair by holding on to the resident by her upper arms. -The resident held onto bathroom grab bars between the sink and the toilet as she stood. -The staff members removed an incontinent brief from Resident #2. -The staff members assisted Resident #2 to sit in the wheelchair. Interview with the LPN on 06/12/19 at 09:50am revealed: -Resident #2 required assistance with bathing, dressing, transfers, and toileting. -Resident #2 had just returned from the Emergency Department (ED) where she was treated for a fall. -She and the MA were going to bathe Resident #2 and wash her hair.	D 263		

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D 263	Continued From page 6 Interview with a MA on 06/11/19 at 9:56am revealed Resident #2 required assistance with toileting, dressing, bathing, and transfers. Interview with Resident #2 on 06/12/19 at 9:30am revealed she required assistance from staff with transfers, toileting, and dressing. Confidential interview with a concerned citizen revealed: -Resident #2 had very poor safety awareness. -Resident #2 required assistance with transfers, and dressing. Interview with Resident #2's current Primary Care Provider (PCP) on 06/11/19 at 4:39 pm revealed: -Resident #2 had a diagnosis of dementia. -Resident #2 required staff assistance with transfers, dressing, bathing, and toileting. Refer to the interview with the facility's PCP on 06/11/19 at 2:50pm. Refer to the interview with the Health Care Coordinator (HCC) on 06/11/19 at 5:20pm. Refer to the interview with the ED/Administrator on 06/11/19 at 5:30pm. 3. Review of Resident #3's current FL-2 dated 04/10/19 revealed: -Diagnoses included diabetes mellitus type I, dementia, anxiety, coronary artery disease, hypothyroidism, insomnia, chronic pain and gait abnormality. -The resident was constantly disoriented, ambulatory, continent of bowel and bladder. Review of Resident #3's Resident Register	D 263		

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revealed an admission date of 02/12/19.

Review of Resident #3's care plan dated 02/12/19 revealed:
-It was not signed by the Primary Care Provider (PCP).
-The ED/Administrator's signature was dated 03/03/19.
-A Registered Nurse's (RN) signature was dated 03/03/19.
-The resident required assistance with ambulating, bathing, dressing, grooming and transfer.

Interview with a medication aide (MA) on 06/05/19 at 1:00pm revealed:
-Resident #3 required assistance with ambulating, bathing, dressing, grooming and transfers.
-Resident #3 required "constant care" because of her uncontrolled blood sugars and her numerous falls.

Interview with Resident #3's family member on 06/07/19 at 11:00am revealed:
-Resident #3 fell a lot before she was admitted in February 2019 and has had several falls since.
-Resident #3 required assistance with ambulation.
-Resident #3 required close monitoring of her blood sugar levels.
-Resident #3 required monitoring of her food intake since that was a major reason her blood sugar levels were unstable.

Observation of Resident #3 on 06/05/19 at 11:30am revealed:
-She was propelling herself in a wheelchair down the hall next to the medication cart.
-She was taking things off the top of the

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medication cart.
-A Licensed Practical Nurse (LPN) was redirecting Resident #3 down the hall.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.

Interview with Resident #3's PCP on 06/11/19 at 2:50pm revealed:
-She had cared for Resident #3 since 02/20/19.
-Resident #3 was constantly disoriented and required staff assistance for transfers, dressing, bathing, and ambulating.
-Resident #3's blood sugars were unstable, and she needed to be closely monitored for her food intake.

Refer to the interview with the facility's PCP on 06/11/19 at 2:50pm.

Refer to the interview with the Health Care Coordinator (HCC) on 06/11/19 at 5:20pm.

Refer to the interview with the ED/Administrator on 06/11/19 at 5:30pm.

4. Review of Resident #4's current FL-2 dated 03/06/19 revealed:
-Diagnoses included congestive heart failure, hypertension, hyperlipidemia, dementia due to Alzheimer's disease, aneurysm, anemia, urinary incontinence, and peripheral neuropathy.
-The resident was intermittently disoriented, semi-ambulatory, continent of bowel and incontinent of bladder.

Review of Resident #4's Resident Register revealed an admission date of 02/28/19.

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Review of Resident #4's care plan dated 03/05/19 revealed:
-It was not signed by the Primary Care Provider (PCP).
-It was not signed by the ED/Administrator.
-It was not signed by a Registered Nurse's (RN).
-The resident required assistance with ambulating, toileting, bathing, dressing, grooming and transfer.

Review of Resident #4's subsequent care plan dated 03/29/19 revealed:
-It was not signed by the Primary Care Provider (PCP).
-It was not signed by the ED/Administrator.
-It was not signed by a Registered Nurse's (RN).
-The resident required assistance with ambulating, toileting, bathing, dressing, grooming and transfer.

Interview with Resident #4 on 06/05/19 revealed:
-She required assistance with bathing.
-Resident needed assistance with washing her back in particularly.

Interview with Resident #4 on 06/07/19 at 2:13pm revealed:
-She needed assistance with ambulation and used a wheelchair.
-She needed assistance with getting into the bed.

Observation of Resident #4 on 06/05/19 at 5:12pm revealed she was sitting in dining area with other residents in her wheelchair.

Interview with Resident #4's family member on 06/11/19 at 2:56pm revealed:
-Staff were expected to bathe resident on Monday, Wednesday, and Friday.
-Staff were to assist her to the dining area during

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meal times by pushing her in the wheelchair.

Refer to the interview with the facility's PCP on 06/11/19 at 2:50pm.

Refer to the interview with the Health Care Coordinator (HCC) on 06/11/19 at 5:20pm.

Refer to the interview with the ED/Administrator on 06/11/19 at 5:30pm.

5. Review of Resident #5's current FL-2 dated 02/07/19 revealed:
-Diagnoses included diabetes mellitus, cognitive disorder, depression, bipolar, delusional disorder and abnormal gait.
-The resident was intermittently disoriented, semi-ambulatory, continent of bowel and bladder.

Review of Resident #5's Resident Register revealed an admission date of 02/28/19.

Review of Resident #5's care plan dated 04/22/19 revealed:
-It was not signed by the Primary Care Provider (PCP).
-The ED/Administrator's signature was dated 04/16/19.
-A Registered Nurse's (RN) signature was dated 04/22/19.
-The resident required assistance with ambulating, toileting, bathing, dressing, grooming and transfer.

Interview with a MA on 06/05/19 at 1:00pm revealed:
-Resident #5 required assistance with ambulating, toileting, bathing, dressing, grooming and transfers.
-Resident #5 needed to be monitored closely

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because her blood sugars had been higher than normal.
-Resident #5 had a private sitter that was with her most of the day, every day.

Observation of Resident #5 on 06/12/19 at 9:00am revealed she was sitting outside in her wheelchair with a private sitter next to her.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

Attempted phone interview with Resident #5's family member on 06/12/19 at 4:00pm was unsuccessful.

Refer to interview with the facility's PCP on 06/11/19 at 2:50pm.

Refer to interview with the Health Care Coordinator (HCC) on 06/11/19 at 5:20pm.

Refer to interview with the ED/Administrator on 06/11/19 at 5:30pm.

_____

Interview with the facility's PCP on 06/11/19 at 2:50pm revealed:
-She was aware that resident care plans were required to be signed by the PCP within 15 days of assessment.
-She had not signed any care plans for the residents in the facility.
-She had not been asked by any staff to sign any care plans for the residents in the facility.
-She thought that because it was a new facility that the time frame requirements for signature may had been different.

Interview with the HCC on 06/11/19 at 5:20 pm

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D 263	Continued From page 12 revealed: -He was a Registered Nurse (RN) hired at the facility on 04/30/19 as the HCC. -It was his responsibility to ensure each resident had a current care plan. -He did not know the care plans required a physician's signature. -He knew care plans were required within thirty days of admission, annually, and with significant changes. -He would get all care plans signed by the PCP immediately. Interview with the ED/Administrator on 06/11/19 at 5:30pm revealed: -He was not aware that the resident care plans were not signed by a physician. -The HCC was an RN and is responsible for ensuring each resident had a current care plan. -He would discuss the status of the care plans with the HCC to ensure all are up-to-date with a physician's signature.	D 263		
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 B VIOLATION

Based on observation, interviews, and record review, the facility failed to provide personal care assistance to 1 of 5 residents (#2) sampled related to incontinent care.

The findings are:

Review of Resident #2's current FL-2 dated 02/01/19 revealed:
-Diagnoses included diabetes mellitus, hypertension, asthma, carpal tunnel syndrome, left ankle and foot acute osteomyelitis, muscle weakness, unsteadiness on feet, and repeated falls.
-The resident was documented as intermittently disoriented, semi-ambulatory, and incontinent of bowel and bladder.
-She required personal care assistance for dressing.
-There was no documented level of assistance required for dressing.

Review of Resident #2's Resident Register revealed there was an admission date of 02/08/19.

Review of Resident #2's current care plan dated 03/11/19 revealed:
-There was documentation the resident required physical assistance of two staff members for ambulating.
-There was documentation the resident was totally dependent of two staff members for all grooming and personal care needs.
-There was documentation the resident was

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totally dependent of two staff members for dressing and undressing.
-There was documentation the resident required physical assistance of one staff member for toileting.
-There was documentation the resident was chair-bound.
-There was documentation the resident was not incontinent of bowel and bladder.
-There was documentation the resident was a high fall risk and needed reminders to ask for help.

Review of Resident #2's task log for 06/01/19 - 06/10/19 revealed:
-There was an action titled Level of Assistance-toileting: Extensive.
-There was a schedule of 3 time(s) per day, every day.
-There was documentation toileting had been provided once on day shift, once on evening shift, and once on night shift.

Review of Resident #2's task log for May 2019 revealed:
-There was an action titled Level of Assistance-toileting: Extensive.
-There was a schedule of 3 time(s) per day, every day.
-There was no documentation toileting had been provided from 05/01/19 - 05/09/19.
-There was documentation toileting had been provided from 05/10/19 - 05/31/19 once on day shift, once on evening shift, and once on night shift.

Review of Resident #2's task log for April 2019 revealed toileting was not listed as a task.

Observation of the outside of the hallway outside

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D 269	Continued From page 15 Resident #2's room on 06/11/19 at 8:00 am revealed there was a strong ammonia smell. Observation of Resident #2's room on 06/11/19 at 8:04 am revealed: -The room smelled strongly of ammonia and urine. -Resident #2's top covers, top sheet, fitted sheet, and cloth chucks were saturated. -There was a Licensed Practical Nurse (LPN) supervisor in the room. -Resident #2 was in the bathroom. Observation of Resident #2 on 06/12/19 at 9:35 am revealed: -A LPN supervisor and a Medication Aide (MA) were preparing to assist the resident with bathing. -There was no skin breakdown on Resident #2's buttocks. Interview with a Licensed Practical Nurse (LPN) Supervisor on 06/11/19 at 8:30 am revealed: -She was responsible for oversight of the Personal Care Aides (PCA) and Medication Aides (MA). -Incontinent checks were performed on residents every two hours. -They documented incontinent checks in a log book. -She did not know where the incontinent log was, but she would find it. Interview with the HCC on 06/11/19 at 9:20 am revealed: -He did not know how often incontinent checks were performed. -He did not know if the facility had an incontinent policy. -The incontinent checks would be documented in the resident progress notes.	D 269		

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D 269	Continued From page 16 A second interview with a LPN Supervisor on 06/11/19 at 9:30 am revealed: -The facility policy for incontinent checks was to be performed "frequently". -The definition of frequently varied per person and was too broad of a term. -Some residents did not want to be "bothered at night" and that would be documented in the care plans. -She had not worked nights in the Secured Assisted Living unit and did not know if Resident #2 did not want to be bothered at night. -She "encouraged" the MA's and PCA's to check on residents every two hours because frequently could vary per person. -Third shift would normally change and get Resident #2 up before leaving at 7:00 am. -There was a "strong smell of urine" when she walked by Resident #2's room as she came on shift this morning (06/11/19). -Resident #2 had "overslept" and had urinated herself. -Resident #2 was a "heavy wetter" and would saturate her brief with urine if she did not get to the bathroom in time. -She did not receive a report on Resident #2 with shift change. -It was important for residents to be dry from urine because incontinence would cause burning, skin breakdown, and odor. Interview with a MA on 06/11/19 at 9:35 am revealed: -They were to perform incontinent checks "frequently". -There was not an incontinent log to document when incontinent checks were performed. -Everyone working first shift "did their job and knows to check for incontinence".	D 269		

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D 269	Continued From page 17 -Incontinent checks were performed after breakfast, before lunch, and "a little" after lunch. Interview with a PCA on 06/11/19 at 9:40 am revealed: -Incontinent checks were performed every two hours. -There was no where to document incontinent checks. -Oncoming staff would be informed of incontinent checks at shift change when walking rounds were made. Interview with a second MA on 06/11/19 at 9:50 am revealed: -Resident #2 was a heavy care resident. -Resident #2 required assistance with transfers, getting out of bed, dressing, bathing, and toileting. -Third shift was supposed to perform incontinent care and get Resident #2 dressed and out of bed before shift change because she required a lot of assistance. A second interview with the HCC on 06/11/19 at 12:00 pm revealed: -There was no specific time requirement for incontinent checks. -He expected "more frequent rounds" and was unable to explain "more frequent rounds". -Incontinent checks were documented on the resident's task logs. Interview with a resident on 06/12/19 at 9:10 am revealed: -Staff would perform incontinent care on Resident #2 between 6:00 am - 6:30 am every day and push her in her wheelchair to the common area of the secured assisted living unit -Resident #2 stayed in the wheelchair located in the common area of the secured assisted living	D 269		

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unit until after lunch.
-When staff would take Resident #2 back to her room after lunch, her pants would be saturated with urine and incontinent of bowel.
-After Resident #2 received incontinent care after lunch staff would push Resident #2 in her wheelchair back to the common area of the secured assisted living unit until "a little before" 8:00 pm when they would put the resident to bed.
-Resident #2 smelled of urine "almost continuously".
-Staff did not check on Resident #2 during the night.

Interview with Resident #2 on 06/12/19 at 10:00 am revealed:
-Staff would help her out of bed early in the morning and put her in the wheelchair in the common area of the secured assisted living unit.
-She would sit in the wheelchair all day.
-Staff did not perform incontinent checks on her when she was sitting in her wheelchair.
-She needed help going to the bathroom but would not ask for help because she wanted to be independent.
-She sometimes knew she had to go to the bathroom and others she did not.
-If she did ask for help she would sometimes have to wait about five minutes for staff to help her.

Interview with the Executive Director/Administrator on 06/12/19 at 6:20 pm revealed:
-Incontinent checks were to be performed "frequently" and that was his expectation.
-There was no set time frame for "frequent" incontinent checks.
-Incontinent checks varied per resident.
-He expected incontinent care to be performed on

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D 269	Continued From page 19 Resident #2 "frequently". Interview with the Vice President of Clinical Services on 06/12/19 at 6:35 pm revealed incontinent checks were performed per resident's care plans. The facility failed to assure Resident #2, who was a diabetic, received personal care assistance with incontinent care which resulted in the resident wearing a saturated brief while sitting in a wheelchair and laying on a wet bed saturated with urine on wet urine-soaked sheets. The facility's failure placed Resident #2 at risk for skin breakdown which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/12/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 27, 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.	D 270		

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) resulting in the resident having multiple falls and sustaining injuries including multiple bruising over her entire body, a fracture to the right eye socket with optic nerve damage, and a laceration to the back of her head requiring sutures.

The findings are:

Review of Resident #2's current FL-2 dated 02/01/19 revealed:
-Diagnoses included diabetes mellitus, hypertension, asthma, carpal tunnel syndrome, left ankle and foot acute osteomyelitis, muscle weakness, unsteadiness on feet, and repeated falls.
-The resident was documented as intermittently disoriented, semi-ambulatory, and incontinent of bowel and bladder.
-She required personal care assistance for dressing.
-There was no documented level of assistance required for dressing.

Review of Resident #2's Resident Register revealed there was an admission date of 02/08/19.

Review of Resident #2's current care plan dated 03/11/19 revealed:
-There was documentation the resident had moderate orientation impairment.

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D 270	Continued From page 21 -There was documentation the resident required supervision and oversight for safety. -There was documentation the resident needed protection and supervision because of unsafe or inappropriate decisions. -There was no documentation of the unsafe or inappropriate decisions made by the resident. -There was documentation the resident required physical assistance of two staff members for ambulating. -There was documentation the resident was totally dependent of two staff members for all grooming and personal care needs. -There was documentation the resident was totally dependent of two staff members for dressing and undressing. -There was documentation the resident required physical assistance of one staff member for toileting. -There was documentation the resident was chair-bound. -There was documentation the resident was a high fall risk and needed reminders to ask for help. -There was documentation the resident had three or more falls in the last 90 days. -Resident #2 scored a "fall potential total" of "16". -A score of "10 - 26 resident is a high potential for falls". Review of Resident #2's care plan dated 02/12/19 revealed: -There was documentation the resident had moderate orientation impairment. -There was documentation the resident required physical assistance of two staff members for ambulating. -There was documentation the resident was totally dependent of two staff members for all grooming and personal care needs.	D 270		

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D 270	Continued From page 22 -There was documentation the resident was totally dependent of two staff members for dressing and undressing. -There was documentation the resident required physical assistance of one staff member for toileting. -Resident #2 scored a "fall potential total" of "13". -A score of "10 - 26 resident is a high potential for falls". Review of Resident #2's progress notes, incident reports, and hospital records dated from 02/12/19 - 06/11/19 revealed: -Resident #2 fell, was found on the floor, and/or had injuries on 17 different occasions. -Resident #2 had 15 of 17 falls that were not witnessed. -Resident #2 had 14 of 17 falls that were in her bedroom/bathroom area. -Resident #2 had 3 of 17 falls in the common area of the secured assisted living unit. -Resident #2 had 1 of 3 falls in the common area of the secured assisted living unit that was not witnessed. -Resident #2 was sent to the emergency department 5 of 17 falls. -Resident #2's Primary Care Provider (PCP) was notified 7 of 17 falls. Review of Resident #2's incident reports for February 2019 revealed: -Resident #2 had 10 falls from 02/12/19 - 02/21/19. -There were falls on 02/12/19, 02/14/19, 02/15/19, 02/17/19, 02/22/19, 02/23/19, 02/26/19, and 02/29/19. -There were 2 falls documented for 02/14/19. -On 02/14/19 one fall did not have a time documented. -On 02/14/19 one fall occurred at 5:15 am.	D 270		

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-There were 2 falls documented for 02/22/19.
-On 02/22/19 one fall occurred at 1:25 am.
-On 02/22/19 one fall occurred at 6:55 pm.
-Resident #2 had 9 of 10 falls that were not witnessed.
-Resident #2 was sent to the emergency department 2 of 10 falls.
-Resident #2's PCP was notified 5 of 10 falls.
-The 02/12/19, 02/23/19, and 02/26/19 incident reports included documentation staff monitored Resident #2 every 15 minutes
-The 02/14/19 at 5:15 am and 2/22/19 at 6:55 pm incident reports included documentation the resident was currently receiving Physical Therapy (PT).

Review of Resident #2's Home Health Therapy notes revealed:
-Resident #2 began PT 02/14/19.
-Resident #2 began Occupational Therapy (OT) 02/21/19.

Based on interviews and record reviews there was no documentation of fifteen and/or thirty-minute checks for Resident #2.

Based on interviews and record reviews there was no documentation of increased supervision for Resident #2.

Review of Resident #2's incident reports for March 2019 revealed:
-There were falls documented for 03/22/19 and 03/28/19.
-The 03/22/19 fall was not witnessed.
-Resident #2 was sent to the emergency department for the 03/22/19 fall.
-Resident #2's PCP was notified of the 03/22/19 fall.
-The 03/22/19 incident report included

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D 270	Continued From page 24 documentation the resident was currently receiving PT and OT. Based on interviews and record reviews there was no documentation of fifteen and/or thirty-minute checks for Resident #2. Based on interviews and record reviews there was no documentation of increased supervision for Resident #2. Review of Resident #2's incident reports for April 2019 revealed: -There were falls documented on 04/06/19, 04/13/19, and 04/16/19. -The 04/06/19 incident report had documentation there was an intervention in place. -There was no documentation of what the 04/06/19 intervention was. -The 04/12/19 incident report had documentation that interventions were "n/a". -The 04/16/19 incident report had an intervention in place documented as "informed to alert staff when help was needed". -Resident #2 had 3 of 3 falls that were not witnessed. -There was no documentation Resident #2's PCP was notified for any of the falls. -There was no documentation Resident #2 was sent to the emergency department. Review of Resident #2's Home Health Therapy notes revealed -Resident #2 was discharged from OT on 04/09/19. -Resident #2 began OT on 05/30/19. Based on interviews and record reviews there was no documentation of fifteen and/or thirty-minute checks for Resident #2.	D 270		

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D 270	Continued From page 25 Based on interviews and record reviews there was no documentation of increased supervision for Resident #2. Review of Resident #2's incident reports for June revealed: -There were unwitnessed falls documented on 06/02/19 and 06/11/19. -The 06/02/19 fall had an intervention documented of booties on the resident's feet. -The 06/11/19 fall had an intervention documented of a locked wheelchair. -Both falls resulted in head injuries. -There was no documentation Resident #2's PCP was notified of the 06/02/19 fall. -There was no documentation Resident #2 was sent to the emergency department for the 06/02/19 or 06/11/19 falls. Based on interviews and record reviews there was no documentation of fifteen and/or thirty-minute checks for Resident #2. Based on interviews and record reviews there was no documentation of increased supervision for Resident #2. Review of an incident report dated 04/16/19 at 1:15 am revealed: -"Resident was trying to get her remote out of her drawer and fell on the floor." -"CNA walk into her room and see her sitting upright on the floor. No injury". -No medical treatment was provided. -The resident was assisted to bed. -The resident was informed to call staff for help if needed. Review of a hospital emergency department note	D 270		

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dated 04/16/19 for Resident #2 revealed:
-She was transported to the emergency department by Emergency Medical Services (EMS) at 6:56 am for a fall.
-She fell while trying to get out of bed.
-She had swelling around her eye. Which eye was not documented.
-There was bruising and swelling to her right cheek.
-She had dried blood in her nares.
-She was diagnosed with a right eye socket fracture, and contusions to the face, neck and scalp.
-She was to follow up with an ophthalmologist in one week.

Review of Resident #2's progress notes dated 04/16/19 revealed:
-Resident #2 returned from the hospital.
-Resident #2 had swelling and bruising on the right side of her face from a fall.
-There was no documentation regarding a fall for Resident #2.

Review of Resident #2's ophthalmologist visit note dated 04/23/19 revealed:
-She was seen for a right eye socket fracture sustained when she " ...fell and hit her face while walking down a hallway".
-She had right optic nerve "infarcts that appear to be related to trauma".
-She had "edema and bruising related to injury".
-"Patient advised to be cautious."
-She was to return in six weeks for re-evaluation.

Review of an incident report for Resident #2 dated 06/02/19 revealed:
-Resident #2 was " ...sleeping and found herself on the floor".
-Resident #2 had a " ...huge bump on the back of

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her head ...small amount of bleeding from her mouth".
-Resident #2 had a cut to her head.
-There was no documentation Resident #2 was transported to the emergency department.
-There was no documentation Resident #2's PCP was notified of the fall with injury.

Review of Resident #2's emergency department after visit summary report dated 06/02/19 revealed:
-Resident #2 was diagnosed with a head injury after a fall.
- "Avoid activities that could potentially result in another head injury until all your symptoms from this head injury are completely resolved for at least 2- 3 weeks."

Observation of Resident #2 on 06/05/19 at 12:05 pm revealed:
-She was in a wheelchair at the dining room table with other residents.
-She had dark plum purple colored discoloration to her left cheek extending under her chin.
-She had dark plum to purple colored discoloration to the back of her head to her neck.
-She had dark plum to purple colored discoloration to her left neck.

Interview with the Executive Director (ED) /Administrator on 06/07/19 at 9:40 am revealed:
-The facility had an "at risk" meeting every Wednesday that included all disciplines.
-The at-risk meeting was a resident-based meeting during which resident concerns were discussed.
-The "top 5" residents were selected who were at risk for a higher level of care, hospice, or any other concerns.
-The team would plan the next steps and/or

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interventions to resolve or address concerns about the residents.
-The "top 5" residents would be discussed at the following weekly at-risk meeting and the process would be repeated.

A second interview with the ED/Administrator on 06/10/19 from 11:50 am - 12:00 pm revealed:
-Resident #2 had not had any falls from 04/16/19 - 06/02/19.
-PT was an intervention put in place for Resident #2 because of her falls.

Based on interviews and record reviews there was no documentation of fifteen and/or thirty-minute checks for Resident #2.

Based on interviews and record reviews there was no documentation of increased supervision for Resident #2.

Review of an incident report dated 06/11/19 and timed for 7:45 pm for Resident #2 revealed:
-Resident #2 was seen laying on the floor through her bedroom window from the courtyard by a staff member at 7:45 pm.
-Resident #2 had a "cut" to her "head/neck".
-Pressure was applied to the wound.
-Resident #2 was attempting to "clean her closet".
-Resident #2's "wheelchair was locked".
-Resident #2 was last seen at 7:35pm during incontinent rounds.

Observation of Resident #2 on 06/11/19 at 9:25 am revealed:
-She had bruising to the back of her head that extended around to her left neck that was dark plum purple in color.
-There was bruising that was dark purple to grey in color to her left cheek closest to her mouth that

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radiated under her left chin.
-The bruise was approximately 4 inches by 2.5 inches.

Review of Resident #2's hospital emergency department "procedure note" dated 06/11/19 revealed:
-Resident #2 " ...got out of her wheelchair earlier today to remove something from her closet and she fell and hit her head on the bed post".
-She had moderate constant soreness that worsened with palpation and nothing made the pain better.
-She had a hematoma to the back of her scalp and dried blood.
-She had a laceration to the back of her scalp that was three centimeters long by five millimeters deep.
-She had four sutures to the wound.
-She was oriented to person, place, and time.
-She had bruising to her left lower jaw.
-She reported the bruising was from a fall she had " ...weeks" ago.
-" ...she had multiple falls in the past".

Observation of Resident #2 on 06/12/19 at 9:35 am revealed:
-She was in her bathroom and two staff were preparing to bathe her.
-She had dried blood on the lower back of her head.
-She had bruising to the back of her head that extended from the middle of her head to the upper part of her neck that was approximately 7 inches by 4 inches in diameter and dark plum purple in color that faded towards the top of her neck.
-She had bruising from the back of her neck that radiated to the left middle and lower neck that was dark plum purple in color.

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D 270	Continued From page 30 -There were two individual bruises to her left neck that radiated from the back of her head. -The left lower neck bruise was approximately 8.5 inches by 1 inch. -The left upper neck bruise was approximately 8 inches by 1 inch. -There was bruising that was dark purple to grey in color to her left cheek closest to her mouth that radiated under her left chin. -The bruise was approximately 4 inches by 2.5 inches. -There was a bruise light purple in color quarter size to her lower mid back, and upper lower back just above her buttocks. -There were various sized small bruises to the back of her left lower rib area. -There was a bruise dark purple to grey in color fading around the edges approximately 3 inches in diameter to her left side above her pelvic bone. -There were at least 6 small bruises of various sizes that were light purple to greyish blue to her left side below her breast. -She had at least 6 bruises of various sizes that were yellow to dark plum and bluish grey in color to the outside of her left shoulder. -One of the bruises was dark plum purple and 2.5 inches in diameter. -She had a bruise to the top of her left shoulder between the shoulder and the neck that was dark purple in color and 1.5 inches in diameter. Observation of Resident #2 on 06/12/19 at 4:50 pm revealed: -She was sitting at the dining room table alone. -Her eyes were closed, head tilted forward with her chin towards her chest, and both arms outstretched on her legs. -Supper had not been served. Interview with Resident #2 on 06/12/19 at 9:30	D 270		

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am revealed:
-It was hard for her to get on her bed because it was too high.
-She got out of the wheelchair by herself last night (06/11/19).
-She hit her head while crawling on the floor to " ...get a pile of stuff ..." to put in her closet.
-She was trying to "rearrange this mess" so she could find "something".
-She could not remember what she was trying to find.

Interview with a Medication Aide (MA) on 06/12/19 at 8:30 am revealed:
-Resident #2 fell 06/11/19 around 7:50 pm.
-A staff member saw Resident #2 on the floor of her room through her room window from the outside courtyard.
-The staff member who saw Resident #2 through the window called her on the radio to go to Resident #2's room.
-When she arrived at Resident #2's room the resident was laying on the floor between the head of her bed and her closet.
-Resident #2's head was by the night stand behind the foot of her bed and her feet were towards the entrance to the room.
-There was blood on the knob of the night stand drawer and on the floor at Resident #2's head.
-Resident #2 was bleeding from the back of her head.
-Resident #2 said she was trying to organize her closet and was going to put on her pajamas.
-Resident #2's wheelchair was positioned at her feet.
-She applied pressure to the wound until the ambulance arrived.

Interview with a Licensed Practical Nurse (LPN) Supervisor on 06/05/19 revealed:

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D 270	Continued From page 32 -Resident #2 had "frequent" falls. -She thought Resident #2 fell 06/01/19. -Resident #2 had been on fifteen, and thirty-minute checks because of the falls. -She did not know when Resident #2 had been on fifteen- and thirty-minute checks. -Staff would get Resident #2 out of bed early in the mornings and assist her back to bed later in the evenings because she had falls in her room. Interview with Resident #2's family member on 06/11/19 at 11:00 am revealed: -Staff kept Resident #2 in her wheelchair in the common area of the secured assisted living unit because she fell when she was in her room. -Staff would not allow Resident #2 to go to bed during the day because of the falls in her room and because they could not monitor her in her room. A third interview with the ED/Administrator on 06/11/19 at 2:30 pm revealed: -Resident #2 was not alert or "cognitively aware". -Resident #2 did not have "safety awareness". -Resident #2 had falls because she tried to go to the bathroom independently without asking for help. -Physical Therapy was working with Resident #2. A second interview with a LPN supervisor on 06/11/19 at 3:20 pm revealed: -Resident #2 was originally on the Assisted Living (AL) side. -Resident #2 was moved to the SAL Unit because of falls. -She did not know when she was transferred to the SAL unit. -Resident #2 was "cognitively unaware" and "confused".	D 270		

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D 270	Continued From page 33 Interview with Resident #2's current PCP on 06/11/19 at 4:39 pm revealed: -Resident #2 needed assistance getting out of bed and with her Activities of Daily Living (ADL). -PT was currently treating Resident #2 because of falls. -She thought Resident #2 was on every fifteen, and thirty-minute checks. -Staff tried to "encourage" the resident to get out of bed and stay in the common area so they could monitor her better to prevent falls. Confidential staff interview revealed: -Resident #2 had a history of a falls and tried to get out of bed by herself. -The interviewee would monitor Resident #2 every 45 minutes - 1 hour when Resident #2 was in bed and she was working. -The interviewee did not document when checks were made on Resident #2. -Resident #2 tried to go from the wheelchair to the bathroom alone and would fall. -Resident #2 was a fall risk when in her bed. -Third shift would get Resident #2 up early in the morning and put her in the wheelchair at the nurse's desk. -Resident #2 would stay in the wheelchair in the common area during the day so she could be monitored. -Second shift would put Resident #2 to bed at night. -Residents who fell were supposed to have been monitored every fifteen to thirty minutes with vital signs for 72 hours after the fall. A third interview with a LPN Supervisor on 06/12/19 at 8:55 am revealed: -Resident #2 was a falls risk. -Third shift would get Resident #2 out of bed before first shift started.	D 270		

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D 270	Continued From page 34 -Resident #2 would sit in her wheelchair all day at the nurse's desk or common area of the unit so she could be monitored because she was a fall risk to go back to bed. -Second shift would put Resident #2 back to bed after she had supper. -Resident #2 was checked on throughout the day. -She did not know if anyone had evaluated the bed height for Resident #2 after changing her mattress and box springs on 06/12/19. -She thought a higher mattress and box springs would be an increased fall risk for Resident #2. -She did not know Resident #2's bed had been rearranged on 06/12/19. -She did not feel rearranging Resident #2's bed was a problem for the resident. -Resident #2's bed had been moved against the wall in the past because she would fall off the bed. Confidential interview with a concerned citizen revealed: -Staff did not check on Resident #2 at night because she had a roommate. -Resident #2's roommate was supposed to call staff during the night if Resident #2 needed anything. -Resident #2's roommate has had to call staff in the past because of Resident #2 falling from the bed and at times could not get staff assistance. -When Resident #2's roommate could not get staff assistance for Resident #2 she would have to find staff to help. A second interview with Resident #2 on 06/12/19 at 10:00 am revealed: -Staff would help her out of bed early in the morning and put her in the wheelchair in the common area of the secured assisted living unit. -She would sit in the wheelchair all day.	D 270		

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D 270	Continued From page 35 -She needed help going to the bathroom but would not ask for help because she wanted to be independent. -She sometimes knew she had to go to the bathroom and others she did not. -If she did ask for help she would sometimes have to wait about five minutes for staff to help her. Confidential interview with another concerned citizen revealed: -Resident #2 had decreased cognitive and safety awareness. -Resident #2 needed a hospital bed to help decrease her falls from the bed and assist with transfers. -A prescription for a hospital bed was given to staff in March 2019 for Resident #2. -Resident #2 still did not have a hospital bed. -Recommendations for the hospital bed, a fall mat, rails for transfers, and every fifteen-minute checks had been discussed with the MA's, LPN Supervisor, and the ED/Administrator. -The recommendations had been made every week during the resident at risk meetings. -It was not known why Resident #2 did not have the interventions in place that were recommended. -Staff were not as aggressive in interventions for Resident #2 as they should have been. -Staff could not provide Resident #2 with the appropriate care she needed to be safe because of the resident's decreased cognitive awareness. -Moving Resident #2's bed could have caused increased confusion for the resident because she had dementia and already had decreased cognitive and safety awareness. Telephone interview with a family member on 06/12/19 at 12:10 pm revealed:	D 270		

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D 270	Continued From page 36 -Resident #2 had difficulty with her balance. -Resident #2 had never fallen as much before she moved into the facility. -She was never aware of Resident #2 falling and sustaining a fracture to her right eye socket. -The facility would call and tell her Resident #2 had fallen and say things were "minor". -She did not know Resident #2 had fallen last night (06/11/19). -Resident #2 was at the facility because the family member could not care for her at home. -She did not know of any interventions the facility had put in place for Resident #2 to prevent her falls. -Resident #2 had dementia and could not function with everyday life. Telephone interview with Resident #2's previous PCP on 06/12/19 at 1:55 pm revealed: -She sent a prescription to the facility on 02/26/19 for a hospital bed for Resident #2. The fax transmission confirmed it was received. -Resident #2 needed to be checked on throughout the night after her falls be certain she did develop a subdural hemorrhage (bleeding in the brain). -Resident #2 needed 'constant supervision" because of her falls. -If a hospital bed was unavailable for Resident #2, the resident would benefit from a fall alert on her bed, or a fall mat. -She had discussed concerns with Resident #2's family member about her falls. -She had told Resident #2's family member to be certain the facility was taking care of the resident. -She had ordered the hospital bed as a safety measure for transfers for Resident #2. -The facility had informed her of 03/22/19, 03/06/19, and a fall in 02/2019. She had not been informed of any other falls.	D 270		

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D 270	Continued From page 37 A second telephone interview with Resident #2's current PCP on 06/12/19 at 4:45 pm revealed: -Resident #2 was at risk for cervical spine fractures and bleeding in the brain from repeated falls. -Injuries Resident #2 could sustain from a fall depended on the type of fall and how she landed because every fall was different. -Resident #2 needed to be monitored daily with falls because for her increased risk for bleeding on the brain. The facility failed to provide supervision to 1 of 5 sampled residents (#2) in accordance with the resident's assessed needs by failing to implement safety interventions for Resident #2 who was known to have decreased safety and cognitive awareness and to be non-compliant in asking for assistance when going to the bathroom, resulting in the resident being found on the floor and/or having multiple unwitnessed falls from her bed and wheelchair to include 17 falls from 02/12/19 - 06/12/19, one fall resulting in a right eye socket fracture and optic nerve damage, one fall requiring sutures to the head, and one fall resulting in a hematoma. The facility's failure resulted in serious injury and neglect to Resident #2 and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/10/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 12, 2019.	D 270		

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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: Based on observations, interviews, and record reviews the facility failed to assure health care referral and follow up was completed for 1 of 5 sampled residents (#1) as evidenced by the failure to obtain a hospital bed as ordered and failure to notify the Primary Care Provider (PCP) the resident did not receive the hospital bed. The findings are: Review of Resident #2's current FL-2 dated 02/01/19 revealed: -Diagnoses included diabetes mellitus, hypertension, asthma, carpal tunnel syndrome, left ankle and foot acute osteomyelitis, muscle weakness, unsteadiness on feet, and repeated falls. -The resident was intermittently disoriented, semi-ambulatory, and incontinent of bowel and bladder. -She required personal care assistance for dressing. Review of Resident #2's Resident Register revealed:	D 273		

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-There was an admission date of 02/08/19.
-The resident was forgetful and needed reminders.
-The resident required assistance from staff for dressing, bathing, nail care, ambulation, transfers, toileting, and grooming.
-There was documentation the resident fell "a lot".

Review of Resident #2's current care plan revealed:
-The assessment was performed on 03/11/19.
-It was signed by the Executive Director/Administrator (ED/Administrator) and Health Care Coordinator (HCC) on 06/05/19.
-The resident had moderate orientation impairment.
-The resident required " ...supervision and oversight for safety".
-The resident needed " ...protection and supervision because of unsafe or inappropriate decisions".
-The resident required physical assistance of two staff members for ambulating.
-The resident was totally dependent of two staff members for all grooming and personal care needs.
-The resident was totally dependent of two staff members for dressing and undressing.
-The resident required physical assistance of one staff member for toileting.
-The resident was chair-bound.
-The resident was a high fall risk and needed reminders to ask for help.
-The resident had three or more falls in the last 90 days.

Review of a physician's order for Resident #2 dated 03/06/19 revealed an order for a hospital bed.

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D 273	Continued From page 40 Observation of Resident #2's room on 06/07/19 at 11:17am revealed: -The resident was laying on her back on a twin sized wooden bed. -There was no hospital bed in the room for the resident. Interview with a Licensed Practical Nurse (LPN) Supervisor on 06/11/19 at 12:50pm revealed: -Resident #2's Primary Care Provider (PCP) had faxed an order in March 2019 to the facility for a hospital bed. -The durable medical equipment company (DME) needed a form completed by Resident #2's PCP to submit to the insurance company. -She faxed the form to Resident #2's PCP. -Resident #2's PCP did not follow up with the DME company. -Resident #2's insurance company had denied the hospital bed because the PCP did not complete the form. -She did not know when Resident #2's hospital bed had been denied by the insurance company. -She had documented communication with the DME company and with Resident #2's PCP regarding the hospital bed. -She would provide the documentation. Review of a document from the LPN supervisor dated 03/29/19 revealed: -It was from the DME company requesting "chart notes" from Resident #2's PCP. -It was sent to the facility from the DME company on 03/25/19. -There was a form titled "Physician's order" to be completed and signed by Resident #2's PCP for a "dry pressure mattress" for Resident #2. -The form was not completed or signed. -There was a form titled "Detailed Written Order Prior to Delivery/CMN".	D 273		

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D 273	Continued From page 41 -On the form was checked "Hospital Bed/Fixed Ht" -There was a section for Resident #2's diagnoses and the PCP's signature. -The diagnoses were blank, and the form was not signed by the PCP. Telephone interview with a representative from the DME company for Resident #2 on 06/11/19 at 4:30pm revealed: -She had never faxed a form to the facility for Resident #2's PCP to complete for the insurance. -In March 2019 Resident #2's family member was given a form for the resident's PCP to complete for the insurance company. -She did not know why the family member was given the form. -The DME company did not receive the completed form back from the facility or the PCP. -On 04/22/19 the DME company received another prescription for a hospital bed signed by a different PCP. -The surveyor would need to speak with named representative of the DME company because the other representative was more familiar with the hospital bed for Resident #2. -She would have the named representative return the call. Telephone interview with Resident #2's previous PCP on 06/12/19 at 1:55pm revealed: -She faxed an order for Resident #2's hospital bed to the facility on 02/26/19. -The fax transmission response was "received". -She did not have documentation of an order for a hospital bed dated 03/06/19. -She had not received anything to complete for Resident #2's hospital bed. -She had not been contacted by the facilty regarding Resident #2's hospital bed	D 273		

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D 273	Continued From page 42 Interview with Resident #2's current PCP on 06/11/19 at 4:39pm revealed: -She did not write Resident #2's prescription dated 03/06/19 for a hospital bed. -She had tried to order a hospital bed on 04/17/19 for Resident #2. -Resident #2 did not qualify through her insurance company for a hospital bed. -She thought Resident #2 would now qualify for a hospital bed because she had congestive heart failure. -She would try to get Resident #2 a hospital bed to assist with decreasing falls from the bed. Confidential interview with a concerned citizen revealed: -Resident #2 needed a hospital bed to help decrease her falls from the bed and assist with transfers. -She obtained an order for a hospital bed for Resident #2 March 2019. -She personally gave Resident #2's hospital bed order to named staff member because she knew that staff member would be able to have the order signed by Resident #2's PCP. -She did not remember the date she gave the hospital bed order to named staff member. -Resident #2 still did not have a hospital bed. Confidential interview with a staff member revealed: -The staff member took the order for Resident #2's hospital bed to the PCP for signature in March 2019. -Resident #2's PCP signed the hospital bed order. -The signed hospital bed order was returned to the facility staff. -The staff member could not remember who at	D 273		

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D 273	Continued From page 43	D 273		

the facility the signed hospital bed order was given.

Telephone interview with Resident #2's family member on 06/12/19 at 12:10pm revealed:
-The facility told her 03/26/19 Resident #2 did not meet the insurance criteria for a hospital bed.
-The facility staff had previously told her Resident #2 could not have a hospital bed because it was a "restraint".
-She did not remember who at the facility, or when she was told the hospital bed was a restraint.
-Resident #2's current PCP told her last week she would reorder the hospital bed for Resident #2 because the resident had congestive heart failure.

Interview with the Health Care Coordinator (HCC) on 06/11/19 at 12:00pm revealed
-Resident #2's hospital bed had not been ordered because Physical Therapy had just recommended a hospital bed for Resident #2 yesterday (06/12/19).
-If an order was filed in the residents chart it was "safe to say all is done".
-He did not know there was an order dated 03/06/19 for Resident #2 to have a hospital bed.

Interview with the Executive Director/Administrator on 06/12/19 at 6:58pm revealed:
-He expected orders to be followed.
-He expected himself or the Health Care Coordinator (HCC), and the PCP to be notified If there were delays or problems in following orders.
-He expected problems or delays with processing orders or obtaining equipment for residents to be documented.

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D 273	Continued From page 44 Based on record review there was no documentation Resident #2's insurance denied the hospital bed. Based on record review there was no documentation Resident #2's PCP had been informed the resident did not have a hospital bed.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.	D 280		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure a licensed health professional support (LHPS) evaluation was completed for 2 of 5 sampled resident (Residents #3, #5) who required finger stick blood glucose (FSBS) testing and medication administration through injection.

The findings are:

1. Review of Resident #3's current FL-2 dated 04/10/19 revealed diagnoses included diabetes mellitus type I, dementia, anxiety, coronary artery disease, hypothyroidism, insomnia, chronic pain and gait abnormality.

Review of Resident #3's Resident Register revealed an admission date of 02/12/19.

Review of physician's orders for Resident #3 revealed:
-There was an order dated 04/10/19 for finger stick blood sugar (FSBS) checks immediately before meals.
-There was an order dated 04/10/19 for FSBS checks one hour after meals.
-There was an order dated 05/22/19 for Lantus 100unit/ml vial, inject 18 units subcutaneously every morning for diabetes. (Lantus is a long-acting insulin.)
-There was an order dated 05/23/19 for Humalog 100 unit/ml vial, inject 5 units subcutaneously 3 times daily with the first bite of meals; do not give if not eating. (Humalog is a fast-acting insulin.)

Review of Resident #3's record revealed:
-There was documentation of an LHPS review dated 02/11/19 (admission) that indicated Resident #3 had no LHPS tasks.

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D 280	Continued From page 46 -There was no documentation for quarterly LHPS reviews and evaluations from 02/12/19 to 06/12/19. Interview with the Health Care Coordinator (HCC) on 06/11/19 at 5:20 pm revealed: -He was not aware that Resident #3's LHPS review was not assessed for FSBS and medication injections. -He was not aware that Resident #3's LHPS review was overdue for a quarterly review. Refer to interview with the HCC on 06/11/19 at 5:20pm. Refer to interview with the Executive Director/Administrator (ED/Administrator) on 06/11/19 at 5:30pm. 2. Review of Resident #5's current FL-2 dated 02/27/19 revealed diagnoses included diabetes mellitus, cognitive disorder, depression, bipolar, delusional disorder and abnormal gait. Review of Resident #5's Resident Register revealed an admission date of 02/28/19. Review of physician's orders for Resident #5 revealed: -There was an order dated 02/27/19 for finger stick blood sugar (FSBS) checks 3 times daily before meals. -There was an order dated 05/08/19 for Tresiba flextouch 100unit/ml vial, inject 30 units subcutaneously daily at 6:00am for diabetes. (Tresiba is a long-acting insulin.) -There was an order dated 06/06/19 for Humalog kwikpen 100 unit/ml, inject 5 units subcutaneously daily before dinner at 5:00pm. (Humalog is a short-acting insulin.)	D 280		

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D 280	Continued From page 47 Review of Resident #5's record revealed: -There was documentation of an LHPS review dated 02/28/19 (admission) that indicated Resident #5 had no LHPS tasks. -There was no documentation for quarterly LHPS reviews and evaluations from 03/01/19 to 06/12/19. Interview with the Health Care Coordinator (HCC) on 06/11/19 at 5:20 pm revealed: -He was not aware that Resident #5's LHPS review was not assessed for FSBS and medication injections. -He was not aware that Resident #5's LHPS review was overdue for a quarterly review. Refer to interview with the HCC on 06/11/19 at 5:20pm. Refer to interview with the ED/Administrator on 06/11/19 at 5:30pm. Interview with the HCC on 06/11/19 at 5:20pm revealed: -He was a Registered Nurse (RN) hired at the facility on 04/30/19 as the HCC. -It was his responsibility to ensure each resident had an initial LHPS review and evaluation upon admission, or within 30 days from the date a resident develops the need for the task, and at least quarterly thereafter. -The initial and quarterly LHPS reviews were completed and documented in the resident's electronic record. -He kept a notebook that included changes in residents' LHPS tasks that may have occurred in between the quarterly reviews. -He discovered shortly after his hire, there were LHPS reviews that were either not initially	D 280		

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D 280	Continued From page 48 completed or were overdue for their quarterly reviews. -He was working to get all residents' LHPS reviews current. Interview with the ED/Administrator on 06/11/19 at 5:30pm revealed: -He was not aware that some of the LHPS reviews were not correct or current for some residents. -The HCC was an RN and was responsible for performing all LHPS reviews. -He would discuss the status of the LHPS reviews with the HCC to ensure all are completed.	D 280		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to assure all food and beverage being stored, prepared, and served to residents were protected from contamination related to a wet pink, brown and black build-up substance in 2 of 2 of the facility's ice machines. The findings are: 1.Observation of the ice machine on the assisted living side of the facility on 06/06/19 9:33am	D 283		

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D 283	Continued From page 49 revealed: -It was approximately 75% full of cubed ice. -On the upper right inside side wall of the ice machine was a plastic and metal component attached to the side wall of the ice machine with 4 black bolts that had wet pink and black substance on the top and sides of the component and the side wall of the ice machine. -The ice in the ice bin was resting on the component inside the ice machine. -There was a wet yellow and black substance on the top of the inner wall of the ice machine. -On the upper inside front wall of the ice machine there was wet pink and brown substance covering half the length of the ice machine. -There was condensation along the inner upper walls, where the black substance was located. -Water from the condensation was dripping down the side walls and the top of the ice machine onto the ice in the ice bin. Review of the facility's ice machine policy revealed: -The exterior of the ice machine was to be cleaned daily with hot water, detergent, clean cloth and sanitizing solution. -The interior of the ice machine was to be cleaned weekly with approved detergent, hot water, sanitizing solution and a clean cloth, making sure liners, gaskets and frames are free from scale and/or mold. Review of the facility's work history report revealed there was documentation on 04/02/19 the Dining Service Director removed ice, cleaned and sanitize inside of the ice bin and other areas as needed. Refer to the interview with the facility's cook on 06/06/19 at 9:24am.	D 283		

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D 283	Continued From page 50 Refer to the interview with a kitchen staff on 06/06/19 at 9:55am. Refer to interview with a dishwasher/utilities staff on 06/06/19 at 11:00am. Refer to the interview with the Maintenance Director on 06/06/19 at 10:00am. Refer to the interview with the Executive Director/Administrator on 06/06/19 at 10:06am and 2:00pm. 2. Observation of the ice machine on the secured assisted living side of the facility on 06/06/19 from 9:55am revealed: -It was approximately 85% full of cubed ice. -On the upper right inside side wall of the ice machine was a metal component attached to the side wall of the ice machine with 4 black bolts that had wet pink and black substance on the top and sides of the component and the side wall of the ice machine. -The ice in the ice bin was resting on more than half of the component inside the ice machine. -There was a black tube attached to the upper left inside wall of the ice machine with wet pink and black substance under the black tube at the insertion site and directly below the tube on the inner wall of the ice machine. -There was an opening with plastic flaps on the upper left inside wall that had wet pink and black substances running the entire length of the opening, along the top, the bottom and the sides of the opening. -There was a wet pink substance along the front inner upper wall of the ice machine. -There was a wet black substance on the front inner lower wall of the ice bin.	D 283		

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D 283	Continued From page 51 -There was a wet pink and black substance along the entire length of the top inner wall of the ice machine. -There was condensation along the inner upper walls, where the black substance was located. -Water from the condensation was dripping down the side walls and the top of the ice machine onto the ice in the ice bin. Review of the facility's ice machine policy revealed: -The exterior of the ice machine was to be cleaned daily with hot water, detergent, clean cloth and sanitizing solution. -The interior of the ice machine was to be cleaned weekly with approved detergent, hot water, sanitizing solution and a clean cloth, making sure liners, gaskets and frames are free from scale and/or mold. Review of the facility's work history report revealed there was documentation on 04/02/19 the Dining Service Director removed ice, cleaned and sanitize inside of the ice bin and other areas as needed. Refer to the interview with the facility's cook on 06/06/19 at 9:24am. Refer to the interview with a kitchen staff on 06/06/19 at 9:55am. Refer to interview with a dishwasher/utilities staff on 06/06/19 at 11:00am. Refer to the interview with the Maintenance Director on 06/06/19 at 10:00am. Refer to the interview with the Executive Director/Administrator on 06/06/19 at 10:06am	D 283		

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D 283	Continued From page 52 and at 2:00pm. _____ Interview with the facility's cook on 06/06/19 at 9:24am revealed: -He was not responsible for cleaning the ice machines in the facility. -The kitchen staff that washed the dishes was responsible for cleaning the two ice machines in the facility. -He had never cleaned either of the two ice machines at the facility. -He did not know when the last time the ice machine had been clean. Interview with a kitchen staff on 06/06/19 at 9:55am revealed: -She had not been responsible for cleaning the ice machine on the secured assisted living unit. -The maintenance staff had flushed the tubing on the ice machine in the assisted living unit last week. -When maintenance staff flushed the tubing on the ice machine the water that ran out smelled bad. -She had wiped down the inside of the ice machine with a cleaning solution used to wash dishes last week. -The dish washer was responsible for cleaning both ice machines in the facility. -Ice from both ice machines had been served to the residents on both the assisted living unit and the secured assisted living unit this morning. Interview with a dishwasher/utilities staff on 06/06/19 at 11:00am revealed: -He had worked as the dishwasher/utilities person since January 2019. -He was responsible for cleaning the dishes and mopping the floors in the kitchen twice per day. -He was not responsible for cleaning the ice	D 283		

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machines at the facility.
-He had never cleaned either of the ice machines at the facility.
-He had never been told that he was responsible for cleaning the ice machines.
-He had never seen nor heard of anyone cleaning the ice machines.
-He had not been trained and did not know how to clean the ice machines.

Interview with the Maintenance Director on 06/06/19 at 10:00am revealed:
-He was not responsible for cleaning the ice machines in the facility.
-He was responsible for repairing the ice machines if needed.
-He was responsible for flushing the tubing of the ice machines.
-He had last flushed the tubing on the ice machine on the secured assisted living side last week.
-The kitchen staff was responsible for cleaning the two ice machines in the facility.
-He did not know the last time the ice machines were cleaned.

Interview with the Executive Director/Administrator on 06/06/19 at 10:06am and 2:00pm revealed:
-He did not know what the wet pink and black substance in the two ice machines was.
-The dish washer was responsible for cleaning both the ice machines in the facility.
-He was uncertain of the last time the ice machines were clean, but thought it was a week ago.
-He expected the ice machines to be checked weekly.
-He did not know what the policy said related to cleaning the ice machines.

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D 283	Continued From page 54 -He would find the policy related to cleaning the ice machine and follow the policy. -The dishwasher (utilities) person was responsible for cleaning the ice machines. -The dishwasher/utilities person was informed today that of the responsibility of cleaning the ice machines along with a brief training. -He had not seen anyone clean the ice machines, he could only go by what the staff told him about cleaning the ice machine. -He was told by maintenance that both the ice machines were cleaned last week. -The Dietary Manager (DM) was responsible for checking the cleaning log. -The DM was no longer employed at the facility as of last week. -He was responsible for ensuring the ice machines were being cleaned in the until a new DM was hired. _____ The facility failed to assure all food and beverage were free from contamination related to a wet pink, brown and black build-up substance in the large ice machine in the kitchen of the assisted living; a pink, tan and black build-up on the ice machine in the secured assisted living unit. The facility's failure resulted in an increased risk for the transmission of disease due to contamination of ice consumed by the residents which was detrimental to the health, safety, and welfare of the residents which constitutes a TYPE B VIOLATION. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 27, 2019	D 283		

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D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure water was served to residents in 2 of 2 facility dining rooms. The findings are: Observation on 06/06/19 from 8:00am to 8:54am of the breakfast meal service in the assisted living dining room revealed: -There was a server taking the resident's food and beverage orders. -There was one wine glass and one stemless wine glass at each table setting. -The residents that had placed their order with the server were served orange juice in their wine glasses and the stemless wine glass remained empty. -At 8:07am there were 11 residents in the dining room seated to eat and no water was served to any of the residents. -There were 11 residents in the dining room eating and only one resident was served water. -At 8:24am there were 13 residents in the dining room seated to eat and only one resident was served water in the stemless wine glass. Interview with a kitchen staff on 06/06/19 at 11:00am revealed the residents had to ask for	D 306		

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D 306	Continued From page 56 water for water to be served. Observation on 06/06/19 at 5:10pm of the dinner meal service in the assisted living dining room revealed there were 14 residents in the dining room eating and only one resident was served water. Observation on 06/06/19 at 5:15pm of the dinner meal service in the secured assisted living dining room revealed there were 21 residents in the dining room eating and only 2 residents were served water. Observation on 06/07/19 at 8:00am of the assisted living dining room revealed there were 14 residents seated to eat and no water being served. Observation on 06/07/19 at 12:10pm of the assisited living dining room revealed there were 14 residents seated to eat and 2 residents had been served water. Observation on 06/07/19 at 12:20pm of the secured assisted living dining room revealed there were 22 residents seated to eat and no water was served. Interview with a resident on 06/05/19 at 10:40am revealed residents must ask for water at meal times. Interview with a second resident on 06/05/19 at 2:22pm revealed: -He had lived at the facility for six weeks. -He was not offered water at meal times. Interview with a third resident on 06/10/19 at 5:45pm revealed:	D 306		

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-Residents had to ask for water with their meals.
-Water was never served at meal times unless the residents asked the server for the water.

Interview with a fourth resident on 06/010/19 at 5:49pm revealed:
-He does not recall being offered water at meal times.
-If he requested water, then staff would give it to him upon request.

Interview with kitchen staff on 06/06/19 at 9:26am revealed:
-She took the residents' order for beverages and meals at meal times.
-Residents could request orange juice, apple juice, cranberry juice and water as beverages with meals.
-Only the beverage the resident requested was served.

Interview with a nursing assistant (NA) on 06/11/19 at 8:30am revealed:
-The residents are offered juice, milk and coffee at meal times.
-The residents had to ask for water if they wanted it.

Interview with a medication aide (MA) on 06/11/19 at 9:25am revealed:
-Everyone got tea, cranberry juice or milk.
-There were pitchers of ice water on the service carts if the residents asked for it.

Confidential interview with staff revealed:
-Resident on both the assisted living side and secured assisted living side only received water with meals when the residents asked for water.
-The residents on both the assisted living side and the secured assisted living side were offered

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D 306	Continued From page 58 tea, juice, and milk. -All the residents in the facility had to ask for water at meal times to receive water. -Water was not served to each resident at each meal. Interview with the Executive Director/Administrator on 06/10/19 at 12:30pm revealed: -He did not know that had to be served to each resident at each meal. -He thought water had to be offered to the residents. -He would inform the kitchen server staff that water had to be served to each resident at each meal now.	D 306		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 59 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 3 of 5 residents (#2, #3, #13) observed during the medication passes including errors with insulin (#2, #3), and Protonix (#13); and for 1 of 5 sampled residents (#5) including a medication to treat and prevent heart failure (#5). The findings are: 1. The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the 8:00 am medication passes on 06/06/19; and 12:00 pm medication passes on 06/07/19. Review of Resident #2's current FL-2 dated 02/01/19 revealed diagnoses included diabetes mellitus, hypertension, asthma, carpal tunnel syndrome, left ankle and foot acute osteomyelitis, muscle weakness, unsteadiness on feet, and repeated falls. a. Review of Resident #2's physician order dated 05/31/19 revealed an order for Humalog Kwikpen inject 8 units subcutaneous 3 times a day "immediately before" breakfast, lunch, and dinner. Hold if fingerstick blood sugar less than 80 (Humalog is a rapid acting insulin with onset within 15 minutes of injection and a peak of 30 to 90 minutes after administration. According to the manufacturer, the Humalog Kwikpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)	D 358		

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D 358	Continued From page 60 Review of Resident #2's June 2019 electronic medication administration (eMAR) revealed: -There was an entry for Humalog Kwikpen inject 8 units subcutaneous 3 times a day "immediately before" breakfast, lunch, and dinner. Hold if fingerstick blood sugar less than 80. -The resident's blood sugars ranged from 60 - 335 from 06/01/19 - 06/06/19. Observation of the 12:00 pm medication pass on 06/06/19 revealed: -The MA asked another MA beside him at a separate medication cart, " ...it's 8 units, right?" -The other MA reviewed Resident #2's eMAR. -The other MA voiced, "Yes. I think last time she got it in her abdomen". -The MA observed during medication pass did not review Resident #2's eMAR to verify the insulin and the dosage due. -Resident #2's blood sugar was 118 at 11:11 am. -The MA applied a needle to the Humalog Kwikpen. -The MA did not dial and perform a 2 unit air shot prior to dialing up the 8 units required for the ordered dosage. -The MA dialed up 8 units of the Humalog Kwikpen. -The MA administered the Humalog 8 units to Resident #2's left lower abdomen at 11:17 am. Review of the facility's "Injectable's" policy revealed there was documentation or instructions regarding Kwikpen's. Interview with the MA on 06/07/19 at 4:10 pm revealed: -He did not know the Humalog Kwikpen required a 2 unit air shot. -He had never performed a 2 unit air shot when	D 358		

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administering Humalog Kwikpen injections.
-He did not remember if he had been trained on the Humalog Kwikpen.

Interview with another MA on 06/07/19 at 4:25 pm revealed:
-She did not know the MA observed during medication pass had not reviewed Resident #2's eMAR before administering the Humalog.
-She had never performed an air shot for Humalog Kwikpen's when administering to any residents.
-She did not know a 2 unit air shot was required prior to administering Humalog Kwikpen's.

Interview with the Licensed Practical Nurse (LPN) Supervisor on 06/07/19 at 4:30 pm revealed:
-She did not know the Humalog Kwikpen required a 2 unit air shot prior to administering.
-She had not administered the Humalog Kwikpen at the facility.

Interview with the Health Care Coordinator (HCC) on 06/07/19 at 4:35 pm revealed:
-He expected MA's to prime the Humalog kwikpen with a 2 unit air shot before administering.
-He had been the HCC for about 3 weeks.
-He had not performed an in-service training on the Humalog Kwikpen since he had been at the facility.
-He did not know if there was an Insulin or kwikpen policy.

Attempted interview with the Executive Director/Administrator (ED/Administrator) on 06/07/19 at 4:45 pm revealed he did not respond to questions related to the kwikpen or air shot.

b. Review of Resident #2's physician order dated

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05/31/19 revealed an order for Humalog Kwikpen inject 8 units subcutaneous 3 times a day "immediately before" breakfast, lunch, and dinner. Hold if fingerstick blood sugar less than 80 (Humalog is a rapid acting insulin with onset within 15 minutes of injection and a peak of 30 to 90 minutes after administration).

Review of Resident #2's June 2019 electronic medication administration (eMAR) revealed:
-There was an entry for Humalog Kwikpen inject 8 units subcutaneous 3 times a day "immediately before" breakfast, lunch, and dinner. Hold if fingerstick blood sugar less than 80.
-The resident's blood sugars ranged from 60 - 335 from 06/01/19 - 06/06/19.

Observation of the 12:00 pm medication pass on 06/07/19 revealed:
-Resident #2's blood sugar was 118 at 11:11 am.
-The medication aide (MA) administered the Humalog 8 units to Resident #2's left lower abdomen at 11:17 am.
-Lunch had not been served to Resident #2.

Observation of Resident #2 on 06/07/19 at 12:05 pm revealed she was in the dining room and lunch had not been served.

Observation of Resident #2 on 06/07/19 at 12:35 pm revealed:
-She was sitting at the dining room table.
-She was conversing with other residents.
-She was eating fruit.
-She did not display signs and/or symptoms of hypoglycemia.

Interview with the MA on 06/07/19 at 4:10 pm revealed:
-"Immediately" in the Humalog order did not

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mean to wait until Resident #2 was served her meal.
-"Immediately" in the Humalog order meant to administer the Humalog as soon as it populated on the eMAR.
-The Humalog 8 units 12:00 pm order would populate for administration at 11:00 am.
-He normally administered the Humalog 8 units between 11:15 am - 11:30 am because lunch was served at 12:00 pm.
-He had always administered Resident #2 Humalog 8 units between 11:15 am and 11:30 am before lunch was served.

Interview with the Health Care Coordinator (HCC) on 06/07/19 at 4:35 pm revealed:
-He expected the Humalog Kwikpen 8 units to have been administered with Resident #2's meal if the order was to administer immediately before.
-He did not know if there was an insulin policy.

Interview with the Executive Director/Administrator (ED/Administrator) on 06/07/19 at 4:45 pm revealed he expected the insulin to have been administered to Resident #2 "immediately" before she had lunch, as ordered.

Telephone interview with the Resident #2's Primary Care Provider (PCP) on 06/11/19 at 4:39 pm revealed
-She expected Humalog to be administered to as ordered.
-She had been monitoring Resident #2's blood sugars weekly when she was at the facility.
-She was comfortable with Resident #2's blood sugars.

2. Review of Resident #5's current FL-2 dated 02/07/19 revealed diagnoses included diabetes mellitus, cognitive disorder, depression, bipolar,

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D 358	Continued From page 64 delusional disorder and abnormal gait. Review of a Resident #5's physician order dated 05/29/19 revealed an order for Humalog Flexpen inject 5 units subcutaneous 3 times a day with the first bite of meal, only if resident takes first bite of food. Hold if not eating, or if premeal blood sugar is less than 80 (Humalog is a rapid acting insulin with onset within 15 minutes of injection and a peak of 30 to 90 minutes after administration). Review of Resident #3's June 2019 electronic medication record (eMAR) revealed: -There was an entry for Humalog 5 units subcutaneous 3 times a day with first bite of meals-don't give if not eating. -The fingerstick blood sugars ranged from 60 - 419 from 06/01/19 - 06/07/19. Review of an insulin vial on 06/07/19 at 12:03 pm revealed: -The vial was Humalog 100 units per milliliter. -There was an administration label to inject 3 units subcutaneous at 8:00 am with breakfast and at 5:00 pm with supper. Observation of the 12:00 pm medication pass on 06/07/19 revealed: -Resident #3's blood sugar was 231 at 11:28 am. -The medication aide (MA) drew up Humalog 5 units. -The MA wiped Resident #3's abdomen with an alcohol pad. -The MA began to administer Humalog 5 units to the abdomen of Resident #3 at 12:05 pm. -The MA was stopped by the surveyor as he was going to administer Humalog 5 units to Resident #3 at 12:05 pm. -Resident #3 had not eaten prior to the beginning of administration of the insulin.	D 358		

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D 358	Continued From page 65 -Lunch had not been served to any of the residents, including Resident #3. Interview with the MA on 06/07/19 at 12:10 pm revealed: -He was going to administer Humalog 5 units to Resident #3 until he was stopped. -He did not look at the administration label on the vial when drawing up the Humalog for Resident #3. -He knew the Humalog order for Resident #3 was for 5 units because had reviewed Resident #3's eMAR before drawing up the Humalog for administration. -He did not know the administration label for the Humalog should have been updated to match the order. -He did not know a change of order label should have been placed on the Humalog vial. -Anyone administering Humalog to Resident #3 would follow the orders on the eMAR instead of the vial. -When an eMAR order was different than the medication label he should let the Licensed Practical Nurse (LPN) supervisor know of the difference. -He did not see the order to administer with the first bite of food and hold if not eating. -He was going to administer to Resident #3 the insulin because the resident "always eats". Interview with the Health Care Coordinator (HCC) on 06/07/19 at 4:35 pm revealed: -He expected medication to be administered as ordered. -He expected the medication label to match the order. -He did not expect the Humalog to have been administered to Resident #3 until she ate because that was the order.	D 358		

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D 358	Continued From page 66 Interview with the Executive Director/Administrator (ED/Administrator) on 06/07/19 at 4:45 pm revealed he expected the Humalog to have been administered to Resident #3 after taking her first bite of food if that's what was ordered. 3. Review of Resident #13's current FL-2 dated 05/28/19 revealed: -Diagnoses included nontraumatic brain injury, hypertension, acid reflux, altered mental status, confusion. -There was an order for Protonix EC 40mg daily. Review of Resident #13's June 2019 electronic medication administration record (eMAR) revealed there was an entry for Protonix DR 40 mg daily (Protonix is a medication used to treat acid reflux). Observation of the medication pass on 06/06/19 at 8:00 am revealed Protonix was not administered to Resident #13. Observation of medications on hand for Resident #13 on 06/06/19 at 10:56 am revealed there was an empty bottle labeled Protonix delayed release (DR) 40 mg take 1 tablet daily. The empty prescription bottle labeled Protonix DR 40mg revealed there were 5 tablets dispensed on 05/29/19. Interview with the Medication Aide (MA) on 06/06/19 at 08:05 am revealed: -Medications were reordered when there were 7 doses remaining. -If a resident's medications ran out, the back up pharmacy would be contacted to fill the	D 358		

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medications.
-She could reorder resident medications from the eMAR.
-She did not realize Resident #13's Protonix had ran out.

Interview with a Licensed Practical Nurse (LPN) supervisor on 06/06/19 at 10:00 am revealed:
-Resident #13's Protonix ran out 06/05/19.
-The Protonix for Resident #13 was an order that came from the hospital when the resident was admitted to the facility.
-The physician who completed the FL-2 for Resident #13 had not seen the resident to clarify the medications.
-She could not remember when she spoke to the physician who wrote the FL-2.
-She needed to contact Resident #13's Primary Care Provider (PCP) to clarify the resident's medications.
-She had faxed a list of Resident #13's current medications to the facility pharmacy on 06/05/19.
-The Protonix was not listed on the list of Resident #13's current medications she faxed to the facility pharmacy on 06/05/19.
-She had not contacted Resident #13's PCP to clarify the resident's medications.
-She did not document any of the conversations she had regarding Resident #13's Protonix.
-She needed a prescription for the Protonix to send to the pharmacy.
-Resident #13's previous pharmacy had transferred the prescriptions to the facility's pharmacy on 06/05/19.

Review of Resident #13's list of current medications submitted by the LPN Supervisor revealed:
-The medication list was not dated.
-The medication list was not signed.

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HARMONY AT HOPE MILLS	7051 ROCKFISH ROAD FAYETTEVILLE, NC 28306

(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 358	Continued From page 68 -Protonix was not listed. Telephone interview with a pharmacist from the facility's pharmacy on 06/06/19 at 11:45 am revealed: -On 05/29/19 the facility's pharmacy received an order dated 05/28/19 for Protonix 40mg for Resident #13. -On the night of 05/29/19 there were 5 tablets of Protonix 40 mg sent to the facility from the back up pharmacy. -The back up pharmacy would only fill a partial quantity of medications. -On 05/28/19 Resident #13 had a full supply of Protonix 40mg filled by another pharmacy. -There was documentation a (named) staff member called the pharmacy and said not to fill the Protonix for Resident #13 because the resident had the Protonix filled on 05/28/19 by another pharmacy and had enough to last for the month of June 2019. -He needed to transfer the call to another representative. A telephone interview with a representative from the facility's pharmacy on 06/06/19 at 12:00 pm revealed: -On 06/05/19 at 3:00 pm the LPN supervisor called and said to follow Resident #13's transfer prescription received from the resident's previous pharmacy. -On 06/05/19 at 4:30 pm the LPN supervisor called and said to follow Resident #13's 05/28/19 FL-2 instead of the residents transfer prescriptions from the resident 's previous pharmacy. -On 06/05/19 at 5:30 the LPN supervisor faxed a medication list for Resident #13. -The LPN supervisor said to follow the medication list for Resident #13's PCP instead of the FL-2.	D 358		

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D 358	Continued From page 69 -Resident #13's faxed medication list was not signed. -The only signed orders for Resident #13 was the 05/28/19 FL-2. -On 06/06/19 the LPN supervisor said to follow the orders on Resident #13's 05/28/19 FL-2. -A (named) staff member phoned the pharmacy on 05/31/19 and reported not to fill Resident #13's Protonix because the resident had the Protonix prescription filled on 05/28/19 and had enough to last the month of June 2019. Interview with another LPN supervisor on 06/07/19 at 11:05 am revealed: -She called the facility pharmacy on Friday (05/31/19) to have the Protonix refilled. -She was told the family would have to pay out of pocket for the Protonix because the medication had been recently filled by another pharmacy. -Resident #13's family member did not want to pay out of pocket for the Protonix. -She did not call and tell the facility pharmacy Resident #13 had the Protonix filled by another pharmacy. -She did not tell the facility pharmacy Resident #13 had enough Protonix to last the month of June 2019. -She did not tell the facility pharmacy to not fill Resident #13's Protonix. -She had not spoken with Resident #13's PCP. Interview with the Health Care Coordinator (HCC) on 06/06/19 at 10:52 am revealed: -Resident #13 came to the facility with her own medications. -Protonix had run out because Resident #13's family member did not want to change to the facility's pharmacy. -Yesterday (06/05/19) Resident #13's family member agreed to use the facility pharmacy.	D 358		

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-The Protonix should have been delivered last night (06/05/19) by the facility's pharmacy.
-He did not know why the Protonix was not delivered last night (06/05/19).
-The facility's pharmacy would deliver the Protonix for Resident #13 today (06/06/19).
-The facility would not normally wait until a resident's medications were out to request refills.

Interview with the Executive Director/Administrator (ED/Administrator) on 06/06/19 at 11:15 am revealed:
-When residents arrived to the facility with their own medications the LPN supervisor reviewed the medications and counted the pills to ensure the medications were refilled before the medication ran out.
-He expected if Resident #13 had 5 pills of Protonix when she came to the facility the LPN supervisor should have contacted the pharmacy for refills to be delivered the same night.
4. Review of Resident #5's current FL-2 dated 02/07/19 revealed:
-Diagnoses included diabetes mellitus, cognitive disorder, depression, bipolar, delusional disorder and abnormal gait.
-There was an order for Digoxin 125mcg, one tablet daily for heart. (Digoxin is a medication used to treat heart failure and irregular heart rhythm.)

Review of subsequent physician orders for Resident #5 dated 06/05/19 revealed an order to check pulse before each dose of Digoxin, and hold dose if pulse is less than 60.

Review of Resident #5's April 2019 medication administration record (MAR) revealed there was documentation Digoxin 125mcg was administered at 8:00am from 04/01/19 - 04/30/19.

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D 358	Continued From page 71 Review of Resident #5's May 2019 MAR revealed there was documentation Digoxin 125mcg was administered at 8:00am from 05/01/19 - 05/31/19. Review of Resident #5's June 2019 MAR revealed: -There was documentation Digoxin 125mcg was administered at 8:00am from 06/01/19 - 06/05/19. -There was an entry that Digoxin 125mcg was discontinued on 06/06/19. -There was an additional entry to check pulse before administering Digoxin and hold dose if pulse is less than 60. -There was documentation that a pulse check was completed on 06/07/19-06/12/19. Observation of Resident #5's medications on hand on 06/12/19 at 11:00am revealed there was no Digoxin available for administration. Interview with the pharmacist from the facility's contracted pharmacy on 06/12/19 at 11:15am revealed: -Digoxin 125mcg was ordered on 02/28/19 for Resident #5. -There was no order to discontinue Digoxin 125mcg for Resident #5. -There was a new order for Resident #5 dated 06/05/19 to check pulse before each dose of Digoxin and hold dose if pulse is less than 60. -When an order was faxed to the pharmacy, the pharmacist entered it into the electronic MAR (eMAR). -The order would then be placed in "pending" status in the eMAR until the facility approved the order. -The original Digoxin order would show discontinued until the facility approved the new order to check the pulse before administering	D 358		

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D 358	Continued From page 72 Digoxin. Interview with the Regional Vice President of Clinical Services for the facility on 06/12/19 at 11:50am revealed: -He was not aware that Resident #5 was not receiving Digoxin as ordered. -The order for the pulse check prior to the Digoxin dose should have been reviewed and approved by the facility to become active in the eMAR, and it should have appeared in the eMAR as one order. Interview with the HCC on 06/12/19 at 12:05pm revealed: -He was not aware that Resident #5 was not receiving Digoxin as ordered. -When an order was faxed to the pharmacy, the pharmacist entered it into the electronic MAR (eMAR). -The order would then be placed in "pending" status in the eMAR until the facility supervisor reviewed and approved the order. -If there were an error in the order entry in the eMAR, the SIC would contact the pharmacist for correction. Interview with Resident #5's PCP on 06/12/19 at 12:15pm revealed: -She was not aware that Resident #5 had not received her daily Digoxin 125mcg for the last seven days. -Resident #5 had hypertension and coronary artery disease and was prescribed the Digoxin for heart failure. -A side effect of not receiving the Digoxin would be an elevated heart rate. -She reviewed Resident #5's heart rate for the last seven days and the ranges were 56-68.	D 358		

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D 358	Continued From page 73 Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. Attempted phone interview with Resident #5's family member on 06/12/19 at 4:00pm was unsuccessful. Interview with the Executive Director (ED) on 06/12/19 at 5:30pm revealed: -He was not aware that Resident #5 had not received her daily Digoxin as ordered. -The HCC was an RN and was responsible for ensuring all eMARS were accurate. -He would follow-up with the RCC. The facility failed to assure medications were administered as ordered related to a rapid acting insulin that was administered 1 hour and 18 minutes before Resident #2 took her first bite of food when the order was to administer it "immediately" before lunch, a rapid acting insulin to Resident #3 before lunch was served when the order was to administer with the first bite of food which placed Resident #2 and Resident #3 at risk for low blood sugar; a medication for acid reflux (Resident #13); and Resident #5 who was ordered Digoxin for heart failure and missed doses for 7 days because it was discontinued without an order, placing the resident at risk for an elevated heart rate. 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 06/10/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 27,	D 358		

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D 358	Continued From page 74 2019.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure infection control measures to prevent the development and transmission of disease or infection and prevent cross-contamination were implemented during the morning medication pass observed on 06/06/19 when 1 medication aide failed to wash or sanitize her hands after administering oral medications, an inhalant, and a nasal spray to 2 residents. The findings are: Observation of a medication aide (MA) administering medications on the "B" hall on 06/06/19 from 8:00 am - 8:30 am revealed: -There was no hand sanitizer on top of the medication cart. -The MA touched the keyboard, opened the drawer to the medication cart, and removed a resident's medication bottles. -The MA did not wash or sanitize her hands prior to preparing the medications and she was not	D 371		

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wearing gloves.
-The MA prepared 3 oral medications and removed 1 suppository.
-The MA gave the pill cup to the resident at 8:00 am.
-The MA took the cup from the resident and threw it in the trash.
-The resident refused the suppository.
-There was a sink in the resident room.
-The MA went back the medication cart, opened the medication cart drawer, returned the suppository, documented on the electronic medication administration record (eMAR), touching the computer keys and mouse.
-The MA pushed the medication cart to another resident's room.
-The MA then started getting out medications for the second resident.
-The MA returned the medications to the medication cart.
-The MA walked to the nurse's desk looking for a medication.
-The MA returned to the medication cart and started getting out the second resident's medications.
-The MA did not wash or sanitize her hands.
-The MA prepared 3 oral medications, 2 inhalers, and mixed a powdered medication in water for the resident.
-The MA put on gloves after entering the residents' room.
-The MA gave the pill cup to the resident.
-The resident began coughing and spit the water and 3 pills in the pill cup.
-The resident swallowed the water and 3 pills she had spit in the pill cup.
-The MA scraped the inside of the cup with a spoon collecting the 3 pills that stuck to the bottom and sides of the pill cup.
-The MA took the spoon with the pills and placed

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D 371	Continued From page 76 in the resident's mouth. -The resident swallowed the pills on the spoon with water. -The resident began coughing again. -The resident had clear liquid coming from her mouth and nose. -The MA wiped the resident's mouth and nose with a tissue and took the pill cup. -The MA administered the nasal inhalant in each nostril of the resident at 8:23 am. -The MA administered an oral inhalant to the resident at 8:24 am. -The MA gave the resident the water with the powdered medication at 8:24 am. -The MA removed her gloves. -There was a sink in the resident room. -The MA went back the medication cart, opened the medication cart drawer, returned the nasal and oral inhaler, documented on the electronic medication administration record (eMAR), touching the computer keys and mouse. -The MA pushed the medication cart to another resident's room on "C" hall. -The MA then started getting out medications for the third resident. -The MA punched a pill for another resident in a pill cup. -The MA did not use hand sanitizer or wash her hands. -The MA was stopped from preparing medications. Interview with the MA on 06/06/19 at 8:30 am revealed: -She did not sanitize her hands between residents because there was no hand sanitizer on the medication cart. -The MA that was working on the medication cart was responsible for stocking the cart with hand sanitizer.	D 371		

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D 371	Continued From page 77 -When there was no hand sanitizer on the medication cart she could wash her hands between residents. -She did not wash her hands between residents because she was nervous from being followed. -There were wall hand sanitizers on the resident halls but they all were empty. Observation of "C" hall on 06/06/19 at 8:37am revealed: -There was a wall hand sanitizer at the intersection of "B" and "C" halls that contained and dispensed hand sanitizer. -There was an empty wall hand sanitizer between the medication cart and a resident's room. Interview with the Licensed Practical Nurse (LPN) supervisor on 06/06/19 at 9:00am revealed: -She expected the MA's top wash hands or use hand sanitizer between each resident during medication administration. -Hand sanitizer was on each medication cart. -There were wall hand sanitizers on each hall the MA's could use if there was no hand sanitizer on the medication cart. -If there was no hand sanitizer on the medication cart or on the wall she expected the MA's to wash their hands in the resident rooms. -She expected the MA's to stock hand sanitizer on the medication carts. -It was her responsibility as a supervisor to be certain the medication carts were stocked with hand sanitizer. Interview with the Health Care Coordinator (HCC) on 06/06/19 at 10:52am revealed: -He expected the MA's to wash or sanitize their hands before they touched the medication cart. -He expected the MA's to wash or sanitize their hands before preparing resident medications.	D 371		

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D 371	Continued From page 78 -He expected the MA's to at the least sanitize their hands after administering resident medications. -There was hand sanitizer on the medication carts. -He expected the MA's to stock the medication carts with hand sanitizer. -There were wall hand sanitizers the MA's could use. -If there was no sanitizer cart on the cart or the walls he expected the MA's to wash their hands. -The MA's could wash their hands in the resident's rooms or the staff area. Interview with the Executive Director/Administrator (ED/Administrator) on 06/06/19 at 11:15am revealed: -He expected the MA's to wash their hands before starting medication passes. -He expected the MA's to sanitize their hands after each medication pass. -The MA's were responsible for stocking the medication carts with hand sanitizer. -If there was no hand sanitizer on the carts the MA's could use the wall hand sanitizers. -If there was no hand sanitizer he expected the MA's to wash their hands between residents.	D 371		
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	D911		

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D911	Continued From page 79 Based on observations, interviews, and record reviews, the facility failed to assure residents were treated with respect, dignity, consideration, and right to privacy for 2 of 5 sampled residents as related to staff denying a resident the right to sleep in her room during the day and moving her bed without discussing with the resident (#2), and a resident's name listed on a document with "nasty habits" by his name that was posted visible to the public (#12). The findings are: 1. Review of Resident #2's current FL-2 dated 02/01/19 revealed: -Diagnoses included diabetes mellitus, hypertension, asthma, carpal tunnel syndrome, left ankle and foot acute osteomyelitis, muscle weakness, unsteadiness on feet, and repeated falls. -The resident was intermittently disoriented, semi-ambulatory, and incontinent of bowel and bladder. -She required personal care assistance for dressing. Review of Resident #2's Resident Register revealed: -There was an admission date of 02/08/19. -The resident was forgetful and needed reminders. -The resident required assistance from staff for dressing, bathing, nail care, ambulation, transfers, toileting, and grooming. -There was documentation the resident fell "a lot". Review of Resident #2's current care plan dated 03/11/19 revealed: -The resident had moderate orientation	D911		

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D911	Continued From page 80 impairment. -The resident required " ...supervision and oversight for safety". -The resident needed " ...protection and supervision because of unsafe or inappropriate decisions". -The resident required physical assistance of two staff members for ambulating. -The resident was totally dependent of two staff members for all grooming and personal care needs. -The resident was totally dependent of two staff members for dressing and undressing. -The resident required physical assistance of one staff member for toileting. -The resident was chair-bound. -The resident was a high fall risk and needed reminders to ask for help. -The resident had three or more falls in the last 90 days. a. Observation of Resident #2 on 06/05/19 at 12:05 pm revealed: -She was in a wheelchair at the dining room table with other residents. -She had dark plum purple colored discoloration to her left cheek extending under her chin. -She had dark plum to purple colored discoloration to the back of her head to her neck. -She had dark plum to purple colored discoloration to her left neck. Interview with the Executive Director/Administrator (ED/Administrator) on 06/10/19 from 11:50 am - 12:00 pm revealed: -Resident #2 had not had any falls from 04/16/19 - 06/02/19 -Resident #2 was being treated by physical therapy (PT) for her falls.	D911		

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	hal026065	A. BUILDING: _____ B. WING _____	C 06/12/2019

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HARMONY AT HOPE MILLS	7051 ROCKFISH ROAD FAYETTEVILLE, NC 28306

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D911	Continued From page 81 Observation of Resident #2 on 06/11/19 at 9:25 am revealed: -She was alone. -She was sitting in her wheelchair in the secured assisted living unit in a walkway to the outside patio, located between the dining room and living room, facing the living room. -She had bruising to the back of her head that extended around to her left neck that was dark plum purple in color. -There was bruising that was dark purple to grey in color to her left cheek closest to her mouth that radiated under her left chin. -The bruise was 4 inches by 2.5 inches. -Her eyes were closed, and her head was tilted back against the back of the wheelchair, and her chin was extended forward. -Her mouth was open. -Her right and left arms were limp and hanging straight down on each side of the wheelchair wheels. -Her right and left legs were extended forward with both heels resting back on the floor. -She was snoring. -The nurse's desk was located behind her and to the left. -There were staff in and out of the nurse's desk. -Staff did not approach Resident #2 to check on her. Observation of Resident #2 on 06/11/19 at 10:48 am revealed: -She was sitting in her wheelchair located in the living room of the secured assisted living unit. -Her eyes were closed, and her head tilted backwards against the back of the wheelchair seat. -Her arms were limp in her lap. -There was an unsecured clear cup containing a clear beverage resting on her right thigh leaning	D911		

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D911	Continued From page 82	D911		

forward against a newspaper and her right hand was beside the cup.
-The fingers on her right hand were in relaxed and in a neutral "C" position and were not holding the cup of beverage.
-There were other residents in the living room.
-The nurse's desk was behind and to the left of the living room.
-The living room was visible from the nurse's desk.
-Staff were walking by the living room.
-Staff did not approach Resident #2.

Observation of Resident #2 on 06/12/19 at 4:50 pm revealed:
-She was sitting at the dining room table alone.
-Her eyes were closed, head tilted forward with her chin towards her chest, and both arms outstretched on her legs.
-Supper had not been served.

Interview with Resident #2 on 06/12/19 at 9:30 am revealed:
-Staff would get her out of bed early in the morning and put her in the wheelchair in the common area of the secured assisted living unit.
-She would sit in the wheelchair all day.
-She would sleep in her wheelchair.
-She did not like sleeping in her wheelchair.
-She wanted to sleep in her bed.
-She had asked staff to help her get back in bed and was told no.
-She did not know who the staff was.

Interview with Resident #2's family member on 06/11/19 at 11:00 am revealed:
-Staff would keep Resident #2 in her wheelchair in the common area of the secured assisted living Unit because she fell when she was in her room.
-Staff would not allow Resident #2 to go to bed

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during the day because of the falls in her room and because they could not monitor her in her room.
-Resident #2 would sleep in her wheelchair after breakfast throughout the day while in the common area.

Interview with a resident on 06/12/19 at 9:10 am revealed:
-Resident #2 would be placed in the common area by staff every day around 6:30 am.
-Resident #2 would stay in the common area until a little before 8:00 pm when the resident was put to bed by staff.
-The only time Resident #2 was not in the common area was when she was taken to her room for incontinent care after lunch.

Review of Resident #2's progress notes revealed:
-On 04/18/19 at 10:38 pm the resident reported to her family member that staff would put her to bed between 9:00 pm - 10:00 pm every night.
-Staff did not put resident to bed between 9:00 pm - 10:00 pm every night.
-The resident would try to go the bathroom without assistance after several falls.
-She was emotional after reminding her she cannot be in her room alone.

Interview with the Mediation Aide (MA) on 06/11/19 at 9:50 am who wrote Resident #2's 04/18/19 progress note revealed:
-She normally worked nights.
-Third shift was supposed get Resident #2 up before first shift started because the resident was "heavy care".
-Resident #2 was kept in the common area daily so she could be monitored for falls.
-She would help Resident #2 to bed if she asked.
-She did not remember Resident #2 being upset.

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D911	Continued From page 84 Confidential staff interview revealed: -Third shift would get Resident #2 up early in the morning and put her in the wheelchair at the nurse's desk. -Resident #2 would stay in the wheelchair in the common area during the day so she could be monitored because of falls. -Second shift would put Resident #2 to bed at night. -Resident #2 had never asked to get back in bed. Confidential interview with a second staff revealed: -He visited the secured assisted living unit daily off and on from 9:30 am - 4:00 pm. -Resident #12 would sleep in her wheelchair located in the common area of the secured assisted living unit "many times". Interview with a Licensed Practical Nurse (LPN) Supervisor on 06/05/19 at 1:00 pm revealed: -Staff would get Resident #2 out of bed early in the mornings. -Resident #2 would stay in the wheelchair all day until staff assist her back to bed later in the evenings because she would fall when in her room. A second interview with a LPN Supervisor on 06/12/19 at 8:55 am revealed: -Resident #2 was a falls risk. -Third shift would get Resident #2 out of bed before first shift started. -Resident #2 would sit in her wheelchair all day at the nurse's desk or common area of the unit so she could be monitored because she was a fall risk to go back to bed. -Second shift would put Resident #2 back to bed after she had supper.	D911		

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D911	Continued From page 85 -Resident #2 was checked on throughout the day. -Resident #2 had never asked to go back to bed during the day. -She had never asked Resident #2 if she wanted to go back to bed during the day. -Staff had never been instructed to ask Resident #2 if she wanted to go back to bed during the day. Interview with the ED/Administrator on 06/11/19 at 2:30 pm revealed: -Some residents would choose to sleep in their wheelchairs. -If Resident #2 wanted to go to bed she should be allowed. -Resident #2 was not alert or cognitively aware to tell staff when she wanted to go to bed. A second interview with the ED/Administrator on 06/12/19 at 6:20 pm revealed he did not expect Resident #2 to sit in her wheelchair throughout the day and sleep. Interview with Resident #2's current Primary Care Provider (PCP) on 06/11/19 at 4:39 pm revealed: -Resident #2 needed assistance getting out of bed and with her Activities of Daily Living (ADL). -Staff tried to "encourage" Resident #2 to get out of bed and stay in the common area so they could monitor her better to prevent falls. b. Observation of Resident #2's room on 06/11/19 at 8:04 am revealed: -The head of her bed was against a wall partition adjoining her roommates sleeping area. -The foot of her bed was closest to her closet. -The top mattress of her bed was approximately 3 feet from the floor. Observation of Resident #2's room on 06/12/19 at 9:30 am revealed:	D911		

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D911	Continued From page 86 -The foot of her bed was on a wall partition facing her roommates sleeping area. -The head of her bed was not against a wall and was located towards the closet. -The top mattress of the bed was approximately 5 foot from the floor. -A night stand was against a wall between the head of the bed and the closet. -On the nightstand was a lamp, clock, tissues, petroleum ointment, and loose papers. Interview with Resident #2 on 06/12/19 at 9:30 am revealed: -"Yesterday someone moved my bed around" -She didn't not like her bed moved. -She did not know why her bed had been moved. -No one asked her before moving her bed. -It was hard for her to get on her bed because it was too high. -She wanted her bed back the way it was. -She could not see her clock on her night stand. -It was hard for her to see the television with her bed moved. -She wanted the head of her bed against the wall facing the television. -She wanted her night stand on the left or right of her bed. Interview with a Licensed Practical Nurse (LPN) Supervisor on 06/12/19 at 8:55 am revealed: -She did not know Resident #2's bed had been moved. -She did not know who moved Resident #2's bed. -Resident #2 should have been asked before moving her bed. -She did not think moving Resident #2's bed was a problem for the resident. -The head of Resident #2's bed used to be against the wall facing the television. -Resident #2 kept falling from her bed so it was	D911		

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D911	Continued From page 87 moved against the wall with the head of the bed against the room partition. Interview with a Medication Aide (MA) on 06/12/10 at 9:25 am revealed: -Resident #2's bed was moved because her roommate complained about the resident snoring. -They did not ask Resident #2 about moving her bed because they did not want to hurt her feelings by telling her the roommate complained about her snoring. Interview with the Health Care Coordinator (HCC) on 06/12/19 at 6:30 pm revealed: -He did not know Resident #2's bed had been moved. -Resident #2 should have been asked before her bed was moved. -Resident #2's bed should not have been moved if she did not want it moved. Interview with the Executive Director/Administrator (ED/Administrator) on 06/12/19 at 6:58 pm revealed: -He did not know Resident #2's bed had been moved. -Resident #2 should have been asked before her bed was moved. -Resident #2's bed should not have been moved if she did not want it moved. 2. Review of Resident #12's current FL-2 dated 02/27/19 revealed: -Diagnosis revealed a history of a cerebrovascular accident (CVA). -He required personal assistance with bathing and dressing. -He was semi-ambulatory. -Bladder continence was not marked.	D911		

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D911	Continued From page 88	D911		

Review of Resident #12's care plan dated 03/06/19 revealed:
-The resident was independent with ambulation.
-The resident was independent with transfers.
-The resident required physical assistance, with prompts/cues of one staff member for bathing.
-The resident required stand by assistance for toileting.
-The resident required physical assistance for dressing and undressing.

Observation on 06/07/19 at 11:58 am of a documented titled "Today's Rundown" revealed:
-It was posted on a filing cabinet at the secured assisted living unit nurses' desk.
-The document was visible to the public entering the secured assisted living unit.
-The document was visible to the public walking by the nurse's desk.
-There was a section titled "move outs/possible"
-Under "move outs/possible" was Resident #12's name.
-Beside Resident #12's name was the comment "nasty habits".

Interview with a Medication Aide (MA) on 06/07/19 at 12:00 pm revealed:
-The paper was a list of things staff needed to know about residents, so they could be more aware of residents and staff concerns.
-The paper was compiled by the Licensed Practical Nurse supervisors daily.
-The information on the paper was compiled during the "stand up" meetings with the nurses and management staff.
-The information on the paper was relayed at shift change from the MA's.
-The paper was normally kept by the computer behind the nurse's desk out of site.
-He did not know who posted the paper on the file

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D911	Continued From page 89	D911		

cabinet visible to people walking by.
-"Today's Rundown" had not been discussed with him today.

Interview with the Licensed Practical Nurse (LPN) Supervisor on 06/07/19 at 12:15 pm revealed:
-She had typed up the documented titled "Today's Rundown".
-No one had instructed her to type the document.
-She did not ask permission from anyone to type and post the document.
-She posted the document on the file cabinet by the nurse's desk.
-The document was intended to keep staff aware of what was going on with residents.
-The "nasty habits" by Resident 12's name referred to the resident requesting a urinal, urinating in his pants, urinating in a cup, and leaving the bathrooms soiled with urine and feces after use.
-Resident #12 would not ask for or allow staff to help him when using the bathroom.
-Resident #12 would intentionally urinate in his pants.
-When Resident #12 would urinate his pants, he would say he couldn't make it to the bathroom.
-"He's in his right mind, he knows what he's doing."
-She did not respond when asked if she thought Resident #12 would actually urinate on himself when he would not ask for help, or if his provider had been informed.
-Resident #12 could not have a urinal because a urinal was a "skilled need".
-There was a facility policy that residents could not have urinals.

Interview with Resident #12 on 06/12/19 at 4:50 pm revealed:
-He was happy at the facility.

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D911	Continued From page 90 -Staff was "ok". -Sometimes he could not make it to the bathroom on time. -He did not want to urinate on himself, he could not help it. -He had asked for a urinal because it was easier to use than having to transfer to the bathroom. -He required a wheelchair for mobility. -He required assistance with transfers, dressing, and bathing. Interview with the Executive Director/Administrator (ED/Administrator) on 06/07/19 at 1:06 pm revealed: -He thought the document titled "Today's Rundown" was information obtained at the last resident at risk meeting on 06/06/19. -He had never seen the document before now. -The document must have typed up by one of the LPN supervisors. -He had never instructed anyone to compile the information on the document. -He did not approve of the information being typed up and posted for the public to see. -He preferred the information be verbally discussed with staff because everyone would be at the meetings. -He did not know what "move outs/possible" meant. -No one mentioned Resident #12 had "nasty habits" during at risk meetings. -The document "Today's Rundown" would be taken down "immediately". -Resident #12 would "pee in a cup" and leave it on a chair. -Resident #12 would leave his incontinent brief on the bathroom floor. -Resident #12 would not ask for help using the bathroom. -He expected Resident #12 to ask for help using	D911		

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D911	Continued From page 91 the bathroom. -He had never told Resident #12's family member the resident would be discharged because the resident could not "hold his urine". -If Resident #12 wanted a urinal he should have a urinal. -There was no facility policy that residents could not have urinals. Interview with the Health Care Coordinator (HCC) on 06/07/19 at 1:5 pm revealed: -The document "Today's Rundown" was "unacceptable". -The information posted for display warranted disciplinary action. -Resident #12 would urinate on the floor and had made inappropriate comments to a visitor at one time. -No one had ever mentioned Resident #12 had "nasty habits". -He did not know the document had been posted. -He expected resident concerns to be discussed verbally with staff instead of posting a document. -None of the residents listed under "move outs/possible" were up for discharge. -He expected who ever posted the document to have first come to him for approval. -He would not have approved the document to be posted. -Information discussed during the residents at risk meeting was confidential and applied to the Health Information Portability Protection Act (HIPPA). The facility failed to assure residents were treated with respect, dignity, consideration, and right to privacy by refusing to allow Resident #2 (who had dementia and multiple falls, and was wheelchair bound) the right to visit her room, sleep in her bed during the day, and causing her to have to	D911		

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D911	Continued From page 92 sleep in a wheelchair of the common area in the secured assisted living unit from before breakfast to after supper, and moving her bed without discussing with her first when she did not want her bed moved because she could not see television well and could not see her clock on her night stand that was behind the head of her bed causing her to have to sit up in bed and turn around to see the clock, or reach over the head of her bed to reach her lamp (#2); and posting a document that listed Resident #12's name and "nasty habits" beside his name at the nurses desk that was visible to the public. 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 06/07/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 12, 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 regulations. This Rule is not met as evidenced by:	D912		

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D912	Continued From page 93 Based on observations, record reviews, and interviews, the facility failed to assure each resident received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules related to personal care and supervision, medication administration, resident rights, and nutrition and food service. The findings are: 1 Based on observation, interviews, and record review, the facility failed to provide personal care assistance to 1 of 5 residents (#2) sampled related to incontinent care. [Refer to Tag D269, 10A NCAC 13F.0901(a) Personal Care and Supervision (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 3 of 5 residents (#2, #3, #13) observed during the medication passes including errors with insulin (#2, #3), and Protonix (#13); and for 1 of 5 sampled residents (#5) including a medication to treat and prevent heart failure (#5). [Refer to Tag D358, 10A NCAC 13F.1004(a) Medication Administration (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure residents were treated with respect, dignity, consideration, and right to privacy for 2 of 5 sampled residents as related to staff denying a resident the right to sleep in her room during the day and moving her bed without discussing with the resident (#2), and a resident's name listed on a document with "nasty habits" by his name that was posted visible to the public (#12).[Refer to Tag D911, G.S.	D912		

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	hal026065	A. BUILDING: _____ B. WING _____	C 06/12/2019

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D912	Continued From page 94 131D-21(1) Declaration of Residents' Rights (Type B Violation)]. 4. Based on observations, interviews, and record reviews the facility failed to assure all food and beverage being stored, prepared, and served to residents were protected from contamination related to a wet pink, brown and black build-up substance in 2 of 2 of the facility's ice machines. [Refer to Tag D283, 10A NCAC 13F.0904(a)(2) Nutrition and Food Service (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: Based on observations, interviews and record reviews, the facility failed to assure each resident received the care and services necessary to maintain their physical health and safety as related to personal care and supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) resulting in the resident having multiple falls and sustaining injuries including multiple bruising over her entire body, a fracture to the right eye socket with optic nerve damage, and a laceration to the back of her head requiring sutures. [Refer to Tag D 270, 10 A NCAC 13F.0901(b) Personal Care and	D914		

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D914	Continued From page 95 Supervision (Type A1 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and	D935		

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D935	Continued From page 96 procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 4 sampled staff (Staff C) who administered medications, had completed the Medication Clinical Skills Competency validation, the 5, 10, or 15 hour state approved medication training required or had a verification of previous employment completed prior to administering medications. The findings are: Review of Staff C, medication aide (MA)/nurse assistant (NA) personnel record revealed: -Staff C was hired 03/05/19 as a MA. -There was documentation Staff C passed the written medication administration examination on 09/10/08. -There was no documentation Staff C had completed the Medication Clinical Skills Competency validation. -There was no documentation of a medication aide verification. -There was no documentation of the 5 hour, 10 hour or 15 hour medication training in the personnel file.	D935		

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D935	Continued From page 97 Review of a resident's April 2019 electronic medication administration record (eMAR) revealed Staff C documented administration of medications on 04/03/19, 04/08/19, 04/17/19, 04/20/19, 04/21/19, 04/22/19 and 04/26/19. Review of a resident's May 2019 eMAR revealed Staff C documented administration of medications on 05/01/19, 05/05/19, 05/06/19, 05/08/19, 05/10/19, 05/15/19, 05/20/19, 05/24/19 and 05/29/19. Review of a resident's June 2019 eMAR revealed Staff C documented administration of medications on 06/01/19, 06/02/19, 06/03/19, 06/04/19, 06/05/19, 06/06/19,06/07/19 and 06/11/19. Interview with a MA on 06/12/19 at 12:26 pm revealed the MA's duties consist of obtaining fingerstick blood sugars, administering insulin, ADLs, and vital signs, and administering medications. Telephone interview with Staff C on 06/13/19 at 12:34pm revealed: -She had worked full time in the facility as a MA/nursing assistant (NA) since 03/05/19. -She could not recall receiving any diabetic training while employed at the facility. -She took the medication aide training on 06/13/19. -Staff C spent the majority of her time at the facility on the medication cart. -Staff C was unaware of completing a medications skills checklist. -She had not completed a check list for the facility since being hired.	D935		

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D935	Continued From page 98 Interview with the Executive Director/Administrator on 06/12/19 at 12:30pm revealed: -Staff C was hired at the facility as a MA. -Staff C did not have documentation of a completed medication skill check list. -Staff C did not have documentation of the 5 hour, 10 hour, or 15 hour state approved medication training nor the verification of previous employment completed prior to administering medications.	D935		