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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services (DSS) conducted a follow-up and complaint survey on 07/23/19 through 07/24/19. The Complaint Investigation was initiated by the County DSS on 07/01/19.	D 000		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter. Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator/SIC In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 51-60 Aide 24 24 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 61-70 Aide 28 28 24	D 219		

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Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

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151-160 Aide 64 64 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
191-200 Aide 80 80 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
221-230 Aide 92 92 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
231-240 Aide 96 96 64
Supervisor 24 24 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

This Rule is not met as evidenced by:

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D 219	Continued From page 3 TYPE A2 VIOLATION Based on observation, interviews and record review, the facility failed to assure the required staffing hours were met on first, second and third shifts (7:00am-3:00pm, 3:00pm to 11:00pm and 11:00pm-7:00am) based on a census of 69 -72 residents, with 29 of 49 shifts sampled from 06/24/19 through 07/14/19 understaffed. The findings are: Review of the facility census, from 06/30/19-07/14/19, there was a census of 69 residents. Review of staff time cards for 06/30/19 through 07/14/19 revealed: -On 06/30/19, on first shift, there was a total of 24 hours of aid coverage with a shortage of 4 hours. -On 06/30/19, on second shift, there was a total of 25.5 hours of aid coverage with a shortage of 2.5 hours. -On 06/30/19, on third shift, there was a total of 16 hours of aide coverage with a shortage of 8 hours. -On 07/01/19, on second shift, there was a total of 18.5 hours of aide coverage with a shortage of 9.5 hours. -On 07/01/19, on third shift, there was a total of 8 hours of aide coverage with a shortage of 16 hours. -On 07/03/19, on third shift, there was a total of 21.5 hours of aide coverage with a shortage of 3.5 hours. -On 07/04/19, on third shift, there was a total of 16 hours of aide coverage with a shortage of 8 hours. -On 07/05/19, on second shift, there was a total of 17.5 hours of aide coverage with a shortage of	D 219		

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10.5 hours.
-On 07/06/19, on second shift, there was a total of 20 hours of aide coverage with a shortage of 8 hours.
-On 07/06/19, on third shift shift, there was a total of 8 hours of aide coverage with a shortage of 16 hours.
-On 07/07/19, on first shift, there was a total of 23 hours of aide coverage with a shortage of 5 hours.
-On 07/07/19, on second shift, there was a total of 20.5 hours of aide coverage with a shortage of 7.5 hours.
-On 07/07/19, on third shift, there was a total of 8 hours of aide coverage with a shortage of 16 hours.
-On 07/08/19, on second shift, there was a total of 9.5 hours of aide coverage with a shortage of 18.5 hours.
-On, 07/09/19, on third shift, there was a total of 16 hours of aide coverage with a shortage of 8 hours.
-On 07/12/19, on second shift, there was a total of 17 hours of aide coverage with a shortage of 11 hours
-On, 07/13/19, on first shift, there was a total of 21 hours of aide coverage with a shortage of 7 hours.
-On 07/13/19, on second shift, there was a total of 16 hours of aide coverage with a shortage of 12 hours.

Review of the facility census from 06/23/19 through 06/29/19 revealed a census of 74 residents.

Review of staff time cards for 06/23/19 through 06/30/19 revealed:
-On 06/24/19, on second shift, there was a total of 2 hours of aide coverage with a shortage of 8

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hours.
-On 06/24/19, on third shift, there was a total of 16 hours of aide coverage with a shortage of 8 hours.
-On 06/25/19, on second shift, there was a total of 12.5 hours of aide coverage with a shortage of 19.5 hours.
-On 06/25/19, on third shift, there was a total of 13.5 hours of aide coverage with a shortage of 18.5 hours.
-On 06/26/19, on third shift, there was a total of 16 hours of aide coverage with a shortage of 8 hours.
-On 06/27/19, on third shift, there was a total of 21 hours of aide coverage with a shortage of 3 hours.
-On 06/28/19, on second shift, there was a total of 20 hours of aide coverage with a shortage of 12 hours.
-On 06/28/19, on third shift, there was a total of 7.75 hours of aide coverage with a shortage of 16.25 hours.
-On 06/29/19, on first shift, there was a total of 23 hours of aide coverage with a shortage of 9 hours
-On 06/29/19, on second shift, there was a total of 22 hours of aide coverage with a shortage of 10 hours.
-On 06/29/19, on third shift there was a total of 14 hours of aide coverage with a shortage of 10 hours.

Confidential interview with two staff revealed:
-"Sometimes we are short staffed on the weekends".
-It was hard to get everything done on the weekends when only one medication aide (MA)/supervisor and one personal care aide (PCA) were working with a census of 70 residents.
-Staff complained to management but were told

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they were looking for more help.
-"I have trouble getting to everyone's needs when we are short staffed."
-It was hard to answer all the call bells when we were short staffed.

Interview with the Resident Care Coordinator (RCC) revealed:
-She was responsible for creating the staff work schedule and approving all changes to the schedule since 07/15/19.
-She tried to staff first and second shifts with 3 medication aides (MAs) and 3 personal care aides (PCAs).
-She scheduled 12 hour shifts for the MAs on first and second shift to provide sufficient coverage.
-One of the MAs on each shift was the lead MA and supervised the shift.
-The schedule was often made 2 weeks in advance so the census in the facility was not always reflected in the staffing.

Interview with the lead MA on 07/29/19 at 11:20pm revealed:
-She had been responsible for the scheduling "for several months, under the supervision of the previous Administrator".
-The current RCC had requested the lead MA to continue to schedule the staff for the month of August.
-She had completed the August schedule at this time.
-She did not request the census of the facility when creating the schedule.
-She was told by the RCC to schedule 2 MAs and 3 PCAs per shift.
-This was the only direction she received in creating a schedule.

Interview with the Administrator on 07/29/19 at

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D 219	Continued From page 7 10:20am revealed: -The RCC was responsible for creating the schedule. -She had been responsible since 07/15/19. -The previous RCC was creating the schedule, but was not addressing the correct staffing ratio according to the census. -The RCC was to staff according to the resident census. -She thought this was reflected in the schedule from 06/30/19-07/14/19. -She had not been overseeing the scheduling since she had delegated this to the RCC. -She did not know there were several shifts that were not staffed according to the census. Interview with the previous RCC on 07/29/19 at 3:20pm revealed: -She had never been responsible for scheduling the staff. -The previous Administrator would do the staff schedule and provide her with a copy. -She would provide the Administrator with the staff's availability and requests for time off. -She did not know if he based the schedule on the current census. REFER TO TAGS 269, 270 and 271. _____ The facility failed to assure the required staffing hours were met for first, second and third shifts, sampled from 06/24/19 through 07/14/19, which resulted in a resident not receiving the necessary personal care assistance post surgery (Resident #5); a lack of supervision of a resident who demonstrated aggressive, disruptive and threatening behaviors toward other residents (Resident #13); and a resident being found deceased on the bathroom floor after a prolonged	D 219		

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D 219	Continued From page 8 period of time without staff's knowledge and emergency responders being unable to locate facility staff upon their arrival (Resident #9). Therefore, the facility's failure to assure minimal staffing to meet the needs of the residents, put the residents at substantial risk for harm and neglect and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D -34 on 07/29/19. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 26, 2019.	D 219		
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. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interviews, and record review, the facility failed to provide personal care	D 269		

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assistance to 2 of 5 residents (#2 and #5) sampled according to the care plans related to Resident #5 colostomy care and personal care and Resident #2 post-surgical care after a knee replacement.

The findings are:

Observation during the initial tour between 9:45am and 11:00pm revealed Resident #5 was in another resident's room and a urine / feces body odor was noted when she was interviewed by the survey team.

1.a. Review of Resident #5's current FL2 dated 07/16/19 revealed:
-Diagnosis included hypertension, diabetes, colostomy and delirium due to medical condition.
-Personal care assistance was documented as "self".

Review of Resident #5's Resident Register revealed an admission date of 10/10/18.

Review of Resident #5's current care plan dated 10/11/18 revealed:
-There was documentation Resident #5 had a colostomy but could not self care.
-There was documentation Resident #5 required extensive assistance with bathing and showers.
-There was documentation Resident #5 required extensive assistance with toileting and hygiene after toileting.
-The care plan was signed by the facility representative and the physician.

Telephone interview with Resident #5's family member on 07/25/19 at 5:55pm revealed:
-He and another family member had admitted Resident #5 to the facility.

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-They both explained to the Administrator and staff Resident #5 was being admitted due to needing assistance with personal care.
-Resident #5 had a colostomy for 20 years but was unable to provide the care now.
-Resident #5 used paper towels and a "Depend" to cover her stoma (a surgical opening on the belly that waste from the bowel leaves the body) instead of applying the colostomy bag.
-Resident #5 had a foul smell of urine and feces at home from not changing her colostomy bag and not taking showers.
-He explained to the facility staff and the Administrator Resident #5 would need assistant with her colostomy care.
-On several occasions he had taken Resident #5 home for a visit and she had smelled of urine and feces.
-He contacted the facility staff over the weekend about 3 weeks ago and informed them Resident #5 needed her colostomy bag checked and could someone at the facility check it.
-He had taken Resident #5 out of the facility on July 4, 2019, he called the facility to let them know to get Resident #5 ready and check her colostomy bag and give her a shower.
-He thought the facility staff had a responsibility to keep Resident #5 clean and without urine, feces and body odor.

Telephone interview with another of Resident #5's family members on 07/25/19 at 6:43pm revealed:
-Resident #5 was not able to care for her colostomy or perform personal care due to her memory "slipping."
-He admitted Resident #5 to the facility along with another family member in October 2018.
-Resident #5 could not care for her personal hygiene or colostomy at home.
-He informed the facility upon admission she

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needed assistance with her colostomy.
-Resident #5 would not apply the ostomy bag and used paper towels or a "Depend" to cover the stoma.
-At home Resident #5 had an odor to her from the colostomy and smelled like feces.
-The two family members could not care for Resident #5 at home so they placed her in the facility for personal care, showers and help with colostomy care.
-Resident #5 could not perform colostomy care on her own.

1. Interview with a Personal Care Aide (PCA) on 07/23/19 at 2:15pm revealed:
-She did not provide care or assist with emptying Resident #5's colostomy.
-The MAs were to check the colostomy for Resident #5.
-She was told Resident #5 did all her colostomy care herself.
-She was aware Resident #5 had "body odor."
-Some days you could not smell [Resident #5] because she wore a lot of perfume.

Interview with a Medication Aide (MA) on 07/23/19 at 2:30pm revealed:
-The MA do not change Resident #5's colostomy bag, the resident did everything herself.
-If Resident #5 needed supplies she would ask for it.
-"I have never smelled her".
-Resident #5's family member did call the facility concerning the colostomy care about a month ago.
-He had taken Resident #5 home and noticed an odor and thought it was coming from her colostomy.
-She did not know where Resident #5's colostomy supplies were kept in the facility.

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D 269	Continued From page 12 Observation of Resident #5 on 07/24/19 at 8:40am revealed: -Resident #5 was dressed in slacks and a sweater. -Resident #5 had a foul smell when she walked toward the surveyor and a MA. -The MA ask Resident #5 to come into the medication room. -In the med-room the MA asked to see Resident #5's colostomy, when Resident #5 rolled the top of her slacks down there were paper towels covering the stoma without a colostomy bag intact. -The MA cleaned Resident #5 and applied a new colostomy bag to Resident #5's stoma. Interview with the MA who applied Resident #5's colostomy bag on 07/24/19 at 8:40am revealed: -She smelled Resident #5 and that is why she ask to see her colostomy on 07/24/19 in the medication room. -On 07/17/19 the physician wrote an order that the MAs are to check Resident #5's colostomy bag and the wafer (an adhesive baseplate that secures to the skin around the stoma holding the colostomy bag inplace) every shift. -Resident #5 did her colostomy herself. -She was unsure if any other MA were changing the bag, or if they even knew how. -The supplies are kept in the medication room and Resident #5 had supplies in her room. Interview with Resident #5 on 07/24/19 at 8:45am revealed: -She was in a hurry on 07/24/19 and forgot to apply the bag to her stoma. -"I guess I just used the paper towels cause I was in a hurry." -Colostomy supplies were kept in her room.	D 269		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 13 -"My colostomy does leak at times and it does smell so "I try to cover the smell up with perfume." -Staff started checking her colostomy bag everyday about a week ago. Review of Resident #5's record revealed a signed physician's order dated 07/17/19 to check colostomy bag every shift change if needed, check colostomy wafer every shift and ensure it is in place. Observation of Resident #5 room on 07/24/19 at 3:15pm revealed, Resident #5 had colostomy supplies that were in her room. The supplies consisted of one colostomy bag and one wafer. Both, she pulled out from under a pillow on her bed. She did not have the other necessary supplies such as scissors or tape to apply the colostomy bag in her room. Interview with Resident #5 on 07/24/19 at 3:52pm revealed: -She completed colostomy care herself. -She needed the scissors to trim the wafer to fit the stoma prior to applying the colostomy bag. -She was unsure where the scissors were or when she had seen them last. -Her colostomy would leak at times, she used paper tape to secure the bag to her skin. -She was unsure where the tape was or when she had last used the tape. Telephone interview with Resident #5's Home Health Nurse on 07/24/19 at 4:05pm revealed: -She had seen Resident #5 once on 07/22/19 for an assessment and evaluation for care of the colostomy. -Resident #5 had told her she used paper towels at times to cover the stoma.	D 269		

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D 269	Continued From page 14 -Resident #5 did complain to her that there was a smell to the colostomy and Resident #5 was embarrassed by the smell. -She was unsure how much Resident #5 could remember to complete her colostomy care on her own. -She completed education and would follow up with Resident #5 two times weekly. Interview with second PCA on 07/25/19 at 8:30am revealed: -The PCAs did not provide care or assist with emptying Resident #5's colostomy. -She was told by the MAs Resident #5 did her own personal care which included colostomy care. Interview with another MA on 07/25/19 at 9:50pm revealed: -Resident #5 did her own colostomy care. -I have never changed the colostomy bag for Resident #5. -The lead MA changed the bag if needed. -The order for checking the colostomy every shift is on the electronic Medication Administration Record (eMAR) so we check it off after we look at the colostomy. -That order started about a week ago but before then we were not checking Resident #5 colostomy. -Colostomy supplies are kept in the medication room. Interview with a third PCA on 07/25/19 at 11:32am revealed: -She had been working for about a month and half at the facility. -She had never changed Resident #5 colostomy bag. -She was told Resident #5 did her own colostomy	D 269		

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care.
-The MAs should check Resident #5's colostomy bag and change it if needed.
-She did know Resident #5 used paper towels to cover the colostomy.
-She was aware Resident #5 had a foul smell "body odor" sometimes.
-She would tell the MAs and they would place a colostomy bag on Resident #5 when she told them.
-"I think [Resident#5] forgets to put the bag on herself.

Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:25pm revealed:
-She had worked in the facility for 3 weeks.
-She knew the physician had written an order to check Resident #5's colostomy and the wafer every shift on July 17, 2019.
-She had requested the physician write the order on 07/17/19 because to Resident #5's had "a body odor which smelled like feces from the colostomy."
-She was not aware one MA did not know where the supplies the colostomy supplies for Resident #5's were kept.
-She did not know MAs did not know how to provide colostomy care to Resident #5.
-She did not know PCAs were not assisting with personal care for Resident #5 or emptying the colostomy bag.
-She expected the staff to assist and provide personal care to Resident #5.
-She knew Resident #5 had home health services since 07/22/19.
-She had not completed the care plan dated 10/11/18 for Resident #5.
-She was not aware of the care Resident #5 required on the care plan dated 10/11/18.
-"If the care plan for [Resident #5] had extensive

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care with toileting the staff should be assisting her with that task.
-"If the care plan said [Resident #5] could not provide care for her colostomy then staff should be providing care for it."
-The care plans were completed by the facility nurse and reviewed in the morning meetings for new admissions.

Interview with the facility LHPS Nurse on 07/26/19 at 1:50pm revealed:
-She was responsible for completing and reviewing care plans for the residents in the facility.
-She had not completed the care plan for Resident #5 on 10/11/18.
-She was responsible for communicating with the floor staff how to provide care for the residents according to the care plans.
-The person who completed Resident #5's care plan told me Resident #5 could do everything for herself.
-She did not know the care plan dated 10/11/18 documented extensive care with personal care and toileting.
-She was not aware the care plan dated 10/11/18 documented Resident #5 could not self-care for her colostomy.
-She was not aware the MAs could not provide colostomy care for Resident #5.
-She did not know the PCAs were not assisting with emptying the colostomy bag for Resident #5.
-She did not know the PCAs were documented personal care completed without supervision of the task being performed.
-She thought Resident #5 had colostomy supplies in her room and could self-care for her colostomy.
-Staff had not spoken to her with concerns for Resident #5's colostomy.

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D 269	Continued From page 17 Interview with a Lead Medication Aide (MA) on 07/29/19 at 4:10pm revealed: -She knew Resident #5 had her colostomy bag off at times, probably 2 or 3 times a week. -She knew Resident #5 used paper towels to cover the stoma and the paper towels would leak and cause Resident #5 to smell like feces. -She would change Resident #5's colostomy bag about ever other day, she was the only MA that knew how to change the bag. -She never told the physician about Resident #5 not having a colostomy bag on. -The PCAs do not check the bag or assist with emptying the bag or doing any personal care for Resident #5. -The MAs did not check Resident #5's colostomy until the physician wrote the order on 07/17/19. -The MAs are to make sure every shift Resident #5's colostomy bag is secured and document on the eMAR. Interview with the Administratoron 07/26/19 at 11:45am revealed: -She started as the Administrator three weeks ago. -She knew resident #5 had a foul body odor around July 4, 2019 when Resident #5's family member contacted her. -She had a MA check her colostomy bag prior to the family taking Resident #5 out of the facility. -She did not know that staff were not assisting Resident #5 with colostomy care. -She did know the physician had written an order on 07/17/19 to check the colostomy every shift. -She did not know Resident #5's care plan dated 10/11/18 had documented extensive care for bathing and toileting. -She did not know Resident #5's care plan dated 10/11/18 had documented Resident #5 had a colostomy but could not provide self-care.	D 269		

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-The staff were to assist and supervise Resident #5 colostomy care.
-The care plans were to be followed so staff provided the appropriate care and services that are right for the residents.

b. Review of Resident #5's current FL2 dated 07/16/19 revealed:
-Diagnosis included hypertension, diabetes, colostomy and delirium due to medical condition.
-Personal care assistance was documented as "self".

Review of Resident #5's current care plan dated 10/11/18 revealed:
-There was documentation Resident #5 had a colostomy but could not self care.
-There was documentation Resident #5 required extensive assistance with bathing and showers.
-There was documentation Resident #5 required extensive assistance with toileting and hygiene after toileting.
-The care plan was signed by the facility representative and the physician.

Interview with a Personal Care Aide (PCA) on 07/23/19 at 2:15pm revealed:
-Resident #5 could perform all personal care on her own.
-She did not provide assistance for Resident#5's showers or grooming.
-She was aware Resident #5 had "body odor."
-Some days you could not smell [Resident #5] because she wore a lot of perfume.

Interview with a second PCA on 07/25/19 at 8:30am revealed:
-Resident #5 could do all her ADLs herself which included washing her hair, taking a shower and changing her colostomy bag.

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-Resident #5 is very private, "I think she takes a sponge bath because of the colostomy."
-She charted Resident #5 baths were completed on the daily shower assignment sheet because "[Resident #5] tells me she had done her shower."
-She never supervised Resident #5 to the shower room or handed her soap and a washcloth.

Interview with a third PCA on 07/25/19 at 11:32am revealed:
-She had worked in the facility for a month and half.
-She was told Resident #5 did her own personal care.
-She was aware Resident #5 had a foul smell "body odor" sometimes.
-Resident #5 was "self-care" with showers and toileting.
-"I ask her [Resident#5] if she showered and then document "Done" on the shower log."
-She did not assist Resident #5 with any personal care task which included showers, washing hair or toileting.

Review of the shower log for Resident #5 revealed showers were being documented as completed throughout the months of June 2019 and July 2019 three times weekly.

Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:25pm revealed:
-She had worked in the facility for 3 weeks.
-She did not know PCAs were not assisting with personal care or showers for Resident #5.
-She expected the staff to assist and provide personal care to Resident #5.
-She knew Resident #5 had home health services since 07/22/19.
-"If the care plan for [Resident #5] had extensive

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care with toileting the staff should be assisting her with that task.
-The care plans were completed by the facility nurse and reviewed in the morning meetings for new admissions.

Interview with the facility LHPS Nurse on 07/26/19 at 1:50pm revealed:
-She was responsible for completing and reviewing care plans for the residents in the facility.
-She had not completed the care plan for Resident #5 on 10/11/19.
-She was responsible for communicating with the floor staff how to provide care for the residents according to the care plans.
-The person who completed Resident #5's care plan told me Resident #5 could do everything for herself.
-She did not know the care plan documented extensive care with personal care and toileting.
-She did not know the PCAs were documented personal care completed without supervision of the task being performed.

Review of Resident #5's psychotherapy notes dated 06/26/19 revealed:
-There was documentation Resident #5's hygiene was still often neglected.
-There was documentation Resident #5 needed time for herself and increase self care.

Review of Resident #5's psychotherapy notes dated 07/10/19 revealed:
-There was documentation Resident #5's hygiene was worsening again per staff.
-There was documentation Resident #5 had urinated on the seat of the community van while attending the day program.
-There was documentation Resident #5

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objectives were to take care of herself and her activities of daily living.

Interview with Resident #5's psychotherapy Social Worker on 07/24/19 at 12:55pm revealed:
-Resident #5 was being seen for anxiety and depression.
-She had worked with Resident #5 about 6 weeks in the facility.
-She noticed Resident #5's hygiene would be an issue, Resident #5 had body odor that was obviously from lack of personal hygiene.
-Resident #5 would tell her she had showered and provided care for her colostomy, "but I did not believe her."
-She informed the staff that Resident #5 could benefit from assistance with her hygiene.
-The staff told me Resident #5 provided all her personal care herself.
-Resident #5 had a boyfriend in the facility and had neglected her personal care due to this new boyfriend.
-She had seen Resident #5 again on 07/17/19 and her hygiene was still an issue and concern.
-She had informed the RCC on 07/17/19 of Resident #5's personal hygiene.

Interview with the Administratoron 07/26/19 at 11:45am revealed:
-She started as the Administrator three weeks ago.
-She knew resident #5 had a foul smell around July 4, 2019 when Resident #5's family member contacted her.
-She had given Resident #5 a shower prior to the family taking Resident #5 out of the facility.
-She did not know that staff were not assisting Resident #5 with personal care or showers.
-She did not know Resident #5's care plan dated 10/11/19 had documented extensive care for

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bating and toileting.
-The staff were to assist and supervise [Resident #5] with showers and toileting.
-She did not know staff were documented on the daily shower assignment log "Done" for Resident #5 when they had not assisted, seen or supervised Resident #5 with her personal care.
-The care plans should be followed so we provide the appropriate care and services that are right for the residents.

3. Review of Resident #2's current FL-2 dated 01/16/19 revealed diagnoses included bipolar disorder, chronic obstructive pulmonary disease, constipation, gastroesophageal reflux disease, hypertension, schizoaffective disorder, tobacco use, and vasomotor symptoms.

Telephone interview with a representative from the orthopedic doctor's office for Resident #2 on 07/24/19 at 11:20am revealed:
-Resident #2 underwent a total right knee arthroplasty on 07/16/19.
-Resident #2 had a normal discharge that was arranged by the hospital.
-Resident #2 was weight bearing as tolerated.

Observation of Resident #2 on 07/23/19 at 10:15am observed:
-Resident #2 sitting on a rolling walker by the smoking area door holding an unlit cigarette.
-Her right leg was swollen with a purplish bruising below the knee and her right foot was dark purple with a reddish area below the knee and above the right ankle.
-A bandage was taped above the knee that extended appropriately 2 inches below the right knee.
-There was a quarter size area of dried blood around the knee area on the bandage.

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D 269	Continued From page 23 Interview with Resident #2 on 07/23/19 at 10:15AM revealed: -Resident #2 had knee surgery last week on her right knee on 07/16/19. -She had trouble bearing weight on her right leg. -She stated that, "my leg hurts like crap." -Resident #2 stated that the staff pushed her to the dining room in her rolling walker. Interview with Resident #2 on 07/29/19 at 10:45am revealed: -The facility staff did not assist her with showering or toileting. -She received a shower in the hospital "that's why I am clean now. -"I try to help myself, but it's hard to move around since I had my surgery.' -Every time I ring the call bell for assistance, "no staff would come to help me." -She had been wetting her diaper and sitting in urine until staff helped. -"My leg is swollen and hurts really bad." -No one at the facility had ever iced her knee for the swelling. -Staff told her she needed to sit down and elevate her right leg. -The doctor wanted her to move around and to try to walk. Review of Resident #2's care plan signed by the physician on 04/24/18 revealed: -Resident #2 required limited assistance with bathing, toileting, eating, and dressing. -Resident #2 was independent with mobility. Record review revealed no current care plan since 04/24/19. Interview with the Lead Medication Aide on	D 269		

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D 269	Continued From page 24 07/24/19 at 10:45am revealed: -Resident #2 returned to the facility 24-hours after surgery to her right knee. -She thought Resident #2 was going to rehab prior to returning the facility. -Resident #2 returned to the facility as weight bearing as tolerated. -Resident #2 was almost total care since the knee surgery. -She was not sure how much assistance Resident #2 required with toileting. Interview with the facility's Nurse Practitioner (NP) on 07/24/19 at 11:40AM revealed: -He had not seen Resident #2 since she returned to the facility from having knee surgery. -He was not aware that Resident #2 was having swelling in her leg. -Physical Therapy had been ordered for Resident #2 to her transfer safely. -The resident needed to move to prevent blood clots and a stroke. Review of the Resident #2's record on 07/24/19 at 12:00pm revealed there was no documentation to reflect Resident #2 was evaluated by the NP since her knee replacement on 07/16/19. Observation of Resident #2 on 07/25/19 at the hospital at 10:10am revealed: -Resident #2 was lying in a hospital bed. -The dressing on her leg had been removed. -The swelling appeared to be decreased. -The surgical area had been cleaned. Interview with Resident #2 on 07/25/19 at the hospital at 10:10AM revealed: -The staff at the hospital helped her more than the facility. -She did not know when she would be	D 269		

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D 269	Continued From page 25 discharged. Interview with the hospital Medical Doctor (MD) on 07/25/19 at 10:30AM revealed: -Resident #2 would receive a physical therapy (PT) and occupational therapy (OT) evaluation. -Resident #2 needed assistance with her activities of daily living, toileting, and ambulation for safety and to prevent falls. -Resident #2 needed to move around to prevent a blood clot or stroke. Interview with another Lead Supervisor on 07/25/19 at 2:55pm revealed. -She was not aware of how much assistance Resident #2 required for her ADL's. -She had observed staff pushing her in her rolling walker with a seat. Interview with the RCC on 07/25/19 at 3:15PM and on 07/29/19 at 4:25PM revealed: -She had been the RCC for the facility since 07/08/19. -Resident #2 was receiving home health services for skilled nursing and physical therapy. -She was not sure how much assistance Resident #2 required for toileting, transfers, getting dressing, and ambulating in the facility. Confidential staff interview with on 07/29/19 revealed: -Resident #2 returned from having knee surgery and could not walk or change her pull up. -Resident #2 was total care with everything except eating. -Staff were never told how to care for Resident #2's knee after surgery. -The RCD came to look at the resident's knee, but she never gave staff any direction on how to care for the knee.	D 269		

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D 269	Continued From page 26 -Resident #2 could barely get out of bed. -Resident #2 was now requiring a 2-person assist. Confidential interview with an employee on 07/29/19 revealed: -Resident #2 was constantly ringing the call bell for assistance over the weekend. -She attempted to assist Resident #2 with toileting, but the resident required a two person assist. -She had trouble finding a second staff member to help her. -She did not recall how long it took to get someone to assist with toileting Resident #2. -She did recall Resident #2 being soaked in urine when providing personal care. -Resident #2 would try to move around with a rolling walker but needed staff assistance. Interview with the Licensed Health Professional Support, LHPS, registered nurse, RN, on 07/26/19 at 2:06PM revealed. -She was never informed Resident #2 had surgery on her right knee. -She had never advised staff on how to provide care to Resident #2's knee. -She had not completed an assessment on Resident #2. -She expected staff to inform her of any changes in a resident's condition so she could assess the resident to ensure proper care was being provided. Review of a facility observation detail list report for Resident #2 dated 07/17/19 revealed: -The observation was completed by the RCC on 07/17/19 at 3:05pm. -The completion date of the observation by the RCC was on 07/18/19 at 10:13am.	D 269		

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-The RCC observed bruising on the left knee and shin area.
-The RCC observed no scars.
-Discoloration was located on the left knee and shin area.
-There was no flaking or pressure sores.
-There was no recommended follow-up.
-The RCC documented that she notified the NP on the report, but there was documentation on what the NP was notified regarding her assessment of Resident #2.

Telephone interview with the home health provider on 07/25/19 at 4:00pm and on 07/29/19 at 11:00am revealed:
-HH was initiated for Resident #2 on 07/11/19 for edema.
-Resident #2 received her first visit from home health nursing on 07/19/19.
-Resident #2 started physical therapy on 7/20/19.
-Resident #2 reported to the physical therapist that the staff had not done anything to help her.
-The home health provider recommended that the assessments and notes be reviewed for further information.

Review of the physical therapy notes for Resident #2 dated 07/23/19 revealed:
-Resident reported, "They don't do anything for me here! My leg hurting to bad to walk now."
-PT documented moderate edema.
-Resident was instructed to elevate her leg throughout the day.
-PT spoke with the RCC about a cold pack management.
-RCC advised that the cold pack could only be provided with a physician order.
-PT attempted to contact the physician will at the facility, but the NP was not available.
-PT documented Resident #2's pain and edema

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required the resident to need much more encouragement to engage in the therapy session.

Review of Resident #2's progress notes revealed:
-The Resident Care Director, RCD, evaluated Resident #2 on 07/18/19 at 4:05pm.
-The RCD documented bilateral extremities were swollen. The left greater than right based on recent left knee replacement surgery.
-Resident #2 was able to weight bear on right leg with a 2 person assist.
-Resident #2 was using a rollator and not ambulating.
-Resident #2 was sitting in the rollator moving around in the facility.
-There was no documentation in the record for staff to monitor or provide any additional care to Resident #2.

Telephone interview with Resident #2's responsible party on 07/29/19 at 11:15am revealed:
-She had taken Resident #2 to medical appointments because the facility would not transport, or the facility would get her to the appointment late.
-Sometimes Resident #2 had body odor when going to appointments.
-Resident #2 constantly called her to say facility staff would not assist her with showering or going to bathroom.
-She had talked with various staff members in management that Resident #2 needed assistance and how staff would talk down to Resident #2.
-Since Resident #2 had the right knee surgery on 07/16/19, she felt Resident #2 needed to be moved closer to the nurses' desk.
-Resident #2 has told her that she wet her pants waiting on someone to take her to bathroom.
-Resident #2 informed her that when she rang her

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D 269	Continued From page 29 call bell nobody answered it. _____ The facility failed to assure residents received necessary assistance with personal care as evidenced by Resident #5 not receiving assistance with colostomy care resulting in the resident using paper towels to cover the stoma site which caused an odor of feces, leakage of feces onto the resident's clothes and onto the seat of the community transportation van, and embarrassment to the resident; Resident #5, who required extensive assistance with showers and bathing, not receiving assistance with showers or bathing which contributed to the resident having a foul odor of urine and feces, as well as a noticeable body odor; and Resident #2 who required assistance with personal care, toileting, transfers and ambulation after a recent knee replacement surgery not receiving assistance from facility staff. The facility's failure to provide the necessary assistance with personal care put Resident #5 at risk for skin breakdown around the stoma site, at risk for urinary infections due to uncleanliness, and continued embarrassment due to foul body odor, and put Resident #2 at risk for infection or a blood clot from non-mobility of the right lower extremity, as well as at risk for falls, after knee replacement surgery. These failures placed the residents at a substantial risk for physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/25/19 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 26, 2019.	D 269		

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure supervision was provided to 2 of 7 sampled residents (Resident #12 and #13) related to a resident with a history of substance abuse, found to have a knife, beer and marijuana in his room, who returned to the facility on several occasions intoxicated and smelling of marijuana, frequently intimidated staff and residents, threatening and assaulting another resident (Resident #13), and a resident who lived on the same hall as Resident #13, in the back corner of the facility, who was threatened and assaulted by him, with no additional supervision provided for her safety by the staff (Resident #12). 1. Review of Resident #13's FL2 dated 01/17/19 revealed diagnoses included gastrointestinal hemorrhage, abdominal distension, gastroesophageal reflux disease, hypertension, muscle weakness, chronic obstructive pulmonary	D 270		

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disease, pneumonia, shortness of breath, tobacco use, unspecified psychosis, rectal prolapse, benign prostatic hyperplasia, and hyperlipidemia.

Observation of Resident #13 on 07/26/19 at 12:06pm revealed:
-Resident #13 was walking down the hallway towards the dining rooming pushing a rolling walker with a radio on the seat, playing loud music.
-Resident had a strong musty, skunk-like odor (what appeared to be marijuana) on him.

Interview with Resident #13 on 07/26/19 at 12:06pm revealed:
-He felt that overall things were good at the facility.
-There was an incident earlier in the week when Resident #12 had "lied on him and called the police."
-Resident #13 stated that he hated to laugh about the incident, but everything was so funny to him.
-According to Resident #13, Resident #12 owed him money.
-He was having a conversation with his medication aide (MA) when Resident #12 that owed him money called the "popo" on him.
-He and the Resident #12 had an agreement that she would pay him back for buying her cigarettes.
-He was not aware of residents smoking, drinking or doing illegal drugs in the smoking area.
-He stated that it was none of his business what anyone else does at the facility.
-He was not aware of the police coming to the facility for residents using drugs.
-He knows what marijuana smells like "because I am from Washington DC area".
-"What people do off property, is off property."
-He acknowledged that he would drink and

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smoke off property.
-Resident #3 stated he was never drunk in the facility.
-He confirmed that he went off property this morning.
-He would not confirm if he had engaged in smoking or drinking that morning.
-He reported that sometimes he had "selective memory."

Observation of Resident #13 on 07/26/19 at 2:30pm revealed:
-Resident #13 was sitting on a rolling walker outside under a tree by the road.
-He had headphones on, but music could still be heard.
-He had a strong musty, skunk-like odor (what appeared to be marijuana smell) that was stronger than earlier that afternoon.

Interview with Resident #13 on 07/26/19 at 2:30pm revealed:
-Resident #13 requested a confidential interview.
-He referenced the interview from earlier on 07/26/19.
-He knew the answers to the questions from earlier that day.
-Resident #13 stated "In a couple days everything would be taken care".
-He would not acknowledge who or what would be taken care of.

Interview with the Administrator on 07/26/19 at 3:55pm revealed:
-She was aware that Resident #13 was upset and believed he was upset when his room was searched on 07/26/19.
-She found a knife, beer, and marijuana in Resident #13's backpack on 07/26/19 during his room search.

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-She planned to issue Resident #13 a discharge notice, but she had not at that time.
-She was issuing the discharge notice once she had two male staff members present to serve as a witness.

Interview with a Lead Medication Aide on 07/26/19 at 4:26 pm revealed:
-Resident #12 reported to the RCC, herself and the police that Resident #13 was threatening her every time she would go out to the smoking area.
-Resident #13 had told the Resident #12 not to talk because he did not want to hear her voice.
-Neither Resident #12 or Resident #13 wanted to move rooms.
-She never documented that either resident was offered a room change.
-She never informed staff on what to do or document when Resident #13 was exhibiting behaviors.
-She had observed Resident #13 bringing beer into the facility last week.
-She never smelled marijuana on Resident #13.
-She thought Resident #13's primary care physician, (PCP), was aware of Resident #13's behaviors and drinking.
-She had never informed the PCP.
-Resident #13 had an incident where he fell out in the hallway smelling of alcohol when he had stayed out all night.
-Resident #13 was involuntarily committed (IVC) after that incident.

Interview with a resident in the facility on 07/29/19 at 10:45am revealed:
-She was outside in the smoking area when the police were called on Resident #13.
-Resident #13 was drinking beer and smoking pot outside in the smoking area.
-She was smoking cigarettes because "she did

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not like the way pot makes her feel and she did not like the taste of beer."
-Resident #13 was talking "a lot of trash" that evening.
-Resident always exhibited behaviors where he cursed, "gets in people faces", and plays loud music.
-Staff was aware of Resident #13's behaviors, but everyone just allowed Resident #13 to do whatever he wanted to do.
-She thought staff was afraid of him.

Telephone interview with a resident's responsible party on 07/29/19 at 11:15am revealed:
-She had taken care of the resident for approximately 17 years.
-She had never known the resident to smoke marijuana or drink beer.
-She did not like the resident being around Resident #13.
-Staff had informed her that the resident was hanging around Resident #13 who "smokes pot."
-Staff informed her that management was aware of Resident #13's behaviors.
-Management would just allow "Resident #13 to go out and do his own thing."
-Staff member did not elaborate on what "go out and do his own thing was."
-No matter what time of day, but especially in the evenings and on weekends, Resident #13 would be in the smoking area blasting loud music.
-"It felt like management did not care no matter how many times she spoke to them about issues in the building."

Confidential interview with a staff member on 07/29/19 revealed:
-Resident #13 did not listen to anyone including management.
-Resident #13 was constantly smoking "weed"

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and drinking beer in the outside smoking area.
-Resident #13 would sometimes smoke in the building.
-Resident #13 would say "they are not going to do anything to me because I am grown."
-Resident #13 was always aggressive with staff and other residents.
-He displayed his aggressive behaviors by arguing with staff and residents.
-Resident #13 had a habit of threatening to hit staff and residents
-The issue was told to the previous ED, but he never did anything about Resident #13's behaviors.
-Resident #13 always played very loud music and would refuse to turn the music down.

Review of facility notes documented the following for Resident #13 revealed:
-The Resident Care Coordinator (RCC) documented on 07/26/19 as a late entry that Resident #13 was observed in the hallway playing loud music and using profanity on 07/23/19. The RCC was able to redirect Resident #13 with no problem.
-The MA documented as a late entry on 07/26/19 that a resident reported she felt threatened by Resident #13 and called 911.
-The RCC documented on 07/18/19 that Resident #13 was observed bringing alcoholic beverages in the facility. The RCC followed Resident #13 to his room and confiscated the alcohol. The RCC explained to Resident #13 the facility's rule and the importance of the effect of alcohol consumption with the medications he takes.

Refer to confidential telephone interview with a visitor on 07/25/19 at 3:45pm.

Refer to interview with the Administrator on

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D 270	Continued From page 36 07/25/19 at 4:30pm. Refer to confidential interview with a resident. Refer to confidential staff interview. 2. Review of Resident #12's FL2 dated 01/17/19 revealed: -Diagnoses included cerebral infarction, pulmonary disease, cerebral aneurysm, hypertension and depression. -Resident #12 was semi-ambulatory with a wheelchair. Interview with Resident #12 on 07/25/19 at 9:00 am revealed: -On 07/23/19 at dinner time, Resident #13 approached Resident #12 at her dining table and said he was on the verge of killing her. -Between 7:00pm and 8:00pm that same evening Resident #12 was in the smoking area of the facility with 2 other women. -In the adjacent screened in porch area, connected to the smoking area, Resident #13 was drinking alcohol and smoking marijuana. -Resident #13 came out from the porch and raised his fist as he approached Resident #12 yelling, "Shut up and go away-you annoy me!" -Resident #12 called the police to report Resident #13's threats toward her. -The Administrator was in the building at the time and stated she would have the staff "watch him." -About one month ago, Resident #13 hit Resident #12 in the back of the head as she was wheeling herself from the smoking area, yelling "I just don't want to hear your voice!". -Resident #12 reported the assault to the police. -Resident #12 did not press charges at that time because the previous Executive Administrator told her she would have to go to court, and she did not have private transportation.	D 270		

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D 270	Continued From page 37 -'I could not inconvenience my daughter who has a family and works full-time." -Resident #12 sleeps with her cane in her "good hand" and will "knock his head off if he, (Resident #13), comes near me." -Resident #12 thinks he (Resident #13) will " keep on with me. He is a ticking time bomb and will snap some day." Refer to confidential telephone interview with a visitor on 07/25/19 at 3:45pm. Refer to interview with the Administrator on 07/25/19 at 4:30pm. Refer to confidential staff interview. Refer to confidential interview with a resident. _____ Confidential telephone interview with a visitor on 07/25/19 at 3:45pm revealed: -A visitor came to the facility to visit a resident on 07/23/19 after the evening meal. -There was a lot of commotion going in the facility. -Visitor reported that a worker had called the police because a staff person was hit by Resident #13. -Visitor did not witness the incident but stated that Resident #13 was always in the smoking area playing loud music where the smell from the area was "more than just cigarettes". -Staff knew of Resident #13's behavior, but the visitor had never observed staff intervene when Resident #13 was aggressive towards residents and staff. -Visitor described aggressive behavior as "talking loudly to others and getting in staff and/or residents' faces in a threatening manner."	D 270		

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D 270	Continued From page 38 Interview with the Administrator on 07/25/19 at 4:30pm revealed: -She confirmed there was an incident with Resident #13 getting into a verbal confrontation with Resident #12 on Tuesday evening (07/23/19). -The Administrator reported that Resident #13, and two other male residents, and a female resident were in the smoking area drinking alcohol and smoking marijuana. -Resident #12 called the police because Resident #13 had verbally threatened her. -The Administrator did not put any measures in place to ensure Resident #12 was protected from Resident #13. -The Administrator confirmed Resident #12, who was threatened, and Resident #13 lived on the same hall just doors apart from each other. Confidential staff interview revealed: -Resident #13 intimidated staff and other residents. -He was loud and aggressive at times. -He obtained drugs across the street from the facility at a "drug house" and returned to the facility "high" and sometimes drunk. Confidential interview with a resident revealed: -She was in the smoking area on 07/23/19. -She witnessed Resident #13 raising his fist and threatening Resident #12. -Resident #12 left the smoking area when Resident #13 threatened her. Shortly after that the police arrived. -A few months ago, Resident #12 was assaulted by Resident #13 as she was leaving the smoking area. -The staff and the management knew Resident #13 and some other residents drink beer and "do	D 270		

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D 270	Continued From page 39 drugs" in the screened in area. _____ The facility failed to provide adequate supervision for 2 of 7 sampled residents, including supervision of Resident #13 who was known to have substance abuse issues, was frequently intoxicated at the facility, and demonstrated aggressive and intimidating behaviors toward other residents and staff, including physically assaulting a female resident; and supervision of Resident #12 who was sleeping with a cane at night in her room for protection from Resident #13 who had threatened and assaulted her, and with whom she had frequent verbal altercations. The facility's failure to supervise these residents and protect them from the threatening and intimidating behaviors of Resident #13 put residents at substantial risk for serious harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/26/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 26, 2019.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	D 271		

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

Based on record reviews and interviews, the facility failed to respond to incidents immediately and in accordance with the facility's established policy and procedures for one resident sampled (Resident #9).

Review of Resident #9's current FL2 dated 02/07/19 revealed diagnoses included dementia, diabetes, cerebral vascular accident, and depression.

Review of Resident #9's facesheetand the electronic Medication Administration Record (eMAR) revealed she was a full code.

Interview with the Administrator on 07/26/19 at 11:45am revealed:
-The facility policy for finding an unresponsive resident is to initiate CPR if the resident is a full code.
-CPR should be continued until EMS arrived to take over or pronounce death.

Review of an Accident/Incident Reports for Resident #9 dated 06/25/19 at 10:03pm revealed:
-Location of incident was in the resident's bathroom.
-The incident was non-witnessed.
-Type of injury was documented as no injury noted.
-First aid was documented as administered by "medics".
-Resident condition was unresponsive; "resident

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has expired".
-The physician and the family were notified.
-There was no documentation Cardiopulmonary Resuscitation CPR was initiated by the facility staff.

Review of Resident #9's electronic progress notes dated 06/24/19 at 5:15am revealed:
-"Resident passed away in the bathroom."
-There was no other documentation.
-There was no documentation CPR was performed per the facility policy.

Review of the Emergency Medical Service (EMS) report for Resident #9 dated 06/24/19 revealed:
-The facility called EMS at 5:26am.
-The unit was dispatched to the facility at 5:27am and arrived at the facility at 5:31am.
-At 5:33am the EMS crew arrived at patient and documented the following:
-"EMS dispatched to ALS for cardiac arrest."
-"Upon arrival an 87 year old is found lying supine on the bathroom floor."
-"The patient is apneic, pulseless, with fixed pupils, showing no signs of life."
-"The patient has dried vomit around her mouth and on her shirt."
-"Noted rigor mortis of the jaw as well as both upper and lower extremities."
-"EKG showed asystole, no mechanical pulse is palpated, all readings are zero."
-"Onset is unknown."
-"Staff were unable to state when patient was last alive."
-"DNR status is unknown."
-"EMS was only given a face sheet."
-"The patient found by her roommate but the time is unknown."

Telephone interview with the Lead Crew Medic on

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07/29/19 at 3:30pm revealed:
-He was dispatched to the facility on the morning of 06/24/19 for Resident #9.
-He found Resident #9 laying on the bathroom floor near the toilet on her back.
-There were no facility staff present in the bathroom and no one performing CPR.
-EMS did not do CPR.
-"There was dried vomit around the patient's mouth."
-There was no staff available to report Resident #9's code status or to report the cause or the time of death.
-"For rigor mortis to be present he would guess 1-2 hours or maybe longer 3-4 hours.
-Resident #9's roommate answered most of the questions.
-"It took several minutes just to get Resident #9's facesheet from the staff."

Telephone interview with Resident #9's Physician on 07/29/19 at 2:10pm revealed;
-The facility made him aware Resident had passed away on 06/24/19.
-He had not seen a death certificate and could not say the cause of death.
-For Resident #9 to have rigor mortis in the jaw and both lower and upper extremities, she must have been laying on the floor for 3-4 hours or maybe more.

Telephone interview with the third shift Medication Aide (MA) on 07/25/19 at 9:00am revealed:
-She had worked on 06/24/19 when Resident #9 was found unresponsive on the bathroom floor.
-There were 3 staff working third shift on 06/23/19 at 11:00pm to 06/24/19 at 7:00am.
-She thought it was around 5:00am when she found Resident #9 on the bathroom floor.
-She was going to obtain Resident #9's Finger

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Stick Blood Sugar when she found Resident #9 laying on her back on the bathroom floor.
-She called 911 and started CPR on Resident #9.
-She did a finger sweep to clean Resident #9's mouth out, then did mouth to mouth and chest compressions.
-"When EMS arrived, they took over CPR".
-The policy was when a resident is a full code you do CPR until EMS arrives in the facility to take over CPR.
-Resident #9 was a full code.
-She had documented in the computer system at 5:15am "Resident passed away in the bathroom."

Interview with a resident in the facility on 07/26/19 at 6:06pm revealed:
-She had gone into the bathroom on 06/24/19 around 5:00am and found Resident #9 laying on the bathroom floor near the toilet.
-Resident #9 was laying on her back.
-She went to find help and found the MA near the dining room hallway.
-The MA came into the bathroom and said, "she is dead".
-The MA closed Resident #9 eyes, "I did not see her do CPR."
-The MA told another staff to call 911.
-Resident #9 was left in the bathroom for a long time.
-EMS arrived and the resident thought they were going to take Resident #9, but they did not.

Telephone interview with a Personal Care Aide (PCA) on 07/26/19 at 7:20pm revealed:
-She had worked a week at the facility prior to 06/24/19.
-There were 3 staff working third shift on 06/23/19 at 11:00pm to 06/24/19 at 7:00am.
-She had worked on third shift when Resident #9 was found unresponsive on the bathroom floor.

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-A resident had found Resident #9 unresponsive around 5:00am on 06/24/19.
-She was not sure what had happened to Resident #9 that morning.
-She remembered checking on Resident #9 around 12:00am and at 3:00am.
-The MA who had worked on 06/24/19 did not perform CPR on Resident #9
-The PCA had performed CPR on Resident #9 but only chest compressions.
-She thought she had CPR training, but could not remember when.
-The MA called 911, she was not sure when the MA called.

Telephone interview with another PCA on 07/27/19 at 10:20am revealed:
-She had worked third shift on 06/24/19 when Resident #9 was found unresponsive in the bathroom.
-There were 3 staff working third shift on 06/23/19 at 11:00pm to 06/24/19 at 7:00am.
-She was assigned to the other side of the hallway, she did not have Resident #9 in her assignment.
-She heard the other PCA yell "she is dead, she is dead."
-She went into the bathroom and saw Resident #9 laying on the bathroom floor near the toilet on her back.
-The MA was standing over Resident #9 calling 911.
-She was unsure what Resident #9's code status was.
-She never saw the MA initiate CPR for Resident #9.
-She did see the MA shake [Resident #9] to see if she would wake up.

A second telephone interview with the third shift

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MA on 07/29/19 at 3:15pm revealed:
-She did not initiate CPR for Resident #9 on 06/24/19, the PCA started CPR.
-She was unable to physically get down on the floor to initiate CPR, and the PCA could.
-She did not know if the PCA had a current CPR or if she been trained in CPR.
-The PCA only did chest compressions, she was unsure for how long.
-She was unsure if the PCA continued chest compression until EMS arrived, she did not stay in the room with Resident #9.
-She could not say why at 5:15am she had documented in the progress notes Resident #9 had passed away, and EMS was not called until 5:26am.
-She documented Resident #9 had died at 5:15am on 06/24/19 without conformation of death from a licensed medical professional, a physician or the EMS crew.
-She had not listened through a stethoscope for a heartbeat or checked for a pulse to determine condition of Resident #9.

Interview with a PCA on 07/25/19 at 8:43am revealed:
-She had worked first shift on 06/24/19 when Resident #5 was found unresponsive on the bathroom floor.
-"I think she choked on something."
-"She was on a pureed diet but would get crackers out of the vending machine."
-"She had to be watched all the time."
-"She was not sick the day before, I am not sure what happened."

Interview with a second MA on 07/25/19 at 9:30am revealed:
-She was not working the morning of 06/24/19 when Resident #9 was found unresponsive on

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the bathroom floor.
-The facility policy was if a resident was a full code we were to do CPR until EMS arrived and took over.
-Resident #9 was a full code.
-Resident #9 was on a pureed diet but other residents would give her crackers and oatmeal cookies.
-If Resident #9 had money she would go to the vending machine and buy snacks.

Interview with a third MA on 07/25/19 at 2:15pm revealed:
-The facility policy was to start CPR if the resident was a full code and continue CPR until EMS arrives and took over.
-CPR consisted of chest compressions.
-We do not have the "plastic mouth shields" to perform mouth to mouth.

Observation with the RCC present in the medication room in the top cabinet on 07/25/19 at 2:27pm revealed there were approximately 20 barrier devices to use for performing mouth to mouth resuscitation.

Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:25pm revealed:
-She had worked in the facility for 3 weeks as the RCC.
-The policy was if a resident is found unresponsive the staff were to initiate CPR which included chest compressions and mouth to mouth until EMS or licensed personal arrived.
-She was unsure what had happened on 06/24/19 when Resident #9 was found on the bathroom floor unresponsive.
-There was no documentation in regard to what happened, the time it happened, or if CPR was performed on Resident #9 on 06/24/19.

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D 271	Continued From page 47 -The lead MA had completed the incident report on 06/24/19. Interview with the lead MA on 07/25/19 at 3:00pm revealed: -She worked on the morning of 06/24/19, but did not arrive a the facility until 9:00am. -Her responsibilities included over-seeing the MAs and the PCAs. -She had completed the incident report on 06/24/19 per the former Administrator's advice. -She had spoken to the staff briefly that worked on 06/24/19 when resident #9 was found on the floor unresponsive. -She had reviewed the progress note written at 5:15am on 06/24/19 by the MA who worked that night. -She was told the MA performed CPR but then the PCA told her she performed CPR. -She was unsure if anyone performed CPR because there was no documentation. -The facility policy was if a resident was found unresponsive the staff are to initiate CPR until EMS arrived. -She could not say what happened or did not happen that shift on 06/24/19 because there was no documentation. Interview with the Administrator on 07/26/19 at 11:45am revealed: -She had worked in the facility since July 1, 2019. -The facility policy for an unresponsive resident was to initiate CPR until EMS arrived to take over CPR, or pronounce dead. -She did not know the MA had not performed CPR on resident #9 on 06/24/19. -She did not know the MA at 5:15am on 06/24/19 had documented in the electronic progress note "resident passed away in the bathroom." -She did not know EMS was not contacted until	D 271		

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D 271	Continued From page 48 5:26am on 06/24/19. -She relied on her lead MA to complete and review the incident reports. -She relied on her clinical staff to follow the policies of the facility. Review on 07/25/19 of the death certificate for Resident #9 located in the facility revealed the document was incomplete; there was no cause of death documented or no medical director / physician's signature on the death certificate. _____ The facility failed to respond immediately in accordance with the facility's policy and procedures for assuring CPR was attempted for Resident #9 who was found unresponsive on the floor and was a "full code." The facility's policy was to perform cardio-pulmonary resuscitation (CPR) whenever a resident was found unresponsive, without a pulse, and/or not breathing until EMS arrives, however, staff failed to perform CPR for Resident #9 after she was found on the bathroom floor unresponsive and without a pulse. The facility's failure to respond immediately in accordance with its policies and procedures in the event of an unresponsive resident, places residents at substantial risk of neglect, physical harm or death which constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/25/19. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 26, 2019.	D 271		
D 273	10A NCAC 13F .0902(b) Health Care	D 273		

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D 273	Continued From page 49 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: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 violation was not abated. Based on observations, interviews and record reviews, the facility failed to assure healthcare referral and follow-up to meet the medical needs for 4 of 7 sampled residents related to not following up with a cardiology and pulmonology consult after a hospitalization for chest pain (Resident #2), not notifying the physician of a missed appointment and delayed rescheduling of an endocrinology consult (Resident #3), and not notifying the physician of 3 missed colonoscopy appointments for two residents (Residents #1 and #8). The findings are: 1. Review of Resident #2's current FL-2 dated 01/16/19 revealed diagnoses of bipolar disorder, chronic obstructive pulmonary disease, constipation, gastroesophageal reflux disease, hypertension, schizoaffective disorder, tobacco use, and vasomotor symptoms.	D 273		

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D 273	Continued From page 50 Review of Resident #2's hospital discharge dated 01/09/19 revealed: -Resident #2 was sent to the emergency room for chest pain. -She underwent a CT angiogram that was negative, but she continued to complain of a dull chest pain. -Her COPD was exacerbated. -Discharge plan was to follow-up the pulmonologist to become an established patient. Review of Resident #2's hospital discharge summary dated 07/28/19 revealed: -Resident #2 was sent to the emergency room for chest pain. -She received ultrasound of her right lower extremity for possible blood clots that was negative. -No further evaluation was indicated. Review of Resident #2's hospital discharge summary dated 07/24/19 revealed: -Resident #2 was seen in the emergency room for a stabling like chest pain. -She reported having shortness of breath. Review of Resident #2's hospital discharge dated 07/19/19 revealed: -Resident #2 seen in the ER for evaluation for pain in central area of her chest after somebody in the facility lifted her up. -She had shortness of breath. -Resident #2 had increased swelling and redness of the right lower extremities. -There was no evidence of Deep Vein Thrombosis. -A recommendation that Resident #2 follow-up with orthopedic doctor with the next available appointment and with the primary care doctor in one day.	D 273		

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D 273	Continued From page 51 Review of Resident #2's hospital discharge dated 06/25/19 revealed: -Resident #2 was sent to the emergency room for chest pain for 2-days. -She complained of having significant left upper chest wall tenderness. -The discharge plan was to follow-up with the cardiologist for the next available appointment. Review of Resident #2's hospital discharge summary dated 05/09/19 revealed: -Resident #2 was sent to the ER with complaints of chest pain for 2-hours with dizziness. -She reported the pain as be being constant and nothing is making the pain better or worse. -Resident #2's workup was negative. -There was no follow-up recommendation. Review of Resident #2's hospital discharge dated on 04/20/19 revealed: -Resident #2 started having chest pain around 10:00AM today, progressively got worse. -Her studies were within normal limits. -There was no follow-up recommendation. Review of Resident #2's hospital discharge dated 01/09/19 revealed: -Resident #2 was sent to the emergency room for chest pain. -She underwent a CT angiogram that was negative, but she continued to complain of a dull chest pain. -Her COPD was exacerbated. Observation of Resident #2 on 07/23/19 at 10:15am revealed: -Resident #2 was sitting on a rolling walker by the smoking area door holding an unlit cigarette. -She wore a night gown.	D 273		

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D 273	Continued From page 52 -Her right leg was swollen with a purplish bruising below the knee, the right foot was dark purple with a reddish area below the knee and above the right ankle. -She was wearing a taped bandage that extended from above the knee to appropriately 2 inches below the right knee. -There was a quarter size area of dried blood around the knee area on the bandage. Review of the Resident #2's record on 07/24/19 at 12:00pm revealed there was no documentation to reflect that Resident #2 was referred to the cardiologist. Interview with Resident #2 on 07/23/19 at 10:15am revealed: -She had knee surgery last week on her right knee on 07/16/19. -She had trouble bearing weight on her right leg and stated, "my leg hurts like crap." -The staff pushed her to the dining room on her rolling walker. -She did not go to rehab after surgery. -She was receiving physical therapy at the facility. A second interview with Resident #2 on 07/29/19 at 10:45am revealed: -"I try to help myself, but it's hard to move around since I had my surgery.' -Sometimes it felt like "I can't catch my breath and my chest hurts." -The chest pain and the shortness of breath had increased more since she had the knee surgery. -She was sent to the emergency room multiple times this year for chest pain and shortness of breath. -She sometimes used an inhaler. -She had never seen a cardiologist for being short of breath or the chest pain.	D 273		

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D 273	Continued From page 53 -The doctors did not seem to know why she was having chest pain. -She was told by the doctor that her shortness of breath would improve if she stopped smoking. Interview with the Lead Medication Aide on 07/24/19 at 10:45am revealed: -Resident #2 required almost total care since the knee surgery. -Theesident was sent to the emergency room early that morning (07/24/19) for chest pain and shortness of breath. -She reported that Resident #2 had shortness of breath and chest pain when she smoked and consumed alcohol. -The Resident Care Director (RCD), or the Resident Care Coordinator (RCC), usually processed the paperwork when a resident returned from the hospital or emergency room. -She was not aware that Resident #2 had orders to have consults with a cardiologist. Interview with the facility's Nurse Practitioner (NP) on 07/24/19 at 11:40am revealed: -He had not seen Resident #2 since she returned to the facility from having knee surgery. -Resident #2 needed to move to prevent blood clots and a stroke. -He was aware that Resident #2 had been sent to the emergency room multiple times for chest pain. -He was not aware that Resident #2 was sent out to the hospital 07/18/19, nor was he aware that Resident #2 was currently at the hospital. -He had examined Resident #2 in the past for the chest pain. -The resident's chest pain subsided when Milk of Magnesium (a medicaion used to treat upset stomach and heart burn) was administered to her.	D 273		

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D 273	Continued From page 54 -He had never referred Resident #2 out to be evaluated with the cardiologist. -He was not aware that Resident #2 had orders to see the cardiologist. Telephone interview with a representative from the orthopedic doctor's office for Resident #2 on 07/24/19 at 11:20AM revealed: -Resident #2 underwent a right total knee arthroplasty on 07/16/19. -Their office was not aware that Resident #2 was sent out to the hospital for the second time since her surgery for chest pain along with swelling in the knee and leg pain. A third interview with Resident #2 on 07/25/19 at 10:10am at the hospital revealed: -She continued to have some mild chest pain. -She did not know when she would be discharged. -The doctor was checking her heart and making sure she did not have a blood clot. Interview with the hospital Medical Doctor on 07/25/19 at 10:30am revealed: -Resident #2's heart was functioning properly. -Resident #2 had an elevated blood pressure. -Resident #2 was being weaned off of the oxygen. -Resident #2 needed to move around to prevent a blood clot or stroke. -Resident #2 would remain in observation until all her test were completed and she was evaluated by PT and OT. Interview with another Lead Medication Aide on 07/25/19 at 2:45pm revealed. -Resident #2 typically had problems with chest pain when she engaged in "smoking and drinking."	D 273		

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-She did not know what was going on with Resident #2 being sent out to the hospital.
-She was not aware that Resident #2 had referrals to see a pulmonologist and the cardiologist.
-The RCD and the RCC reviewed the paperwork from physician visits, hospital admissions, emergency room visits, and all the admission paperwork prior to giving the documents to the Medication Aides.
-Sometimes the referrals and orders were put under put under her door, but the information was routed to RCD or the RCC to process.
-Paperwork from doctor's appointments, hospital visits or emergency room visits "ended up all over the place."

Interview with the RCC on 07/25/19 at 3:15pm and on 07/29/19 at 4:25pm revealed:
-She was told that Resident #2 was sent out to the hospital on 07/18/19 and 07/24/19.
-She was not aware Resident #2 needed appointments to see the caridiologisit.
-She was not aware that Resident #2 was sent to ER 7 times since January for having chest pains.
-She was not aware the last three ER visits occurred after her right knee placement that included Resident #2 having chest pain and experiencing pain and swelling of the right knee.

Interview with the Licensed Health Professional Support (LHPS) Registered Nurse on 07/26/19 at 2:06pm revealed.
-She had not completed an evaluation on Resident #2.
-She expected staff to inform her of any changes in a resident's condition so she could assess the person to ensure proper care was being provided.

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D 273	Continued From page 56 b. Review of the Resident #2's record on 07/24/19 at noon revealed: -There was no documentation to reflect that Resident #2 was referred to the pulmonologist. -There was no documentation to reflect Resident #2 was evaluated by the NP since her knee replacement on 07/16/19. Interview with Resident #2 on 07/23/19 at 10:15am revealed: -She had knee surgery last week on her right knee on 07/16/19. -She had trouble bearing weight on her right leg and stated, "my leg hurts like crap." Interview with Resident #2 on 07/29/19 at 10:45am revealed: -She was sent to the emergency room multiple times this year for chest pain and shortness of breath. -She sometimes used an inhaler. -She had never seen a pulmonologist for being short of breath or the chest pain. -She was told by the doctor that her shortness of breath would improve if she stopped smoking. Interview with the Lead Medication Aide on 07/24/19 at 10:45am revealed: -Resident #2 was sent to the emergency room early that morning (07/24/19) for chest pain and shortness of breath. -She reported that Resident #2 had shortness of breath and chest pain when she smoked and consumed alcohol. -The Resident Care Director (RCD) or the Resident Care Coordinator (RCC) usually processed the paperwork when a resident returned from the hospital or emergency room. -She was not aware that Resident #2 had orders to have a consult with a pulmonologist.	D 273		

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D 273	Continued From page 57 Interview with the facility's Nurse Practitioner (NP) on 07/24/19 at 11:40am revealed: -He had not seen Resident #2 since she returned to the facility from having knee surgery. -Resident #2 needed to move to prevent blood clots and a stroke. -He was not aware that Resident #2 was sent out to the hospital 07/18/19, nor was he aware that Resident #2 was currently at the hospital. -He had never referred Resident #2 out to be evaluated with the pulmonologist. -He was not aware that Resident #2 had orders to see the pulmonologist. Another interview with Resident #2 on 07/25/19 at 10:10am at the hospital revealed: -She continued to have some mild chest pain. -She did not know when she would be discharged. -The doctor was checking her heart and making sure she did not have a blood clot. Interview with the hospital Medical Doctor on 07/25/19 at 10:30am revealed: -Resident #2 had an elevated blood pressure. -Resident #2 was being weaned off of the oxygen. -Resident #2 needed to move around to prevent a blood clot or stroke. Interview with Lead Supervisor on 07/25/19 at 2:45pm revealed. -She did not know what was going on with Resident #2 being sent out to the hospital. -She was not aware that Resident #2 had referrals to see a pulmonologist. -She did not recall seeing the referrals for Resident #2 to see a pulmonologist.	D 273		

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D 273	Continued From page 58 Interview with the RCC on 07/25/19 at 3:15pm and on 07/29/19 at 4:25pm revealed: -She was told that Resident #2 was sent out to the hospital on 07/18/19 and 07/24/19. -She was not aware that Resident #2 needed appointments to see the pulmonologist. Another confidential staff interview with on 07/29/19 revealed: -Resident #2 was constantly ringing the call bell for assistance over the past weekend. -She attempted to assist Resident #2, but the resident required a two person assist. -Resident #2 would try to move around with a rolling walker but needed staff assistance. -She had not seen Resident #2 walk since having the knee surgery. Review of Resident #2's hospital discharge summary dated 07/24/19 revealed: -Resident #2 was seen in the emergency room for a stabling like chest pain. -She reported having shortness of breath. 2. Review of Resident #3's current FL2 dated 07/03/19 revealed diagnoses included chronic kidney disease, type 2 diabetes, and peripheral neuropathy. Review of Resident #3's letter from the referred endocrinology office dated 02/13/19 revealed the resident missed a scheduled appointment scheduled on 02/12/19. Telephone interview with the endocrinology office on 07/24/19 at 8:40am revealed: -Resident #3 was a "no show" for his 02/12/19 appointment for a consultation. -Resident #3 had a second appointment scheduled 06/28/19 and the endocrinology	D 273		

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provider cancelled the appointment.
-Resident #3's next scheduled appointment was for 09/11/19.

Interview with Resident #3 on 07/23/19 at 9:37am revealed:
-He thought he had a referral to the endocrinologist; however, he had not been yet.
-He was not sure why his endocrinology appointment had been rescheduled.
-His blood sugars had been "kind of high" and he was not sure why they were high.

Review of Resident #3's vital signs report revealed:
-In May 2019, Resident #3's fingerstick blood sugars (FSBS) ranged from122mg/dL-337mg/dL.
-In June 2019, Resident #3's FSBS ranged 122mg/dL-386mg/dL.
-In July 2019, Resident #3's FSBS ranged 121mg/dL-516mg/dL.

Interview with the registered nurse (RN) for the primary care provider (PCP) for Resident #3 on 07/25/19 at 10:25am revealed:
-Resident #3 was referred for a consultation with endocrinology on 01/29/19 for uncontrolled diabetes.
-The PCP's office did not know Resident #3's first scheduled appointment with endocrinology was missed and the second appointment was cancelled by the endocrinology provider.
-The PCP expected to be notified of missed and rescheduled appointments.
-The PCP would have completed a consult with another endocrinologist.
-The PCP would have expected the facility to communicate any missed or delayed appointments.
-It was important for Resident #3 to be seen by

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the endocrinologist to prevent a decline in his health.

Review of a medic report dated 06/17/19 for Resident #3 revealed upon arrival at the facility, Resident #3 had a blood glucose level of 60 mg/dL (reference range 65-100mg/dL).

Review of a discharge summary from a local hospital for Resident #3 dated 06/20/19 revealed:
-Resident #3 was admitted to the hospital on 06/17/19 with a primary diagnosis of encephalopathy (altered brain function).
- "Patient's encephalopathy most likely from hypoglycemia (low blood sugar)".
-Resident #3 was discharged back to the facility on 06/20/19.
-Resident #3's A1C (test used to measure average blood glucose) was 5.6 mg/dL (reference range 4.0-6.0).

Interview with the facility's contracted nurse practitioner (NP) on 07/24/19 at 1:05pm revealed:
-He did not know Resident #3 had a referral for an endocrinology appointment.
-He had been trying to get Resident #3's diabetes more controlled with medication.

Review of Resident #3's laboratory results completed on 06/26/19 revealed the resident had an A1C of 7.3mg/dL, the reference range was 4.0-6.0.

Interview with the lead medication aide/previous Resident Care Coordinator (RCC) on 07/24/19 at 10:48am revealed:
-She did not realize Resident #3 had a referral for an endocrinology in January 2019.
-She did not know Resident #3 missed an endocrinology appointment in February 2019.

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D 273	Continued From page 61 -Resident #3's endocrinology appointment was cancelled by the endocrinology provider in June 2019. -She would have contacted the facility NP regarding a referral to another endocrinologist. -She did not know Resident #3's A1C was now 7.3mg/dL. Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 11:40am revealed: -She became the RCC on 07/08/19. -The RCC was responsible for coordinating resident appointments. -She did not know Resident #3 had a referral for an endocrinology consult that was made in January 2019. -Resident #3's appointment should have been made sooner, "the appointment should not be scheduled 9 months out". -The endocrinology office should have been contacted to see if the appointment could be sooner. -The referring physician could have been contacted to get a referral for another provider. Interview with the Director of Resident Care (DRC) on 07/24/19 at 2:55pm revealed: -She was hired 07/08/19 as the DRC. -She was still learning all of her responsibilities as the DRC. -She knew she was responsible for the overall care of the residents. -The lead medication aide (MA) and the RCC were responsible for scheduling appointments. -She could not remember if Resident #3 had an appointment scheduled with an endocrinology specialist. -She was not sure why Resident #3's PCP was not contacted regarding his endocrinology appointment.	D 273		

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D 273	Continued From page 62 -She completed a review of Resident #3's record when she became the DRC. Interview with the Administrator on 07/24/19 at 9:22am revealed: -She expected the referral for Resident #3's endocrinology consultation to be discussed with the physician after the provider cancelled to determine next steps. - "We don't have the staff that goes back and call, I'm working on that". - Resident #3 "fell between the cracks". 3. Review of Resident #1's current FL-2 dated 01/16/19 revealed diagnoses included schizophrenia and type 2 diabetes mellitus. Review of Resident #1's subsequent physician's orders dated 03/03/19 revealed an order for a colorectal cancer screening with GI (gastroenterologist). Review of Resident #1's physician's orders dated 05/06/19 revealed a medication order from her GI for Golytely oral solution reconstituted; use as directed for bowel prep. Review of Resident #1's medical or emergency referral form revealed the facility had requested an order from Resident #1's Nurse Practitioner (NP) on 05/20/19 for "GaviLyte-G (a bowel prep solution) to have colonoscopy done" and the NP had signed the order on 05/22/19. Review of Resident #1's colonoscopy instructions sheet from the GI dated 05/06/19 revealed: -The date of the procedure (05/06/19) was crossed out with the words "No Show" handwritten beside it. -There was a handwritten note documenting	D 273		

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D 273	Continued From page 63 Resident #1 had a colonoscopy rescheduled for 07/15/19. Review of Resident #1's progress notes revealed: -There was documentation of a late entry dated 05/21/19 Resident #1 "refused colonoscopy on 05/20/19. Resident made office visit aware that she has eaten breakfast, however told staff that she did not eat breakfast." -There was documentation dated 07/15/19 Resident #1's "appointment with [GI practice name] has been rescheduled due to resident being non-compliant and eating breakfast." Interview with Resident #1 on 07/23/19 at 10:10am revealed: -She missed a scheduled colonoscopy appointment the prior week. -She missed the scheduled colonoscopy appointment because the medication aide (MA) could not locate her "drink with electrolytes" (bowel prep solution) she had to take the day before the colonoscopy appointment. -The MA had asked another MA on duty that day and told Resident #1 that neither of them could locate her "drink" (bowel prep solution). -She did not know if her colonoscopy had been rescheduled. -She had never refused to go to a colonoscopy appointment. -She would sometimes forget and eat breakfast on the morning of her colonoscopy appointments. Telephone interview with Resident #1's GI physician on 07/24/19 at 9:41am revealed: -Resident #1 had been referred to him for a colonoscopy by her Primary Care Provider (PCP). -He saw Resident #1 for a consultation on 04/12/19 and she complained of blood in her stool and bloating.	D 273		

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D 273	Continued From page 64 -Resident #1 had a history of colon polyps removed approximately 9 years prior. -He scheduled Resident #1 for a colonoscopy on 05/06/19. -Resident #1 was a "no show" to the 05/06/19 colonoscopy appointment and was rescheduled for a colonoscopy on 05/20/19. -Resident #1 was a "no show" to the 05/20/19 colonoscopy appointment and was rescheduled for a colonoscopy on 07/15/19. -Resident #1 was a "no show" to the 07/15/19 colonoscopy appointment. -Patients undergoing a colonoscopy had to follow certain instructions or else he could not perform the colonoscopy. -These instructions included adhering to a clear liquid diet the day prior to the scheduled colonoscopy, holding their diabetic medications the day prior and until after the colonoscopy, have nothing to eat after midnight the night prior to the colonoscopy and drink the full container of bowel prep solution starting at 5:00pm the evening prior to the colonoscopy. -These written instructions and a prescription for the bowel prep solution were provided to the transportation driver and faxed to the facility on the day of Resident #1's initial consultation and faxed to the facility every day that she was a "no show" to her colonoscopy appointments. -A representative from his office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions. -Facility staff reported to his office they did not bring Resident #1 to her three scheduled colonoscopy appointments because they did not administer her bowel prep solution the day prior and Resident #1 was also allowed to eat breakfast the morning of the scheduled colonoscopies.	D 273		

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D 273	Continued From page 65 -It was very important for facility staff to assure residents were administered the bowel prep solution and followed the other colonoscopy instructions. "The residents cannot do these things themselves." -With Resident #1's history of colon polyps, blood in the stool, and bloating she could have more colon polyps at present or colon cancer. "We just don't know [until she has the colonoscopy]." -After 3 "no shows," he would not reschedule the resident for another colonoscopy until someone at the facility could assure him, they would take responsibility for following through with the preparation instructions, and the resident would be required to have another consultation appointment. Interview with Resident #1's Nurse Practitioner (NP) on 07/24/19 at 12:07pm revealed: -He had referred Resident #1 to the GI for a colonoscopy as a routine screening. -He could not remember being notified Resident #1 had missed 3 scheduled colonoscopy appointments. -If he had been notified, he would have discussed it with Resident #1 to find out why she had missed the appointments and provided encouragement if necessary, but he could not remember discussing it with her. -Resident #1 could not be expected to assure her own preparation for the colonoscopy especially with her psychiatric diagnoses. -The facility staff would have to monitor Resident #1 closely to assure she did not eat breakfast on the morning of the colonoscopy appointment. -The MAs should be responsible for assuring Resident #1 adhered to a clear liquid diet, did not eat breakfast and drank the bowel prep solution. Review of Resident #1's May 2019 Electronic	D 273		

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Medication Administration record (eMAR) revealed:
-There was no entry for the bowel prep solution to be administered on 05/05/19 prior to the 05/06/19 scheduled colonoscopy.
-There was no entry for the bowel prep solution to be administered on 05/19/19 prior to the 05/20/19 scheduled colonoscopy.
-There was an entry for the bowel prep solution (GaviLyte) to be administered at 8:00am on 05/23/19 with documentation it had not been administered.

Review of Resident #1's July 2019 eMAR revealed there was an entry for the bowel prep solution GaviLyte to be administered at 5:00pm on 07/14/19 with documentation it had not been administered.

Interview with a first shift MA on 07/24/19 at 11:45am revealed:
-She had never administered bowel prep solution to Resident #1.
-She had only seen bowel prep solution populated on the eMAR on one occasion for Resident #1 and that was on 05/23/19.
-She asked the Lead MA/previous Resident Care Cooordinator (RCC) if she should administer the bowel prep on 05/23/19 and she was told she could not because Resident #1 did not have a colonoscopy scheduled for the following day.

Telephone interview with a second shift MA on 07/25/19 at 11:35am revealed:
-She had never administered bowel prep solution to Resident #1.
-She had only seen bowel prep solution populated on the eMAR on one occasion for Resident #1 and that was on 07/14/19.
-She did not administer the bowel prep solution to

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Resident #1 on 07/14/19 because she could not locate it in the facility.
-She asked another MA if she knew where it was, and she could not locate it either.
-She did not attempt to contact the pharmacy or a supervisor to help her locate the bowel prep solution.

Telephone interview with a representative from the facility's contracted pharmacy on 07/24/19 at 9:06am revealed:
-They had received only one order from the facility for Resident #1's bowel prep solution (GaviLyte).
-The GaviLyte order was received on 05/22/19 and the pharmacy dispensed a one-time supply on the same day.

A second telephone interview with a representative from the facility's contracted pharmacy on 07/25/19 at 10:37am revealed:
-The facility faxed physician's orders to the pharmacy.
-The pharmacy entered the orders into the eMAR system.
-If the order provided a start date, the pharmacy would enter the medication onto the eMAR for that date.
-If the order did not provide a start date, the pharmacy would enter the medication onto the eMAR for the following day.
-If the physician's order was new, the facility had to go into the eMAR system and approve it before it would populate onto the eMAR for administration.
-The pharmacy entered Resident #1's GaviLyte order received on 05/22/19 for the following day (05/23/19) because it did not have a start date.
-The facility had the ability to adjust dates and times of scheduled administration, if necessary,

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D 273	Continued From page 68 to coordinate the bowel prep solution with the scheduled colonoscopy. Interview with the Lead MA/RCC on 07/24/19 at 12:49pm revealed: -She had worked at the facility since 04/16/19. -Processes were very different in the Assisted Living Facility (ALF) and she had received no training on those processes when she began working. -She did not know Resident #1 was scheduled for a colonoscopy on 05/06/19. -Whichever facility staff received the order for the bowel prep solution given at Resident #1's GI consult on 04/12/19 should have faxed the order to the pharmacy and given the colonoscopy date to the RCC who was employed at that time. -She knew Resident #1 had a colonoscopy scheduled for 05/20/19 and thought she missed it because she had eaten breakfast that morning. -She did not know Resident #1 was not administered the bowel prep solution on 05/19/19. -She did not know why Resident #1's order for the bowel prep solution dated 05/06/19 had not been sent to the pharmacy so that it could have been administered the day prior to her 05/20/19 colonoscopy appointment. -It would have been her responsibility to fax the bowel prep solution order to the pharmacy because she was the RCC at that time. -She did not know why an order for the bowel prep solution had been requested from Resident #1's NP on 05/20/19 when they already had an order from the GI dated 05/06/19. -She knew Resident #1 had a colonoscopy scheduled on 07/15/19. -Resident #1 missed her colonoscopy on 07/15/19 because the bowel prep solution was not administered on 07/14/19.	D 273		

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D 273	Continued From page 69 -The bowel prep solution was not administered on 07/14/19 because the MA on duty that day could not locate the solution even though it was in the medication room. -She expected the MAs to call her or another supervisor if they could not locate a medication, but the MA did not do so. Interview with the RCC on 07/25/19 at 2:33pm revealed: -She had been the RCC since 07/08/19. -It was the RCC's responsibility to fax referrals made by the Primary Care Provider (PCP) to outside providers and schedule the appointments. -The RCC was responsible for faxing new orders to the pharmacy and approving those orders in the eMAR system after they were entered by the pharmacy. -She had the capability of adjusting dates and times of administration in the eMAR system if needed so medications such as bowel prep solutions could be administered based on the appointment date for the colonoscopy. -The RCC was responsible for printing instructions regarding a resident not being allowed to eat breakfast and providing those instructions to the MAs and the Dietary Manager (DM). -She verbalized instructions regarding clear liquid diets to the MAs and the DM. -The DM was responsible for assuring residents on clear liquid diets were served appropriate liquids. -The DM was responsible for assuring residents who were NPO (nothing by mouth) would not be served breakfast. -She did not work at the facility during Resident #1's 05/06/19 and 05/20/19 scheduled colonoscopy appointments. -Resident #1 missed her 07/15/19 colonoscopy	D 273		

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appointment because she was not administered the bowel prep solution on 07/14/19 and because she ate breakfast on 07/15/19.
-Resident #1 was not administered the bowel prep solution on 07/14/19 because the MA could not locate it even though it was in the medication room.
-The MA should have contacted either her or the pharmacy to help her locate the bowel prep solution, but she did not.

Interview with the DM on 07/25/19 at 3:09pm revealed:
-He had worked at this facility since 06/12/19.
-He was only aware of one resident who had been on a clear liquid diet and NPO for a colonoscopy since he had worked at the facility.
-The RCC had verbally communicated the information to him during a morning stand up meeting.
-It was his and the other dietary staff's responsibility to assure the resident was not served breakfast.
-He was never told Resident #1 was to be on a clear liquid diet or NPO.

Interview with the Administrator on 07/25/19 at 9:04am revealed:
-She had worked at this facility for 3 weeks.
-The RCC was responsible for scheduling appointments, sending orders to the pharmacy and setting up transportation for colonoscopies.
-The pharmacy entered orders for bowel prep solutions into a resident's computer profile.
-Once the bowel prep solution was dispensed to the facility, it was the RCC's responsibility to verify and approve the order entered onto the eMAR by the pharmacy.
-The RCC was responsible for entering the date on the eMAR the bowel prep solution should be

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administered based on the date of the colonoscopy appointment.
-The RCC was responsible for assuring all instructions for colonoscopy preparation were followed by the MAs.
-The Administrator or the RCC would communicate instructions regarding clear liquid diet orders and NPO orders to the DM.
-The DM was responsible for assuring the resident was served only clear liquids the day prior to the colonoscopy and was not served breakfast the day of the scheduled colonoscopy.
-She provided oversight to both the RCC and DM.
-The bowel prep solution should not have been on the eMAR to be administered to Resident #1 on 05/23/19 because she did not have a colonoscopy scheduled for 05/24/19.
-The bowel prep solution should have been on the eMAR and available for administration on 05/05/19 and 05/19/19 for Resident #1.
-She was told Resident #1 missed all three colonoscopy appointments because she refused to go and then ate breakfast.
-It would not have mattered if Resident #1 ate breakfast on the day of the colonoscopy appointment because she would not have been able to have the colonoscopy performed anyway due to not being administered the bowel prep solution the day prior.

4. Review of Resident #8's current FL-2 dated 01/16/19 revealed diagnoses included Parkinson's diseaseand major depression.

Review of Resident #8's subsequent physician's orders dated 03/03/19 revealed an order for a colorectal cancer screening with GI (gastroenterologist).

Review of Resident #8's physician's orders dated

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04/12/19 revealed a medication order from her GI for Golytely oral solution reconstituted; use as directed for bowel prep.

Review of Resident #8's medical or emergency referral form revealed the facility had requested an order from Resident #8's Nurse Practitioner (NP) on 05/20/19 for "GaviLyte-G (a bowel prep solution) to have colonoscopy done" and the NP had signed the order on 05/22/19.

Review of Resident #8's colonoscopy instructions sheet from the GI dated May 2019 revealed:
-The date of the procedure was crossed out with the words "No Show" written beside it. The date was May 2019 with the day being illegible because it was crossed through.
-There was a handwritten note documenting Resident #8 had a colonoscopy rescheduled for 05/13/19 with the words "No Show" written beside it.
-There was a handwritten note documenting Resident #8 had a colonoscopy rescheduled for 07/15/19.

Review of Resident #8's progress notes revealed there was documentation dated 07/15/19 Resident #8's "appointment with [GI practice name] has been cancelled due to resident being non-compliant and eating breakfast this morning."

Attempted interview with Resident #8 on 07/25/19 at 3:43pm was unsuccessful.

Interview with Resident #8's GI physician's Medical Assistant on 07/25/19 at 11:22am revealed:
-Resident #8 had been referred to GI for a colonoscopy by her Primary Care Provider (PCP).
-Resident #8 had been seen by the GI on

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04/12/19 for a consultation.
-It was difficult for them to understand Resident #8 due to a language barrier, but as far as they could understand, she was not experiencing any symptoms but had never had a colonoscopy performed.
-It was important for all residents to have a colonoscopy performed at least every 10 years beginning at age 50 and Resident #8 was over the age of 70.
-Resident #8 was scheduled for a colonoscopy on 05/03/19.
-Resident #8 was a "no show" to the 05/03/19 colonoscopy appointment and was rescheduled for a colonoscopy on 05/13/19.
-Resident #8 was a "no show" to the 05/13/19 colonoscopy appointment and was rescheduled for a colonoscopy on 07/15/19.
-Resident #8 was a "no show" to the 07/15/19 colonoscopy appointment.
-Patients undergoing a colonoscopy had to follow certain instructions or else a colonoscopy could not be performed.
-These instructions included adhering to a clear liquid diet the day prior to the scheduled colonoscopy, have nothing to eat after midnight the night prior to the colonoscopy and drink the full container of bowel prep solution starting at 5:00pm the evening prior to the colonoscopy.
-These written instructions and a prescription for the bowel prep solution were provided to the transportation driver and faxed to the facility on the day of Resident #8's initial consultation and faxed to the facility every day that she was a "no show" to her colonoscopy appointments.
-Representatives from their office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions.
-Facility staff reported to the GI office they did not

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bring Resident #8 to her three scheduled colonoscopy appointments because they did not administer her bowel prep solution the day prior and Resident #8 was also allowed to eat breakfast the morning of the scheduled colonoscopies.
-After 3 "no shows," their office would not schedule residents for another colonoscopy until they had another consultation with the GI.
-The GI physician was not willing to reschedule Resident #8 for another consultation until the facility could assure him, they would take responsibility for following the preparation instructions.

Review of Resident #8's May 2019 Electronic Medication Administration record (eMAR) revealed:
-There was no entry for the bowel prep solution to be administered on 05/02/19 prior to the 05/03/19 scheduled colonoscopy.
-There was no entry for the bowel prep solution to be administered on 05/12/19 prior to the 05/13/19 scheduled colonoscopy.
-There was an entry for the bowel prep solution (GaviLyte) to be administered on 05/23/19 at 1:00am with documentation it had not been administered.

Review of Resident #8's July 2019 eMAR revealed there was an entry for the bowel prep solution GaviLyte to be administered on 07/14/19 at 5:00pm with documentation it had been administered.

Interview with a second shift medication aide (MA) on 07/25/19 at 4:11pm revealed:
-She worked 7:00am to 12:15am on 07/14/19 and was the only supervisor on staff that day.
-She was very busy and did not remember

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Resident #8's GaviLyte populating on the eMAR for administration.
-She did not administer the GaviLyte but documented she had administered it "probably because she was so busy."

Telephone interview with a representative from the facility's contracted pharmacy on 07/25/19 at 10:37am revealed:
-The facility faxed physician's orders to the pharmacy.
-The pharmacy entered the orders into the eMAR system.
-If the order provided a start date, the pharmacy would enter the medication onto the eMAR for that date.
-If the order did not provide a start date, the pharmacy would enter the medication onto the eMAR for the following day.
-If the physician's order was new, the facility had to go into the eMAR system and approve it before it would populate onto the eMAR for administration.
-The pharmacy had received only one order for Resident #8's bowel prep solution.
-The pharmacy received an order for Resident #8's GaviLyte on 05/22/19 and dispensed a one-time supply to the facility on the same day.
-The pharmacy entered Resident #8's GaviLyte order onto the eMAR for the following day (05/23/19) because it did not have a start date.
-The facility had the ability to adjust dates and times of scheduled administration, if necessary, to coordinate the bowel prep solution with the scheduled appointments.

Interview with the RCC on 07/25/19 at 2:33pm revealed:
-She had been the RCC since 07/08/19.
-It was the RCC's responsibility to fax referrals

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made by the Primary Care Provider (PCP) to outside providers and schedule the appointments.
-The RCC was responsible for faxing new orders to the pharmacy and approving those orders in the eMAR system after they were entered by the pharmacy.
-She had the capability of adjusting dates and times of administration in the eMAR system if needed so medications such as bowel prep solutions could be administered based on the appointment date for the colonoscopy.
-The RCC was responsible for printing instructions regarding a resident not being allowed to eat breakfast and providing those instructions to the MAs and the Dietary Manager (DM).
-She verbalized instructions regarding clear liquid diets to the MAs and the DM.
-The DM was responsible for assuring residents on clear liquid diets were served appropriate liquids.
-The DM was responsible for assuring residents who were NPO (nothing by mouth) would not be served breakfast.
-She did not work at the facility during Resident #8's 05/03/19 and 05/13/19 scheduled colonoscopy appointments.
-Resident #8 missed her 07/15/19 colonoscopy appointment because she was not administered the bowel prep solution on 07/14/19 and because she ate breakfast on 07/15/19.
-She did not know why the MA did not administer the bowel prep solution to Resident #8 on 07/14/19.

Interview with the DM on 07/25/19 at 3:09pm revealed:
-He had worked at this facility since 06/12/19.
-He was only aware of one resident who had been on a clear liquid diet and NPO for a

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colonoscopy since he had worked at the facility.
-The RCC had verbally communicated the information to him during a morning stand up meeting.
-It was his and the other dietary staff's responsibility to assure the resident was not served breakfast.
-He was never told Resident #8 was to be on a clear liquid diet or NPO.

Interview with the Administrator on 07/25/19 at 9:04am revealed:
-She had worked at this facility for 3 weeks.
-The RCC was responsible for scheduling appointments, sending orders to the pharmacy and setting up transportation for colonoscopies.
-The pharmacy entered orders for bowel prep solutions into a resident's computer profile.
-Once the bowel prep solution was dispensed to the facility, it was the RCC's responsibility to verify and approve the order entered onto the eMAR by the pharmacy.
-The RCC was responsible for entering the date on the eMAR the bowel prep solution should be administered based on the date of the colonoscopy appointment.
-The RCC was responsible for assuring all instruction for colonoscopy preparation were followed by the MAs.
-The Administrator or the RCC would communicate instructions regarding clear liquid diet orders and NPO orders to the DM.
-The DM was responsible for assuring the resident was served only clear liquids the day prior to the colonoscopy and was not served breakfast the day of the scheduled colonoscopy.
-She provided oversight to both the RCC and DM.

The facility failed to assure follow-up with

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D 273	Continued From page 78 physician's orders for Resident #2 who was ordered a cardiology and pulmonology consult which led to a re-admission to the local hospital for chest pains; Resident #3 who missed an endocrinology consult for treatment of uncontrolled diabetes as ordered, which resulted in an elevated A1C, hospitalization for encephalopathy, and a blood glucose of 60 mg/dL, and the primary care provider was never contacted; Resident #1 who had a medical history of polyps, blood in the stool, and stomach bloating who missed 3 consecutive colonoscopy appointments; and Resident #8 who had never had a colon cancer screening and missed 3 consecutive colonoscopy appointments. This failure to assure healthcare referral and follow-up on physician's orders resulted in serious physical harm and neglect and constitutes a Type A1 Violation. This Type A1 is unabated from the previous survey. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/26/19. CORRECTION DATE FOR THE UNABATED TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 26, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	D 276		

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D 276	Continued From page 79	D 276		

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

Based on observations, interviews, and record reviews, the facility failed to assure physicians' orders were implemented for 3 of 7 sampled residents related to preparation instructions for scheduled colonoscopies (#1 and #8), medication administration, finger stick blood sugar checks, and blood pressure checks (#3).

The findings are:

1. Review of Resident #3's current FL-2 dated 07/03/19 revealed diagnoses included chronic kidney disease, type 2 diabetes, peripheral neuropathy, history of cerebral vascular disease with left sided weakness, and hypertension.

a. Review of Resident #3's physician's orders dated 12/28/18 revealed:
-There was an order to administer Novolog insulin 100 units/mL inject 2 to 10 units (sliding scale) before meals and at bedtime for diabetes.
-The sliding scale was as follows: 150-200; 2 units, 201-250; 4 units, 251-300; 6 units, 301-350; 8 units, 351-400; 10 units, if greater than 401 go the emergency room or urgent care.

Review of Resident #3's May 2019 electronic Medication Administration Record (eMAR)

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D 276	Continued From page 80 revealed: -There was an entry for Novolog insulin 100unit/mL, check fingerstick blood sugar (FSBS) and inject per sliding scale at 6:30am. -The entry for 6:30am included the initials of the medication aide that administered the medication. -There was no space to document the FSBS result. -There was no space to document the units of insulin administered. -There was no entry for the Novolog order to be implemented before lunch, dinner, or bedtime. -It could not be determined how many units of insulin was administered to the resident per the sliding scale from 05/01/19-05/31/19 at 6:30am. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Novolog insulin 100unit/mL, check fingerstick blood sugar (FSBS) and inject per sliding scale for 6:30am. -The entry for 6:30am included an entry include the initials of the medication aide that administered the medication. -There was no space to document the FSBS result. -There was no space to document the units of insulin administered. -There was no entry for the Novolog order to be implemented before lunch, dinner, or bedtime. -It could not be determined how many units of insulin was administered to the resident per the sliding scale from 06/01/19-06/26/19 at 6:30am. Review of signed physician's order dated 06/26/19 revealed there was an order to discontinue sliding scale insulin. Interview with a representative with Resident #3's outside pharmacy on 07/29/19 at 12:41 pm	D 276		

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D 276	Continued From page 81 revealed: -The pharmacy received an order for Novolog sliding scale insulin on 12/28/18. -The pharmacy had dispensed one box of five 3mL insulin pens on 01/22/19 and 06/21/19. Review of Resident #3's vital signs report revealed: -FSBS were recorded daily at various times from 05/01/19-06/17/19. -In May 2019, Resident #3's fingerstick blood sugars (FSBS) ranged 122mg/dL-337mg/dL. -In June 2019, Resident #3's FSBS ranged 18mg/dL-386mg/dL. Review of medic report dated 06/17/19 for Resident #3 revealed upon arrival at the facility Resident #3 had a blood glucose level of 60 mg/dL. Review of a discharge summary from a local hospital for Resident #3 dated 06/20/19 revealed: -Resident #3 was admitted to the hospital on 06/17/19 with a primary diagnosis of encephalopathy (altered brain function). - "Patient's encephalopathy most likely from hypoglycemia (low blood glucose)". -Resident #3 was discharged back to the facility on 06/20/19. Review of pharmacist's medication regimen review consultation completed on 06/25/19 revealed there was instruction for nursing to "review how the order for NovoLog sliding scale before meals and at bedtime was entered into the eMAR system, review of the June MAR indicates only being done at 6:30am, please make sure the sliding scale is evaluated for administration prior to each meal and at bedtime as ordered".	D 276		

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D 276	Continued From page 82 Interview with Resident #3 on 07/24/19 at 12:50pm revealed: -His blood sugars were taken by the staff at the facility. -He could not remember when or how often his blood sugars were taken when he was ordered sliding scale insulin. Interview with a lead medication aide (MA) on 07/24/19 at 3:53pm revealed: -On 06/17/19, "in the morning" she observed Resident #3 leaning on one side, unable to walk straight, she checked his blood sugar and it was "good". -She could not remember what Resident #3's blood sugar was when she initially checked it on 06/17/19, she did not document. -Resident #3 refused to go to the emergency room initially, therefore she assisted the resident to his room. -On 06/17/19, "a little before lunch" she went to check on Resident #3, his communication was limited, she then called the paramedics and sent the resident to the hospital for further observation. -She did not recall giving Resident #3 his insulin on 06/17/19 before he went to the hospital. -When Resident #3 was ordered sliding scale insulin, there was not a place on the eMAR to record the BS or the number of units administered. -She notified the Resident Care Coordinator (RCC) and the Director of Resident Care (DRC) and nothing was done. -She could not remember when she notified the RCC and DRC. -The DRC said to "give us time to get it done". Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:05am revealed: -She became the RCC on 07/08/19.	D 276		

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-The fingerstick blood sugar (FSBS) order for Resident #3 was on the eMAR, however the parameters were not checked when the order was entered.
-The parameters were not checked and initiated in the eMAR system therefore the orders did not appear on the eMAR.

Interview with the lead medication aide/previous Resident Care Coordinator (RCC) on 07/24/19 at 10:48am revealed:
-She was the RCC until 07/08/19.
-She approved the Novolog sliding scale order in the eMAR system for Resident #3.
-She did not realize the sliding scale units for the Novolog was not checked in the eMAR system.
-The corporate nurse gave her orders to enter into the eMAR system.
-She did not have any training on the eMAR system.
- "No one explained the eMAR system to me".
-She did not know the parameters for the sliding scale insulin were not entered, "I would have fixed it".
-There was no process to review the eMARs for accuracy.

Interview with the Registered Nurse (RN) for the primary care provider (PCP) for Resident #3 on 07/25/19 at 10:25am revealed:
-The PCP expected Resident #3 to be administered the Novolog insulin as ordered to prevent hypoglycemia.
-If Novolog was not administered as ordered Resident #3's blood sugar would be high and could cause the resident to be more tired, headaches, and confusion.

Interview with the Administrator on 07/25/19 at 4:20pm revealed:

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D 276	Continued From page 84 -The lead MA was the previous RCC, however she did not receive training on the eMAR system and was asked to step down. -The RCC and the DRC were responsible for implementing parameters populated on the eMAR. -The eMARs were to be checked daily by the MAs, RCC, and the DRC and changes were to be made as needed. b. Review of a signed physician's orders dated 06/26/19 revealed there was an order with a start date of 08/03/18 for Metoprolol Tartrate (used to treat high blood pressure) 50mg twice daily, hold for systolic blood pressure less than 125. Review of Resident #3's May 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Metoprolol Tartrate 50mg twice daily hold for systolic blood pressure less than 125. -There was documentation the Metoprolol Tartrate was administered from 05/01/19-05/31/19. -There was no space for blood pressures to be documented on the eMAR. -There was no documentation that the resident's blood pressure was recorded from 05/01/19-05/31/19. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Metoprolol Tartrate 50mg twice daily hold for systolic blood pressure less than 125. -There was documentation the Metoprolol Tartrate was administered from 06/01/19-06/21/19. -There was no space for blood pressures to be	D 276		

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documented on the eMAR.
-There was no documentation that the resident's blood pressure was recorded from 06/01/19-06/21/19.

Review of Resident #3's vital signs report for Resident #3 from revealed:
-There were no documented blood pressures from 05/01/19-06/19/19.
-There were 4 blood pressures documented from 06/20/19-06/21/19.

Interview with a lead medication aide (MA) on 07/24/19 at 3:53pm revealed:
-She did not know why Resident #3's blood pressures were not listed on the eMAR, but "I always check his blood pressure".
-She did not record blood pressures on the eMAR if there was no space to document.
-There was no other place used to document Resident #3's blood pressure from 05/01/19-06/21/19.
-No one ever told her to document the blood pressures anywhere else.

Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:05am revealed:
-She became the RCC on 07/08/19.
-The parameters were not checked and initiated in the eMAR system therefore the orders did not appear on the eMAR.
-She noticed that the parameters were not showing up on the eMAR and corrected it.

Interview with the lead medication aide/previous Resident Care Coordinator (RCC) on 07/24/19 at 10:48am revealed:
-She was the RCC until 07/08/19.
-She did not realize the blood pressure parameters were not implemented on the eMAR.

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D 276	Continued From page 86 -The corporate nurse gave her orders to enter into the eMAR system. -She did not have any training on the eMAR system. - "No one explained the eMAR system to me". -She did not know the parameters for the blood pressure parameters were not entered, "I would have fixed it". -There was no process to review the eMARs for accuracy. Interview with the registered nurse (RN) for the primary care provider (PCP) for Resident #3 on 07/25/19 at 10:25am revealed: -The PCP would expect the blood pressure to be checked prior to administering Metoprolol Tartrate. -The Metoprolol Tartrate was to be held if the systolic blood pressure is less than 125. -If the Metoprolol Tartrate was administered and the systolic blood pressure was lower than 125, the resident's blood pressure would drop too low and cause the resident to experience "dizziness and could cause the resident to faint". Interview with the Administrator on 07/25/19 at 4:20pm revealed: -The lead MA was the previous RCC, however she did not receive training on the eMAR system and was asked to step down. -The RCC and the DRC were responsible for implementing parameters populated on the eMAR. -The eMARs were to be checked daily by the MAs, RCC, and the DRC and changes were to be made as needed. 2. Review of Resident #1's current FL-2 dated 01/16/19 revealed diagnoses included schizophrenia and type 2 diabetes mellitus.	D 276		

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D 276	Continued From page 87 Review of Resident #1's subsequent physician's orders dated 03/03/19 revealed an order for a colorectal cancer screening with GI (gastroenterologist). Review of Resident #1's colonoscopy instructions sheet from the GI dated 05/06/19 revealed: -The date of the procedure (05/06/19) was crossed out with the words "No Show" handwritten beside it. -There was a handwritten note documenting Resident #1 had a colonoscopy rescheduled for 07/15/19. Telephone interview with Resident #1's GI physician on 07/24/19 at 9:41am revealed: -Resident #1 had been referred to him for a colonoscopy by her Primary Care Provider (PCP). -He saw Resident #1 for a consultation on 04/12/19 and she complained of blood in her stool and bloating. -Resident #1 had a history of colon polyps removed approximately 9 years prior. -He scheduled Resident #1 for a colonoscopy on 05/06/19. -Resident #1 was a "no show" to the 05/06/19 colonoscopy appointment and was rescheduled for a colonoscopy on 05/20/19. -Resident #1 was a "no show" to the 05/20/19 colonoscopy appointment and was rescheduled for a colonoscopy on 07/15/19. -Resident #1 was a "no show" to the 07/15/19 colonoscopy appointment. -Patients undergoing a colonoscopy had to follow certain instructions or else he could not perform the colonoscopy. -These instructions included adhering to a clear liquid diet the day prior to the scheduled colonoscopy, holding their diabetic medications	D 276		

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the day prior and until after the colonoscopy, and have nothing to eat after midnight the night prior to the colonoscopy.
-These written instructions were provided to the transportation driver and faxed to the facility on the day of Resident #1's initial consultation and faxed to the facility every day that she was a "no show" to her colonoscopy appointments.
-A representative from his office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions.
-Facility staff reported to his office they did not bring Resident #1 to her three scheduled colonoscopy appointments because they did not administer her bowel prep solution the day prior and Resident #1 was also allowed to eat breakfast the morning of the scheduled colonoscopies.
-It was very important for facility staff to assure residents were administered the bowel prep solution and followed the other colonoscopy instructions. "The residents cannot do these things themselves."
-With Resident #1's history of colon polyps, blood in the stool, and bloating she could have more colon polyps at present or colon cancer. "We just don't know [until she has the colonoscopy]."
-After 3 "no shows," he would not reschedule the resident for another colonoscopy until someone at the facility could assure him, they would take responsibility for following through with the preparation instructions, and the resident would be required to have another consultation appointment.

a. Review of Resident #1's current FL-2 dated 01/16/19 revealed a medication order for Janumet 50/1000mg (an oral medication used to treat diabetes) take one tablet once daily with

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D 276	Continued From page 89 meals. Review of Resident #1's colonoscopy instructions sheet from the GI dated 05/06/19 revealed: -"If you have diabetes, please do not take your insulin or oral diabetic medication the day before your procedure." -On the day of the procedure, "If you are diabetic, please do not take your morning insulin or oral diabetic medications. Bring it with you and take after your procedure is completed." Review of Resident #1's May 2019 Electronic Medication Administration record (eMAR) revealed: -There was an entry for Janumet 50/1000mg one tablet to be administered daily at 8:00am. -There was no entry to hold Janumet 50/1000mg on the day prior to Resident #1's scheduled colonoscopies (05/05/19 and 05/19/19). -There was no entry to hold Janumet 50/1000mg on the days Resident #1 had scheduled colonoscopies (05/06/19 and 05/20/19). -Janumet 50/1000mg was administered 31 of 31 opportunities. Review of Resident #1's July 2019 eMAR (07/01/19-07/23/19) revealed: -There was an entry for Janumet 50/1000mg one tablet to be administered daily at 8:00am. -There was no entry to hold Janumet 50/1000mg on the day prior to Resident #1's scheduled colonoscopy (07/14/19). -There was no entry to hold Janumet 50/1000mg on the day Resident #1 had a scheduled colonoscopy (07/15/19). -Janumet 50/1000mg was administered 23 of 23 opportunities. Interview with a first shift Medication Aide (MA) on	D 276		

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D 276	Continued From page 90 07/23/19 at 3:03pm revealed: -She did not know Resident #1 had ever been scheduled for a colonoscopy. -She did not know of any time Janumet had been put on hold for Resident #1. Interview with a second first shift MA on 07/25/19 at 12:07pm revealed: -She administered Janumet to Resident #1 on days prior to and days of her scheduled colonoscopies because there was no hold order entered onto the eMAR. -"I only do what the eMAR tells me to do." -She had never been told oral diabetes medications or insulin should be held for residents with colonoscopy appointments. Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:33pm revealed: -She had been the RCC since 07/08/19. -The facility did not consider instructions from the GI to be a physician's order. -When instructions for colonoscopies were received from the GI, it was the RCC's responsibility to contact the resident's Primary Care Provider (PCP) to obtain an order to hold diabetes medications. -The PCP would review all the residents' medications and indicate which medications were for diabetes and would provide an order to hold them temporarily. -Once an order was received from the PCP, the RCC was responsible for adding a stop date and a new start date to the eMAR so MAs would not administer the medications. -She did not work at the facility during Resident #1's 05/06/19 and 05/20/19 scheduled colonoscopy appointments. -She was the RCC during Resident #1's 07/15/19 colonoscopy appointment but did not know why	D 276		

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her diabetes medications had not been placed on hold.
-The colonoscopy instructions must have been received by the facility prior to her starting as the RCC.

Telephone interview with Resident #1's GI physician's Medical Assistant on 07/25/19 at 11:22am revealed:
-During Resident #1's initial consultation, the GI reviewed her blood sugar levels.
-Resident #1 had blood sugar levels that were well controlled, so the GI instructed the facility to hold her diabetes medications because she was required to be on a clear liquid diet the day prior to the colonoscopy and NPO (nothing by mouth) the day of the colonoscopy.
-If diabetes medications were not held for Resident #1 and she followed a clear liquid diet and NPO, there was a risk of her becoming hypoglycemic (having a low blood sugar level).

Interview with the Administrator on 07/25/19 at 9:04am revealed:
-She had worked at this facility for 3 weeks.
-The RCC was responsible for assuring all instructions for colonoscopy preparation were followed by the MAs.
-She provided oversight to the RCC.
-She did not know Resident #1's Janumet had not been held as instructed by the GI.

b. Review of Resident #1's colonoscopy instructions sheet from the GI dated 05/06/19 revealed:
-The day before the colonoscopy, "All day, all liquids which include: broth, water, juices, tea soda, and Jell-O (nothing red in color and no milk or milk products)."
-"Nothing to eat or drink after midnight (the night

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EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

(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 276	Continued From page 92 before your colonoscopy)." Review of Resident #1's progress notes revealed: -There was documentation of a late entry dated 05/21/19 Resident #1 "refused colonoscopy on 05/20/19. Resident made office visit aware that she has eaten breakfast, however told [facility] staff that she did not eat breakfast." -There was documentation dated 07/15/19 Resident #1's "appointment with [GI practice name] has been rescheduled due to resident being non-compliant and eating breakfast." Interview with Resident #1 on 07/23/19 at 10:10am revealed: -She missed a scheduled colonoscopy appointment the prior week. -She was not supposed to eat breakfast on the morning of her colonoscopy appointments, but she would sometimes forget and eat what was served to her in the dining room. Interview with Resident #1's Nurse Practitioner (NP) on 07/24/19 at 12:07pm revealed: -He had referred Resident #1 to the GI for a colonoscopy as a routine screening. -Resident #1 could not be expected to assure her own preparation for the colonoscopy especially with her psychiatric diagnoses. -The facility staff would have to monitor Resident #1 closely to assure she did not eat breakfast on the morning of the colonoscopy appointment. -The MAs should be responsible for assuring Resident #1 adhered to a clear liquid diet and did not eat breakfast. Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:33pm revealed: -She had been the RCC since 07/08/19. -The RCC was responsible for printing	D 276		

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instructions regarding a resident not being allowed to eat breakfast and providing those instructions to the MAs and the Dietary Manager (DM).
-She verbalized instructions regarding clear liquid diets to the MAs and the DM.
-The DM was responsible for assuring residents on clear liquid diets were served appropriate liquids.
-The DM was responsible for assuring residents who were NPO would not be served breakfast.
-She did not work at the facility during Resident #1's 05/06/19 and 05/20/19 scheduled colonoscopy appointments.
-Resident #1 missed her 07/15/19 colonoscopy appointment because she was not administered the bowel prep solution on 07/14/19 and because she ate breakfast on 07/15/19.

Interview with the DM on 07/25/19 at 3:09pm revealed:
-He had worked at this facility since 06/12/19.
-He was only aware of one resident who had been on a clear liquid diet and NPO for a colonoscopy since he had worked at the facility.
-The RCC had verbally communicated the information to him during a morning stand up meeting.
-It was his and the other dietary staff's responsibility to assure the resident was not served breakfast.
-He was never told Resident #1 was to be on a clear liquid diet or NPO.

Interview with the Administrator on 07/25/19 at 9:04am revealed:
-The RCC was responsible for assuring all instructions for colonoscopy preparation were followed by the MAs.
-The Administrator or the RCC would

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communicate instructions regarding clear liquid diet orders and NPO orders to the DM.
-The DM was responsible for assuring the resident was served only clear liquids the day prior to the colonoscopy and was not served breakfast the day of the scheduled colonoscopy.
-She provided oversight to both the RCC and DM.
-She was told Resident #1 missed all three colonoscopy appointments because she refused to go and then ate breakfast.

3. Review of Resident #8's current FL-2 dated 01/16/19 revealed diagnoses included Parkinson's disease and major depression.

Review of Resident #8's subsequent physician's orders dated 03/03/19 revealed an order for a colorectal cancer screening with GI (gastroenterologist).

Review of Resident #8's colonoscopy instructions sheet from the GI dated May 2019 revealed:
-The date of the procedure was crossed out with the words "No Show" written beside it. The date was May 2019 with the day being illegible because it was crossed through.
-There was a handwritten note documenting Resident #8 had a colonoscopy rescheduled for 05/13/19 with the words "No Show" written beside it.
-There was a handwritten note documenting Resident #8 had a colonoscopy rescheduled for 07/15/19.

Review of Resident #8's progress notes revealed there was documentation dated 07/15/19 Resident #8's "appointment with [GI practice name] has been canceled due to resident being non-compliant and eating breakfast this morning."

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D 276	Continued From page 95 Attempted interview with Resident #8 on 07/25/19 at 3:43pm was unsuccessful. Telephone interview with Resident #8's GI physician's Medical Assistant on 07/25/19 at 11:22am revealed: -Resident #8 had been referred to GI for a colonoscopy by her Primary Care Provider (PCP). -Resident #8 had been seen by the GI on 04/12/19 for a consultation. -It was difficult for them to understand Resident #8 due to a language barrier, but as far as they could understand, she was not experiencing any symptoms but had never had a colonoscopy performed. -It was important for all residents to have a colonoscopy performed at least every 10 years beginning at age 50 and Resident #8 was over the age of 70. -Resident #8 was scheduled for a colonoscopy on 05/03/19. -Resident #8 was a "no show" to the 05/03/19 colonoscopy appointment and was rescheduled for a colonoscopy on 05/13/19. -Resident #8 was a "no show" to the 05/13/19 colonoscopy appointment and was rescheduled for a colonoscopy on 07/15/19. -Resident #8 was a "no show" to the 07/15/19 colonoscopy appointment. -Patients undergoing a colonoscopy had to follow certain instructions or else a colonoscopy could not be performed. -These instructions included adhering to a clear liquid diet the day prior to the scheduled colonoscopy and have nothing to eat after midnight the night prior to the colonoscopy. -These written instructions were provided to the transportation driver and faxed to the facility on the day of Resident #8's initial consultation and faxed to the facility every day that she was a "no	D 276		

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show" to her colonoscopy appointments.
-Representatives from their office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions.
-Facility staff reported to the GI office they did not bring Resident #8 to her three scheduled colonoscopy appointments because they did not administer her bowel prep solution the day prior and Resident #8 was also allowed to eat breakfast the morning of the scheduled colonoscopies.
-After 3 "no shows," their office would not schedule residents for another colonoscopy until they had another consultation with the GI.
-The GI was not willing to reschedule Resident #8 for another consultation until the facility could assure him, they would take responsibility for following the preparation instructions.

Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:33pm revealed:
-She had been the RCC since 07/08/19.
-The RCC was responsible for printing instructions regarding a resident not being allowed to eat breakfast and providing those instructions to the MAs and the Dietary Manager (DM).
-She verbalized instructions regarding clear liquid diets to the MAs and the DM.
-The DM was responsible for assuring residents on clear liquid diets were served appropriate liquids.
-The DM was responsible for assuring residents who were NPO would not be served breakfast.
-She did not work at the facility during Resident #8's 05/03/19 and 05/13/19 scheduled colonoscopy appointments.
-Resident #8 missed her 07/15/19 colonoscopy appointment because she was not administered

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D 276	Continued From page 97 the bowel prep solution on 07/14/19 and because she ate breakfast on 07/15/19. Interview with the DM on 07/25/19 at 3:09pm revealed: -He had worked at this facility since 06/12/19. -He was only aware of one resident who had been on a clear liquid diet and NPO for a colonoscopy since he had worked at the facility. -The RCC had verbally communicated the information to him during a morning stand up meeting. -It was his and the other dietary staff's responsibility to assure the resident was not served breakfast. -He was never told Resident #8 was to be on a clear liquid diet or NPO. Interview with the Administrator on 07/25/19 at 9:04am revealed: -The RCC was responsible for assuring all instructions for colonoscopy preparation were followed by the MAs. -The Administrator or the RCC would communicate instructions regarding clear liquid diet orders and NPO orders to the DM. -The DM was responsible for assuring the resident was served only clear liquids the day prior to the colonoscopy and was not served breakfast the day of the scheduled colonoscopy. -She provided oversight to both the RCC and DM. _____ The facility failed to implement physicians' orders for Resident #3 related to blood pressure checks, sliding scale insulin administration and finger stick blood sugar checks which resulted in a four day hospitalization for hypoglycemia and encephalopathy; for Resident #1 who had blood in the stool, stomach bloating and a history of	D 276		

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D 276	Continued From page 98 colon polyps, and was ordered a clear liquid diet, no breakfast and to hold Janumet (diabetes medication) for colonoscopy preparation resulting in her missing 3 of 3 consecutive appointments for scheduled colonoscopies; and for Resident #8 who had orders for a clear liquid diet and no breakfast for colonoscopy preparation which resulted in her also missing 3 of 3 consecutive appointments for scheduled colonoscopies. The failure of the facility to assure implementation of physicians' orders resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/26/19 CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 26, 2019.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure contact with the resident's physician for clarification of orders for 1 of 12 residents regarding instructions to hold an oral diabetic medication (Resident #1).

Review of Resident #1's current FL-2 dated 01/16/19 revealed:
- Diagnoses included schizophrenia and type 2 diabetes mellitus.
-There was a medication order for Janumet 50/1000mg (an oral medication used to treat diabetes) take one tablet once daily with meals.

Review of Resident #1's colonoscopy instructions sheet from the gastroenterologist (GI) dated 05/06/19 revealed:
-"If you have diabetes, please do not take your insulin or oral diabetic medication the day before your procedure."
-On the day of the procedure, "If you are diabetic, please do not take your morning insulin or oral diabetic medications. Bring it with you and take after your procedure is completed."

Telephone interview with Resident #1's GI physician on 07/24/19 at 9:41am revealed:
-Resident #1 had been referred to GI for a colonoscopy by her Primary Care Provider (PCP).
-Resident #1 had been seen by the GI on 04/12/19 for a consultation.
-Patients undergoing a colonoscopy had to follow certain instructions or else a colonoscopy could

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not be performed.
-These instructions included holding of their diabetes medications the day prior to and the day of a scheduled colonoscopy appointment.
-These written instructions were provided to the transportation driver and faxed to the facility on the day of Resident #1's initial consultation on 04/12/19, and faxed to the facility again on 05/06/19, 05/20/19 and 07/15/19.
-Representatives from their office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions.

Telephone interview with Resident #1's GI physician's Medical Assistant on 07/25/19 at 11:22am revealed:
-During Resident #1's initial consultation, the GI reviewed her blood sugar levels.
-Resident #1 had blood sugar levels that were well controlled, so the GI instructed the facility to hold her diabetes medications because she was required to be on a clear liquid diet the day prior to the colonoscopy and NPO (nothing by mouth) the day of the colonoscopy.
-If diabetes medications were not held for Resident #1 and she followed a clear liquid diet and was NPO, there was a risk of her becoming hypoglycemic (having a low blood sugar level).

Review of Resident #1's May 2019 Electronic Medication Administration record (eMAR) revealed:
-There was an entry for Janumet 50/1000mg one tablet to be administered daily at 8:00am.
-There was no entry to hold Janumet 50/1000mg on the day prior to Resident #1's scheduled colonoscopies (05/05/19 and 05/19/19).
-There was no entry to hold Janumet 50/1000mg on the days Resident #1 had scheduled

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colonoscopies (05/06/19 and 05/20/19).
-Janumet 50/1000mg was documented as administered 31 of 31 opportunities.

Review of Resident #1's July 2019 eMAR (07/01/19-07/23/19) revealed:
-There was an entry for Janumet 50/1000mg one tablet to be administered daily at 8:00am.
-There was no entry to hold Janumet 50/1000mg on the day prior to Resident #1's scheduled colonoscopy (07/14/19).
-There was no entry to hold Janumet 50/1000mg on the day Resident #1 had a scheduled colonoscopy (07/15/19).
-Janumet 50/1000mg was documented as administered 23 of 23 opportunities.

Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:33pm revealed:
-The facility did not consider instructions from the GI to be a physician's order.
-When instructions for colonoscopies were received from the GI, it was the RCC's responsibility to contact the resident's Primary Care Provider (PCP) to obtain an order to hold diabetes medications.
-It was the RCC's responsibility to fax referrals made by the Primary Care Provider (PCP) to outside providers and schedule the appointments.
-The PCP would review all the residents' medications and indicate which medications were for diabetes and would order the ones that needed to be held.
-Once an order was received from the PCP, the RCC was responsible for adding a stop date and a new start date to the eMAR so medication aides (MA) would not administer the medications.
-She did not know why Resident #1's diabetes medications had not been placed on hold for her 07/15/19 colonoscopy.

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D 344	Continued From page 102 -She could not provide any documentation the facility had attempted to clarify the instructions with Resident #1's PCP. Attempted telephone interview with Resident #1's PCP on 07/29/19 at 10:35am was unsuccessful. Interview with the Administrator on 07/25/19 at 9:04am revealed: -The RCC was responsible for assuring all instructions for colonoscopy preparation were followed by the MAs. -She provided oversight to the RCC. -She did not know Resident #1's Janumet had not been held as instructed by the GI. CORRECTION DATE FOR THE STANDARD DEFICIENCY SHALL NOT EXCEED SEPTEMBER 1, 2019.	D 344		
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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This Rule is not met as evidenced by:
FOLLOW-UP TO CONTINUING TYPE A2 VIOLATION

Based on these findings, the previously Unabated A2 Violation has not been abated.
Non-compliance continues with increased severity resulting in serious physical harm.

THIS IS A TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 residents observed during a medication pass related to a muscle relaxant and an anti-seizure medication (Residents #10 and #11) and 5 of 8 sampled residents (Residents #1, #3, #4, #8 and #13) including a medication used to clean the colon prior to a colonoscopy (Residents #1 and #8), a medication used to lower high cholesterol, a medication used to treat high blood pressure, and artificial tears for dry eyes (Resident #3), a medication used to treat diabetes and two medications used to prevent difficulty in breathing (Resident #4), a medication used as a muscle relaxant (Resident #10), a medication used to treat seizures and bipolar disorder (Resident #11) and a medication used for agitation (Resident #13).

The findings are:

The medication error rate was 6% based on the observation of 2 errors out of 33 opportunities during the 8:00am medication pass on 07/24/19.

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D 358	Continued From page 104 1. Review of Resident #10's current FL2 dated 01/17/19 revealed diagnoses included cerebral infarction, hypertension and hemiplegia and hemiparesis. Review of Resident #10's signed physician's orders dated 06/05/19 included Cyclobenzaprine (a muscle relaxant) 5mg take 1 tablet twice daily. Review of Resident #10's July 2019 electronic Medication Administration Record (eMAR) revealed there was an entry for Cyclobenzaprine 5mg to be administered at 8:00am and 8:00 pm. Observation on 07/24/19 at 7:48am of the 8:00am medication pass revealed: -The Medication Aide (MA) consulted the eMAR computer monitor prior to administering the medications. -The MA prepared and administered 7 tablets and 1 nasal spray to Resident #10. -The MA documented by initials on the eMAR "administered" after she had administered the 7 tablets and the nasal spray to Resident #10. -Cyclobenzaprine 5mg was not included in the 7 tablets administered to Resident #10 on 07/24/19 at 7:48am. Observation on 07/24/19 at 9:03am of the medications on hands for Resident #10 revealed Cyclobenzaprine 5mg was not available on the medication cart for administering. Interview with the day shift MA on 07/24/19 at 9:05am revealed: -Resident #10 was ordered Cyclobenzaprine 5mg two times daily. -She had initialed as administering Cyclobenzaprine 5mg to Resident #10 on	D 358		

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D 358	Continued From page 105 07/24/19 at 8:00am -She was not sure why she documented on the eMAR Cyclobenzaprine 5mg as administered when the medication was not administered. -The Cyclobenzaprine 5mg was not available on the medication cart to administer to Resident #10. -"The medication is probably in our overstock." -"I must have selected administered by mistake." Interview with Resident #10 on 07/24/19 at 9:15am revealed; -She thought she had received all her medications on 07/24/19 at 8:00am. -She denied pain or discomfort. -She relied on the facility staff to administer her medications as ordered by the physician. Observation of the overstock "cycle bins" located in the medication room on 07/24/19 at 10:42am revealed there were 56 tablets of Cyclobenzaprine 5mg dispensed on 07/14/19 for Resident #10 in the overstock bin. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 11:40am revealed: -She did not know Cyclobenzaprine 5mg was documented as administered to Resident #10 on 07/24/19 at 8:00am when the medication was not available on the medication cart. -The facility was on "cycle fill" which meant the residents never run out of their medications. -She did not know the MAs were not filling the medication carts with the overstock medications for the residents. -The lead MA was responsible for overseeing the MA and assuring the medications were available for administering to the residents. -The MAs were to retrieve the medications from overstock and administer the medications on time and as ordered by the physicians.	D 358		

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D 358	Continued From page 106 2. Review of Resident #11's current FL2 dated 01/17/19 revealed: -Diagnoses included multiple sclerosis, epilepsy and unspecified convulsions. -Physician orders included Lamotrigine (anticonvulsant used to treat seizures) 200mg two times daily. Review of Resident #11's July 2019 electronic Medication Administration Record (eMAR) revealed there was an entry for Lamotrigine 200mg to be administered at 8:00am and 8:00 pm. Observation on 07/24/19 at 7:40am of the 8:00am medication pass revealed: -The Medication Aide (MA) consulted the eMAR computer monitor prior to administering the medications. -The MA prepared and administered 7 tablets to Resident #11. -The MA documented by initials on the eMAR "administered" after she had administered the 7 tablets to Resident #11. -Lamotrigine 200mg was not included in the 7 tablets administered to resident #11 on 07/24/19 at 7:40am. Observation on 07/24/19 at 9:03am of the medications on hands for Resident #11 revealed Lamotrigine 200mg was not available on the medication cart for administering. Interview with the day shift MA on 07/24/19 at 9:05am revealed: -Resident #11 was ordered Lamotrigine 200mg two times daily. -She had initialed and documented "Cycle" on the eMAR for Lamotrigine 200mg for Resident #11 on	D 358		

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D 358	Continued From page 107 07/24/19 at 8:00am. -The Lamotrigine 200mg was not available on the medication cart to administer to Resident #11. -"The medication is probably in our overstock." -The facility is on "cycle fill" which meant we never run out of the medications for the residents. -She did not have time to pull the overstock medications for Resident #11 prior to 06/24/19 at 8:00am. -The overstock medications were located in the medication room. -The MAs were responsible for stocking the medication carts and pulling the resident's medications from the overstock. -'I should had went and got the medication for Resident #11." -"I do not have time to go the med room during my morning med pass and check for the medications in the overstock." Interview with Resident #11 on 07/24/19 at 8:50am revealed; -She thought she had received all her medications on 07/24/19 at 8:00am. -The MA did not explain she had not received all her morning medications at 8:00am. -She denied seizure activity. -She relied on the facility staff to administer her medications as ordered by the physician. Observation of the overstock "cycle bins" located in the medication room on 07/24/19 at 10:42am revealed there were 56 tablets of lamotrigine 200mg dispensed on 07/14/19 for Resident #11 in the overstock bin. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 11:40am revealed: -She did not know lamotrigine 200mg was documented as "cycle" to Resident #11 on	D 358		

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07/24/19 at 8:00am when the medication was not available on the medication cart.
-The MA should retrieve the lamotrigine 200mg from overstock in the medication room and administer the medication on time.
-The MA should not be charting "cycle" when the medication was available in overstock.

3. Review of Resident #1's current FL-2 dated 01/16/19 revealed diagnoses included schizophrenia and type 2 diabetes mellitus.

Review of Resident #1's physician's orders dated 05/06/19 revealed a medication order from her GI (gastroenterologist) for GoLytely (a medication used to cleanse the colon prior to a colonoscopy) oral solution reconstituted; use as directed for bowel prep.

Review of Resident #1's medical or emergency referral form revealed the facility had requested an order from Resident #1's Nurse Practitioner (NP) on 05/20/19 for "GaviLyte-G (a mediation used to cleanse the colon prior to a colonoscopy) to have colonoscopy done" and the NP had signed the order on 05/22/19.

Review of Resident #1's colonoscopy instructions sheet from the GI dated 05/06/19 revealed:
-The date of the procedure (05/06/19) was crossed out with the words "No Show" handwritten beside it.
-There was a handwritten note documenting Resident #1 had a colonoscopy rescheduled for 07/15/19.

Interview with Resident #1 on 07/23/19 at 10:10am revealed:
-She missed a scheduled colonoscopy appointment the prior week.

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D 358	Continued From page 109 -She missed the scheduled colonoscopy appointment because the Medication Aide (MA) could not locate her "drink with electrolytes" (GoLytely) she had to take the day before the colonoscopy appointment. -The MA had asked another MA on duty that day and told Resident #1 that neither of them could locate her "drink" (GoLytely). -She did not know if her colonoscopy had been rescheduled. Telephone interview with Resident #1's GI physician on 07/24/19 at 9:41am revealed: -Resident #1 had been referred to him for a colonoscopy by her Primary Care Provider (PCP). -He saw Resident #1 for a consultation on 04/12/19 and she complained of blood in her stool and bloating. -Resident #1 had a history of colon polyps removed approximately 9 years prior. -He scheduled Resident #1 for a colonoscopy on 05/06/19. -Resident #1 was a "no show" to the 05/06/19 colonoscopy appointment and was rescheduled for a colonoscopy on 05/20/19. -Resident #1 was a "no show" to the 05/20/19 colonoscopy appointment and was rescheduled for a colonoscopy on 07/15/19. -Resident #1 was a "no show" to the 07/15/19 colonoscopy appointment. -Patients undergoing a colonoscopy had to follow certain instructions or else he could not perform the colonoscopy including drinking a full container of bowel prep solution (GoLytely) starting at 5:00pm the evening prior to the colonoscopy. -An order for GoLytely was provided to the transportation driver and faxed to the facility on the day of Resident #1's initial consultation and faxed to the facility every day that she was a "no show" to her colonoscopy appointments.	D 358		

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D 358	Continued From page 110 -A representative from his office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions. -Facility staff reported to his office they did not bring Resident #1 to her three scheduled colonoscopy appointments because they did not administer GoLytely the day prior and Resident #1 was also allowed to eat breakfast the morning of the scheduled colonoscopies. -It was very important for facility staff to assure residents were administered GoLytely and followed the other colonoscopy instructions. "The residents cannot do these things themselves." -With Resident #1's history of colon polyps, blood in the stool, and bloating she could have more colon polyps at present or colon cancer. "We just don't know [until she has the colonoscopy]." -After 3 "no shows," he would not reschedule the resident for another colonoscopy until someone at the facility could assure him, they would take responsibility for following through with the preparation instructions, and the resident would be required to have another consultation appointment. Review of Resident #1's May 2019 Electronic Medication Administration Record (eMAR) revealed: -There was no entry for GoLytely to be administered on 05/05/19 prior to the 05/06/19 scheduled colonoscopy. -There was no entry for GoLytely to be administered on 05/19/19 prior to the 05/20/19 scheduled colonoscopy. -There was an entry for GaviLyte-G (generic for GoLytely) to be administered at 8:00am on 05/23/19 with documentation it had not been administered.	D 358		

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D 358	Continued From page 111 Review of Resident #1's July 2019 eMAR revealed there was an entry for the bowel prep solution GaviLyte-G to be administered at 5:00pm on 07/14/19 with documentation it had not been administered. Observation of Resident #1's medications available for administration on 07/25/19 at 12:07pm revealed an unopened container of GaviLyte-G solution with a dispense date of 05/22/19. Telephone interview with a representative from the facility's contracted pharmacy on 07/24/19 at 9:06am revealed: -They had received only one order from the facility for Resident #1's GoLytely. -The GoLytely order was received on 05/22/19 and the pharmacy dispensed a one-time supply on the same day. A second telephone interview with a representative from the facility's contracted pharmacy on 07/25/19 at 10:37am revealed: -The facility faxed physician's orders to the pharmacy. -The pharmacy entered the orders into the eMAR system. -If the order provided a start date, the pharmacy would enter the medication onto the eMAR for that date. -If the order did not provide a start date, the pharmacy would enter the medication onto the eMAR for the following day. -If the physician's order was new, the facility had to go into the eMAR system and approve it before it would populate onto the eMAR for administration. -The pharmacy entered Resident #1's GoLytely order received on 05/22/19 for the following day	D 358		

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(05/23/19) because it did not have a start date.
-The facility had the ability to adjust dates and times of scheduled administration, if necessary, to coordinate administration of the GoLytely with the scheduled colonoscopy.

Interview with a first shift MA on 07/24/19 at 11:45am revealed:
-She had never administered GoLytely to Resident #1.
-She had only seen GoLytely populated on the eMAR on one occasion for Resident #1 and that was on 05/23/19.
-She asked the Lead MA/previous Resident Care Coordinator (RCC) if she should administer the GoLytely on 05/23/19 and she was told no that Resident #1 did not have a colonoscopy scheduled for the following day.

Telephone interview with a second shift MA on 07/25/19 at 11:35am revealed:
-She had never administered GoLytely to Resident #1.
-She had only seen GoLytely populated on the eMAR on one occasion for Resident #1 and that was on 07/14/19.
-She did not administer GoLytely to Resident #1 on 07/14/19 because she could not locate it in the facility.
-She asked another MA if she knew where it was, and she could not locate it either.
-She did not attempt to contact the pharmacy or a supervisor to help her locate the medication.

Interview with the Lead MA/previous RCC on 07/24/19 at 12:49pm revealed:
-She had worked at the facility since 04/16/19.
-She transferred from another facility where she had worked in a Special Care Unit (SCU).
-Processes were very different in the Assisted

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D 358	Continued From page 113 Living Facility (ALF) and she had received no training on those processes when she began working. -She did not know Resident #1 was scheduled for a colonoscopy on 05/06/19. -Whomever received the order for the GoLytely given at Resident #1's GI consult on 04/12/19 should have faxed the order to the pharmacy and given the colonoscopy date to the RCC who was employed at that time. -She knew Resident #1 had a colonoscopy scheduled for 05/20/19 and thought she missed it because she had eaten breakfast that morning. -She did not know Resident #1 was not administered GoLytely on 05/19/19. -She did not know why Resident #1's order for the GoLytely dated 05/06/19 had not been sent to the pharmacy so that it could have been administered the day prior to her 05/20/19 colonoscopy appointment. -It would have been her responsibility to fax the GoLytely order to the pharmacy because she was the RCC at that time. -She did not know why an order for the GoLytely had been requested from Resident #1's NP on 05/20/19 when they already had an order from the GI dated 05/06/19. -She knew Resident #1 had a colonoscopy scheduled on 07/15/19. -Resident #1 missed her colonoscopy on 07/15/19 because the GoLytely was not administered on 07/14/19. -GoLytely was not administered on 07/14/19 because the MA on duty that day could not locate the medication even though it was in the medication room. -She expected the MAs to call her or another supervisor if they could not locate a medication, but the MA did not do so.	D 358		

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D 358	Continued From page 114 Interview with the RCC on 07/25/19 at 2:33pm revealed: -She had been the RCC since 07/08/19. -The RCC was responsible for faxing new orders to the pharmacy and approving those orders in the eMAR system after they were entered by the pharmacy. -She had the capability of adjusting dates and times of administration in the eMAR system if needed so medications such as GoLytely could be administered based on the appointment date for the colonoscopy. -She did not work at the facility during Resident #1's 05/06/19 and 05/20/19 scheduled colonoscopy appointments. -Resident #1 missed her 07/15/19 colonoscopy appointment because she was not administered GoLytely on 07/14/19 and because she ate breakfast on 07/15/19. -Resident #1 was not administered GoLytely on 07/14/19 because the MA could not locate it even though it was in the medication room. -The MA should have contacted either her or the pharmacy to help her locate the medication, but she did not. Interview with the Administrator on 07/25/19 at 9:04am revealed: -She had worked at this facility for 3 weeks. -The RCC was responsible for sending orders to the pharmacy. -The pharmacy entered orders into a resident's computer profile. -Once the medication was dispensed to the facility, it was the RCC's responsibility to verify and approve the order entered onto the eMAR by the pharmacy. -The RCC was responsible for entering the date on the eMAR GoLytely should be administered based on the date of the colonoscopy	D 358		

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appointment.
-The RCC was responsible for assuring all instructions for colonoscopy preparation, including GoLytely administration, were followed by the MAs.
-She provided oversight to the RCC.
-GoLytely should not have been on the eMAR to be administered to Resident #1 on 05/23/19 because she did not have a colonoscopy scheduled for 05/24/19.
-GoLytely should have been on the eMAR and available for administration on 05/05/19 and 05/19/19 for Resident #1.
-She did not know the MA was unable to find the GoLytely in the medication room on 07/14/19, but she would have expected her to contact a supervisor for help.

4. Review of Resident #8's current FL-2 dated 01/16/19 revealed diagnoses included Parkinson's disease and major depression.

Review of Resident #8's physician's orders dated 04/12/19 revealed a medication order from her GI (gastroenterologist) for GoLytely (a medication used to cleanse the colon prior to a colonoscopy) oral solution reconstituted; use as directed for bowel prep.

Review of Resident #8's medical or emergency referral form revealed the facility had requested an order from Resident #1's Nurse Practitioner (NP) on 05/20/19 for "GaviLyte-G (a medication used to cleanse the colon prior to a colonoscopy) to have colonoscopy done" and the NP had signed the order on 05/22/19.

Review of Resident #8's colonoscopy instructions sheet from the GI dated May 2019 revealed:
-The date of the procedure was crossed out with

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the words "No Show" written beside it. The date was May 2019 with the day being illegible because it was crossed through.
-There was a handwritten note documenting Resident #8 had a colonoscopy rescheduled for 05/13/19 with the words "No Show" written beside it.
-There was a handwritten note documenting Resident #8 had a colonoscopy rescheduled for 07/15/19.

Attempted interview with Resident #8 on 07/25/19 at 3:43pm was unsuccessful.

Interview with Resident #8's GI physician's Medical Assistant on 07/25/19 at 11:22am revealed:
-Resident #8 had been referred to GI for a colonoscopy by her Primary Care Provider (PCP).
-Resident #8 had been seen by the GI on 04/12/19 for a consultation.
-It was difficult for them to understand Resident #8 due to a language barrier, but as far as they could understand, she was not experiencing any symptoms but had never had a colonoscopy performed.
-It was important for all residents to have a colonoscopy performed at least every 10 years beginning at age 50 and Resident #8 was age 70.
-Resident #8 was scheduled for a colonoscopy on 05/03/19.
-Resident #8 was a "no show" to the 05/03/19 colonoscopy appointment and was rescheduled for a colonoscopy on 05/13/19.
-Resident #8 was a "no show" to the 05/13/19 colonoscopy appointment and was rescheduled for a colonoscopy on 07/15/19.
-Resident #8 was a "no show" to the 07/15/19 colonoscopy appointment.
-Patients undergoing a colonoscopy had to follow

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certain instructions or else a colonoscopy could not be performed including drinking a full container of bowel prep solution (GoLytely) starting at 5:00pm the evening prior to the colonoscopy.
-An order for GoLytely was provided to the transportation driver and faxed to the facility on the day of Resident #8's initial consultation and faxed to the facility every day that she was a "no show" to her colonoscopy appointments.
-Representatives from their office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions.
-Facility staff reported to the GI office they did not bring Resident #8 to her three scheduled colonoscopy appointments because they did not administer her GoLytely the day prior and Resident #8 was also allowed to eat breakfast the morning of the scheduled colonoscopies.
-After 3 "no shows," their office would not schedule residents for another colonoscopy until they had another consultation with the GI.
-The GI was not willing to reschedule Resident #8 for another consultation until the facility could assure him, they would take responsibility for following the preparation instructions.

Review of Resident #8's May 2019 Electronic Medication Administration Record (eMAR) revealed:
-There was no entry for GoLytely to be administered on 05/02/19 prior to the 05/03/19 scheduled colonoscopy.
-There was no entry for GoLytely to be administered on 05/12/19 prior to the 05/13/19 scheduled colonoscopy.
-There was an entry GaviLyte-G (generic for GoLytely) to be administered on 05/23/19 at 1:00am with documentation it had not been

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D 358	Continued From page 118 administered. Review of Resident #8's July 2019 eMAR revealed there was an entry for the bowel prep solution GaviLyte-G to be administered on 07/14/19 at 5:00pm with documentation it had been administered. Observation of Resident #8's medications available for administration 07/25/19 at 12:07pm revealed an unopened container of GaviLyte-G solution with a dispense date of 05/22/19. Telephone interview with a representative from the facility's contracted pharmacy on 07/25/19 at 10:37am revealed: -The facility faxed physician's orders to the pharmacy. -The pharmacy entered the orders into the eMAR system. -If the order provided a start date, the pharmacy would enter the medication onto the eMAR for that date. -If the order did not provide a start date, the pharmacy would enter the medication onto the eMAR for the following day. -If the physician's order was new, the facility had to go into the eMAR system and approve it before it would populate onto the eMAR for administration. -The pharmacy had received only one order for Resident #8's GoLytely. -The pharmacy received an order for Resident #8's GoLytely on 05/22/19 and dispensed a one-time supply to the facility on the same day. -The pharmacy entered Resident #8's GoLytely order onto the eMAR for the following day (05/23/19) because it did not have a start date. -The facility had the ability to adjust dates and times of scheduled administration, if necessary,	D 358		

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to coordinate administration of the GoLytely with the scheduled colonoscopy.

Interview with a second shift Medication Aide (MA) on 07/25/19 at 4:11pm revealed:
-She worked 7:00am to 12:15am on 07/14/19 and was the only supervisor on staff that day.
-She was very busy and did not remember Resident #8's GoLytely populating on the eMAR for administration.
-She did not administer the GoLytely but documented she had administered it probably because she was so busy.

Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:33pm revealed:
-She had been the RCC since 07/08/19.
-The RCC was responsible for faxing new orders to the pharmacy and approving those orders in the eMAR system after they were entered by the pharmacy.
-She had the capability of adjusting dates and times of administration in the eMAR system, if needed, so medications such as GoLytely could be administered based on the appointment date for the colonoscopy.
-She did not work at the facility during Resident #8's 05/03/19 and 05/13/19 scheduled colonoscopy appointments.
-Resident #8 missed her 07/15/19 colonoscopy appointment because she was not administered GoLytely on 07/14/19 and because she ate breakfast on 07/15/19.
-She did not know why the MA did not administer GoLytely to Resident #8 on 07/14/19.

Interview with the Administrator on 07/25/19 at 9:04am revealed:
-She had worked at this facility for 3 weeks.
-The RCC was responsible for sending orders to

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the pharmacy.
-The pharmacy entered orders into a resident's computer profile.
-Once the medication was dispensed to the facility, it was the RCC's responsibility to verify and approve the order entered onto the eMAR by the pharmacy.
-The RCC was responsible for entering the date on the eMAR GoLytely should be administered based on the date of the colonoscopy appointment.
-The RCC was responsible for assuring all instructions for colonoscopy preparation, including GoLytely administration, were followed by the MAs.
5. Review of Resident #3's FL2 dated 07/03/19 revealed diagnoses included chronic kidney disease, type 2 diabetes, and hypertension.

a. Review of Resident #3 dated 07/03/19 revealed an order for Gemfibrozil 600mg (a medication used to treat high cholesterol)

Review of an order for Resident #3 dated 06/26/19 revealed an order for Gemfibrozil 600mg twice daily.

Review of Resident #3's June 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Gemfibrozil 600mg one tablet twice daily at 8:00am and 8:00pm.
-There was documentation Gemfibrozil 600mg was administered 4 out of 8 opportunities from 06/27/19-06/30/19.
-There was documentation Gemfibrozil was not administered 4 out of 8 opportunities on 06/28/19 at 8:00am and 8:00pm and 06/30/19 at 8:00pm, no reason was documentation.

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D 358	Continued From page 121 Review of Resident #3's July 2019 eMAR revealed: -There was an entry for Gemfibrozil 600mg one tablet twice daily at 8:00am and 8:00pm. -There was documentation Gemfibrozil 600mg was administered twice daily from 07/01/19-07/19/19 twice daily and at 8:00am on 06/21/19, 06/22/19, and 06/23/19. -There was documentation Gemfibrozil 600mg was not administered on 06/20/19 at 8:00am and 8:00pm, and at 8:00pm on 06/21/19 and 06/22/19. Observation of medications available for administration on 07/23/19 at 2:50pm revealed Gemfibrozil 600mg was not available for administration. Telephone interview with the facility's contracted pharmacy on 07/24/19 at 9:04am revealed: -Resident #3 was "profile only" and his medications were dispensed from another pharmacy. -The pharmacy dispensed medications for Resident #3 upon the facility's requested -An order for Gemfibrozil 600mg to be administered twice daily was received on 07/02/19 and 30 pills (15-day supply), and was dispensed on 07/02/19. -There were no other requests received to fill Gemfibrozil 600mg for Resident #3. Interview with a representative with the veteran administration (VA) pharmacy on 07/29/19 at 12:41pm revealed the pharmacy had not received an order for Gemfibrozil 600mg. Review of Resident #3's lipid panel laboratory results dated 06/26/19 revealed: -Resident #3's triglyceride level was 264mg/dL.	D 358		

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D 358	Continued From page 122 -The reference range listed for triglycerides was 35-150mg/dL. Interview with Resident #3 on 07/24/19 at 12:50pm revealed: -He thought her received his medications as ordered most of the time. -He was not sure what medications he was ordered. -At times, there seemed to be less pills than normal. Interview with a medication aide (MA) on 07/23/19 at 2:50pm revealed: -She normally worked first shift as a MA. -Gemfibrozil was not available for administration for Resident #3. -She could not remember when Resident #3 ran out of Gemfibrozil. -She called the facility's contracted pharmacy to get the medication reordered, but she could not remember when she called the pharmacy. -She had not contacted Resident #3's contracted pharmacy (VA) because it took "forever" for medications to come into the facility. -She told the RCC and lead MA but she could not remember when she notified her. Interview with the lead medication aide (MA)/previous RCC on 07/29/19 at 3:20pm: -She did not know what happened with Resident #3's Gemfibrozil medication. -Resident #3's medications took a while to come from the veteran administration (VA) pharmacy. -None of the MAs informed her that Resident #3's Gemfibrozil was not available for administration. -There was a lack of communication between her and the MAs. - She completed cart audits before, she could not remember the last cart audit that she completed.	D 358		

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D 358	Continued From page 123 Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 11:40am revealed: -She became the RCC on 07/08/19. -Medication orders were supposed to be faxed and to the veteran's administration (VA) and a progress note should be made. -She did not know Gemfibrozil was not available for administration. -She spoke with facility's contracted licensed prescriber on 07/25/19 to notify and he provided an order to hold Gemfibrozil for Resident #3 until it was in the building. -The MAs should have notified her that the Gemfibrozil was not available and should have faxed the pharmacy. - "No one followed up on the medication to make sure it was in the building". Interview with the Director of Resident Care (DRC) on 07/24/19 at 2:55pm revealed: -She did not know Resident #3's Gemfibrozil was not available for administration. -MAs were expected to communicate with her verbally about any issues regarding the residents. -She expected the MAs to notify her or the RCC if there were issues getting a medication delivered from the pharmacy. -If a medication after 24 hours, the MAs were responsible for following up with the pharmacy. -There were supposed to be weekly audits of the eMAR, but she was not sure if there were being completed. -She was not sure if a cart audit included review of Resident #3's medications. Interview with the facility's contracted nurse practitioner (NP) on 07/24/19 at 1:05pm revealed: -He ordered Gemfibrozil 600mg twice daily after her received lab results for a high triglyceride	D 358		

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level.
- "If his [Resident #3] triglycerides are not lowered, his blood sugars will remain uncontrolled".
-If Gemfibrozil was not administered as ordered, Resident #3 would continue to have elevated blood sugars which could result in altered mental status, confusion, and hospitalization.
-He did not know if he was told that the Gemfibrozil was not available for administration.

Interview with the registered nurse (RN) for the primary care provider (PCP) for Resident #3 on 07/25/19 at 10:25am revealed the PCP was not aware the resident was ordered Gemfibrozil by the facility's contracted nurse practitioner.

Interview with the Administrator on 07/25/19 at 4:20pm revealed:
-MAs were supposed to contact the pharmacy immediately if medications were not available for administration.
-MAs were to notify the RCC or DRC within 24 hours if the medication was not available after requesting it from the pharmacy.
-The RCC and DRC were supposed to check the eMAR system every morning for medication errors.
-Cart audits were to be completed weekly by the RCC and MAs.
-She implemented cart audits "three weeks ago".

b. Review of a physician's order dated 12/28/18 revealed an order for Metoprolol Tartrate 50mg (medication used to treat high blood pressure) one table to be administered twice daily, hold is the systolic blood pressure is less than 125.

Review of an order for Resident #3 dated 06/26/19 revealed an order to discontinue

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D 358	Continued From page 125 Metoprolol Tartrate 50mg twice daily and begin Metoprolol Tartrate 100mg one tablet twice daily. Review of Resident #3's FL2 dated 07/03/19 revealed an order for metoprolol 100mg one tablet twice daily. Review of Resident #3's June 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Metoprolol Tartrate 100mg one tablet twice daily at 8:00am and 8:00pm. -There was documentation Metoprolol Tartrate 100mg was administered twice daily from 06/27/19-06/30/19. Review of Resident #3's July 2019 eMAR from 07/01/19-07/23/19 revealed: -There was an entry for Metoprolol Tartrate 100mg one tablet twice daily at 8:00am and 8:00pm. -There was documentation Metoprolol Tartrate 100mg was administered twice daily from 07/01/19-07/23/19. Observation of medications available for administration for Resident #3 on 07/23/19 at 2:50pm revealed: -There was a bottle of Metoprolol Tartrate 50mg available for administration. -There were 83 pills remaining available for administration. Interview with a representative with Resident #3's outside pharmacy on 07/29/19 at 12:41pm revealed: -The pharmacy received an order for metoprolol 50mg twice daily on 08/03/18. -The pharmacy filled 180 metoprolol 50mg tablets	D 358		

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on 02/18/19 and on 05/16/19.
-The pharmacy had not received an order for metoprolol 100 twice daily that was written on 06/26/19.

Telephone interview with the facility's contracted pharmacy on 07/24/19 at 9:04am revealed:
-Resident #3 was "profile only" and his medications were primarily dispensed from another pharmacy.
-The pharmacy had never filled an order for Metoprolol Tartrate.
-The pharmacy received an order for Metoprolol Tartrate 100mg to be administered twice daily, however the medication had not been dispensed.
-Medications for Resident #3 were only dispensed if the facility called and made a request.

Interview with Resident #3 on 07/24/19 at 12:50pm revealed:
-He thought he received his medications as ordered most of the time.
-He was not sure what medications he was ordered.

Interview with a medication aide (MA) on 07/23/19 at 2:50pm revealed:
-She normally worked first shift as a MA.
-She told the RCC but she could not remember when she notified her.
-Resident #3 was prescribed Metoprolol Tartrate 100mg twice daily.
-She administered the one tablet twice daily to Resident #3.
-She had not noticed the Metoprolol Tartrate was 50mg tablets.

Interview with the lead medication aide (MA)/previous RCC on 07/29/19 at 3:20pm the MAs should be giving metoprolol 100mg twice

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D 358	Continued From page 127 daily twice daily, "I guess it was not caught". Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 11:40am revealed: -She noticed the order for Resident #3's metoprolol changed from 50mg twice daily to 100mg twice daily. -She thought Resident #3 had metoprolol 100mg tablets on the cart. -Resident #3 was "profile only" with the contracted pharmacy as he received his medications from an outside. Interview with the Director of Resident Care (DRC) on 07/24/19 at 2:55pm revealed: -She did not know Metoprolol Tartrate 100mg tablets were not dispensed for Resident #3. -She expected the MAs to administer two 50mg Metoprolol Tartrate tablets and contact the pharmacy to 100mg tablets dispensed. -She was not sure if a cart audit included review of Resident #3's medications. Interview with the facility's contracted nurse practitioner (NP) on 07/24/19 at 1:05pm revealed: -He ordered Metoprolol Tartrate 100mg twice daily for Resident #3 to treat high blood pressure. -If Resident #3 was not administered Metoprolol Tartrate as ordered, the residents' blood pressure would remain high and but the resident at risk for a stroke. Interview with the Administrator on 07/25/19 at 4:20pm revealed she expected MAs to administer medications as ordered by the physician. c. Review of a physician's order dated 12/21/18 revealed an order for Artificial Tears Polyvinyl Alcohol 1.4% instill one drop in both eyes four times daily.	D 358		

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D 358	Continued From page 128 Review of signed physician order for Resident #3 dated 06/26/19 revealed an order for Artificial Tears Polyvinyl Alcohol 1.4% instill one drop in both eyes four times daily. Review of Resident #3's June 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Artificial Tears Polyvinyl Alcohol 1.4% instill one drop in both eyes four time daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation artificial tears was not administered 17 out of 120 opportunities from 06/01-06/30/19, the reasons were not printed. Review of Resident #3's July 2019 eMAR from 07/01/19-07/23/19 revealed: -There was an entry for Artificial Tears Polyvinyl Alcohol 1.4% instill one drop in both eyes four time daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation artificial tears was not administered 40 out of 90 opportunities from 07/01/19-07/23/19, the reasons were not printed. Observation of medications available for administration for Resident #3 on 07/23/19 at 2:50pm revealed there was a one 15mL bottle of Artificial Tears Polyvinyl Alcohol 1.4% available for administration. Interview with a representative with Resident #3's outside pharmacy on 07/29/19 at 12:41pm revealed: -The pharmacy received an order for artificial tears, one drop in each eye four times daily on 12/18/19. -The pharmacy dispensed one 15mL bottle on	D 358		

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D 358	Continued From page 129 12/19/18 and on 06/21/19 and both were for a 30-day supply. Telephone interview with the facility's contracted pharmacy on 07/24/19 at 9:04am revealed: -Resident #3 was "profile only" and his medications were primarily dispensed from another pharmacy. -The pharmacy had never filled an order for artificial tears for Resident #3. -Medications for Resident #3 were only dispensed if the facility called and made a request. Interview with Resident #3 on 07/24/19 at 12:50pm revealed: -He thought her received his medications as ordered most of the time. -He received eye drops "sometimes". -He needed eye drops because one of the tear ducts in his eyes were damaged. -He had not suffered from dry eyes. Interview with a medication aide (MA) on 07/23/19 at 2:50pm revealed: -She normally worked first shift as a MA. -She administered Resident #3's eye drops and documented when administered. -She could not remember the reason why the artificial tears were not documented in June 2019. -The artificial tears were administered in July 2019, she did not know why it did not reflect administered on the eMAR. Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 11:40am revealed: -She had not noticed there were missed administrations of artificial tears. -She had not noticed the artificial tears were only dispensed twice by the pharmacy. -The MAs may had used the as needed artificial	D 358		

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EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

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tears medication to administer to Resident #3.
-She did not know Resident #3 missed doses of artificial tears in June and July 2019.
-She did not know why documented administrations of artificial tears did not appear on the eMAR 07/02/19-07/10/19.
-Resident #3 was profile only with the contracted pharmacy as he received his medications from the veteran's administration (VA) pharmacy.

Interview with the Director of Resident Care (DRC) on 07/24/19 at 2:55pm revealed:
-She expected the MAs to administer medications as ordered.
-She expected the MAs to notify her or the RCC if medications were not administered after 3 missed doses.

Interview with the registered nurse (RN) for the primary care provider (PCP) for Resident #3 on 07/25/19 at 10:25am revealed:
-Resident #3 was ordered artificial tears four times per day to treat dry eyes.

Interview with the Administrator on 07/25/19 at 4:20pm revealed she expected MAs to administer medications as ordered by the physician.

6. Review of Resident #13 FL2 dated 01/17/19 revealed diagnosis included insomnia.

Review of a psychotherapy follow-up note signed and dated by the mental health physician's assistant (PA) on 06/24/19 for Resident #13 revealed:
-Current medications included Vistaril 50mg at bedtime.
-"At last visit, patient was started on Vistaril 50mg for insomnia".

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D 358	Continued From page 131 Review of psychotherapy follow-up note signed and dated by the mental health PA on 07/23/19 for Resident #13 revealed current medications included Vistaril 50mg for insomnia at bedtime. Review of Resident #13's June and July 2019 electronic Medication Administration Record (eMAR) revealed there was no entry for Vistaril 50mg at bedtime. Telephone interview with the facility's contracted pharmacy on 07/29/19 at 11:18am revealed the Vistaril 50mg order was never received. Interview with the lead medication aide/former RCC on 07/29/19 at 3:55pm revealed: -Prior to 07/08/19, she was the RCC and was responsible for receiving orders for the mental health PA. -She never seen the order for the Vistaril 50mg for Resident #13. -The mental health PA would often write therapy notes about a medication and the order was not left in the building. -When she was the RCC, she would retrieve the psychotherapy notes from email and place in the residents' record. -She did not remember reviewing the psychotherapy notes for Resident #13. Interview with the Resident Care Coordinator (RCC) on 07/29/19 at 3:45pm revealed: -She became the RCC on 07/08/19. -She did not know where the original order for Vistaril 50mg was located. -She did not realize Resident #13 was ordered Vistaril 50mg. -She had not reviewed Resident #13's psychotherapy notes. -She placed a call to the psychotherapy provider	D 358		

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D 358	Continued From page 132 on 07/29/19 to retrieve the original order. Interview with the Director of Resident Care (DRC) on 07/29/19 at 3:50pm revealed: -She became the DRC on 07/08/19. -Since being in the role of DRC, she had not had the chance to review Resident #13's record. -She had not noticed that the Vistaril ordered had not been implemented. -She looked for the original order but could not find the order written by the mental health PA. -The PA reviewed the eMARs regularly and would let her know if anything was missed. -She would have expected the mental health PA to review the eMARs and notify her or the RCC that the medication was not on the eMAR. Interview with the mental health physician assistant (PA) on 07/29/19 at 3:33pm revealed: -He initially ordered Vistaril 50mg for Resident #13 during his June 2019 visit. -He ordered Vistaril because Resident #13 complained of having trouble falling asleep. -He expected Resident #13 to receive Vistaril 50mg as ordered every evening. -He did not know Resident #13 was not receiving the Vistaril 50mg as ordered. -If Resident #13 was not administered Vistaril as ordered he would have trouble falling asleep at night. -Resident #3's lack of sleep would cause him to be "more irritable during the day". -When he ordered medications for residents, he would leave the order with the Resident Care Coordinator (RCC). Interview with the Administrator 07/29/19 at 4:17pm revealed: -The RCC or the DRC should have reviewed psychotherapy notes from their email when sent	D 358		

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from the mental health provider.
-The Vistaril 50mg order for Resident #13 should have been caught and faxed to the pharmacy.

7. Review of Resident #4's FL2 dated 01/21/19 revealed diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypoxia, acute renal failure and diabetes.

a. Review of Resident #4's physician order dated 05/22/19 revealed an order for Levemir U-100 insulin, (a medication used to control elevated blood sugar), 30 units to be administered at bedtime.

Review of Resident #4's physician order dated 06/19/19 revealed an order for Levemir U-100 insulin, administer 24 units at bedtime.

Review of Resident #4's May and June 2019 electronic Medication Administration Record (eMAR), from 05/22/19 through 06/18/19 revealed:
-There was an entry for Levemir insulin 30 units to be administered daily at 8:00pm, from 05/22/19 through 06/18/19.
-There was documentation Levemir insulin was administered 28 out of 28 opportunities from 05/22/19 through 06/18/19.

Review of Resident #4's June and July 2019 eMAR, from 06/19/19 through 07/24/19 revealed:
-There was an entry for Levemir insulin 24 units to be administered daily at 8:00pm from 06/18/19 through 07/24/19.
-There was documentation Levemir insulin was administered 37 out of 37 opportunities from 06/18/19 through 07/24/19.

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D 358	Continued From page 134 Observation of medications available for administration on 07/23/19 at 2:55pm revealed there was no Levemir insulin vial or flexpen on the medication cart or in the medication refrigerator. Observation of medications available for administration on 07/24/19 at 9:10am revealed: -There was a 10ml vial of Levemir insulin U-100 on the medication cart. -The Levemir vial had a computer generated label attached to the vial, which read "Inject 30 units at bedtime." -The vial was in a medication bottle with the open date handwritten as 07/08/19. -The insulin was pictured with the contents to the neck of the vial. Interview with the first shift Lead Medication Aide (MA) on 07/24/19 at 10:15am revealed: -She had been auditing the medications on the carts with the other Lead MA. -She did not remember if she had audited Resident #4's medications in the past month. -When she performed a cart audit, she would print the physician order summary (POS) and ensure the medications listed were on the cart. -If the medications were tablets or hand held inhalers, she would check the quantity remaining and record on the POS. -She submitted the POS to the Resident Care Coordinator (RCC) or the Administrator. -She did not remember checking the Levemir insulin vial for Resident #4. -She did not generally administer evening medications. -She had administered Resident #4's Levemir insulin twice in the past month when she worked second shift, and she used the Levemir vial of insulin.	D 358		

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D 358	Continued From page 135 -She did not know why the insulin vial "looked unused". -She thought the MAs may have used Resident #4's Novolog flexpen in error instead of the Levemir vial, since all of the insulin medications were sent as flexpens. Interview with the Primary Care Physician (PCP) on 07/24/19 at 12:45pm revealed: -Resident #4 was being monitored for his diabetes. -The PCP requested a print out of Resident #4's blood sugars weekly to evaluate the blood sugar ranges. -If Resident #4's blood sugar was too high he would become disoriented and end up hospitalized. -The PCP states Resident #4's blood sugars were controlled on his current medication regiment. -He did not know Resident #4 had not been receiving the night time dose of Levemir which was ordered at 24 units. -He expected his medication orders to be administered. Interview with the Director of Resident Care (DRC) on 07/24/19 at 2:55pm revealed: -The MAs were expected to communicate with her verbally about any issues regarding the residents. -There were supposed to be weekly audits of the eMAR, but she was not sure if they were being completed. -She was not sure if a cart audit included a review of the medications as to the quantity. -She thought the RCC was monitoring the eMARs and the medications. -She was conducting record audits since she assumed this position on 07/08/19.	D 358		

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-She did not know Resident #4 had a Levemir insulin vial sent from the pharmacy on 05/27/19 that was almost completely full.
-No one had brought this to her attention.
-She did not know why the Levemir insulin vial was almost full when the medication had been documented as administered 58 times since it had been dispensed.

Telephone interview with the facility's contracted pharmacy on 07/24/19 at 3:30pm revealed:
-Resident #4 had an order dated 05/22/19 for Levemir 30 units to be administered in the evening.
-A 10ml vial of Levemir, administer 30 units in the evening, was sent to the facility on 05/27/19.
-Resident #4 had an order dated 06/19/19 for Levemir 24 units to be administered in the evening, and was the most current order.
-No additional vials or flexpens of Levemir have been requested by the facility or dispensed from the pharmacy.
-The 10ml vial of Levemir insulin sent on 05/27/19 at 24 units daily would have lasted 41 days (until 07/07/19).
-Since Resident #4 was administered 30 units for 28 days, the insulin would have been depleted sooner than 41 days.
-Insulin is only sent to the facility with a physician's order and at the staff's request.
-The fill history was as follows:
-One vial was sent to the facility on 03/04/19, 04/11/19 and 05/27/19.

Telephone interview with the second shift MA on 07/25/19 at 10:30am revealed:
-Resident #4 has a vial of Levemir insulin.
-Resident #4 never refused his medications or insulin injections.
-She administered the Levemir insulin from the

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vial for Resident #4's injections.
-He never had a flexpen for his Levemir insulin.
-She did not know why the insulin vial was almost full.
-She always administered Resident #4's Levemirinsulin from the vial.
-She did not know of any other Levemir insulin for Resident #4.

Review of Resident #4's A1C laboratory results dated 05/01/19 revealed:
-Resident #4's A1C on 05/01/19 was 7.6%
-The reference range listed for A1C was 4.0-6.0%.

Interview with the Administrator on 07/25/19 at 4:20pm revealed:
-The RCC and DRC were supposed to check the eMAR system every morning for medication errors.
-Cart audits were to be completed weekly by the RCC and MAs.
-She implemented cart audits "three weeks ago".
-She did not know Resident #4's Levemir insulin vial had not been used every evening since 05/27/19 for administration.

Attempted interview with Resident #4 on 07/24/19 at 9:40am was unsuccessful.

b. Review of Resident #4's physician order on 05/11/19 revealed an order for a Novolog flexpen U-100 insulin (a medication used to control elevated blood sugar), 8 units three times a day with meals.

Review of Resident #4's physician order on 06/19/19 revealed an order for a Novolog flexpen U-100 insulin 10 units three times a day with meals.

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D 358	Continued From page 138 Review of Resident #4's June 2019 electronic medication administration record (eMAR) from 06/19/19 through 06/25/19 revealed: -There was an entry for Novolog flexpen 8 units three times a day with meals, to be administered at 7:00am, 12:00pm and 5:00pm. -There was documentation Novolog flexpen 8 units was administered daily at 7:00am, 12:00pm and 5:00pm from 06/19/19 through 06/25/19. -There was an entry for a Novolog flexpen 10 units to be administered three times a day with meals at 6:30am, 11:30am and 4:30pm. -There was documentation Novolog 10 units was administered three times a day at 6:30am, 11:30am and 4:30pm from 06/19/19 through 06/25/19. -On 06/20/19, 06/21/19, 06/22/19, 06/24/19 and 06/25/19 at 6:30am the third shift MA documented the administration of 10 units of Novolog insulin to Resident #4. -On 06/20/19, 06/21/19, 06/22/19, 06/24/19 and 06/25/19 at 7:00am the first shift MA documented the administration of 8 units of Novolog insulin to Resident #4. -On 06/21/19 and 06/24/19, at 4:30pm, the second shift MA documented the administration of 10 units of Novolog insulin to Resident #4. -On 06/21/19 and 06/24/19 at 5:00pm, another second shift MA documented the administration of 8 units of Novolog insulin to Resident #4. Interview with the first shift Medication Aide (MA) on 07/24/19 at 11:15am revealed: -She administered the medications on her medication cart when they appeared on the eMAR. -She can not view previous shift's medication administration. -She did not notice there were 2 entries on the	D 358		

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eMAR and 2 different dosages for administration for novolog insulin.
-She administered the 7:00am dose of 8 units of Novolog insulin to Resident #4.

Telephone interview with the facility's contracted pharmacy on 07/24/19 at 3:30pm revealed:
-Orders received by the pharmacy from a physician were entered on the eMAR.
-For an order to be discontinued, the pharmacy staff were required to have a discontinue order from the physician.
-The pharmacy computer system does not interface with the facility software.
-The facility management staff could discontinue an order from their site.
-The physician's order for Novolog flexpen 10 units to be administered three times a day before meals was entered on the eMAR on 06/19/19 by the pharmacy staff.
-The default time for orders not specifically indicated by the physician was 1:00am.
-It was the responsibility of the facility staff to adjust the times as needed for administration.

Interview with the RCD on 07/25/19 at 3:20pm revealed:
-She did not review the eMARs for accuracy.
-She thought the RCC reviewed the eMARs for accuracy.
-The RCC and the RCD were employed at the facility in July of 2019.
-She did not know who entered the times for the Novolog insulin to be administered.

Interview with the RCC on 07/25/19 at 4:10pm revealed:
-She reviewed new orders on the eMAR before approving the entry.
-She did not review the eMARs for accuracy with

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existing orders.
-She had been implementing and training the MAs to audit their carts weekly.
-She also had been auditing the medication carts herself.
-She verified the resident's physician order summary with the resident's medications on the cart.
-She did not know the Novolog insulin was documented as administered for 8 units and 10 units on the eMAR.

c. Review of Resident #4's physician's order dated 06/06/19 revealed an order for Incruse Ellipta 62.5mcg hand held inhaler, (used as a maintenance breathing medication for COPD) 1 puff every day.

Review of Resident #4's June and July 2019 electronic Medication Administration Record (eMAR) from 06/06/19 through 07/23/19 revealed:
-There was an entry for Incruse Ellipta, 1 puff, to be administered daily at 8:00am from 06/06/19 through 07/23/19.
-There was documentation Incruse Ellipta was administered daily at 8:00am from 06/06/19 through 07/23/19.
-Incruse Ellipta was documented as administered 48 times from 06/06/19 through 07/23/19.

Observation of medications available for administration on 07/23/19 at 2:55pm revealed:
-There was an Incruse Ellipta hand held device inside a plastic bag with a computer generated pharmacy label.
-The dispense date on the label was 06/06/19 and the handwritten open date was 06/06/19.
-There were 30 doses in the device to be administered.

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D 358	Continued From page 141 -The number 12 was displayed on the dose counter, indicating 12 doses were left to be administered, and 18 doses had been administered since 06/06/19. Interview with the Primary Care Physician (PCP) on 07/24/19 at 12:45pm revealed: -Resident #4 had congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) with difficulty in breathing and shortness of breath. -He was on two scheduled and one as needed (PRN) hand held inhalers, and on a PRN nebulizer treatment for shortness of breath (SOB) due to his diagnoses. -It was important for his health that he received his scheduled breathing treatments and his PRN treatments. -He did not know Resident #4 had not been receiving the Incrusa Ellipta as ordered. -Resident #4 had not complained to him of any breathing difficulties. Observation on 07/24/19, Resident #4 was sent to the hospital with a diagnosis of dyspnea and exacerbation of COPD. Telephone interview with the facility's contracted pharmacy on on 07/24/19 at 3:30pm revealed: -Resident #4 had an active order dated 06/06/19 for Incruse Ellipta 62.5mcg, inhale 1 puff by mouth daily. -The pharmacy dispensed inhalers for residents with a physician's order and at the facility's request, when the medication was completed or the medication had expired.. -One Incruse Ellipta inhaler was sent each time to the facility and there were 30 doses in each device. -Resident #5's last Incruse Ellipta was dispensed	D 358		

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D 358	Continued From page 142 on 06/06/19. -No further requests from the facility for Incruse Ellipta were received or dispensed from the pharmacy. -The starting dose was identified as "30" in the dose counter window. -Each administration will bring this number down by 1. -If Resident #4 was receiving daily doses of the Incruse Ellipta, he should have completed the medication on 07/07/19. Interview with a Medication Aide (MA) on 07/25/19 at 10:40am revealed: -She administered the Incrusa Ellipta breathing treatment to Resident #4 when she worked on this medication cart. -She did not put the open date on the plastic bag that the device was in. -She did not know how long the medication should last-she thought 30 or 45 days. -She did not usually assist with cart audits. -When she did assist with cart audits, she made sure the medication was on the cart but did not check to see how many doses were left with the inhalers Interview with the Director of Resident Care (DRC) on 07/25/19 at 3:20pm revealed: -She had been reviewing the resident's records for compliance. -The RCC had been overseeing the medications, the medication carts and the orders. -She did not know the process used to audit the medication carts in this facility. -She expected the MAs to report to her or the RCC if there was a problem with medications. -She expected the MAs to administer the medications as ordered by the licensed practitioner.	D 358		

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D 358	Continued From page 143 -She did not know the daily scheduled Incruse Ellipta had 18 doses administered in 48 days. Interview with the Administrator on 07/25/19 at 4:20pm revealed: -The RCD and the RCC were responsible for the clinical aspects of the facility. -She had requested audits of the medication carts to be completed as soon as possible last week. -The completed cart order forms were given to the RCC and herself. -She had not reviewed the current cart audits to date. -She did not know the Incruse Ellipta had 18 doses administered in 48 days. -She expected the MAs to administer medications as ordered by the physician. Interview with the Resident Care Coordinator (RCC) on 07/26/19 at 12:15pm revealed: -She had been transitioning the cart audits to the MAs as the process should be. -She trained the MAs on the process and oversaw the cart audits. -The MAs would be assigned 4-5 residents each day on their medication cart and verify the physician's order summary (POS) with the medications for that resident. -The MAs returned the POS with their notes to the RCC and she reviewed the information. -She had not audited all the medication carts herself. -The MAs should be checking the handheld inhalers, eye drops, creams, insulin-any medication that does not come on cycle fill from the pharmacy- for dates opened and refills. -She did not know the Incruse Ellipta had 18 doses administered in 48 days. -She would be doing daily cart audits until all the	D 358		

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resident's medications on the carts had been audited.

Interview with the lead MA/previous RCC on 07/29/19 at 3:20pm revealed:
-She had assisted in auditing the medication carts for the past few months.
-The process in auditing the medication cart was to print the POS and determine if the medications on the POS were on the cart.
-She usually audited 4 or 5 resident's medications at a time.
-The POS sheet was given to the Administrator or RCD for their review.
-If the medications were not on the cart she would order them through the pharmacy.
-She had audited Resident #4's medication cart, but could not remember if she audited his medications.
-The MAs should also be reviewing the medications and eMARS every day and reporting any discrepancies they find.
- "I guess it was not caught".

d. Review of Resident #4's physician order dated 05/28/19 revealed an order for Spiriva handihaler, inhale 1 capsule via device daily.

Review of Resident #4's May and June 2019 electronic Medication Administration Record (eMAR) from 05/28/19 through 06/05/19 revealed:
-There was an entry for Spiriva handihaler, inhale 1 capsule via device once daily, to be administered at 8:00am.
-There was no documentation the Spiriva was administered from 05/28/19 through 06/05/19.
-There was an entry for Spiriva, inhale 1 capsule via device once daily, to be administered at 8:00am, and was discontinued on 06/05/19.

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D 358	Continued From page 145 Telephone interview with the facility's contracted pharmacy on on 07/24/19 at 3:30pm revealed there was no record of the pharmacy dispensing Spiriva handihaler to the facility for Resident #4. Observation of medications available for administration on 07/23/19 at 2:55pm revealed there was no Spiriva handihaler on the medication cart. Interview with the MA on 07/23/19 at 3:05pm revealed she did not recall administering Spiriva to Resident #4. Interview with the lead MA/former Resident Care Coordinator on 07/29/19 at 3:30pm revealed: -Resident #4 had gone out to the hospital several times. -The Spiriva may have been a discharge order and his insurance would not cover it. -She did not remember the order. _____ The facility failed to assure medications were administered as ordered for several residents, including Resident #4 who had a diagnosis of chronic obstructive pulmonary disorder (COPD) and missed 30 of 48 doses of Incruse Ellipta and 8 of 8 doses of Spiriva, resulting in a hospitalization for shortness of breath. The failure of the facility to assure medications were administered resulted in physical harm to Resident #4 and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/24/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 26, 2019.	D 358		

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D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 4 of 10 sampled residents related to documenting parameters for the administration of an insulin used to treat diabetes and a medication used to	D 367		

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treat high blood pressure (Resident #3), a medication used to prepare for a colonoscopy procedure (Resident #1 and #8), and documenting the administration of a hand held inhaler under the incorrect eMAR entry (Resident #4).

The findings are:

1. Review of Resident #3's current FL-2 dated 07/03/19 revealed diagnoses included chronic kidney disease, type 2 diabetes, peripheral neuropathy, history of cerebral vascular disease with left sided weakness, and hypertension.

a. Review of Resident #3's physician's orders dated 12/28/18 revealed:
-There was an order to administer Novolog insulin 100 units/mL inject 2 to 10 units (sliding scale) before meals and at bedtime for diabetes.
-The sliding scale was as follows: 150-200; 2 units, 201-250; 4 units, 251-300; 6 units, 301-350; 8 units, 351-400; 10 units, if greater than 401 go to the emergency room or urgent care.

Review of Resident #3's May 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Novolog insulin 100unit/mL, check fingerstick blood sugar (FSBS) and inject per sliding scale for 6:30am.
-The entry for 6:30am included the initials of the medication aide that administered the medication.
-There was no space to document the FSBS result.
-There was no space to document the units of insulin administered.
-There was no entry for the Novolog order to be implemented before lunch, dinner, or bedtime.
-It could not be determined how many units of

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D 367	Continued From page 148 insulin was administered to the resident per the sliding scale from 05/01/19-05/31/19 at 6:30am. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Novolog insulin 100unit/mL, check fingerstick blood sugar (FSBS) and inject per sliding scale for 6:30am. -The entry for 6:30am included the initials of the medication aide that administered the medication. -There was no space to document the FSBS result. -There was no space to document the units of insulin administered. -There was no entry for the Novolog order to be implemented before lunch, dinner, or bedtime. -It could not be determined how many units of insulin was administered to the resident per the sliding scale from 06/01/19-06/26/19 at 6:30am. Review of the facility's contracted pharmacist's medication regimen review consultation completed on 06/25/19 revealed there was instruction for nursing to "review how the order for NovoLog sliding scale before meals and at bedtime was entered into the eMAR system, review of the June MAR indicates only being done at 6:30am, please make sure the sliding scale is evaluated for administration prior to each meal and at bedtime as ordered". Interview with a lead medication aide (MA) on 07/24/19 at 3:53pm revealed: -When Resident #3 was ordered sliding scale insulin, there was not place on the eMAR to record the blood sugar or the amount of units administered. -She notified the Resident Care Coordinator (RCC) and the Director of Resident Care (DRC) and nothing was done.	D 367		

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D 367	Continued From page 149 -She could not remember when she notified the RCC and DRC. -The DRC told her to "give us time to get it done". Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:05am revealed: -The fingerstick blood sugar (FSBS) order for Resident #3 was on the eMAR, however the parameters were not checked when the order was entered. -The parameters were not checked in the eMAR system therefore the orders did not appear on the eMAR. Interview with the lead medication aide/previous Resident Care Coordinator (RCC) on 07/24/19 at 10:48am revealed: -She was the RCC until 07/08/19. -She approved the Novolog sliding scale order in the eMAR system for Resident #3. -She did not realize the sliding scale units for the Novolog were not checked in the eMAR system. -The corporate nurse gave her orders to enter into the eMAR system, she did not have any training on the eMAR system. -She did not know the parameters for the sliding scale insulin were not entered. -There was no process to review the eMARs for accuracy. Interview with the Administrator on 07/25/19 at 4:20pm revealed: -The lead MA was the previous RCC, however she did not receive training and was asked to step down. -The RCC and the DRC were responsible for implementing parameters populated on the eMAR. -The eMARs were to be checked daily by the MAs, RCC, and the DRC and changes were to be	D 367		

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D 367	Continued From page 150 made as needed. b. Review of a signed physician's order dated 06/26/19 revealed: -There was an order for metoprolol tartrate (used to treat high blood pressure) 50mg twice daily, hold for systolic blood pressure less than 125, the start date was 08/06/18. Review of Resident #3's May 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metoprolol tartrate 50mg twice daily hold for systolic blood pressure less than 125. -The metoprolol tartrate was documented as administered from 05/01/19-05/31/19. -There was no space for blood pressures to be documented on the eMAR. -There was no documentation that the resident's blood pressure was recorded from 05/01/19-05/31/19. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for metoprolol tartrate 50mg twice daily hold for systolic blood pressure less than 125. -The metoprolol tartrate was documented as administered from 06/01/19-06/21/19. -There was no space for blood pressures to be documented on the eMAR. -There was no documentation that the resident's blood pressure was recorded from 06/01/19-06/21/19. Review of Resident #3's vitals signs report revealed: -There were no documented blood pressures from 05/01/19-06/19/19.	D 367		

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D 367	Continued From page 151 -There were 4 blood pressures documented from 06/20/19-06/21/19. Interview with a lead medication aide (MA) on 07/24/19 at 3:53pm revealed: -She did not know why Resident #3's blood pressures were not listed on the eMAR, but "we always check his blood pressure". -No one ever told her to document the blood pressures anywhere else. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:05am revealed: -The parameters were not checked in the eMAR system therefore the orders did not appear on the eMAR. -She noticed that the parameters were not showing up on the eMAR and corrected it. Interview with the lead medication aide/previous Resident Care Coordinator (RCC) on 07/24/19 at 10:48am revealed: -She did not realize the blood pressure parameters were not implemented on the eMAR. -The corporate nurse gave her orders to enter into the eMAR system, and she did not have any training on the eMAR system. -She did not know the parameters for the blood pressure parameters were not entered. -There was no process to review the eMARs for accuracy. Interview with the Administrator on 07/25/19 at 4:20pm revealed: -The lead MA was the previous RCC, however she did not receive training and was asked to step down. -The RCC and the DRC were responsible for implementing parameters populated on the eMAR.	D 367		

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D 367	Continued From page 152 -The eMARs were to be checked daily by the MAs, RCC, and the DRC and changes were to be made as needed. 2. Review of Resident #1's current FL-2 dated 01/16/19 revealed diagnoses included schizophrenia and type 2 diabetes mellitus. Review of Resident #1's physician's orders dated 05/06/19 revealed a medication order from her GI (gastroenterologist) for GoLytely (a medication used to cleanse the colon prior to a colonoscopy) oral solution reconstituted; use as directed for bowel prep. Review of Resident #1's "medical or emergency referral form" revealed the facility requested an order from Resident #1's Nurse Practitioner (NP) on 05/20/19 for "GaviLyte-G (a medication used to cleanse the colon prior to a colonoscopy) to have colonoscopy done" and the NP had signed the order on 05/22/19. Telephone interview with Resident #1's GI physician on 07/24/19 at 9:41am revealed: -Resident #1 had been referred to him for a colonoscopy by her Primary Care Provider (PCP). -He saw Resident #1 for a consultation on 04/12/19. -An order for GoLytely was provided to the transportation driver and faxed to the facility on the day of Resident #1's initial consultation on 04/12/19, and faxed to the facility again on 05/06/19, 05/20/19 and 07/15/19. Review of Resident #1's May 2019 Electronic Medication Administration record (eMAR) revealed: -There was no entry for GoLytely to be administered on 05/05/19 prior to the 05/06/19	D 367		

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scheduled colonoscopy.
-There was no entry for GoLytely to be administered on 05/19/19 prior to the 05/20/19 scheduled colonoscopy.
-There was an entry for GaviLyte-G (generic for GoLytely) to be administered at 8:00am on 05/23/19 with documentation it had not been administered.

Telephone interview with a representative from the facility's contracted pharmacy on 07/25/19 at 10:37am revealed:
-The facility faxed physician's orders to the pharmacy.
-The pharmacy entered the orders into the eMAR system.
-If the order provided a start date, the pharmacy would enter the medication onto the eMAR for that date.
-If the order did not provide a start date, the pharmacy would enter the medication onto the eMAR for the following day.
-If the physician's order was new, the facility had to go into the eMAR system and approve it before it would populate onto the eMAR for administration.
-The pharmacy did not receive Resident #1's order dated 04/12/19 or 05/06/19 for GoLytely.
-The pharmacy entered Resident #1's GoLytely order received on 05/22/19 onto the eMAR for the following day (05/23/19) because it did not have a start date.
-The facility had the ability to adjust dates and times of scheduled administration, if necessary, to coordinate administration of the GoLytely with the scheduled colonoscopy.

Interview with the lead Medication Aide (MA)/previous Resident Care Coordinator (RCC) on 07/24/19 at 12:49pm revealed:

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D 367	Continued From page 154 -She did not know Resident #1 was scheduled for a colonoscopy on 05/06/19. -Whomever received the order for GoLytely given at Resident #1's GI consult on 04/12/19 should have faxed the order to the pharmacy and given the colonoscopy date to the RCC at that time. -She did not know Resident #1 was not administered GoLytely on 05/19/19 because it was not on the eMAR. -She did not know why Resident #1's order for GoLytely dated 05/06/19 had not been sent to the pharmacy so that it could be added to the eMAR and administered the day prior to her 05/20/19 colonoscopy appointment. -It would have been her responsibility to fax the GoLytely order to the pharmacy because she was the RCC at that time. Interview with the RCC on 07/25/19 at 2:33pm revealed: -The RCC was responsible for faxing new orders to the pharmacy and approving those orders in the eMAR system after they were entered by the pharmacy. -She had the capability of adjusting dates and times of administration in the eMAR system if needed so medications such as GoLytely could be administered based on the appointment date for the colonoscopy. A second interview with the Resident Care Coordinator (RCC) on 07/29/19 at 11:46am revealed: -She was responsible for auditing eMARs once monthly. -She would compare the resident's most recent FL2 or physician order sheet to their eMAR to ensure dosages and frequency of administration were correct, and she would also ensure any parameters requiring physician notification had	D 367		

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been reported.
-She did not compare any new orders received since the last FL2 or physician's order sheet to the eMAR because she thought if she had verified them in the computer system, they would have to be correct and would not need to be audited.

Interview with the Administrator on 07/25/19 at 9:04am revealed:
-She provided oversight to the RCC.
-The RCC was responsible for sending orders to the pharmacy.
-The pharmacy entered orders into a resident's computer profile.
-Once the medication was dispensed to the facility, it was the RCC's responsibility to verify and approve the order entered onto the eMAR by the pharmacy.
-The RCC was responsible for entering the date on the eMAR GoLytely should be administered based on the date of the colonoscopy appointment.
-GoLytely should not have been on the eMAR to be administered to Resident #1 on 05/23/19 because she did not have a colonoscopy scheduled for 05/24/19.
-GoLytely should have been on the eMAR and available for administration on 05/05/19 and 05/19/19 for Resident #1.

A second interview with the Administrator on 07/25/19 at 3:57pm revealed the medication aides (MA), the Resident Care Coordinator (RCC) and the Director of Resident Care (DRC) were responsible for checking eMARS for accuracy daily.

3. Review of Resident #8's current FL-2 dated 01/16/19 revealed diagnoses included

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D 367	Continued From page 156 Parkinson's disease and major depression. Review of Resident #8's physician's orders dated 04/12/19 revealed a medication order from her GI (gastroenterologist) for GoLytely (a medication used to cleanse the colon prior to a colonoscopy) oral solution reconstituted; use as directed for bowel prep. Review of Resident #8's "medical or emergency referral form" revealed the facility had requested an order from Resident #1's Nurse Practitioner (NP) on 05/20/19 for "GaviLyte-G (a medication used to cleanse the colon prior to a colonoscopy) to have colonoscopy done" and the NP had signed the order on 05/22/19. Telephone interview with Resident #8's GI physician's Medical Assistant on 07/25/19 at 11:22am revealed: -Resident #8 had been referred to GI for a colonoscopy by her Primary Care Provider (PCP). -Resident #8 had been seen by the GI on 04/12/19 for a consultation. -An order for GoLytely was provided to the transportation driver and faxed to the facility on the day of Resident #8's initial consultation on 04/12/19 and faxed to the facility again on 05/06/19, 05/13/19, and 07/15/19. Review of Resident #8's May 2019 Electronic Medication Administration record (eMAR) revealed: -There was no entry for GoLytely to be administered on 05/02/19 prior to the 05/03/19 scheduled colonoscopy. -There was no entry for GoLytely to be administered on 05/12/19 prior to the 05/13/19 scheduled colonoscopy. -There was an entry GaviLyte-G (generic for	D 367		

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GoLytely) to be administered on 05/23/19 at 1:00am with documentation it had not been administered.

Review of Resident #8's July 2019 eMAR revealed there was an entry for the bowel prep solution GaviLyte-G to be administered on 07/14/19 at 5:00pm with documentation it had been administered.

Telephone interview with a representative from the facility's contracted pharmacy on 07/25/19 at 10:37am revealed:
-The facility faxed physician's orders to the pharmacy.
-The pharmacy entered the orders into the eMAR system.
-If the order provided a start date, the pharmacy would enter the medication onto the eMAR for that date.
-If the order did not provide a start date, the pharmacy would enter the medication onto the eMAR for the following day.
-If the physician's order was new, the facility had to go into the eMAR system and approve it before it would populate onto the eMAR for administration.
-The pharmacy did not receive Resident #8's GoLytely order dated 04/12/19.
-The pharmacy entered Resident #8's GoLytely order received 05/22/19 onto the eMAR for the following day (05/23/19) because it did not have a start date.
-The facility had the ability to adjust dates and times of scheduled administration, if necessary, to coordinate administration of the GoLytely with the scheduled colonoscopy.

Interview with a second shift Medication Aide (MA) on 07/25/19 at 4:11pm revealed:

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D 367	Continued From page 158 -She worked 7:00am to 12:15am on 07/14/19 and was the only supervisor on staff that day. -She was very busy and did not remember Resident #8's GoLytely populating on the eMAR for administration. -She did not administer the GoLytely but documented she had administered it probably because she was so busy. Interview with the Resident Care Cooordinator (RCC) on 07/25/19 at 2:33pm revealed: -The RCC was responsible for faxing new orders to the pharmacy and approving those orders in the eMAR system after they were entered by the pharmacy. -She had the capability of adjusting dates and times of administration in the eMAR system, if needed, so medications such as GoLytely could be administered based on the appointment date for the colonoscopy. -She did not know why the MA had documented she administered GoLytely on 07/14/19 but had not administered it. A second interview with the RCC on 07/29/19 at 11:46am revealed: -She was responsible for auditing eMARs once monthly. -She would compare the resident's most recent FL2 or physician order sheet to their eMAR to ensure dosages and frequency of administration were correct, and she would also ensure any parameters requiring physician notification had been reported. -She did not compare any new orders received since the last FL2 or physician's order sheet to the eMAR because she thought if she had verified them in the computer system, they would have to be correct and would not need to be audited.	D 367		

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D 367	Continued From page 159 Interview with the Administrator on 07/25/19 at 9:04am revealed: -She provided oversight to the RCC. -The RCC was responsible for sending orders to the pharmacy. -The pharmacy entered orders into a resident's computer profile. -Once the medication was dispensed to the facility, it was the RCC's responsibility to verify and approve the order entered onto the eMAR by the pharmacy. -The RCC was responsible for entering the date on the eMAR GoLytely should be administered based on the date of the colonoscopy appointment. A second interview with the Administrator on 07/25/19 at 3:57pm revealed the medication aides (MA), the Resident Care Coordinator (RCC) and the Director of Resident Care (DRC) were responsible for checking eMARS for accuracy daily. 4. Review of Resident #4's FL2 dated 01/21/19 revealed diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypoxia, acute renal failure and diabetes. a. Review of Resident #4's physician order on 05/11/19 revealed an order for a Novolog flexpen U-100 insulin (a medication used to control elevated blood sugar), 8 units three times a day with meals. Review of Resident #4's physician order on 06/19/19 revealed an order for a Novolog flexpen U-100 insulin, 10 units three times a day with meals.	D 367		

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D 367	Continued From page 160 Review of Resident #4's June 2019 electronic Medication Administration Record (eMAR) from 06/19/19 through 06/25/19 revealed: -There was an entry for Novolog flexpen, 8 units three times a day with meals, to be administered at 7:00am, 12:00pm and 5:00pm. -There was documentation Novolog flexpen 8 units was administered daily at 7:00am, 12:00pm and 5:00pm from 06/19/19 through 06/25/19. -There was an entry for a Novolog flexpen 10 units to be administered three times a day with meals at 6:30am, 11:30am and 4:30pm. -There was documentation Novolog 10 units was administered three times a day at 6:30am, 11:30am and 4:30pm from 06/19/19 through 06/25/19. -For seven days there were 2 entries on the June 2019 eMAR, from 06/19/19 through 06/25/19, for a Novolog flexpen, 8 units and 10 units, to be administered three times a day with meals.. Interview with the lead Medication Aide/previous Resident Care Coordinator (RCC) on 07/24/19 at 10:48am revealed: -She was the RCC until 07/08/19. -She had received no training on those processes when she began working. - "No one explained the eMAR system to me". -There was no process to review the eMARs for accuracy. -She was not sure who discontinued the Novolog 8 units three times a day with meals, or why it continued on the eMAR for 7 days. Interview with the first shift Medication Aide (MA) on 07/24/19 at 11:15am revealed: -She administered the medications on her medication cart when they appeared on the eMAR.	D 367		

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D 367	Continued From page 161 -She can not view previous shift's medication administration. -She did not notice there were 2 entries on the eMAR and 2 different dosages for administration for Novolog insulin from 06/19/19 through 06/25/19. -She administered the 7:00am dose of Novolog insulin, 10 units, to Resident #4. Telephone interview with the facility's contracted pharmacy on 07/24/19 at 3:30pm revealed: -Orders received by the pharmacy from a physician were entered on the eMAR. -For an order to be discontinued, the pharmacy staff were required to have a discontinue order from the physician. -The pharmacy computer system does not interface with the facility's computer software. -The facility management staff could discontinue an order on the eMAR from their site. -The physician's order for Novolog flexpen 10 units to be administered three times a day before meals was entered on the eMAR on 06/19/19 by the pharmacy staff. -The default time for orders not specifically indicated by the physician was 1:00am. -It was the responsibility of the facility staff to adjust the times as needed for administration. Interview with the Director of Resident Care (DRC) on 07/25/19 at 3:20pm revealed: -She did not review the eMARs for accuracy. -She thought the RCC reviewed the eMARs for accuracy. -She did not know who entered the times for the Novolog insulin to be administered, from 06/19/19 through 06/25/19. Interview with the RCC on 07/25/19 at 4:10pm revealed:	D 367		

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D 367	Continued From page 162 -She reviewed new orders on the eMAR before approving the entry. -She did not review the eMARs for accuracy with existing orders. -She did not know the Novolog insulin was documented as administered for 8 units and 10 units on the eMAR from 06/19/19 through 06/25/19. Interview with the Administrator on 07/25/19 at 4:20pm revealed: -The lead MA was the previous RCC, however she did not receive training and was asked to step down. -The eMARs were to be checked daily by the MAs, RCC, and the DRC and changes were to be made as needed. b. Review of Resident #4's physician's order dated 06/06/19 revealed an order for Incruse Ellipta 62.5mcg hand held inhaler, (used as a maintenance breathing medication for COPD) 1 puff every day. Review of Resident #4's June and July 2019 electronic Medication Administration Record (eMAR) from 06/06/19 through 07/23/19 revealed: -There was an entry for Incruse Ellipta, 1 puff, to be administered daily at 8:00am from 06/06/19 through 07/23/19. -There was documentation Incruse Ellipta was administered daily at 8:00am from 06/06/19 through 07/23/19. -Incruse Ellipta was documented as administered 48 times from 06/06/19 through 07/23/19. Observation of medications available for administration on 07/23/19 at 2:55pm revealed: -There was an Incruse Ellipta hand held device	D 367		

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inside a plastic bag with a computer generated pharmacy label.
-The dispense date on the label was 06/06/19 and the handwritten open date was 06/06/19.
-There were 30 doses in the device to be administered.
-The number 12 was displayed on the dose counter, indicating 12 doses were left to be administered, and 18 doses had been administered since 06/06/19.

Telephone interview with the facility's contracted pharmacy on on 07/24/19 at 3:30pm revealed:
-Resident #4 had an active order dated 06/06/19 for Incruse Ellipta 62.5mcg, inhale 1 puff by mouth daily.
-The pharmacy dispensed inhalers for residents with a physician's order and at the facility's request, when the medication was completed or the medication had expired..
-One Incruse Ellipta inhaler was sent each time to the facility and there were 30 doses in each device.
-Resident #5's last Incruse Ellipta was dispensed on 06/06/19.
-No further requests from the facility for Incruse Ellipta were received or dispensed from the pharmacy.
-The starting dose was identified as "30" in the dose counter window.
-Each administration will bring this number down by 1.
-If Resident #4 was receiving daily doses of the Incruse Ellipta, he should have completed the medication on 07/07/19.

Interview with a medication aide (MA) on 07/25/19 at 10:40am revealed:
-She administered the Incrusa Ellipta breathing treatment to Resident #4 when she worked on

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this medication cart.
-She did not put the open date on the plastic bag that the device was in.
-She did not know how long the medication should last-she thought 30 or 45 days.
-She did not usually assist with cart audits.
-When she did assist with cart audits, she made sure the medication was on the cart but did not check to see how many doses were left with the inhalers.

Interview with the Director of Resident Care (DRC) on 07/25/19 at 3:20pm revealed:
-She has been reviewing the resident's records for compliance.
-The Resident Care Coordinator (RCC) had been overseeing the medications, the medication carts and the orders.
-She did not know the process used to audit the medication carts in this facility.
-She expected the MAs to report to her or the RCC if there was a problem with medications.
-She expected the MAs to administer the medications as ordered by the licensed practitioner.
-She did not know the Incruse Ellipta had 18 doses administered in 48 days.

c. Review of Resident #4's physician's order dated 05/21/19 revealed an order for an Advair diskus blister with device, 250-50mcg/dose, inhale one puff into the lungs twice a day.

Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) from 07/01/19 through 07/24/19 revealed:
-There was an entry for Advair diskus inhale 1 puff twice a day, to be administered at 8:00am and 8:00pm.
-There was documentation Advair diskus inhale 1

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puff twice a day was administered at 8:00am and 8:00pm from 07/01/19 through 07/12/19 .
-There was an entry for the end date of Advair diskus administer at 8:00pm on 07/12/19.
-There was an entry for Wixela blister with device, 250-50mcg, inhale one puff twice a day, to be administered at 8:00am and 8:00pm, from 07/12/19 through 07/24/19.
-There was documentation Wixela blister with device had been administered at 8:00am and 8:00pm from 07/12/19 through 07/24/19.

Observation of medications on hand on 07/23/19 at 2:55pm revealed:
-There was an Advair diskus 250-50mcg device in a plastic bag with a computerized pharmacy label and directions -1 puff twice a day.
-There was a handwritten opened date of 07/04/19 on the plastic bag.
-The dose counter window on the Advair diskus read "42".
-There was no Wixela blister with device on the medication cart.

Telephone interview with the facility's contracted pharmacy on on 07/24/19 at 3:30pm revealed:
-Resident #4 had an active order dated 07/12/19 for Wixela 250-50mcg, inhale 1 puff by mouth twice daily.
-The pharmacy dispensed inhalers for residents with a physician's order and at the facility's request, when the medication was completed or the medication had expired..
-The facility was contacted and it was explained that the generic inhaler (Wixela) would be sent in place of the Advair diskus for insurance reasons.
-Wixela Inhaler was sent to the facility on 07/12/19 for Resident #4.

Interview with the medication aide (MA) on

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D 367	Continued From page 166 07/23/19 at 3:05pm revealed: -She did not know where the Wixela inhaler for Resident #4 was located. -She had not seen the Wixela inhaler. -The pharmacist had conveyed to the MA the Wixela inhaler was a generic form of the Advair diskus. -Since she had the Advair diskus on the cart, she administered the Advair to Resident #4. -She documented that she administered the Advair Diskus under the Wixela entry on the eMAR because the Advair diskus entry was discontinued. Interview with the Administrator on 07/25/19 at 9:04am revealed: -The RCC was responsible for sending orders to the pharmacy. -The pharmacy entered orders into a resident's computer profile. -Once the medication was dispensed to the facility, it was the RCC's responsibility to verify and approve the order entered onto the eMAR by the pharmacy -The eMARs were to be checked daily by the MAs, RCC, and the DRC and changes were to be made as needed. -She did not know the MAs were administering Advair breathing treatments and documented Wixela breathing treatments were administered. CORRECTION DATE FOR THE STANDARD DEFICIENCY SHALL NOT EXCEED SEPTEMBER 1, 2019.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of	D 375		

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D 375	Continued From page 167 Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 sampled residents with an order for a hand held inhaler, used to treat shortness of breath (SOB), had a physician's order to self administer the medication, (Resident #4). The findings are: Review of Resident #4's current FL2 dated 01/21/19 revealed diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypoxia, acute renal failure and diabetes. Review of Resident #4's physician order on 06/19/19 revealed an order for Albuterol Sulfate inhaler, 90mcg, inhale 2 puffs every 4-6 hours as needed for shortness of breath. Review of Resident #4's June and July 2019 electronic medication administration record (eMAR) from 06/19/19 through 07/24/19	D 375		

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revealed:
-There was an entry for Albuterol Sulfate inhaler 90mcg, inhale 2 puffs, to be administered every 4-6 hours as needed for shortness of breath.
-There was no documentation the Albuterol inhaler was administered from 06/19/19 through 07/24/19.

Observation of the medications on hand for Resident #4 on 07/23/19 at 2:55pm revealed the Albuterol inhaler was not available for administration.

Interview with the first shift Medication Aide (MA) on 07/23/19 at 2:55pm revealed:
-Resident #4 kept the Albuterol inhaler on his person to self administer when he felt short of breath.
-The MA did not keep the Albuterol inhaler on the medication cart.
-Resident #4 did not self administer any of his other medications.
-Resident #4 did not report to the MAs when he used the Albuterol inhaler.
-There was no documentation of Resident #4's frequency of usage for the Albuterol inhaler.

Interview with Resident #4 on 07/23/19 at 1:05pm revealed:
-He kept the albuterol handheld inhaler in a cloth pouch on the back of his wheelchair.
-He used the inhaler when he was short of breath.
-He did not report to the MA's when he needed the inhaler.
-He did not know he was supposed to use the albuterol inhaler every 4-6 hours as needed.

Observation of the cloth pouch on the back of Resident #4's wheelchair 07/23/19 at 1:10pm

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	HAL060149	A. BUILDING: _____ B. WING _____	07/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

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revealed:
-There was a hand held Albuterol sulfate inhaler in the cloth bag.
-The inhaler did not have Resident #4's name on the device nor the directions for proper administration.

Review of the facility's policy and procedure for Resident Self-Administration of Medications revealed:
-Residents would meet the following requirements for self administration of medications:
-The resident would be competent and physically able.
-The resident would have an order by a physician to self administer, and kept in the resident's record.
-Specific instructions for administration of the medication would be printed on the label.
-The physician would be notified if a resident had a change in mental or physical ability or was non compliant with the physicians orders or facilities policies.

Interview with the Primary Care Provider (PCP) on 07/23/19 at 1:35pm revealed:
-The PCP had prescribed the Albuterol inhaler as needed for shortness of breath for Resident #4.
-Resident #4 also was prescribed an Albuterol nebulizer treatment, administered with a mask, as needed for shortness of breath..
-The Albuterol inhaler was prescribed for the times the resident left the facility and may experience shortness of breath.
-The Albuterol inhaler was not prescribed for use in the facility.
-The PCP had not given an order for Resident #4 to self administer the Albuterol hand held inhaler.
-If Resident #4 was short of breath in the facility

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the MA should administer the Albuterol nebulizing treatment with the mask for maximum effectiveness.
-Due to Resident #4's diagnoses, the PCP would want to review the eMARs to determine how often Resident #4 was requesting prn breathing treatments.
-He did not know Resident #4 was self administering the Albuterol inhaler.

Interview with the RCC on 07/25/19 at 4:10pm revealed:
-She had been implementing and training the MAs to audit their carts weekly.
-She also had been auditing the medication carts herself.
-She verified the resident's physician order summary with the resident's medications on the cart.
-She did not know Resident #4 was self administering his Albuterol inhaler.
-She does not know why that was not observed during an audit of Resident #4's medications.

Interview with the Director of Resident Care (DRC) on 07/25/19 at 3:20pm revealed:
-The RCC had been overseeing the medications, the medication carts and the orders.
-She did not know the process used to audit the medication carts in this facility.
-She expected the MAs to administer the medications as ordered by the licensed practitioner.
-She did not know the Resident #4 was self administering his Albuterol inhaler.

Interview with the Administrator on 07/25/19 at 4:20pm revealed:
-The RCD and the RCC were responsible for the clinical aspects of the facility.

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D 375	Continued From page 171 -She had requested audits of the medication carts to be completed as soon as possible last week. -The completed cart order forms were given to the RCC and herself. -She had not reviewed the current cart audits to date. -She did not know Resident #4 was self administering his Albuterol inhaler as needed. -She expected the MAs to administer medications as ordered by the physician. CORRECTION DATE FOR THE STANDARD DEFICIENCY SHALL NOT EXCEED SEPTEMBER 1, 2019.	D 375		
D 444	10A NCAC 13F .1208 (g) Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (g) With regard to any resident death under circumstances described in G.S. 130A-383, a facility shall notify the appropriate law enforcement authorities so the medical examiner of the county in which the body is found may be notified. Documentation of such notification shall be maintained by the facility and be made available for review by the Division upon request. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to assure notification of local law enforcement for 1 of 1 resident (Resident #9) who was found unresponsive on the bathroom floor.	D 444		

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D 444	Continued From page 172 The findings are: Review of Resident #9's current FL2 dated 02/07/19 revealed diagnoses included dementia, diabetes, cerebral vascular accident, and depression. Review of Accident/Incident Reports for Resident #9 dated 06/25/19 at 10:03pm revealed: -The location of the incident was in the resident's bathroom. -The incident was non witnessed. -The type of injury was documented as "no injury. -First aid was documented as administered by "medics". -The resident condition was documented as unresponsive; "resident has expired". -The physician and the family were notified. -There was no documentation the local law enforcement were contacted. Review of Resident #9's electronic progress note dated 06/24/19 at 5:15am revealed "Resident passed away in the bathroom." Telephone interview on 07/25/19 at 9:00am with the medication aide (MA) who worked on 06/24/19 when Resident #9 was found unresponsive revealed: -She was unsure what happened to Resident #9 on 06/24/19 around 5:00am. -The policy is when a resident is a full code you do CPR until EMS arrived in the facility to take over CPR. -The residents were to be check every 2 hours and documented on a facility 2-hour check log. -She had charted in the computer system at 5:15am "Resident passed away in the bathroom." -Resident #9 was ordered a pureed diet but would eat "oatmeal cakes" the other residents would	D 444		

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give her.
-There was "vomit on the floor near [Resident #9's] body."
-"Maybe she choked."
-She did not think she needed to contact the local law enforcement.

Review of the EMS call report dated 06/24/19 revealed:
-The facility had not contacted EMS until 5:26 am.
-There was documentation there were no staff doing CPR for Resident #9.

Telephone interview with the Lead Crew Medic on 07/29/19 at 3:30pm revealed:
-He was dispatched to the facility on the morning of 06/24/19 for Resident #9.
-He found Resident #9 laying on the bathroom floor near the toilet on her back.
-There was no staff available to report Resident #9's code status or to report the cause or the time of death.

Interview with the Lead Supervisor on 07/25/19 at 3:00pm revealed:
-She completed an Incident Accident Report when Resident #9 was found unresponsive and gave it to the former Administrator.
-She was not aware the local law enforcement was to be called in regards to Resident #9 found unresponsive on the bathroom floor.
-She completed the incident form but was not present at the facility when Resident #9 was found unresponsive on the floor.
-She completed the incident report because the former Administrator requested she complete the form.
-She was not sure exactly what happened that morning on 06/24/19 because each staff person had a different story about the incident.

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D 444	Continued From page 174 -She filled out the incident report but did not think to call the local law enforcement. Interview with the Resident Care Coordinator (RC) on 07/26/19 at 10:25 am revealed: -She was unsure why the local law enforcement were not notified. -She was unsure why there was no documentation by the MA that was working that morning. -The MA should contacted the local law enforcement when she found Resident #9 unresponsive on the bathroom floor. Interview with the Administrator on 07/26/19 at 11:45 am revealed: -She had been working in the facility since July 1, 2019. -She did not know the local law enforcement were not notified regarding Resident #9 found unresponsive on the bathroom floor. -She thought if Emergency Medicinal Services were contacted, they would be the ones to contact the local law enforcement, if they were needed. -She relied on her lead supervisor to follow up on all incidents reports and to contact the proper authority if needed for any death or injury. Telephone interview with the former Administrator on 07/29/19 at 12:1 revealed: -His last day as Administrator of this facility was 06/28/19. -The night shift MA called him on 06/24/19 between 4:30 am and 5:30am to report Resident #9 had expired. -He did not know if EMS had performed CPR because he did not receive a report from them. -The facility did not notify law enforcement of Resident #9's death.	D 444		

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D 444	Continued From page 175 REFER TO TAG 271 CORRECTION DATE FOR THE STANDARD DEFICIENCY SHALL NOT EXCEED SEPTEMBER 1, 2019.	D 444		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure the county department of social services (DSS) was notified of an incident which resulted in death to 1 of 1 sampled resident (#9) who was found unresponsive on the bathroom floor without a pulse. The findings are: Review of Resident #9's current FL2 dated 02/07/19 revealed diagnoses included dementia, diabetes, cerebral vascular accident, and depression.	D 451		

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D 451	Continued From page 176 Review of Accident/Incident Reports for Resident #9 dated 06/25/19 at 10:03pm revealed: -The location of the incident was in the resident's bathroom. -The incident was non witnessed. -The type of injury was documented as "no injury. -First aid was documented as administered by "medics". -The resident condition was documented as unresponsive; "resident has expired". -The physician and the family were notified. -There was no documentaion the incident report weas faxed to the local county DSS. Review of Resident #9's electronic notes dated 06/24/19 at 5:15am revealed "Resident passed away in the bathroom." Interview with a representative from the local county DSS on 04/18/19 a 10:02am revealed: -There was no documentation for receipt of a faxed incident report for Resident #9 regarding unresponsive without a pulse requiring emergency medical evaluation on 04/24/19. -She had not received any Incident and Accident Reports related to Resident #9. Interview with the Lead Supervisor on 07/25/19 at 3:00pm revealed: -She completed an Incident Accident Report when Resident #9 was found unresponsive and gave it to the former Administrator. -It was the facility's policy to notify a representative of the local county DSS through an Incident and Accident report when a resident required anything other than first aide. -She was responsible for faxing the Incident Accident Reports to the local county DSS. -She thought she had sent the Incident Accident	D 451		

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Report to the local county DSS.
-She could not find the fax confirmation the incident report for Resident #9 was sent to the local DSS.

Interview with the Resident Care Coordinator (RCC) on 07/26/19 at 10:25am revealed:
-The lead Supervisor would be responsible for completing Incident and Accident Reports and faxing the report to the local DSS.
-Incident and Accident reports were given to the Administrator after they were completed.

Interview with the Administrator on 07/26/19 at 11:45am revealed:
-She had been working in the facility since July 1, 2019.
-The lead Supervisor and the Administrator were responsible for notifying the local county DSS of reports of incidents and accidents.
-Incident and Accident Reports were usually faxed or emailed to a representative of the local county DSS.
-She did not know the local county DSS had not been notified regarding Resident #9 found unresponsive.
-It was the facility's policy to notify a representative of the local county DSS through an Incident and Accident report when a resident required anything other than first aide.
-The facility kept a copy of the fax confirmation when reports were sent to the local county DSS.
-No fax confirmation was available for review documenting that the incident report for 06/24/19 had been faxed to the local county DSS.

CORRECTION DATE FOR THE STANDARD DEFICIENCYSHALL NOT EXCEED SEPTEMBER 1, 2019.

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D912	Continued From page 178	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate and in compliance with relevant state laws and rules related to medication administration, personal care, healthcare and supervision. The findings are: Based on observation, interviews, and record review, the facility failed to provide personal care assistance to 2 of 5 residents (#2 and #5) sampled related to colostomy care, bathing and post-surgical care after a knee replacement. [Refer to Tag 0269, 10A NCAC 13F. 0901(a) Personal Care and Supervision (Type B Violation)]. Based on observations, interviews, and record reviews, the facility failed to assure physicians' orders were implemented for 3 of 7 sampled residents (Residents #1, #3, #8) related to preparation instructions for scheduled	D912		

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D912	Continued From page 179 colonoscopies (#1 and #8), medication administration, finger stick blood sugar checks, and blood pressure checks (#3). [Refer to Tag 0276, 10A NCAC 13F. 0902(c)(4) Health Care (Type A2 Violation)]. Based on observation, interviews and record review, the facility failed to assure the required staffing hours were met on first, second and third shifts (7:00am-3:00pm, 3:00pm to 11:00pm and 11:00pm-7:00am) based on a census of 69 -72 residents, with 29 of 49 shifts sampled from 06/24/19 through 07/14/19 understaffed. [Refer to Tag 0219, 10A NCAC 13F. 0606 Staffing Chart (Type B Violation)]. Based on observations, interviews and record reviews, the facility failed to assure healthcare referral and follow-up to meet the medical needs for 4 of 7 sampled residents related to not following up with a cardiology and pulmonology consult after a hospitalization for chest pain (Resident #2), not notifying the physician of a missed appointment and delayed rescheduling of an endocrinology consult (Resident #3), and not notifying the physician of 3 missed colonoscopy appointments (Residents #1 and #8). [Refer to Tag 0273, 10A NCAC 13F. 0902(b) Health Care (Type A1 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 180 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents are free of neglect in compliance with federal and state laws and rules and regulations related Staffing, Personal Care and Supervision. The findings are: Based on observation, interviews and record review, the facility failed to assure the required staffing hours were met on first, second and third shifts (7:00am-3:00pm, 3:00pm to 11:00pm and 11:00pm-7:00am) based on a census of 69 -72 residents, with 29 of 49 shifts sampled from 06/24/19 through 07/14/19 understaffed.[Refer to tag 219, 10A NCAC 13F .0606 Staffing Chart (Type A2 Violation).] Based on observation, interviews, and record review, the facility failed to provide personal care assistance to 2 of 5 residents (#2 and #5) sampled according to the care plans related to Resident #5 colostomy care and personal care and Resident #2 post-surgical care after a knee replacement.[Refer to tag 269,10A NCAC 13F. 0901(a) Personal Care and Supervision (Type A2 Violation).] Based on observations, interviews, and record reviews, the facility failed to assure supervision was provided to 2 of 7 sampled residents (Resident #12 and #13) related to a resident with a history of substance abuse, found to have a knife, beer and marijuana in his room, who returned to the facility on several occasions intoxicated and smelled of marijuana, frequently intimidated staff and residents, threatening and assaulting another resident (Resident #13), and a	D914		

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D914	Continued From page 181 resident who lived on the same hall as Resident #13, in the back corner of the facility, who was threatened and assaulted by him, with no additional supervision provided for her safety by the staff (Resident #12)..[Refer to tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] Based on record reviews and interviews, the facility failed to respond to incidents immediately and in accordance with the facility's established policy and procedures for one resident sampled (Resident #9) as evidenced by failing to perform cardiopulmonary resuscitation (CPR) who was found unresponsive.[Refer to tag 271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A2 Violation).]	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on other recommendations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care, supervision, referral and follow-up, health care implementation, medication administration, accuracy of the	D980		

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D980	Continued From page 182 electronic medication administration record (eMAR), resident rights, staffing, self administration, reporting of accidents and incidents, and death reporting. The findings are: Interview with the Administrator on 07/26/19 at 11:45am revealed: -She started as the Administrator 3 weeks ago. -She knew Resident #5 had a foul body odor around July 4, 2019 when Resident #5's family member contacted her. -She did not know that staff were not assisting Resident #5 with colostomy care. Interview with the Administrator on 07/29/19 at 10:20am revealed: -The Administrator had not been overseeing the scheduling since she had delegated this to the RCC. -She did not know there were several shifts that were not staffed according to the census. Interview with the Administrator on 07/24/19 at 9:22am revealed, "We don't have the staff to" initiate follow up phone calls to the physicians - "I'm working on that". Telephone interview with Resident #2's responsible party on 07/29/19 at 11:15am revealed: -There were so many changes in management that "no one seems to care." -When she came to visit after 5:00pm and on weekends, she could never find staff. -"It appears that the residents are watching themselves." Non-compliance was identified at violation level in	D980		

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	HAL060149	A. BUILDING: _____ B. WING _____	07/29/2019

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D980	Continued From page 183 the following rule areas: 1. Based on observations, interviews and record reviews, the facility failed to assure healthcare referral and follow-up to meet the medical needs for 4 of 7 sampled residents related to not following up with a cardiology and pulmonology consult after a hospitalization for chest pain (Resident #2), not notifying the physician of a missed appointment and delayed rescheduling of an endocrinology consult (Resident #3), and not notifying the physician of 3 missed colonoscopy appointments (Residents #1 and #8). [Refer to tag 273, 10A NCAC 13F .0902(b) HealthCare (Unabated Type A1 Violation).] 2. Based on record reviews and interviews, the facility failed to respond to incidents immediately and in accordance with the facility's established policy and procedures for one resident sampled (Resident #9) as evidenced by failing to perform cardiopulmonary resuscitation (CPR) who was found unresponsive.[Refer to tag 271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A2 Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 residents observed during a medication pass related to a muscle relaxant and an anti-seizure medication (Residents #10 and #11) and 5 of 8 sampled residents (Residents #1, #3, #4, #8 and #13) including a medication used to clean the colon prior to a colonoscopy (Residents #1 and #8), a medication used to lower high cholesterol, a medication used to treat high blood pressure, and artificial tears for dry eyes (Resident #3), a medication used to treat diabetes and two	D980		

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D980	Continued From page 184	D980		

medications used to prevent difficulty in breathing (Resident #4), a medication used as a muscle relaxant (Resident #10), a medication used to treat seizures and bipolar disorder (Resident #11) and a medication used for agitation (Resident #13). [Refer to tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation).]

4. Based on observations, interviews, and record reviews, the facility failed to assure supervision was provided to 2 of 7 sampled residents (Resident #12 and #13) related to a resident with a history of substance abuse, found to have a knife, beer and marijuana in his room, who returned to the facility on several occasions intoxicated and smelled of marijuana, frequently intimidated staff and residents, threatening and assaulting another resident (Resident #13), and a resident who lived on the same hall as Resident #13, in the back corner of the facility, who was threatened and assaulted by him, with no additional supervision provided for her safety by the staff (Resident #12). [Refer to tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).]

5. Based on observations, interviews, and record reviews, the facility failed to assure physicians' orders were implemented for 3 of 7 sampled residents (Residents #1, #3, #8) related to preparation instructions for scheduled colonoscopies (Residents #1 and #8), medication administration, finger stick blood sugar checks, and blood pressure checks (Resident #3).[Refer to tag 276, 10A NCAC 13F .0902(c)(4) Personal Care and Supervision (Type A1 Violation).]

6. Based on observation, interviews and record review, the facility failed to assure the required staffing hours were met on first, second and third

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D980	Continued From page 185 shifts (7:00am-3:00pm, 3:00pm to 11:00pm and 11:00pm-7:00am) based on a census of 69 -72 residents, with 29 of 49 shifts sampled from 06/24/19 through 07/14/19 understaffed. [Refer to tag 219, 10A NCAC 13F .0606 Staffing Chart (Type A2 Violation).] 7. Based on observation, interviews, and record review, the facility failed to provide personal care assistance to 2 of 5 residents (Residents #2 and #5) sampled according to the care plans related to Resident #5's colostomy care and personal care and Resident #2's post-surgical care after a knee replacement. [Refer to tag 0269, 10A NCAC 13F .0901(a) Personal Care (Type A2 Violation)]. The Administrator's failure to assure responsibility for the overall operation of the facility resulted in significant noncompliance with state rules and regulations regarding: -Resident #2 not scheduled for cardiology and pulmonology appointments leading to a readmission to the local hospital for chest pains; Resident #3 missing an endocrinology consult for treatment of uncontrolled diabetes which resulted in an elevated A1C and hospitalization for encephalopathy and a blood glucose of 60mg/dL, and Residents #1 and #8 each missing three scheduled colonoscopy appointments. -Resident #9 who was found unresponsive and CPR was not attempted. -Failure to implement physicians' orders for Resident #1 and Resident #8 for colonoscopy preparation; Resident #3 for blood pressure checks, sliding scale insulin administration and finger stick blood sugar checks resulting in a four-day hospitalization with hypoglycemia and encephalopathy, and Resident #13 not receiving Vistaril resulting in increased irritability with behaviors	D980		

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D980	Continued From page 186 -Resident #3 who missed 23 of 53 doses of Gemfibrozil and was administered the incorrect dose of Metoprolol resulting in uncontrolled diabetes and high blood pressure; and Resident #4 who missed 30 of 48 doses of Incruse Ellipta, missed 9 of 9 doses of Spiriva, with no documentation of as needed Albuterol nebulizing treatment or as needed Albuterol hand held breathing treatment administered resulting in a hospitalization for dyspnea. -Resident #5 not receiving showers and appropriate care of her colostomy resulting in a noticeable foul body odor and Resident #2 not receiving proper care after a knee replacement resulting in risk of falls and a blood clot due to non-mobility. -Lack of sufficient staffing of personal care aides for 20 of 46 shifts resulting in resident not receiving the necessary personal care assistance after surgery; a lack of supervision of a resident who demonstrated aggressive, disruptive, and threatening behaviors toward other residents and a resident being found deceased on the bathroom floor after a prolonged period of time without staff's knowledge. Failure of the Administrator to assure responsibility for the overall operation, administration, management and supervision of the facility resulted in serious physical harm and serious neglect of residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/26/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 26, 2019.	D980		