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D 000	Initial Comments The Adult Care Licensure Section and Hoke County Department of Social Services conducted an annual and follow up survey and complaint investigations on August 7-9, 2019 and August 12-15, 2019. The Hoke County Department of Social Services initiated the complaint investigations on 06/10/19, 07/11/19, 07/22/19 and 07/25/19.	D 000		
D 204	10A NCAC 13F .0604(e)(1)(E) Personal Care and Other Staffing 10A NCAC 13F .0604 Personal Care and Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure there were enough staff to meet the needs of residents in the facility who required additional staff assistance with transfers, turning and repositioning, bathing, toileting, incontinence care, feeding and	D 204		

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supervision resulting in pressure ulcers for two residents (#4 and #13) and delayed feeding assistance at meals for multiple residents including Residents #2 and #18.

The findings are:

Review of the Daily Census dated 08/07/19 revealed there were 39 residents on the assisted living (AL) side and 28 residents on the locked hall.

Interview with a PCA on 08/07/19 at 10:08am revealed there were two PCAs and one MA working on the locked hall side of the facility for first shift on 08/07/19.

Interview with a second PCA on 08/07/19 at 10:44am revealed:
-There used to be three PCAs on the locked hall for the 300 and 400 halls; approximately two months ago it changed to 2 PCAs on all three shifts.
-It was hard to care for the residents with just two PCAs.
-All of the residents on the 300 hall were incontinent and needed assistance with toileting and incontinence care.
-The 300 hall was assigned to one PCA and the 400 hall was assigned to the second PCA.
-Showers for residents were split between the first and second shifts; she had three residents to give a shower on first shift on 08/07/19.
-Resident #12 needed two staff to assist because he would not move, was tall and heavy and was difficult with staff.
-A female resident on the 300 hall was heavy and her legs were stiff and did not bend; the resident should have two staff but sometimes there were not two staff available and one staff would have to

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"pick her up" alone.
-Resident #18's family member wanted incontinence care done for the resident every two hours.
-Staff tried to complete incontinence care for Resident #18 every two hours, but it was hard when there were only two PCAs.
-Staff might be able to provide incontinence care for Resident #18 every three hours.
-Resident #18 needed two staff for incontinence care because the resident had multiple sclerosis, was stiff and required a hydraulic lift for transfers.
-There were two residents (Resident #4 and Resident #18) on the 300 hall who required a hydraulic lift for transfers in and out of bed; the hydraulic lift required two staff for safety.
-Two staff were needed to get Resident #4 and Resident #18 out of bed for breakfast, back in bed after breakfast and out of bed for lunch; it took time to get the residents in and out of bed.
-The PCA assigned to Resident #4 and Resident #18 had to go and get help and "help was not always readily available."
-Resident #4 needed two staff for assistance because he was completely dependent on staff for all his activities of daily living (ADLs).
-There were five residents on the locked hall, including Resident #12 and Resident #16, who were combative by hitting staff and required two staff for assistance with bathing and incontinence care for safety.

Interview with the first PCA on 08/07/19 at 11:13am revealed:
-She was assigned the 400 hall for first shift on 08/07/19.
-She had three residents to assist with a shower, but she had not done any showers yet.
-She usually washed the residents face in the morning before breakfast and then completed

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showers throughout the day.
-There were nine residents on the 400 hall who needed assistance with incontinence care.
-There were three residents who needed two staff "every now and then" to assist with bathing, toileting and incontinence care because the residents would "stiffen up" and/or become combative by trying to hit staff.

Observation on 08/08/19 at 10:50am revealed when the activities director (AD) changed Resident #10, she held both of the resident's arms together by the wrist.

Interview with the AD on 08/08/19 at 11:05am revealed:
-It usually took two PCA's to change Resident #10, but another PCA was not always available.
-Resident #10 pulled away from staff when personal care was provided.
-Today she managed to change Resident #10 by herself.

Interview with a third PCA on 08/12/19 at 3:41pm revealed:
-It took two PCAs to provide Resident #10 with incontinent care.
-When providing Resident #10 with incontinent care she held onto her clothes and pulled away.
-If there were two PCAs providing incontinence care one PCA would hold Resident #10's hands out the way.
-There was no particular way the PCA would hold Resident #10's hands, just "held them out the way".
-If there was only one PCA providing incontinent care they would have to hold Resident #10's hands out the way and provide incontinent care "at the same time".
-If there was only one PCA providing incontinent

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D 204	Continued From page 4 care it was because there was "no one around to help". Interview with a fourth PCA on 08/13/19 at 9:12am revealed: -There were 12 residents on the locked hall that needed two staff for incontinence care, toileting, transfers, bathing and dressing due to being heavy care or having resistant and combative behaviors. -It was hard to get all the residents toileted or changed, showered, fed and supervised when there were only two PCAs on the locked hall. -First shift PCAs worked with second shift PCAs by keeping some residents up in their chairs all day so second shift did not have to get the residents out of bed and into their chairs. -There was usually one PCA in the common area while the second PCA provided toileting and incontinence care. -Usually the PCA on the 400 hall went first to provide toileting and incontinence care to residents so the MA was available (after passing medications) to help the PCA on the 300 hall. -Most of the time at meals, she did not ask for the resident's plate from the kitchen if the resident was waiting to be fed until she was able to feed that resident. -There were residents who were at the table waiting to be fed while staff were feeding other residents. -The Resident Care Coordinator (RCC) and the Administrator knew there were not enough staff to feed all the residents. -The RCC and the Administrator knew how many residents needed two staff for assistance due to heavy care and/or behaviors. -Multiple staff had told the RCC and the Administrator several times.	D 204		

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D 204	Continued From page 5 Observations of incontinence care and toileting rounds for assignment #1 on the 300 hall on 08/09/19 from 3:22pm until 5:32pm revealed: -There were three PCAs and one MA working on the locked hall which included the 300 and 400 halls. -It took one PCA two hours and 10 minutes to provide toileting and incontinence care to five residents. Interview with the PCA assigned to the 300 hall on 08/09/19 at 3:22pm revealed: -There was one MA and three PCAs working on second shift on 08/09/19 so the 300 hall and 400 hall were divided into three assignments. -There were five residents on his assignment who required two staff for assistance; Resident #4 and Resident #18 needed a hydraulic lift for transfers out of bed and Resident #12 needed two staff for safety. -There were eight residents that needed to be fed the dinner meal at 5:30pm. -The MA would step in and help with feeding residents their dinner. -When there were only two PCAs and one MA working on the locked hall, the PCAs would get "backed up" on getting residents changed. -The PCAs had to change all the residents before dinner because the family members would come to visit at that time. Interview with the PCA assigned to the 300 and 400 halls on 08/09/19 at 3:34pm revealed there were seven residents on her assignment that required two staff for assistance, including Resident #16. Interview with a MA 08/09/19 at 3:16pm revealed: -Second shift PCAs did a walk through with the outgoing PCA laying eyes on each resident.	D 204		

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D 204	Continued From page 6 -The first toileting and incontinence care rounds for second shift were done by PCAs at 5:00pm. -When she worked as PCA, she usually started her first rounds early, especially for the 300 hall because that hall was "work". -The work was nonstop on the 300 hall because staff had to help residents to the bathroom, change residents and get residents to and from dinner. -Residents were at dinner from 5:30pm until approximately 6:45pm, then PCAs did incontinence care rounds, the medication aide passed medications and that was "pretty much it for second shift." Confidential interview with a family member revealed: -It seemed like there were not enough personal care aides (PCAs) working at the facility most of the time. -Family members came to feed residents because there were not enough staff to feed all the residents who needed help. -It was hard for the staff to rotate between residents they were feeding. -Staff were feeding one resident while another resident was disruptive and yet another trying to take food from another resident's plate. -There were too many residents who needed help and/or redirection; there was no way one staff could take care of them all and feed them all. -There was not enough staff to take care of the residents and the rotation of staff in and out of the facility was concerning; staff were hired, worked for a short time and then left the facility so staff did not know the residents. -The management would hide the actual numbers of staff working on the locked hall by saying there was staff on the other side of the building. -The staff on the AL side had other residents to	D 204		

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take care of and there were locked doors between the different sides of the building so the staff could not be of much help on the locked hall.

Confidential interview with a second family member revealed:
-The staff would say staffing at the facility was based on state regulations.
-For the number of residents who needed extra care, three staff (two PCAs and one medication aide) on the locked hall were just not enough.
-The medication aide (MA) would be busy doing something and the PCAs would be helping others so if a resident needed something, a visitor could not find staff to help.

Confidential interview with a third family member revealed:
-The facility did not have enough staff.
-Management staff said three staff was all they needed for 28 residents on the locked hall.
-The family member could not remember exactly who said three staff was enough.

Confidential interview with a fourth family member revealed:
-There had been a decrease in care of the residents.
-The facility did not have enough staff.
-On the locked hall there were so many residents that had issues such as behaviors.
-Staffing was erratic.

Interview with the Administrator on 08/13/19 at 3:22pm revealed:
-The staffing pattern on the locked hall (300 and 400 hall) was two PCAs and one MA for 28 residents.
-The staffing was changed from three PCAs to two PCAs sometime in June 2019 due to a drop

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in the census.
-Acuity of the residents was taken into consideration when the staffing was decreased; there was a decline in some of the residents over the last few months.
-There were six to seven residents on the locked hall that required two staff for assistance.
-There were about six residents who needed help with feeding.
-There were four to five residents who had behavior issues.
-She had worked third shift as direct care staff and knew the residents on the 300 hall were heavy care.
-She had discussed a concern for the acuity of the residents on the 300 hall with the Regional Director prior to 08/07/19, but she was not sure exactly when.

[Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care (Type A2 Violation)]

[Refer to Tag 270 10A NCAC 13F .0901(b) Supervision (Type B Violation)]

[Refer to Tag 312 10A NCAC 13F .0904(f)(2) Nutrition & Food Service]

The facility failed to assure there were enough staff to meet the needs of residents in the facility who required additional staff assistance with transfers, turning and repositioning, bathing, toileting, incontinence care, feeding and supervision resulting in pressure ulcers for two residents (#4 and #13) and delayed feeding assistance at meals for multiple residents including Residents #2 and #18.The facility's failure to assure there were enough staff to meet the needs of the residents was detrimental to the health, safety and welfare of residents and

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D 204	Continued From page 9 constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/08/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 29, 2019.	D 204		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II,	D 255		

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D 255	Continued From page 10 which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure an assessment was completed within 10 days of a significant change for 2 of 6 sampled residents (#1 and #4) including Resident #1 who had deteriorated cognitive ability with increased behaviors affecting his ability to self-administer medications and interact safely with his roommate; and Resident #4 who had new stage II pressure ulcers on both feet. The findings are: Review of Resident #4's current FL-2 dated 04/02/19 revealed: -Diagnoses included Alzheimer's dementia, seizure disorder, type II diabetes mellitus and right cerebral hematoma. -Resident #4 was constantly disoriented,	D 255		

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non-ambulatory, incontinent of bowel and bladder and required total care.

Review of Resident #4's current care plan dated 06/10/19 revealed:
-Resident #4 required total assistance from staff with all activities of daily living (ADLs).
-Resident #4 was incontinent of bowel and bladder and ambulatory with a geriatric chair and staff assistance.
-Resident #4 required a hydraulic lift for transfers to and from his bed.
-There was no documentation of pressure ulcer prevention or any active wounds with wound care for Resident #4.

Review of a progress notes dated 06/13/19 through 08/03/19 for Resident #4 revealed:
-On 06/13/19 at 1:00pm, staff documented there were new wound care orders for a "spot" on the resident's right foot.
-On 07/20/19 at 1:20pm, staff documented the was an open blister on the resident's right ankle.
-On 07/21/19 at 2:15pm, staff documented there were new wound care orders for the resident's right heel.
-On 07/22/19 at 10:40am, staff documented there was a blister on the side of the resident's right foot, a pressure point on the left ankle and the left foot was red and blistered on the side.
-On 08/03/19 at 2:10pm, there were two spots on the top of the resident's right foot with blisters on the side.

Interview with a personal care aide (PCA) on 08/07/19 at 10:44am revealed Resident #4 wore foot cushions because he had pressure ulcers on both of his feet.

Interview with a second PCA on 08/07/19 at

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3:59pm revealed:
-Resident #4's genitals, groin and gluteal fold had been red and raw for approximately one week and staff were using a barrier cream with each incontinence change.
-She did not know Resident #4 had bandages on his left ankle, mid left back and right elbow.

Telephone interview with Resident #4's Power of Attorney (POA) on 08/09/19 at 1:05pm revealed:
-Resident #4 was confined to a chair and staff "pretty much had to do everything for him."
-Resident #4 had personal care provided in the morning after breakfast, usually laid down after lunch, back up between 3:00pm and dinner and then up until bedtime.
-Resident #4 had a bad wound on his (right) heel and had wound care nurses coming into the facility to take care of the wound.

Interview with Resident #4's primary care provider (PCP) on 08/08/19 at 9:12am revealed:
-She was seeing Resident #4 every week for wound care.
-She had referred Resident #4 for home health (HH) services but he was not picked up due to insurance issues, so she did the dressing changes every week.
-She wrote wound care orders for the staff.

Refer to interview with the Administrator on 08/13/19 at 3:22pm.

2. Review of Resident #1's current FL-2 dated 05/03/19 revealed:
-Diagnoses included coronary artery disease, post-percutaneous coronary intervention, severe aortic stenosis, post-transcatheter aortic valve replacement, Type II diabetes mellitus, chronic obstructive pulmonary disease (COPD),

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hypothyroidism, and paroxysmal atrial fibrillation.
-Resident #1 was ambulatory and there was no documentation of his orientation status.

Review of Resident #1's Resident Register revealed an admission date of 05/06/19.

Review of Resident #1's care plan dated 05/28/19 revealed:
-Resident #1 was oriented and had adequate memory.
-There was assessment for the need of mental health services for Resident #1.

Review of Resident #1's consultation notes revealed:
-Resident #1 was referred for mental health counseling by his primary care provider on 06/20/19 to deal with adjustment issues and receiving medications from the medication aides at the facility.
-Resident #1 was recommended for weekly outpatient therapy to assist with decreasing and/or alleviating mental health symptoms as well as developing coping skills by a licensed clinical social worker (LCSW).
-Resident #1 was seen by a LCSW for treatment of adjustment disorder on 07/03/19 and 07/24/19.

Interview with a medication aide (MA) on 08/07/19 at 11:05am revealed:
-Resident #1 was sometimes disoriented and "it was hard to manage" Resident #1 since he was admitted to the facility.
-Resident #1 was verbally aggressive to his roommate and there had been a report that Resident #1 had grabbed his roommate that resulted in a bruise on the roommate's forearm.

Review of an accident/injury report dated

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D 255	Continued From page 14 07/24/19 at 11:30am revealed there was an allegation that Resident #1 grabbed and bruised the left forearm of another resident. Interview with Resident #1 on 08/07/19 at 11:35am revealed: -He was alert and oriented person, place, and time. -He raised voice and began yelling at the survey member when asked questions about his care and medications. -He replied, "you are asking too many questions that should not be your concern". Observation of Resident #1 on 08/07/19 at 4:25pm revealed: -He was sitting in a chair in his room. -He leaned forward in his chair as he became increasingly angry and yelled at the survey team during the interview. Second interview with Resident #1 on 08/07/19 at 4:25pm revealed: -He did not remember speaking with the survey team earlier on 08/07/19. -He thought the survey team member was part of the staff at the facility. -He was tired of staff at the facility asking him questions. -He could take of himself and "nobody needed to worry" about you. Interview with a personal care aide (PCA) on 08/14/19 at 9:35am revealed: -Resident #1 yelled and used profanity towards another resident and he refused to listen to staff when they tried to intervene. -Resident #1 was forgetful at times and he became angry if staff tried to correct him. -She did not know if Resident #1 was receiving	D 255		

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mental health services.
-If staff tried to ask Resident #1 questions to try to better assist him, it only made him angry.

Interview with Resident #11's health care provider on 08/08/10:35am revealed:
-She noticed that Resident #1 had some mental changes and he was sometimes very forgetful.
-It was able to answer her questions appropriately when she checked Resident #1's orientation status when he was admitted to the facility.
-Resident #1 now was becoming increased forgetful and sometimes confused as to the identity of staff at the facility.
-She occasionally had to reorient Resident #1 to who she was his health care provider.
-His forgetfulness seemed worse in the afternoon and evening.

Telephone interview with Resident #1's mental health provider on 08/15/19 at 9:41am revealed:
-She had started mental health services with Resident #1 when she noticed he had anger and anxiety problems in June 2019.
-She had noticed Resident #1 had some changes in his cognitive status and had become increasingly forgetful since he was admitted to the facility.
-Resident #1's forgetfulness was worse in the afternoon because he would sometimes forget speaking to her in the morning on the same day.
-She thought Resident #1's anger and anxiety problems had gotten better.
-No staff had reported any increased or continued issues with Resident #1's anger and anxiety issues.
-She did not know Resident #1 had allegations of being physical abusive in July 2019.
-She would have increased her visits with Resident #1 if she had known it was an ongoing

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D 255	Continued From page 16 problem. Refer to interview with the Administrator on 08/13/19 at 3:22pm. Interview with the Administrator on 08/13/19 at 3:22pm revealed: -The Resident Care Coordinator (RCC) was responsible for completing resident assessments and care plans. -She had been covering the RCC's responsibilities in addition to her own since the RCC had been out on leave (07/31/19). -She did not know an assessment should be completed whenever there was a change in a resident's condition such as a new pressure ulcer and decreased cognitive ability.	D 255		
D 261	10A NCAC 13F .0802 (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (c) The care plan shall include the following: (1) a statement of the care or service to be provided based on the assessment or reassessment; and (2) frequency of the service provision. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure there was a statement of care and services to be provided on the care plan for 1 of 6 sampled residents (#18) who was no longer able to use her hands well enough to feed herself, required a hydraulic lift for transfers and had a family request for female only staff to provide personal care for the resident. Review of Resident #18's current FL-2 dated	D 261		

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D 261	Continued From page 17 07/11/19 revealed: -Diagnoses included Alzheimer's dementia, multiple sclerosis and chronic pain. -There was documentation Resident #18 required assistance with bathing and dressing and set up for feeding. Review of Resident #18's current care plan dated 07/09/19 revealed: -There was documentation Resident #18 was totally dependent on staff for all activities of daily living (ADL). -Resident #18 was ambulatory in a geriatric chair with staff assistance. -Resident #18 needed encouragement at meal times occasionally. -Resident #18's right hand was contracted. -Resident #18 was incontinent of bowel and bladder. -Resident #18 was independent with eating, and total dependent on staff for toileting, ambulation, transfers, bathing, dressing and grooming. -There was no documentation for the use a hydraulic lift and requiring two staff for assistance with transfers and incontinence care. -There was no documentation Resident #18 was no longer able to feed herself and was totally dependent on staff for eating meals. -There was no documentation of the family member's request for female staff only to provide personal care for Resident #18. Interview with the personal care aide (PCA) on 08/09/19 at 4:35pm revealed: - Resident #18 needed a hydraulic lift for transfers out of bed which required two staff for safety. -Resident #18 needed to be fed; sometimes Resident #18's family member came to feed the resident.	D 261		

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D 261	Continued From page 18 -Resident #18's family member did not want male PCAs to provide incontinence care or bath the resident. Interview with a second PCA on 08/07/19 at 10:44am revealed: -Resident #18's family member wanted incontinence care provided for the resident every two hours. -Staff tried to provide incontinence care for Resident #18 every two hours but it was hard when there were only two PCAs. -Staff might be able to provide incontinence care for Resident #18 every three hours. -Resident #18 needed two staff for incontinence care because the resident had multiple sclerosis, was stiff and required a hydraulic lift for transfers. Telephone interview with Resident #18's Hospice Nurse (HN) on 08/15/19 at 1:30pm revealed Resident #18 had a drastic decline over the past month, Resident #18 was no longer able to feed herself. Interview with the Administrator on 08/13/19 at 3:22pm revealed: -The Resident Care Coordinator (RCC) was responsible for completing resident assessments and care plans. -She had been covering the RCC's responsibilities in addition to her own since the RCC had been out on leave (07/31/19). -She did not know the care plan should include change in the ability use ones hands and what measures to assist the resident were put in place.	D 261		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision	D 269		

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D 269	Continued From page 19 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 observations, interviews and record reviews, the facility failed to assure personal care assistance including toileting, incontinence care, nail care and turning and repositioning was done according to the needs of 3 of 9 sampled residents (#3, #4, and #13) which resulted in overgrown and ingrown toenails (#3), multiple pressure ulcers and a genital rash (#4 and #13). The findings are: 1. Review of Resident #4's current FL-2 dated 04/02/19 revealed: -Diagnoses included Alzheimer's dementia, seizure disorder, type II diabetes mellitus and right cerebral hematoma. -There was documentation Resident #4 was constantly disoriented, non-ambulatory, incontinent of bowel and bladder and required total care. Review of Resident #4's Resident Register	D 269		

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revealed the resident was admitted to the facility on 03/16/16.

Observations on 08/07/19 at 3:59pm revealed:
-Two personal care aides provided incontinence care for Resident #4; the incontinence brief was moderately wet.
-Resident #4's genitals, groin and gluteal fold were red and raw.
-There was a quarter sized area of darker redness left of Resident #4's sacrum and a similar size and color area to the right of his sacrum.
-There was a large bandage marked "7/23 6am" on Resident #4's left outer ankle.
-There was a large unmarked bandage on Resident #4's right elbow.
-There was an aged large bandage on Resident #4's mid left back; the bandage was wrinkled, rolled at the bottom edge and had an accumulation of lint on the rolled edge.
-There was a cling compression wrap on Resident #4's right foot.
-There was no barrier cream applied with the incontinence care.

Review of Resident #4's current care plan dated 06/10/19 revealed:
-Resident #4 required total assistance from staff with all activities of daily living (ADLs).
-Resident #4 was incontinent of bowel and bladder and ambulatory with a geriatric chair and staff assistance.
-Resident #4 required a hydraulic lift for transfers to and from his bed.
-There was no documentation related to skin condition, turning schedules, application of barrier cream or wound care.

Review of the licensed health professional

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support (LHPS) evaluation dated 06/07/19 for Resident #4 revealed there was documentation the skin assessment was within normal limits.

Review of a primary care provider (PCP) visit note dated 07/23/19 for Resident #4 revealed there was an order for home health (HH) to evaluate and treat.

Interview with the Home Health Nurse (HHN) on 08/14/19 at 1:05pm revealed:
-Resident #4 was seen for an initial evaluation, wound assessment and measurement and to obtain wound care orders on 08/14/19.
-Resident #4 had a stage II pressure ulcer on his sacral/coccyx area which measured 6.8cm by 3.4cm.
-Resident #4 had a stage II pressure ulcer on his right heel which measured 4cm by 6.7cm with slight bleeding from the wound.
-Resident #4 had dead tissue on his right lateral upper foot measuring 1.3cm by 1 cm, on his right mid lateral foot measuring 2.5cm by 2.5cm, on his right lateral ankle measuring 1cm by 0.3cm, on his left lateral ankle measuring 1cm by 0.5cm and on his right elbow measuring 1cm by 1cm.
-Resident #4 had a reddened, inflamed rash on his genitals and groin.
-The redness on Resident #4's right foot seemed to be from pressure.

Interview with a personal care aide (PCA) on 08/07/19 at 10:44am revealed:
-Resident #4 required a hydraulic lift for transfers in and out of bed; the hydraulic lift required two staff for safety.
-Resident #4 was not always in his bed; PCAs repositioned the resident when he was transferred to his chair for meals.
-Two staff were needed to get Resident #4 out of

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bed for breakfast, back in bed after breakfast and out of bed for lunch; it took time to get the resident in and out of bed.
-The PCA assigned to Resident #4 had to go and get help and "help was not always readily available."
-Resident #4 needed two staff for assistance because he was completely dependent on staff for all his activities of daily living (ADLs).
-Resident #4 wore foot cushions because he had pressure ulcers on both of his feet.
-Staff were not always able to turn and reposition Resident #4 because there was not enough staff.
-Resident #4 would have incontinence care after lunch and then the next time would be on second shift.

Interview with a second PCA on 08/07/19 at 3:59pm revealed:
-Incontinence rounds were done every two hours; her shift started at 3:00pm so her first rounds were due at 5:00pm.
-Resident #4's genitals, groin and gluteal fold had been red and raw for approximately one week and staff were using a barrier cream with each incontinence change.
-The barrier cream was not in the room for the incontinence care done 08/07/19 at 3:59pm.
-She did not know Resident #4 had bandages on his left ankle, mid left back and right elbow.
-Resident #4 was repositioned when staff got the resident up for each meal and he kept up in the chair for one hour after meals before staff assisted the resident back to bed.

Interview with a medication aide (MA) on 08/07/19 at 4:08pm revealed:
-She knew Resident #4 had a dressing on his left ankle.
-All of Resident #4's bandages and/or dressings

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were change twice daily, including the ones on his left mid back, right elbow, left ankle and right foot.
-She did not know why the dressing on Resident #4's left foot was dated 7/23.
-The MA documented wound care and dressing changes on the medication administration record (MAR).

Review of an undated verbal order signed by the PCP on 07/23/19 for Resident #4 revealed an order to wash the resident's right heel with water, apply triple antibiotic ointment, cover with gauze and wrap daily for seven days.

Review of a PCP order dated 07/25/19 revealed an order to apply barrier cream with each incontinence care until healed.

Review of a telephone order dated 07/28/19 signed by the PCP on 08/08/19 for Resident #4 revealed an order to continue wound care to right heal as ordered; PCP to re-evaluate on 08/08/19 and apply heel protectors to both heels.

Review of Resident #4's August 2019 MAR revealed:
-There was a hand-written entry for wound care to right heel: wash area with water, apply antibiotic ointment, cover with 4 inch by 4 inch gauze and wrap daily from 7:00am to 3:00pm.
-There was documentation the wound care had been done 08/01/19 through 08/06/19.
-There was a hand written entry for barrier cream apply a thin layer to sacrum with incontinence care until healed scheduled for 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm-7:00am.
-There was documentation barrier cream had been applied 7:00am-3:00pm on 08/01/19 through 08/07/19; and 3:00pm-11:00pm on

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08/01/19 through 08/06/19.
-There was no documentation the barrier cream was applied 11:00pm-7:00am 08/01/19 through 08/06/19.
-There were no other wound care entries on the MAR.

Second interview with the PCA on 08/07/19 at 4:10pm revealed:
-PCAs completed a skin assessment on the resident's shower days.
-The shower schedule was kept in the assignment book.

Review of skin assessment forms dated 06/13/19 through 08/03/19 revealed:
-On 06/13/19, staff documented Resident #4 had one open wound - a blister on the right heel and a bruise on his right elbow.
-On 06/17/19, 06/24/19, 07/01/19, 07/04/19 and 07/08/19, staff documented there were no open wounds, bruises or other abnormalities.
-On 07/11/19, staff documented there was a bruise on Resident #4's right arm and elbow and no open wounds or other lesions.
-On 07/11/19, a second staff documented there were no open wounds, bruises or other abnormalities.
-On 07/15/19 and 07/18/19, staff documented there were no open wounds, bruises or other abnormalities.
-On 07/21/19, staff documented Resident #4 had an open wound on the right heel, blisters on the right side of the foot and a "pressure area" on his left ankle.
-On 07/22/19, staff documented Resident #4's right heel was wrapped, blisters on the side of the foot and a "pressure area" on the left side of his ankle.
On 07/22/19, a second staff documented

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D 269	Continued From page 25 Resident #4 had redness to his "mid area" and left elbow, lesions on the top of his "butt" and a "little" lesion "in the butt." -On 07/24/19, staff documented Resident #4 had a skin at the top and bottom of his buttocks and no other open wounds, bruises or other abnormalities. -On 07/29/19, staff documented Resident #4 had a skin tear on his bottom and no other open wounds, bruises or other abnormalities. -On 08/01/19, staff documented Resident #4 had redness and a blister on his right heel and no other open wounds, bruises or other abnormalities. -On 08/03/19, staff documented Resident #4 had no open wounds, two red spots on the top of his right foot and a blister on the side of the right foot. Interview with a second MA on 08/08/19 at 10:41am revealed: -Resident #4's right elbow had a bandage because it was healing; she thought there might be a bandage on the resident's back and she knew about the bandage on the resident's left ankle. -She did not know why the dressing was dated 07/23 because she was "on the floor (as a PCA) more then she was on the medication cart (as a MA)." -She did not do wound care when she worked on the floor as PCA; she was responsible for incontinence care and getting Resident #4 in and out of bed for meals. -The MAs knew to change the bandages because when the resident's clothes were changed the personal care aides did skin assessments and let the MAs know about any wounds and bandages. -Skin assessment sheets were completed by the PCA, reviewed by the MA and given to the Resident Care Coordinator (RCC) or the	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 26 Administrator. -MAs also told oncoming MAs about any dressing changes at shift change. Second interview with the second MA on 08/12/19 at 3:52pm revealed: -The barrier cream for Resident #4 was kept on the medication cart. -The PCAs did not apply the barrier cream, the MAs did. Observations of wound care for Resident #4's by his PCP on 08/08/19 at 9:11am revealed: -Resident #12 was sitting in his geriatric chair in the common area. -There was slight swelling of and redness around each wound area on Resident #12's right foot. -There was a dime sized dried open blister on the top of the foot. -There was a dime sized scabbed area on the outer ankle. -There was a silver dollar sized area of black and dark red decolorization on the heel. -There were pink and yellow drainage from the heal when the PCP patted the area with gauze. -There was a quarter sized thick black, brown area on the outer lateral aspect of the foot. -There was a nickel sized thick black, brown area on the outer lateral aspect of the foot near the pinky toe. Interview with Resident #4's PCP on 08/08/19 at 9:12am revealed: -She was seeing Resident #4 every week for wound care. -She had referred Resident #4 for home health (HH) services but he was not picked up due to insurance issues, so she did the dressing changes every week. -She wrote wound care orders for the staff.	D 269		

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-She changed the bandage on Resident #4's left ankle on 08/08/19.
-She was not concerned about the bandage being labeled "7/23 6am" because it was a small area which was almost healed.
-She was in the middle of changing the dressing on Resident #4's right foot.
-The redness on Resident #4's bottom was not really new and she was not sure about a wound on his back and right elbow.
-She did not know if any teaching had been done with the MAs on caring for Resident #4's wounds.

Observations during incontinence rounds on 08/09/19 at 3:48pm revealed:
-The PCA and the MA were assisting the licensed health professional support (LHPS) Registered Nurse (RN) with a head to toe skin assessment.
-There was no bandage on Resident #4's right elbow; there was a dime sized scabbed area on the right elbow.
-There was old pink, yellow bruises on Resident #4's left elbow.
-There was no bandage on Resident #4's left mid back; there was a nickel sized area of redness.
-There was a half dollar sized red, raw area on Resident #4's right buttock near the sacrum.
-The LHPS RN said she did not get a chance to assess Resident #4's right foot.
-There was a dime sized dark brown colored area on Resident #4's left outer ankle.
-The LHPS RN said it was a blood blister on Resident #4's left outer ankle that was open in the center.

Interview with the LHPS RN on 08/09/19 at 3:48pm revealed:
-She was new to the facility since 08/07/19 as the LHPS RN.
-Her first time completing and assessment and

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evaluation for Resident #4 and his wounds was on 08/09/19.

Interview with a third PCA on 08/13/19 at 9:12am revealed:
-Resident #4 was usually already up and in his geriatric chair when her shift started at 7:00am.
-Resident #4 was laid back down in his bed after breakfast and then back up for lunch.
-The second shift staff got Resident #4 back up around 4:00pm.
-Resident #4 was one of two residents that were not kept up in their chairs all day.
-PCAs were able to turn and reposition Resident #4 at least 2-3 times per day.
-Resident #4 was changed when staff laid him down in the bed if he was wet.
-Resident #4 was not always wet when the PCAs laid him down so they would check him again when they got him up.
-Resident #4 often would urinate as soon as he was laid down and therefore soaked when the PCAs returned.

Telephone interview with Resident #4's Power of Attorney (POA) on 08/09/19 at 1:05pm revealed:
-Resident #4 was confined to a chair and staff "pretty much had to do everything for him."
-Resident #4 was changed in the morning after breakfast, usually laid down after lunch, back up between 3:00pm and dinner and then up until bedtime.

Interview with the Administrator on 08/15/19 at 3:41pm revealed:
-Skin assessments were done by the PCAs on residents' shower days and reviewed by the MA; any concerns about skin assessments were reported to the RCC.
-The RCC or Administrator reviewed the skin

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assessments every other day.
-Residents were bathed every day and showered two to three days per week.
-Staff were expected to provide incontinence care and toileting assistance every two hours and as needed.
-MAs were responsible to make sure showers were done as assigned each day by the PCAs.
-Staff were expected to turn and reposition Resident #4 every two hours.
-She did not know about the discrepancies in documentation on skin assessments done for Resident #4.
-She could not say whether or not staff had actually checked the resident's skin on shower days.

The RCC was not available for interview 08/07/19 through 08/15/19.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

3. Review of Resident #3's current FL-2 dated 05/03/19 revealed:
-Resident #3's diagnoses included dementia, post-traumatic stress disorder, metabolic encephalopathy and essential hypertension.
-Resident #3's recommended level of care was secured.
-Resident #3 needed assistance with bathing.

Review of Resident #3's Resident Register revealed:
-He was admitted to the facility on 03/20/17.
-He was forgetful and needed reminders.
-He needed assistance with dressing, bathing, nail care, shaving and grooming.

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D 269	Continued From page 30 Review of Resident #3's current assessment and care plans signed on 07/23/18 and 05/03/19 by resident's primary care physician revealed that Resident #3 required supervision with bathing. Observation of Resident #3's fingernails and toenails on 08/09/19 at 9:24 a.m. revealed they were clean and extented approximately 1 ½ inches in length beyond his finger and toes with irregular edges. Based on observations, record reviews and interviews, it was determined that Resident #3 on 08/09/19 at 9:24 a.m. was not interviewable. Review of Resident #3's progress notes revealed: -Documentation dated 05/13/19 at 3:15 p.m. stating that Resident #3 was complaining of left foot great toe pain. -The left great toe appeared to have a split or cut on the side of the left great toe. -Documentation dated 05/13/19 at 10:00 p.m. stating that Resident #3's had pain to his left foot great toe with discoloration and bloody discharge. -Resident #3 was given pain medication and the facility's physician and the resident's family member were notified about resident's left great toe. Interview with a medication aide (MA) on 08/09/19 at 9:45 a.m. revealed: -Resident #3's family member sometimes cut the resident's toenails -PCAs were responsible for cutting Resident #3's fingernails and toenails. -Resident #3's fingernails were filed but not cut by a PCA on Monday, 08/05/19. -She could not recall the last time that Resident #3's toenails were cut by staff.	D 269		

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D 269	Continued From page 31 Interview with a personal care aide (PCA) on 08/09/19 at 10:10 a.m. revealed: -The PCAs were responsible for the personal care of the residents, which included making sure their nails were kept clean and trimmed low. -The PCAs were responsible for cutting residents' nails if their fingernail or toenails needed it. -Someone, she did not know who the person was, came into the facility and cut the residents' fingernails and toenails. -They were here at the end of last month, July 2019. -The facility had a list of residents' names that they came in and cut their nails. -The PCA did not know if Resident #3 was on the list last month to have his fingernails and toenails cut. Interview with another personal care aide (PCA) on 08/09/19 at 3:15 p.m. revealed: -She was aware that Resident #3's left great toe was painful on 08/07/19 when she tried to help him put on his shoes. -She took him to the front common area and soaked his foot, then tried to remove ingrown toenail for him because she got ingrown toenails alot and that was how she removed hers. -She was not able to remove Resident #3's ingrown toenail because he was in too much pain. -The Activities Director was near by so she mentioned to her about Resident #3's toe pain. -She should have told the medication aide (MA) but MA was busy at the time with another resident. -She forgot to report Resident #3's toe pain to the MA later that day. -When she returned to work the next day, 08/08/19, Resident #3 had his socks and shoes on, so she thought his toe pain was better.	D 269		

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-She did not ask Resident #3 if his toe was still hurting.

Interview with Resident #3's family member on 08/09/19 at 11:53 a.m. revealed:
-Resident #3 was cutting his own fingernails and toenails when he was on assisted living unit.
-He would dig any ingrown toenails out himself.
-She last cut his fingernails and toenails six to eight weeks ago.
-Her expectation was that the facility would cut his fingernails and toenails if they saw them getting too long.

Interview with the Executive Director/ Administrator (ED/ Adm) on 08/09/19 at 10:20 a.m. revealed:
-A podiatrist came in every other month to cut residents' fingernails and toenails who were on their listing of residents.
-She did not think Resident #3 was on the podiatrist list.
-Resident #3's family member took him to the veterans' affairs (VA) for all his medical care.
-She assumed that included having his fingernails and toenails cut.
-She did not know when the last time Resident #3's fingernails and toenails were cut.
-She was not aware that Resident #3's fingernails and toenails needed cutting.
-If there were any concerns about a residents' personal care such as long fingernails and toenails or an ingrown toenail, the PCAs were to report their concerns to the MA.

4. Review of Resident #13's current FL-2 dated 05/02/19 revealed:
-Resident #13's diagnoses included Pick's disease, degeneration disease of the nervous system, metabolic encephalopathy, frontal

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temporal demitia.
-Resident #13 was incontinent of bladder and bowel.
-Resident #13 was non- ambulatory.
-Resident #13 required total assistance with all her personal care.

Observation of Resident #13 on 08/07/19 at 9:40 a.m. revealed:
-Resident #13 was lying on her back on an air mattress in a hospital bed.
-Her body movements were stiff and spastic.
-She had a strong body odor.
-Her incontinence brief was dry.
-There was a fall mat on the floor next to Resident #13's bed.
-A wheelchair was in the shower of Resident #13's bathroom and the legs of the wheelchair were against the right wall next to the shower.

Observation of Resident #13 on 08/09/19 at 3:10pm revealed:
-Resident #13 was lying on her right side in her hospital bed and there was a fall mat next to her bed.
-Resident #13 had a large foam dressing to her lower back and upper sacral area which measured approximately 4-inches wide and 4-inches long.
-Resident #13 had square dressing to her right knee which measured approximately three inches wide and three inches long.
-There were no dates on either dressing.
-Resident #13 had redness to her left elbow and her body smelled strongly of urine.

Review of Resident #13's care plan signed by primary care physician (PCP) 07/11/19 revealed:
-Resident #13 was non-ambulatory and bed bound per hospice.

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D 269	Continued From page 34 -Resident #13 required total assistance with all activities of daily living (ADL). -Resident #13 required to be turned every two hours daily. -Resident #13 was non-verbal. Observation of Resident #13 on 08/13/19 at 10:04 a.m. through 4:10 p.m. revealed: -At 10:04 a.m. Resident #13 lying in hospital bed on her back with head of bed 30 degrees and pillow roll at her left side next to her. - At 12:13 p.m. Resident #13 lying in hospital bed on her back with head of bed 30 degrees and pillow roll at her left side next to her. -At 12:42 p.m. Resident #13 lying in hospital bed on her back with head of bed 30 degrees and pillow roll at her left side next to her. - At 2:15 p.m. Resident #13 lying in hospital bed on her back with head of bed 30 degrees and pillow roll at her left side next to her. -At 4:10 p.m. Resident #13 lying in hospital bed on her back with head of bed 30 degrees and pillow roll at her left side next to her with a strong urine order in her room. Based on observations, interviews and record reviews, it was determined Resident #13 was not interviewable. Interview with a medication aide (MA) on 08/13/19 at 2:15 p.m. revealed: -Resident #13 was toileted and repositioned every 2 hours by the PCAs. -She did not know when Resident #13 was last toileted and repositioned. Interview with Executive Director/ Administrator (ED/ Adm) on 08/13/19 at 4:20 p.m. revealed: -Resident #13 was under hospice care and was bed bound.	D 269		

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D 269	Continued From page 35 -ED/Adm was not sure how often hospice visited. -The facility staff followed hospice's plan of care for Resident #13. -ED/Adm did not know if hospice plan of care included repositioning Resident #13 every 2 hours. -Residents were provided toileting assistance by staff every 2 hours during their rounds. -ED/ Adm did not know if facility staff were aware that because Resident #13 was bedbound, she required repositioning every 2 hours. -Staff would be made aware that a resident required to be repositioned every two hours and what position the resident was placed in during the last positioning during their shift to shift reporting. Observation of Resident #13 on 08/13/19 at 4:50 p.m. revealed: -Resident #13 was toileted and repositioned to lay on her left side by facility staff. -Resident #13 had a square 4-inches wide by 4-inches long foam dressing to her sacrum and upper back between shoulder blades. -Resident #13 had a square 3-inches wide by 3-inches long foam dressing to her right knee. -There were no dates on either dressing. -Red areas of pressure marks and creases were observed throughout Resident #13's back after she was turned by facility staff. Interview with two personal care aides on 08/13/19 at 4:50 p.m. revealed: -Resident #13 required two staff members to change her because she stiffened her body making it difficult to change her with just one staff member. -They could not recall been instructed to reposition Resident #13 every 2 hours prior to this evening.	D 269		

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-They could not recall being instructed on how to reposition Resident #13 in bed prior to this evening.
-If there were any changes in Resident #13's plan of care, it would be reported to the medication aide (MA) during the change of shift, then to personal care aides (PCAs) by the MA.

Observation of Resident #13's on 08/14/19 at 8:55 a.m. revealed that resident laid in bed with bed raised 45 degrees been fed breakfast by facility staff.

Interview with a personal care aide (PCA) on 08/14/19 at 8:55 a.m. revealed:
-Resident #13 was repositioned every 2 hours.
-PCA was instructed by ED/ Adm yesterday evening, 08/13/19, to reposition Resident #13 every 2 hours.
-Prior to 08/13/19 Resident #13 was not being changed as frequently, maybe every 3 to 4 hours.

Observation of Resident #13's care by hospice Registered Nurse (RN) on 08/14/19 at 9:52 a.m. revealed:
-An area 1 centimeter(cm) wide by 1 cm long stage II wound to Resident's right knee.
- A second area 1 ½ cm wide by 2 cm long red mark and unmeasured red mark to Resident's upper back between shoulder blades.
-A third reddened area to Resident's sacrum.
-Wound care/skin care was performed by hospice RN to all 3 areas and foam dressing was applied.

Interview with Resident #13's hospice RN on 08/14/19 at 9:52 a.m. revealed:
-She had been providing hospice care for Resident #13 this time for 3 weeks.
-Resident #13 had being place under the care of another hospice care service and returned to her

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D 269	Continued From page 37 care 3 weeks ago. -She provided wound care for Resident #13 2 times each week. -She was not aware that Resident #13 was not been repositioned every 2 hours daily. -She had not instructed the facility's staff on how to reposition Resident #13 because she expected the facility to follow the care plan which included turning Resident #13 every 2 hours daily. -Resident #13 had a skin condition that caused her skin to breakdown easily. _____ The facility failed to provide personal care assistance according to the needs of three sampled residents. The facility's failure to provide personal care assistance including toileting and incontinence care, turning and repositioning and nail care which resulted in Resident #3 suffering pain due to an ingrown toenail for 3 months; Resident #4 having multiple stage II pressure ulcers on his feet, sacrum and buttocks; and Resident #13 having a stage II pressure ulcer on her right knee and multiple reddened areas to resident's sacrum and upper back. The failure of the facility to provide toileting, incontinence care, repositioning and nail care assistance resulted in substantial risk of serious injury of Residents #3, #4 and #13 and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/08/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2019.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

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D 270	Continued From page 38 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 B VIOLATION Based on interviews, observations, and record reviews, the facility failed to assure supervision was provided to 2 of 10 sampled residents (#8 and #16) who suffered multiple falls (#8) resulting in skin tears and head injuries (#16). The findings are: 1. Review of Resident #16's current FL-2 dated 04/02/19 revealed: -Diagnoses included Alzheimer's Disease, hypertension, anxiety disorder, type II diabetes mellitus, benign prostrate hypertrophy, late affect stroke. -Resident #16 was constantly disoriented. -Resident 16 was ambulatory with wandering behaviors. Observations on 08/09/19 at 5:09 p.m. revealed Resident #16 was lying on his back in the floor between his bed and the window. Review of Resident #16's facility's occurance	D 270		

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THE CROSSINGS AT WAYSIDE	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 270	Continued From page 39 reports revealed: -Resident had a fall on 01/09/19 at 12:04 p.m. with no injury. -Resident was placed on 30 minutes checks on 01/19/19 for 72 hours. -Resident had a fall on 02/01/19 at 07:50 a.m. with no injury. -Resident had a fall on 02/02/19 at 3:45 p.m. with no injury. -Resident had a fall on 02/05/19 at 2:09 p.m. with red mark to his bottom with no documentation about resident sent to the emergency room (ER). -Resident had a fall on 02/17/19 at 7:06 a.m. with bruise to back and was sent to ER. -Resident was placed on 30 minutes checks on 02/17/19 for 72 hours. -Resident had a fall on 03/12/19 at 6:50 a.m. with no injury. -Resident was placed on 30 minutes checks on 03/12/19 for 72 hours. -Resident had a fall on 04/12/19 at 2:20 p.m. with no documentation of injury. -Resident had a fall on 04/15/19, no time of incident documented with no injury. -Resident had a fall on 04/16/19 at 12:15 a.m. with no injury. -Resident had a fall on 04/23/19 at 7:14 a.m. with bruise to back and was not sent to ER. -Resident was placed on 30 minutes checks on 04/23/19 for 72 hours. -Resident had a fall on 04/25/19 at 5:26 p.m. with redness to skull/scalp and was sent to ER. -Resident had a fall on 05/31/19 at 5:35 a.m. with no injury. -Resident had a fall on 06/02/19 at 2:45 p.m. with no injury. -Resident had a fall on 07/23/19 at 2:45 a.m. with no injury. -Resident had a fall on 07/29/19 at 10:30 p.m. with bruise to forehead, skin tear to nose and was	D 270		

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sent to ER.
-Resident had a fall on 08/09/19 at 5:15 p.m. with head injury and was sent to ER.
-Resident was placed on 30 minutes checks on 08/09/19 after his return from the ER for 72 hours and furniture rearranged in room.

Interview with the Executive Director/Administrator (ED/Adm) on 08/09/19 at 5:09 p.m. revealed:
-Staff found Resident #16 lying on the floor in his room between the bed and the window.
-No one knew how Resident #16 got there because his bed was usually close to the window.
-The Activity Director (AD) placed a pillow under Resident #16's head.
-Staff were waiting for emergency medical services (EMS) and did not want to move Resident #16.
-Resident #16 was not bleeding from anywhere that she could see.

Interview with a medication aide (MA) on 08/15/19 at 10:40 a.m. revealed:
-She saw maybe one or two falls when Resident #16 lost his balance.
-Resident #16 was placed on 15 minutes checks after falls.
-She could not recall for how long Resident #16 was on 15 minutes.
-There was no paperwork to document these 15 minutes checks.
-MA had not noticed any changes due to his falls.
-Nothing changed as far as implementing anything.

Interview with a personal care aide (PCA) on 08/15/19 at 10:46 a.m. revealed:
-Resident #16's bed was moved against the wall so there were no gaps within the last week due to

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his fall last week.
-She had not witnessed any of resident's falls.
-There were no other changes made since last fall other than moving the bed.

Interview with a second PCA on 08/15/19 at 10:52 a.m. revealed:
-Resident #16 had a fall last week where Resident #16 rolled off his bed.
-Resident #16 was alone in his room, she did not know who found him.
-Resident #16's bed was moved against the wall from the middle of the floor.
-She thought Resident #16 was on 30 minutes checks.
-She did not document these 30 minutes.

Interview with the facilities' ED/Adm and another ED from a sister facility on 08/15/19 at 11:52 a.m. revealed:
-The ED from the sister facility was there to assist and lend guidance to this facility's new ED/Adm.
-Resident #16 was moved closer to the nursing station at the end of July, the beginning of August 2019.
-Resident #16 was placed on 30 minutes checks after falls for 72 hours.
-Resident #16 was kept busy with varied activities.
-There was a request from Resident #16's family member for a bed alarm in his record.
-Resident #16's room furniture was rearranged on 08/09/19 after his last fall to prevent injury from any future falls.

Interview with Resident #16's PCP's call center nurse on 08/15/19 at 3:30 p.m. revealed:
-On 08/11/19, PCP's office received a message from Resident #16's family member requesting an order be sent to the facility for a bed buzzer

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due to resident's falls out of bed.
-On 08/12/19, Resident #16's PCP faxed the order for the bed alarm due to increase in falls to the facility.
-On 08/14/19, Resident #16's PCP's office received a call from the facility to discontinue the order for the bed alarm because it was considered a restraint.

Interview with Resident #16's family member on 08/15/19 at 4:11 p.m. revealed:
-Resident #16 has had many falls since January 2019.
-the facility had not really done anything to prevent Resident #16's falls.
-She asked facility a month ago to move Resident #16 closer the nursing station.
-She asked the ED/Adm about getting a buzzer for Resident #16 around two weeks ago because he continued to have falls.
-She did not hear or received any follow-up about the buzzer.
-She spoke to the ED/Adm again on 08/11/19 about the buzzer and the ED/Adm told her the facility needed an order from Resident #16's primary care physician (PCP).
-She sent a message to Resident #16's PCP on the evening of 08/11/19.
-The PCP called her on 08/12/19 to let her know he had sent the order for a bed alarm to the facility.
-She then called the facility right after she received the call from the PCP and spoke with the ED/Adm.
-The Ed/Adm told her they received the PCP's order for the bed alarm and had placed an order for it.
-She had asked the previous ED for the buzzer at the beginning of the year.
-She had seen other residents that had the

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buzzers.
-She asked one of the MA about getting a bed alarm and she told me yes.
-She did not hear or received any follow-up about the bed alarm.
-The facility had never asked her about a floor mat to place beside Resident #16's bed.

Interview with the ED/Adm on 08/15/19 at 5:35 p.m. revealed:
-She was aware that Resident #16 has had many falls.
-She did not recall having had a conversation with Resident #16's family member concerning getting a bed alarm/buzzer for resident due to his many falls.
-She could not recall implementing any other fall interventions for Resident #16 other than the 30 minutes checks for 72 hours and the rearrangement of his room furniture.

2. Review of Resident #8's FL-2 dated 07/02/19 revealed:
-Diagnoses included dementia without behaviors, peripheral vascular disease, chronic obstruction pulmonary disease and emphysema.
-Resident #8 was semi-ambulatory with a wheelchair.

Review of Resident #8's care plan dated 07/22/19:
-Staff were to continue increased supervision for Resident #8.
-Resident #8 was placed in common areas to increase supervision.
-A bed alarm, chair alarm and fall mat were put into place for Resident #8.

Review of Resident #8's observations checks and incident/acident reports revealed:

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D 270	Continued From page 44 -It was documented on the observation checks between 5:15am and 5:30am on 07/05/19, Resident #8 was asked if she needed anything. However, on the incident and accident report, Resident #8 was found on the floor in her room on 07/05/19 at 5:25am -Resident #8 was placed on thirty-minute checks on 07/05/19. -It was documented on the observation checks at 7:00am on 07/14/19, Resident #8 was sleeping. However, on the incident and accident report, Resident #8 was found in the doorway of her room sliding toward the hallway on 07/14/19 at 6:45am. -Resident #8 was placed on thirty-minute checks on 07/21/19. -It was documented on the observation checks, Resident #8 was sleeping on 07/20/19 at 11:30pm. However, on the incident and accident report, Resident #8 fell out of her bed on 07/20/19 at 11:30pm. -Resident #8 was placed on fifteen-minute checks on 07/20/19. -It was documented on the observation checks, Resident #8 was sleeping on 07/23/19 at 10:30pm. However, on the incident and accident report, Resident #8 was found on the floor by her bed on 07/23/19 at 10:30pm. -Resident #8 was placed on fifteen-minute checks. Attempted telephone interview with Resident #8's responsible party on 08/12/19 at 8:42am was unsuccesful. Interview with a family member on 08/13/19 at 11:24am revealed: -Resident #8 was ambulatory when she was admitted to the facility. -The facility placed Resident #8 in a wheelchair	D 270		

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after a few falls because she was not able to ambulate on her own.
-The facility did not provide supervision for Resident #8.
-The facility did not have a plan in place to prevent Resident #8 from falling.
-The facility staff "never came to (Resident #8's) room to check on her."
-Resident #8 was discharged from the facility and placed in another facility on 07/31/19.

Interview with Executive Director (ED) on 08/13/19 at 4:08pm revealed:
-Resident #8 was able to ambulate on her own upon admission.
-The plan for Resident #8 was increased checks (two-hour checks, thirty-minute checks, and fifteen-minute checks), a fall mat was put in place and the facility had Resident #8's medications reconciled.

Interview with a medication aide (MA) on 08/09/19 at 10:54am revealed:
-Resident #8 was very agitated, yelling and screaming; there was "rarely a calm moment with her."
-Resident #8 was placed in the television room to watch shows that she liked.
-Resident #8 was not to be left alone due to falls per the Resident Care Coordinator (RCC).

Interview with a second MA on 08/13/19 at 2:58pm revealed:
-Resident #8 was self-independent and ambulatory upon admission.
-Resident #8 declined after the falls.
-Resident #8 needed one on one supervision; "the staff was not able to provide it."
-"It was impossible to provide one on one assistance to residents."

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D 270	Continued From page 46 Interview with a third MA on 08/14/19 at 9:33am revealed: -Resident #8 was able to ambulate on her own when she first came to the facility. -Staff were told to "watch Resident #8." -Resident #8 required one on one supervision. -Resident #8 was placed on thirty-minute checks and fifteen-minute checks. -The staff was responsible for documenting when they completed their checks. -The facility was "not able to provide one on one supervision; it was impossible." The facility failed to assure residents were supervised according to the needs of 2 of 9 sampled residents (#8 and #16). The facility's failure to supervise residents resulted in Resident #16 sustaining injuries including skin tears and head injuries due to multiple falls and Resident #8 having mulitple falls related to lack of supervision as evidence by documentation of records. The facility's failure to supervise residents was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/08/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 29, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs	D 273		

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D 273	Continued From page 47 of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow up with the residents' primary care provider for 4 of 7 sampled residents (#3, #4, #10 and #18) including the follow up and podiatry referral for an ingrown toenail for 3 weeks (#3); home health referral for wound care for 3 weeks and a neurology referral for 6 weeks (#4); follow up with the orthopedic physician for discontinuation orders for an orthopedic boot (#10);and reporting a total of 11 pound weight loss in 6 weeks to the PCP (#18). The findings are: 1. Review of Resident #3's current FL-2 dated 05/03/19 revealed: -Resident #3's diagnoses included dementia, post-traumatic stress disorder, metabolic encephalopathy and essential hypertension. -Resident #3's recommended level of care was secured. Review of Resident #3's Resident Register revealed: -He was admitted to the facility on 03/20/17. -He needed assistance with dressing, bathing,	D 273		

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D 273	Continued From page 48 nail care, shaving and grooming. Review of Resident #3's after visit summary dated 07/29/19 from the emergency room (ER) revealed: -Resident #3's reason for visit to the ER was for toe pain. -Resident #3 was diagnosed with ingrown toenail of the left foot with infection. -Resident #3 was given a prescription for antibiotics for to take for 10 days. -Resident #3 was instructed to schedule an appointment with a podiatrist as soon as possible. Observation on 08/08/19 at 11:05 a.m. revealed: -Resident #3 ambulated to the front desk with a limp and complained of pain in his left foot. -A staff assisted Resident #3 to walk to and sit in the common area. Interview with Resident #3 on 08/09/19 at 9:24 a.m. revealed: -His left great toe hurt 20, 30, 40 on a scale of 1-10. -He has had an ingrown toenail around 20 times. Interview with a medication aide (MA) on 08/09/19 at 9:45 a.m. revealed: -Resident #3's family member told her around two weeks ago that resident was complaining of toe pain and took him to the emergency room (ER). -Resident #3 was placed on antibiotic for 10 days for his toe. -Resident #3's family member told her that she was waiting for resident's primary care physician so they could do a referral. -Resident #3's PCP had not seen him as yet. -Resident #3's family member told her on 08/08/19 that she was going to call resident's PCP again.	D 273		

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D 273	Continued From page 49 -Resident #3 did not have an order for pain medication. -Resident #3 walked fine to the dining room for breakfast. -Resident #3 did not complain of pain. Observation of Resident #3 on 08/09/19 at 10:04 a.m. revealed: -He sat on the side of his bed with tears in his eyes and mumbled about the pain in his left great toe. -Resident #3's left great toe was swollen with slight redness on the inner aspect of the nailbed with some scabbing. Observation of Resident #3 on 08/09/19 at 10:15 a.m. revealed: -Resident #3 slowly walked down the hall, stopped and complained of pain to toe on his left foot. -Resident #3 stated "it doesn't look like nothing but it hurts". - "It is a pain and a half." -Facility staff notified the Executive Director/Administrator (ED/Adm) who walked Resident #3 back to his room and had the Registered Nurse Educator to assess Resident #3's left great toe. -Resident #3 was administered pain medication. Interview with Resident #3's family member on 08/09/19 at 11:53 a.m. revealed: -She had taken Resident #3 to the ER on 07/29/19 because he complained of toe pain. -The facility was aware of the ER visit and the instruction to schedule an appointment to a podiatrist as soon as possible. -She reviewed the ER visit summary with the facility staff both the night of 07/29/19 and the morning of 07/30/19.	D 273		

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D 273	Continued From page 50 -She called Resident #3's PCP's office and left a message on their message line 07/30/19 concerning resident's ER visit. -She usually heard back from Resident #3's PCP within 24 hours but as of today, 08/09/19 she had not heard back from PCP. Interview with the ED/Adm on 08/09/19 at 10:28 a.m. revealed: -She was not aware of Resident #3's ingrown toenail, infection and pain. -She was not aware Resident #3 had been taken to the ER and had a referral in his record with instruction to schedule an appointment to see a podiatrist as soon as possible. -The resident care coordinator (RCC) was responsible for reviewing residents' discharge paperwork. -The RCC was also responsible for making any follow up appointments for the residents and making sure all orders were implemented. -The RCC had been out from work and she had been performing the duties of both the RCC and ED/Adm positions. 3. Review of Resident #4's current FL-2 dated 04/02/19 revealed: -Diagnoses included Alzheimer's dementia, seizure disorder, type II diabetes mellitus and right cerebral hematoma. -There was documentation Resident #4 was constantly disoriented, non-ambulatory, incontinent of bowel and bladder and required total care. a. Review of a primary care provider (PCP) visit note dated 07/23/19 for Resident #4 revealed there was an order for home health (HH) to evaluate and treat.	D 273		

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Review of Resident #4's current care plan dated 06/10/19 revealed:
-Resident #4 required total assistance from staff with all activities of daily living (ADLs).
-Resident #4 was incontinent of bowel and bladder and ambulatory with a geriatric chair and staff assistance.
-Resident #4 required a hydraulic lift for transfers to and from his bed.
-There was no documentation of pressure ulcer prevention or any active wounds with wound care for Resident #4.

Observations on 08/07/19 at 3:59pm revealed:
-There was a large bandage marked "7/23 6am" on Resident #4's left outer ankle.
-There was a large unmarked bandage on Resident #4's right elbow.
-There was an aged large bandage on Resident #4's mid left back; the bandage was wrinkled, rolled at the bottom edge and had an accumulation of lint on the rolled edge.
-There was a cling compression wrap on Resident #4's right foot.

Observations of Resident #4's right foot on 08/08/19 at 9:11am revealed:
-There was slight swelling of and redness around each wound area.
-There was a dime sized dried open blister on the top of the foot.
-There was a dime sized scabbed area on the outer ankle.
-There was a silver dollar sized area of black and dark red decolorization on the heel.
-There was pink and yellow drainage from the heal when the PCP patted the area with gauze.
-There was a quarter sized thick black, brown area on the outer lateral aspect of the foot.
-There was a nickel sized thick black, brown area

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D 273	Continued From page 52 on the outer lateral aspect of the foot near the pinky toe. Observation of Resident #4's back on 08/08/19 at 11:06am revealed: -There was a quarter sized dark brown spot on the bandage removed from the resident's left mid back. -The area of the bandage with the brown spot stuck to the wound when removed. -There was a nickel sized red and raw area at the mid left back. Telephone interview with Resident #4's Power of Attorney (POA) on 08/09/19 at 1:05pm revealed: -Resident #4 had a bad wound on his (right) heel and had wound care nurses coming into the facility to take care of the wound. -Resident #4's PCP had said she was referring Resident #4 for wound care a couple of weeks ago (07/26/19). Interview with Resident #4's PCP on 08/08/19 at 9:12am revealed: -She was seeing Resident #4 every week for wound care. -She had referred Resident #4 for HH services but he was not picked up due to insurance issues, so she did the dressing changes every week. -She wrote wound care orders for the staff. Review of a PCP visit note dated 08/01/19 for Resident #4 revealed there was documentation for Resident #4 to continue HH services. Second interview with the MA on 08/09/19 at 3:48pm revealed: -HH came once a week to change Resident #4's dressing on his right foot.	D 273		

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-She had just changed the dressing on Resident #4's right foot.
-It was the "wound care lady" that did the dressing changes every week and checked to see that staff were doing the dressing right.
-She did not know the name of the "wound care lady" and was not sure when the "wound care lady" was coming to the facility again.
-MAs changed the dressing on Resident #4's right foot three times a day.
-The MAs called the Resident Care Coordinator (RCC) or the Administrator whenever there were hospital discharge orders and referrals.
-Then the RCC or the Administrator told the MA what to do.
-The orders were faxed to the pharmacy or PCP office once the RCC or Administrator said the MA could.
-The RCC or Administrator "must okay first and know what was going on."

Second telephone interview with Resident #4's PCP on 08/12/19 at 9:01am revealed:
-"Ultimately" the Administrator did tell her there were issues with getting HH for wound care for Resident #4 so she wrote wound care orders for staff.
-It could have been on 08/08/19 when the Administrator notified her, they were unable to get HH services for Resident #4.

Interview with the Administrator on 08/12/19 at 4:35pm revealed:
-She sent the HH referral to one agency that was unable to provide wound care services due to Resident #4's insurance.
-She then sent the HH referral to a second agency that was also unable to provide wound care services for Resident #4.
-She then sent the HH referral to a third agency

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and was waiting to hear back.
-She would have to check her notes for dates and times the referral was sent to each agency.

Telephone interview with the first HH agency representative on 08/13/19 at 11:23am revealed:
-The agency received a referral on 07/24/19 for wound care for Resident #4.
-The agency was not able to accept the referral due to insurance.
-The agency referred the Administrator to the second HH agency for Resident #4 on 07/24/19.

Telephone interview with the second HH agency representative on 08/13/19 at 11:25am revealed:
-The agency received a referral for wound care services for Resident #4 on 07/30/19.
-The agency was unable to accept the referral because they were out of network with Resident #4's insurance.
-She would have to check when the facility was made aware.

Telephone interview with the third HH agency representative on 08/13/19 at 11:28am revealed:
-The agency received a referral for wound care services for Resident #4 on 08/12/19.
-A HH nurse was scheduled to see Resident #4 at the facility on 08/14/19.

Interview with the Administrator on 08/13/19 at 3:22pm revealed:
-The HH referral should have been sent to the first agency on 07/23/19.
-She was notified on 07/24/19 by the first HH agency; the first HH agency told her they were forwarding the referral to second HH agency.
-She was "in conversation" with a representative from the second HH agency to follow up and was expecting the second agency to send a HH nurse

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on 07/27/19 to evaluate Resident #4.
-She did not know of the second HH agency contacting facility on 07/24/19.
-She knew the second HH agency was not going to accept the referral for Resident #4 "sometime at the beginning of the month (August 2019)."
-She talked to Resident #4's PCP about the HH referral issues the first or second week of August 2019.
-She contacted the third HH agency on 08/12/19 because she had to get a new referral order which she received 08/12/19.
-She did not have documentation of her follow up efforts, including dates and when the PCP was notified, for the HH referral for Resident #4.

Interview with the Administrator on 08/14/19 at 10:42am revealed:
-The new HH referral order was written on 08/08/19 because of the type of dressing the PCP ordered.
-Staff were not able to do an antimicrobial/hydrocolloid dressing; she did not know staff were not doing any dressing changes.
-Staff have been doing dressing changes daily according to the previous order; staff wash Resident #4's right foot, apply ointment and cover with gauze.

Interview with the Home Health Nurse (HHN) on 08/14/19 at 1:05pm revealed:
-Resident #4 was seen for an initial evaluation, wound assessment and measurement and to obtain wound care orders on 08/14/19.
-Resident #4 had a stage II pressure ulcer on his sacral/coccyx area which measured 6.8cm by 3.4cm.
-Resident #4 had a stage II pressure ulcer on his right heel which measured 4cm by 6.7cm with slight bleeding from the wound.

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D 273	Continued From page 56 -Resident #4 had scabbed dead tissue on his right lateral upper foot measuring 1.3cm by 1 cm, on his right mid lateral foot measuring 2.5cm by 2.5cm, on his right lateral ankle measuring 1cm by 0.3cm, on his left lateral ankle measuring 1cm by 0.5cm and on his right elbow measuring 1cm by 1cm. -The redness on Resident #4's right foot seemed to be from pressure. The Resident Care Coordinator (RCC) was not available for interview 08/07/19 through 08/15/19. Attempted interview with Resident #4's PCP on 08/15/19 at 10:24am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. b. Review of emergency room (ER) discharge instructions for Resident #4 dated 06/18/19 revealed there was documentation to follow up with a neurologist within one week 06/25/19. Review of a primary care provider (PCP) order dated 08/08/19 for Resident #4 revealed there was an order to discontinue the neurology follow up. Telephone interview with Resident #4's Power of Attorney (POA) on 08/09/19 at 1:05pm revealed: -She was not aware of a neurology referral from the emergency room on 06/18/19. -Resident #4 had been back and forth to the hospital a several times for seizures; twice in September/October 2017 and in June 2019. Telephone interview with Resident #4's PCP on 08/12/19 at 9:01am revealed:	D 273		

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D 273	Continued From page 57 -She did not remember if she was aware of the neurology referral. -She thought the family did not want Resident #4 to go for the neurology appointment. -She did not know exactly when or who notified her of the neurology appointment. Interview with the Administrator on 08/12/19 at 4:35pm revealed: -Resident #4's PCP got copies of the ER discharge instructions. -She would have to find out from the transportation staff if a neurology appointment was scheduled for Resident #4. -Normally when a resident returned from the hospital, the Resident Care Coordinator (RCC) reviewed the discharge paperwork. -The RCC let the transportation staff know, verbally and with a copy of the order, if there were any referral appointments to be scheduled. Interview with the transportation staff on 08/12/19 at 4:47pm revealed: -She did not schedule a neurology appointment because she did not get the referral for Resident #4. -Normally, if she picked the resident up from the hospital or physician's office, she was able to see the paperwork. -Resident #4 must have returned to the facility by ambulance and the medication aide (MA) would have gotten the paperwork. -The MA would have given the paperwork to the RCC and the RCC would have given the referral order to her. -She would not have been able to take Resident #4 to a neurology appointment because the resident was in a geriatric chair. -She would have been responsible for scheduling the appointment and contacting the POA to	D 273		

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arrange medical transport.

Interview with the Administrator on 08/13/19 at 3:22pm revealed:
-She was not aware of the neurology referral order on the ER discharge instructions dated 06/18/19 for Resident #4.
-The RCC would have handled the referral for Resident #4.
-She became aware of the neurology referral on 08/07/19.

The Resident Care Coordinator (RCC) was not available for interview 08/07/19 through 08/15/19.

4. Review of Resident #18's current FL-2 dated 07/11/19 revealed:
-Diagnoses included Alzheimer's dementia, multiple sclerosis and chronic pain.
-There was documentation Resident #4 required assistance with bathing and dressing and set up for feeding.

Review of Resident #18's current care plan dated 07/09/19 revealed:
-There was documentation Resident #18 was totally dependent on staff for all activities of daily living (ADL).
-Resident #18 was ambulatory in a geriatric chair with staff assistance.
-Resident #18 needed encouragement at meal times occasionally.
-Resident #18's right hand was contracted.
-Resident #18 was incontinent of bowel and bladder.

Review of Resident #18's monthly weight results revealed:
-On 04/26/19, Resident #18 weighed 135 pounds.
-On 05/25/19, Resident #18 weighed 131.2

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pounds.
-On 06/25/19, Resident #18 weighed 128.4 pounds.
-On 07/30/19, Resident #18 weighed 122 pounds.
-There was no documentation Resident #18's primary care provider (PCP) was notified.
-There was documentation Resident #18's geriatric chair weighed 81.6 pounds.

Observation on 08/14/19 at 9:46am revealed Resident #18 weighed 198.6 pounds while sitting in her geriatric chair (equaling total weight of 117 pounds).

Review of progress notes for Resident #18 revealed there were no entries after 06/16/19.

Review of Fax Notifications for Resident #18 revealed there was no documentation of notification to the PCP about Resident #18's weight loss.

Telephone interview with Resident #18's Power of Attorney (POA) on 08/15/19 at 11:59am revealed:
-She lived out of state and was not able to visit frequently.
-She last saw Resident #18 on Easter; the resident "looked good" and there were no weight loss concerns.
-Resident #18 weighing 117 pounds was a "huge" concern even being on hospice.
-She did not know Resident #18 had lost weight, but the staff may have told a family member that visited daily.

Telephone interview with Resident #18's family member on 08/15/19 at 12:39pm revealed:
-Up until the weekend before last (08/03/19), Resident #18 had been doing good.
-Resident #18 was home with the family member

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that weekend, and she did not eat all her breakfast, none of her lunch and barely ate dinner.
-He asked the staff that following Monday (08/05/19) how Resident #18 had been eating.
-The staff said Resident #18 had not been eating well; he did not remember the staff's name.
-He knew Resident #18 "definitely" lost weight because he picked her up to get her in and out of the car and she was much lighter.

Interview with a medication aide (MA) on 08/14/19 at 9:20am revealed:
-Resident #18 had some weight loss.
-She did not miss any meals and ate well, but she did go home with a family member a few days at a time.

Interview with a second MA on 08/14/19 at 9:42am revealed:
-First shift PCAs and MAs weighed residents each month around the 18th of the month; if there were any weights not done by first shift then second shift finished the weights.
-All resident weight results were given to the Resident Care Coordinator (RCC) or the Administrator.

Interview with a third MA on 08/15/19 at 12:55pm revealed:
-MAs documented any weight loss on a fax notification form and faxed it to the PCP.
-MAs filed the fax notification form in the resident's record.

Telephone interview with Resident #18's Hospice Nurse (HN) on 08/15/19 at 1:30pm revealed:
-Resident #18 had a drastic decline over the past month, Resident #18 was no longer able to feed herself.

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-She had not been told of Resident #18's weight loss from 128.4 pounds on 06/25/19 to 122 pounds 07/30/19 to 117 pounds on 08/14/19.
-She did have Resident #18's May and June 2019 weights, but not July 2019.
-The facility's contracted PCP was Resident #18's PCP, Hospice was supplemental.

Interview with Resident #18's PCP on 08/15/19 at 10:44am revealed:
-She may have been aware of Resident #18's weight loss on 07/30/19.
-She signed off on residents' weights when she was at the facility.
-She was not aware Resident #18 weighed 117 pounds on 08/14/19.
-A five pound weight loss would not be alarming but 10 pounds would be concerning.

Interview with the Administrator on 08/15/19 at 1:00pm revealed:
-The RCC was responsible for reviewing resident monthly weights for any needed re-weighs and assuring weight loss had been reported to the PCP.
-She had not had a chance to review residents' weights while covering for the RCC.

Interview with the Administrator on 08/15/19 at 4:45pm revealed she was not able to find documentation the PCP was notified of Resident #18's weight loss.

5. Review of Resident #10's current FL-2 dated 07/02/19 revealed:
-Diagnoses included dementia/Alzheimer's, Type II diabetes without complications, hypertension and disorder of lipoprotein metabolism.
-Resident #10 was constantly disoriented.
-Resident #10 was to wear the orthopedic boot at

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D 273	Continued From page 62 all times except when showering. Observation of Resident #10's room on 08/07/19 at 10:24am revealed there was an orthopedic boot at the foot of the bed. Review of Resident #10's care plan dated 07/03/19 revealed the resident could ambulate when she had her orthopedic boot on. Review of Resident #10's facility progress notes dated 06/06/19 revealed: -Resident #10 complained of pain to left ankle whenever it was touched by staff. -Resident #10 had an order to have her left ankle x-rayed. -Resident #10 was ordered to take Tylenol 325mg 2 tablets as needed for pain every six hours. Review of Resident #10's facility progress notes dated 06/07/19 revealed: -Resident was sent to the local emergency department (ED). -Resident #10 was diagnosed with a fracture of the bottom of the left shin bone. -Resident #10 was given an orthopedic boot to wear when awake. -Resident #10 was to follow up with orthopedic surgery (no date specified). Observation on 08/13/19 at 9:43am revealed Resident #10 did not have on the orthopedic boot. Interview with medication aide (MA) on 08/13/19 at 10:06am and at 11:06am revealed: -She was not sure if Resident #10 should be wearing the orthopedic boot. -The MA reviewed Resident #10's FL-2 it revealed the orthopedic "boot should be on at all times except for showering".	D 273		

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D 273	Continued From page 63 -She would have the personal care aide (PCA) to put the orthopedic boot on Resident #10. Based on observations, interviews and record reviews, it was determined Resident #10 was not interviewable. Telephone interview with Resident # 10's family member/legal guardian on 08/13/18 at 10:21am revealed: -She visits Resident #10 at least five times a week. -Sometime around the first of June 2019 Resident #10 was had trouble putting weight on the left foot, therefore it was x-rayed and she had a "fractured left ankle". -When Resident #10 first got the orthopedic boot "she had to only wear it for a certain amount of days, but the facility kept it in case she had problems walking on the left side". -She was unsure if Resident #10 had any follow up appointments with the orthopedic doctor. -The facility made the appointments for Resident #10. Interview with a PCA on 08/13/19 at 10:53am revealed the PCA was not sure if Resident #10 was supposed to wear the orthopedic boot. Interview with a second PCA on 08/13/19 at 10:55am revealed: -She thought Resident #10's left ankle had healed, but she was not sure. -Resident #10 had not worn the orthopedic boot the past couple of weeks. -Resident #10 used a wheelchair to ambulate at times. -The MA went to find out if Resident #10 needed to wear the orthopedic boot.	D 273		

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D 273	Continued From page 64 Interview with the Resident #10's Hospice nurse on 08/13/19 at 12:10am revealed: -Resident #10 was admitted to Hospice services on 06/11/19. -Resident #10 had the fractured ankle when she was admitted to Hospice services. -She had not written the order for Resident #10 to wear the orthopedic boot. -The Hospice nurse had visited with Resident #10 yesterday [08/12/19], and asked several PCAs "if an order had been written to discontinue the orthopedic boot". -The PCA or MA could not tell her if Resident #10 had an order to discontinue wearing the orthopedic boot. -The PCA informed Resident #10's hospice nurse that the resident had walked fine and did not need to wear the orthopedic boot. -The Executive Director (ED) or the Regional Director of Clinical services (RDCS) could not tell her if Resident #10's orders had changed. Observation of Resident #10 on 08/13/19 at 12:36pm revealed: -Resident #10 had the orthopedic boot on. -Resident #10 ambulated down the hallway. Interview with the facility transporter and appointment scheduler on 08/13/19 at 12:58pm revealed: -She had called the orthopedic office to verify Resident #10's follow-up appointment for July 18, 2019. -She informed the orthopedic nurse that Resident #10 was admitted to Hospice services. -The orthopedic office informed the facility transporter that since Resident #10 was on Hospice services they would not need to see the resident.	D 273		

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D 273	Continued From page 65	D 273		

Telephone interview with the appointment scheduler at Resident #10's orthopedic doctor's office on 08/13/19 at 2:47pm revealed:
-Resident #10 was seen in the office on June 20, 2019.
-Resident #10 had a follow-up appointment scheduled for July 18, 2019.
-The follow-up appointment for Resident #10 was canceled.
-She did not know who had canceled the appointment for Resident #10, she assumed it was the facility or the resident.
-The follow-up scheduled for July 18,2019 would have determined if Resident #10 needed to continue wearing the orthopedic boot.

Review of Resident #10's physician visit form dated 07/18/19 revealed:
-Resident #10 displayed discomfort with the left ankle.
-Resident #10 was ordered to take Tylenol 325mg two tablets by mouth three times a day.

Attempted telephone interview with Resident #10's orthopedic doctor on 08/13/19 at 3:00pm was unsuccessful.

Telephone interview with the nurse at Resident #10's orthopedic doctor's office on 08/13/19 at 3:03pm revealed:
-The facility had called and informed them Resident #10 was admitted to Hospice services.
-When the orthopedic doctor heard Resident #10 had been admitted to Hospice services, he assumed she was actively dying and that was why he did not need to see her.
-The facility did not explain to her that Resident #10 was not actively dying.

Observation of Resident #10 on 08/15/19 at

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D 273	Continued From page 66 9:09am revealed Resident #10 did not have on the orthopedic boot on. Interview with a third PCA on 08/15/19 at 10:00am revealed: -Resident #10 should have the orthopedic boot on. -There had not been an order written for Resident #10 to discontinue wearing the orthopedic boot. -She would put the orthopedic boot in Resident #10. Second interview with the facility transporter and appointment scheduler on 08/15/19 at 10:23am revealed: -She called Resident #10's orthopedic doctor and tried to get an order to discontinue wearing the orthopedic boot. -She was informed they could not write an order to discontinue the order until Resident #10 was seen in the office. -She would talk with the ED before she scheduled the appointment for Resident #10. _____ The facility failed to follow up and make referrals on the health care needs of 4 of 7 sampled residents (#3, #4, #10 and #18). The facility's failure resulted in pain and difficulty walking for 3 weeks due to an ingrown toenail not evaluated and treated by podiatry for Resident #3; no home health services for 3 weeks for wound care of multiple stage II pressure ulcers for Resident #4; and significant weight loss for Resident #18. The facility's failure to follow up and make referrals was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/09/19 for this violation.	D 273		

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D 273	Continued From page 67 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 29, 2019.	D 273		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial	D 278		

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D 278	Continued From page 68 ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of	D 278		

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D 278	Continued From page 69 practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure a licensed health professional provided an onsite evaluation of the health status for 1 of 5 sampled residents (#4) who developed pressure ulcers requiring wound care by facility staff which was not identified on the care plan and staff competency was not validated. The findings are: Review of Resident #4's current FL-2 dated 04/02/19 revealed: -Diagnoses included Alzheimer's dementia, seizure disorder, type II diabetes mellitus and right cerebral hematoma. -Resident #4 was constantly disoriented, non-ambulatory, incontinent of bowel and bladder and required total care. Review of Resident #4's current care plan dated 06/10/19 revealed: -Resident #4 required total assistance from staff with all activities of daily living (ADLs). -Resident #4 was incontinent of bowel and bladder and ambulatory with a geriatric chair and staff assistance. -Resident #4 required a hydraulic lift for transfers to and from his bed. -There was no documentation of pressure ulcer prevention or any active wounds with wound care for Resident #4.	D 278		

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D 278	Continued From page 70 Review of a progress notes dated 06/13/19 through 08/03/19 for Resident #4 revealed: -On 06/13/19 at 1:00pm, staff documented there were new wound care orders for a "spot" on the resident's right foot. -On 07/20/19 at 1:20pm, staff documented the was an open blister on the resident's right ankle. -On 07/21/19 at 2:15pm, staff documented there were new wound care orders for the resident's right heel. -On 07/22/19 at 10:40am, staff documented there was a blister on the side of the resident's right foot, a pressure point on the left ankle and the left foot was red and blistered on the side. -On 08/03/19 at 2:10pm, there were two spots on the top of the resident's right foot with blisters on the side. Review of a primary care provider (PCP) order dated 06/13/19 for Resident #4 revealed there was an order to apply triple antibiotic ointment to right ankle daily and keep covered for 7 days. Review of a PCP order dated 07/23/19 for Resident #4 revealed there was an order to apply triple antibiotic ointment, cover with a 4 inch by 4 inch gauze and wrap right heel for 7 days. Review of a PCP order dated 08/08/19 for Resident #4 revealed there was an order to continue wound care as ordered and heel protectors to both heels. Interview with the Home Health Nurse (HHN) on 08/14/19 at 1:05pm revealed: -Resident #4 was seen for an initial evaluation, wound assessment and measurement and to obtain wound care orders on 08/14/19. -Resident #4 had a stage II pressure ulcer on his	D 278		

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D 278	Continued From page 71	D 278		

sacral/coccyx area which measured 6.8cm by 3.4cm.
-Resident #4 had a stage II pressure ulcer on his right heel which measured 4cm by 6.7cm with slight bleeding from the wound.
-Resident #4 had scabbed eschar on his right lateral upper foot measuring 1.3cm by 1 cm, on his right mid lateral foot measuring 2.5cm by 2.5cm, on his right lateral ankle measuring 1cm by 0.3cm, on his left lateral ankle measuring 1cm by 0.5cm and on his right elbow measuring 1cm by 1cm.
-Resident #4 had a reddened, inflamed rash on his genitals and groin.
-The redness on Resident #4's right foot seemed to be from pressure.

Review of the licensed health professional support (LHPS) evaluation dated 06/07/19 for Resident #4 revealed:
-There was documentation the skin assessment was within normal limits.
-There was no documentation of staff competency validation for dressing changes or wound care.

Interview with the LHPS Registered Nurse (RN) on 08/09/19 at 11:50am revealed she had just started doing LHPS assessments at the facility within the last couple of days; she had not seen Resident #4 yet.

Interview with the Regional Director on 08/09/19 at 12:13pm revealed:
-The former LHPS RN was not available for contact.
-The former LHPS RN was last in the facility on 06/11/19.
-She did not know if the former LHPS RN was aware of Resident #4's wounds.

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D 278	Continued From page 72 -She did not know if any teaching had been done with staff on caring for Resident #4's wounds. Interview with the Administrator on 08/13/19 at 3:22pm revealed: -The LHPS RN was new to the facility. -There was no LHPS assessment and evaluation done for Resident #4's wounds. -There was no wound care competency validation done for staff. -There was no guidance and support from a LHPS nurse related to obtaining home health services for wound care. -She did not know an LHPS assessment was not done for Resident #4's wounds prior to 08/07/19. -The Resident Care Coordinator (RCC) usually notified the LHPS RN of any new LHPS tasks when the LHPS RN was at the facility. -The RCC followed up on LHPS assessments, evaluations and recommendations; she was now following up due to the RCC being out of work. -She did not know a resident assessment should be completed within 10 days of a change in condition such as a new pressure ulcer. Based on interviews, the Resident Care Coordinator (RCC) was not available for interview 08/07/19 through 08/15/19.	D 278		
D 311	10A NCAC 13F .0904(f)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (1) Sufficient staff shall be available for individual feeding assistance as needed. This Rule is not met as evidenced by:	D 311		

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Based on observations, interviews and record reviews, the facility failed to assure there was sufficient staff available to provide feeding assistance for 5 of 7 sampled residents (#2, #5, #12, #16 and #18) resulting in lack of prompting to eat meals(#2 and #5); delayed assistance with eating meals while sitting in the dining room with other residents eating the meal (#18); and residents with a diagnosis of dementia who slept late or wandered during meals were assisted with eating (#12 and #16).

The findings are:

Interview with a personal care aide (PCA) on 08/08/19 at 8:24am revealed:
-It was usually "rush, rush" in the mornings with getting all residents up and to the dining room for breakfast.
-Residents who needed assistance with eating were grouped together at the ends of table.
-PCAs would rotate between residents to provide assistance with eating.
-When the AD was on the locked hall, she would help the PCAs assist residents with eating.
-Some of the residents were late sleepers and were not at the breakfast meal including Resident #12, Resident #16 and three other residents.

Interview with a second PCA on 08/13/19 at 9:12am revealed:
-There were eight residents who needed to be fed on the locked hall.
-The RCC and the Administrator knew there were not enough staff to feed all the residents.

Telephone interview with a former staff on 08/13/19 at 7:32pm revealed:
-Sometimes there were not enough PCAs to assist residents with meals on the assisted living

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D 311	Continued From page 74 (AL) side. -There were two residents on the AL side who ate their meals in their rooms and the staff assisted those residents after the dining room meal. -There were six residents on the AL side who needed assistance with eating their meal. Interview with a third PCA on 08/09/19 at 4:35pm revealed: -There were eight residents that needed to be fed on the locked hall. -Sometimes Resident #18's family member came to feed the resident. -The MA would step in and help with feeding residents their dinner. -Each of the three staff on duty would sit between two residents and feed them; there would still be two residents who had to wait to eat until staff was done feeding the other residents. 1. Review of Resident #18's current FL-2 dated 07/11/19 revealed: -Diagnoses included Alzheimer's dementia, multiple sclerosis and chronic pain. -Resident #4 required assistance with set up for feeding. Review of Resident #18's current care plan dated 07/09/19 revealed: -Resident #18 was totally dependent on staff for all activities of daily living (ADL). -Resident #18 was ambulatory in a geriatric chair with staff assistance. -Resident #18 needed encouragement at meal times occasionally. -Resident #18's right hand was contracted. Interview with kitchen staff on 08/08/19 at 11:03am revealed breakfast was served at 8:00am on the locked hall.	D 311		

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D 311	Continued From page 75 Observations of the breakfast meal on 08/09/19 from 8:33am until 8:45am revealed: -Resident #18 was sitting in her geriatric chair at the breakfast table across from a personal care aide (PCA) feeding the female resident. -The PCA stopped feeding the female resident and retrieved Resident #18's plate from the kitchen. -At 8:34am, the PCA began feeding Resident #18. Interview with Resident #18 on 08/09/19 at 4:38pm revealed: -Staff left her in her bed for a long time; she was "wet a lot and felt sore on her bottom." -Staff were, "just were not here." -She often had to wait to eat while sitting in the dining room, but the staff would warm up her plate, so it was warm when she ate it. Interview with a PCA on 08/07/19 at 10:44am revealed: -Resident #18 required a hydraulic lift for transfers in and out of bed; the hydraulic lift required two staff for safety. -Two staff were needed to get Resident #18 out of bed for breakfast, back in bed after breakfast and out of bed for lunch; it took time to get the resident in and out of bed. -The PCA assigned to Resident #18 had to go and get help and "help was not always readily available." Refer to interview with the Administrator on 08/08/19 at 12:26pm. Refer to interview with the Administrator on 08/13/19 at 3:22pm.	D 311		

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D 311	Continued From page 76 2. Review of Resident #12's current FL-2 dated 05/20/19 revealed: -Diagnoses included Alzheimer's dementia, vascular dementia, essential hypertension, type II diabetes mellitus, chronic obstructive pulmonary disease, hypothyroidism, malignant neoplasm of the prostate and hyperlipidemia. -Resident #12 was constantly disoriented, ambulatory and wandered. -Resident #12 needed assistance with feeding. Review of Resident #12's current care plan dated 05/24/19 revealed: -Resident #12 was ambulatory and needed moderate assistance with activities of daily living (ADLs). -Resident #12 was not an "early riser" and needed cueing and encouragement to get up in the morning. -Resident #12 liked to sleep until close to lunch time and liked a gentle approach especially in the morning. -Resident #12 was sometimes disoriented, forgetful and needed reminders. Observations on 08/07/19 from 9:38am until 11:17am revealed: -At 9:49am, Resident #12 was sleeping in his bed. -At 10:35am, the medication aide responded to a call light in the resident's room. -At 10:38am, a personal care aide (PCA) and a medication aide (MA) emerged from Resident #12's room with the resident. -At 10:44am, the PCA got a glass of water, glass of cranberry juice and a package of peanut butter crackers for Resident #12. Interview with a PCA on 08/07/19 at 10:44am revealed:	D 311		

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-She had to wake Resident #12 because he was normally a late sleeper.
-There were three residents that she knew of that slept late in the morning.

Observations of the breakfast meal on 08/08/19 from 8:24am until 8:54am revealed Resident #12 was not in the dining room.

Observation on 08/08/19 at 11:06am revealed:
-Resident #12 was escorted from his room to the common area by a PCA.
-Resident #12 had just gotten up and dressed for the day.
-The PCA went back down the hall and assisted another resident.
-Resident #12 followed the PCA.
-Resident #12 was not offered breakfast.

Observations of the breakfast meal on 08/09/19 from 8:33am until 8:45am revealed:
-Resident #12 was not in the dining room.
-At 8:43am, Resident #12 was sleeping in his bed.

Interview with a second PCA on 08/14/19 at 9:35am revealed:
-Resident #12 would try to fight staff if they tried to wake him up in the morning so staff would just let him sleep until he woke up.
-Once Resident #12 woke up, the PCA would fix him a peanut butter and jelly sandwich to hold him over until lunch.

Interview with a MA on 08/08/19 at 10:41am revealed:
-The kitchen saved a plate for any resident who slept late and was not at the breakfast meal.
-She did not know why there was no breakfast plate for Resident #12 on 08/07/19.

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D 311	Continued From page 78 -Resident #12 usually slept until lunch time. Interview with a second MA on 08/14/19 at 9:20am revealed: -When she worked, she would have the PCAs get Resident #12 up as soon as they finished the breakfast meal. -She needed to have all the residents up by 10:00am so she could finish the medication pass. -She would ask the kitchen manager to hold a plate for Resident #12. Interview with kitchen staff on 08/08/19 at 11:03am revealed: -Breakfast was served at 8:00am on the locked hall. -If residents were not in the dining room by 9:30am for breakfast, their plates were thrown out. -If it was after 9:30am, the resident was served a snack such as yogurt, peanut butter crackers, or whatever was available. -The residents would also be served juice, water or coffee. Based on observations, interviews and record reviews, it was determined Resident #12 was not interviewable. Refer to interview with the Administrator on 08/08/19 at 12:26pm. Refer to interview with the Administrator on 08/13/19 at 3:22pm. 3. Review of Resident #16's current FL-2 dated 04/02/19 revealed: -Resident #16 diagnoses to include Alzheimer's Disease, hypertension, anxiety disorder, type II diabetes mellitus, benign prostrate hypertrophy,	D 311		

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late affect stroke.
-Resident #16 was constantly disoriented.
-Resident 16 was ambulatory and wanderered.

Interview with a medication aide (MA) on 08/08/19 at 10:41am revealed:
-She worked as a personal care aide (PCA) on 08/07/19.
-The kitchen staff saved a plate for any resident who slept late and was not at the breakfast meal.
-She did not know why there was no breakfast plate for Resident #16 on 08/07/19.
-Resident #16 was irritable on 08/07/19 and when he was like that, staff had to let him walk around because he was not going to sit down and eat.

Observations of the breakfast meal on 08/08/19 from 8:24am until 8:54am revealed Resident #16 was not in the dining room.

Observations of the breakfast meal on 08/09/19 from 8:33am until 8:45am revealed:
-Resident #16 were not in the dining room.
-At 8:43am, Resident #16 was sleeping in his bed.

Observations on 08/15/19 from 12:23pm until 12:35pm revealed:
-Resident #16 was walking through the dining room and stopped at a table where there were half eaten plates and no residents.
-Resident #16 picked up a meatball from one of the plates and ate it.
-A PCA, dietary aide and a housekeeper were removing dishes and linens from tables.
-Resident #16 was attempting to pick up more food and drink water from one of the cups when the Activity Director (AD) redirected the resident and covered the plates with the table linens.
-A second PCA was assisting a resident with

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eating the lunch meal and a third PCA was assisting a second resident with eating.
-The AD got a bowl of food from the kitchen and assisted Resident #16 with eating while walking around the dining room.
-The AD got a cup of water for Resident #16 and he drank the entire glass without stopping.

Interview with kitchen staff on 08/08/19 at 11:03am revealed:
-Breakfast was served at 8:00am on the locked hall.
-If residents were not in the dining room by 9:30am for breakfast, their plates were thrown out.
-If it was after 9:30am, the resident was served a snack such as yogurt, peanut butter crackers, or whatever was available.
-The residents would also be served juice, water or coffee.

Refer to interview with the Administrator on 08/08/19 at 12:26pm.

Refer to interview with the Administrator on 08/13/19 at 3:22pm.

4. Review of Resident #5's current FL-2 dated 01/29/19 revealed:
-Diagnoses included dementia, Type II diabetes, benign hypertension, chronic interstitial cystitis, and chronic systolic congestive heart failure.
-Resident #5 was intermittently disorientated and ambulatory.

Review of Resident #5's care plan dated 02/04/19 revealed:
-Resident #5 resided on the locked assisted living side of the facility.
-Resident #5 was independent with eating.

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D 311	Continued From page 81 Interview with a personal care aide (PCA) on 08/13/19 at 9:12am revealed Resident #5 sometimes needed to be coached with meals; she could not always see the plate and did not have her eye glasses. Observations of the breakfast meal on 08/08/19 from 8:24am until 8:54am revealed: -At 8:30am, Resident #5 was sitting at the table staring at her plate and not eating. -At 8:35am, the Activity Director (AD) brought a second serving of toast to Resident #5. -At 8:47am, Resident #5 left the dining room, she did not receive any prompting or assistance with the breakfast meal. -Resident #5 did not eat the eggs and grits served; she only ate toast and drank 100% of water, milk and cranberry juice. Refer to interview with the Administrator on 08/08/19 at 12:26pm. Refer to interview with the Administrator on 08/13/19 at 3:22pm. 4. Review of Resident #2's FL-2 dated 12/04/18 revealed: -Diagnoses included Parkinson's disease, dementia, hypertension, hyperlipidemia and constipation. -Resident #2 needed feeding assistance by cueing during meals. Observation of the breakfast meal in the assisted living dining room on 08/07/19 between 8:30am to 9:10am revealed: -There were no personal care aides (PCA) nor any other facility staff sitting at the table with Resident #2.	D 311		

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-There were three facility staff assisting three other residents at an adjoining table.
-At 8:30am, Resident #2 had her food on a fork up to her mouth; she did not eat the food and placed the fork back onto her plate.
-At 8:31 am, Resident #2 was reaching for her beverages at the table but was not successful picking up the beverage.
-At 8:34 am, Resident #2 was holding her food with a fork up to her mouth but did not eat; she was cued by a dining staff to eat; Resident #2 then placed the food in her mouth.
-At 8:37am, Resident #2 had her food on a fork up to her mouth; she did not eat the food and placed the fork back onto her plate.
-At 8:40am, Resident #2 had her food on a fork up to her mouth; she did not eat the food and placed the fork back onto her plate.
-At 8:47am, Resident #2 was holding her food with a fork up to her mouth but did not eat; the facility staff started to clear the tables in the dining room.
-At 8:49am, Resident #2 continued to hold her food to her mouth.
-At 8:50am, a resident was seated at the same table with Resident #2 and was provided feeding assistance by a PCA.
-At 8:53am, Resident #2 placed her food back into the plate and attempted to pick it up again with her fork.

Interview with a PCA on 08/07/19 at 9:00am revealed:
-There were two feeding assistance tables in the assisted living dining room.
-Resident #2 would often pick up her food and hold it up to her mouth; "she needed to be cued while eating."
-She offered feeding assistance to two other residents who needed total assistance during

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breakfast.

Interview with another PCA on 08/07/19 at 9:15am revealed:
-Resident #2 needed staff to cue her to start eating.
-"We would put our hand on her utensil, and she would start eating."
-"We assisted Resident #2 with feeding, if needed."

Interview with the Executive Director (ED) on 08/08/19 at 10:29am revealed:
-There were two feeding assistance tables in the assisted living dining room.
-There should be a PCA at each table offering feeding assistance in the assisted living dining room.
-The dietary staff should not be cueing residents in the dining room.
-The PCAs should be cueing residents to eat or offering feeding assistance.

Observation of the breakfast meal in the assisted living dining room on 08/09/19 between 8:40am to 9:30am revealed:
-There was not a PCA nor any other facility staff sitting at the table with Resident #2.
-Resident #2 was not offered cueing by staff.

Interview with a family member on 08/09/19 at 11:04am revealed:
-Resident #2 ate slow and had a good appetite.
-She had noticed Resident #2 was not eating due to dropping most of her food.
-She thought the facility staff offered feeding assistance when Resident #2 needed it.

Observation of the assisted living dining room on 08/09/19 between 12:23pm and 12:31pm

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D 311	Continued From page 84 revealed: -There were two feeding assistance tables. -There were seven residents at the feeding assistance tables. -There were two staff offering feeding assistance. Observation of Resident #2 in the assisted living dining room on 08/14/19 between 9:09 and 9:15am revealed: -There was not a PCA at the table with Resident #2. -There were 4 staff in the dining room (2 PCAs and 2 MAs). -The staff in the dining room were cleaning the dining room and removing dishes at the same table as Resident #2; the staff did not offer Resident #2 cueing. -The PCA removed Resident #2's plate without offering any cueing to finish her meal. Based on observations, interviews, and record reviews, it was determined Resident #2 was not able to interview. Refer to interview with the Administrator on 08/08/19 at 12:26pm. Refer to interview with the Administrator on 08/13/19 at 3:22pm. Interview with the Administrator on 08/08/19 at 12:26pm revealed all staff were expected to help during meal times to make sure there was enough staff to assist the residents. Interview with the Administrator on 08/13/19 at 3:22pm revealed: -The staffing pattern on the locked hall was two PCAs and one MA for 28 residents. -The staffing was changed from three PCAs to	D 311		

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D 311	Continued From page 85 two PCAs sometime in June 2019 due to a drop in the census. -Acuity of the residents was taken into consideration; there was a decline in some of the residents over the last few months. -There were about six residents who needed help with feeding. -There were four to five residents who had behavior issues.	D 311		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to abuse, neglect and treating residents with respect and dignity. The findings are: 1. Based on observation, interviews, and record review, the facility failed to assure 1 of 1 sampled resident (#11) was protected from abuse and injury which resulted in verbal abuse and bruising from another resident. [Refer to Tag 914 G.S.131D-21(4) Residents' Rights (Type A2 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure Resident #5	D 338		

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D 338	Continued From page 86 was treated with dignity and respect related to her bedroom door being kept locked by staff restricting access to the bathroom resulting in preventable episodes of incontinence [Refer to Tag 911 G.S.131D-21(1) Residents' Rights].	D 338		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure staff observed the resident taking the medications for 1 of 4 residents (#19) observed during the medication pass on 08/08/19. The findings are: Review of Resident #19's current FL-2 dated 04/02/19 revealed: - Diagnoses included seizure disorder, chronic obstructive pulmonary disease, coronary arterial disease with myocardial infarction, and hyperlipidemia.	D 366		

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D 366	Continued From page 87 -There was a medication order for diphenoxylate with atropine 2.5-0.25mg take one table four times a day as needed for diarrhea (Diphenoxylate with atropine is used to treat diarrhea). -There was a medication order for Vimpat 200mg one tablet twice a day (Vimpat is used to treat seizure disorder). -There was a medication order for Phenobarbital 30mg one tablet twice a day (Phenobarbital is used to treat seizure disorder). -There was a medication order for Clonazepam 1mg one tablet twice a day (Clonazepam is used to treat seizure disorder). -There was a medication order for Oxycodone-Acetaminophen 5-325mg one tablet every eight hours as needed for pain (Oxycodone-Acetaminophen is used to manage pain). -There was a medication order for Levothyroxine 75mcg take one tablet every morning (Levothyroxine is used to treat hypothyroidism). -There was a medication order for Baclofen 20mg take one daily (Baclofen is used to treat muscle spasms). -There was a medication order for Albuterol Sulfate 0.083% - 2.5mg/3ml nebulizer treatment inhale one ampule every four hours as needed for shortness of breath (Albuterol Sulfate is a medication used to treat shortness of breath). -There was a medication order for Thera-M 9mg-400mcg take one tablet daily (Thera-M is used as a dietary supplement). -There was a medication order for Eliquis 5mg take one tablet twice daily (Eliquis is used to reduce the risks of blood clots and stroke). -There was a medication order for Magnesium Oxide 400mg take one tablet once a day (Magnesium Oxide is used as a dietary supplement).	D 366		

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D 366	Continued From page 88 -There was a medication order for Plaquenil 200mg take one half tablet every morning (Plaquenil is used to treat arthritis). -There was a medication order for Lexapro 20mg take one tablet once daily (Lexapro is used to treat anxiety and depression). -There was a medication order for Prednisone 20mg one tablet once daily (Prednisone is used to treat respiratory inflammation). -There was a medication order for Keppra 750mg take two tablets twice daily (Keppra is used to treat seizure disorder). -There was a medication order for Acetaminophen 325mg take two tablets every six hours as needed for pain (Acetaminophen is a used to treat pain). -There was a medication order for Vitamin B-1 100mg take one tablet once daily (Vitamin B-1 is used as a dietary supplement). -Ventolin 90mcg inhale two puffs four times as needed for shortness of breath (Ventolin is used to treat shortness of breath. Observation of the morning medication pass on 08/08/19 from 8:20am to 8:40am revealed: -Diphenoxylate with atropine 2.5-0.25mg was prepared by the medication aide (MA) and placed in a medication cup for administration. -Phenobarbital 30mg was prepared by the MA and placed in a medication cup for administration. -Clonazepam 1mg was prepared by the MA and placed in a medication cup for administration. -Oxycodone-Acetaminophen 5-325mg was prepared by the MA and placed in a medication cup for administration. -Levothyroxine 75mcg was prepared by the MA and placed in a medication cup for administration. -Baclofen 20mg was prepared by the MA and placed in a medication cup for administration. -Thera-M 9mg-400mcg was prepared by the MA	D 366		

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and placed in a medication cup for administration.
-Eliquis 5mg was prepared by the MA and placed in a medication cup for administration.
-Magnesium Oxide was prepared by the MA and placed in a medication cup for administration.
-Plaquenil 200mg - one half tablet was prepared by the MA and placed in a medication cup for administration.
-Lexapro 20mg was prepared by the MA and placed in a medication cup for administration.
-Prednisone 20mg was prepared by the MA and placed in a medication cup for administration.
-Keppra 750mg - two tablets were prepared by the MA and placed in a medication cup for administration.
-Acetaminophen 325mg - two tablets were prepared by the MA and placed in a medication cup for administration.
-Vitamin B-1 100mg was prepared by the MA and placed in a medication cup for administration.
-Albuterol Sulfate 0.083% - 2.5mg/3ml - one ampule was removed by the MA for administration.
-The medications in the medication cup were handed to Resident #19 who was sitting upright on her bed and the MA placed the ampule of Albuterol Sulfate on top of Resident #19's nightstand next to her bed.
-Resident #19 poured the pills from the medication cup onto a napkin that was spread across her lap and requested her Ventolin inhaler from the MA at 8:25am.
-The MA left Resident #19 to return to the medication cart located in the hallway outside of Resident #19's room to get Resident #19's Ventolin inhaler and Resident #19 began to take the pills that were on the napkin.
-The MA returned to Resident #19's room and administered two puffs of the Ventolin inhaler to Resident #19 at 8:27am.

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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 366	Continued From page 90 -There were approximately twelve pills still on the napkin on Resident #19's lap and the ampule of Albuterol Sulfate on Resident #19's nightstand. -The MA did not watch Resident #19 take her the remaining medications and the MA did not administer the ampule of Albuterol Sulfate left on Resident #19's nightstand. -The MA did not return to ask Resident #19 if she had taken the medications or set-up the nebulizer to administer the Albuterol Sulfate. -The MA returned to the medication cart in the hallway and documented the medications had been administered at 8:29am. -The MA was prompted by the survey team staff to return to Resident #19's room to assure Resident #19 had taken medications left with the resident. -The MA returned to Resident #19's room at 8:30am and there were no pills remaining on the napkin on Resident #19's lap and the ampule of Albuterol Sulfate was still on the nightstand at bedside. -The MA put the ampule of Albuterol Sulfate in the Resident #19's nebulizer machine and administered it. Review of Resident #19's August 2019 medication administration record (MAR) on 08/08/19 at 8:29am revealed: -There was an entry for Vimpat 200mg, Phenobarbital 30mg, Clonazepam 1mg, and Eliquis 5mg take one tablet twice daily at 8:00am and 8:00pm and was documented as administered on 08/08/19 at 8:00am. -There was an entry for Thera-M 9mg-400mcg, Magnesium Oxide 400mg, Levothyroxine 75mcg, Baclofen 20mg, Lexapro 20mg, Prednisone 20mg, and Vitamin B-1 100mg take once daily at 8:00am and was documented as administered on 08/08/19 at 8:00am.	D 366		

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D 366	Continued From page 91 -There was an entry for Plaquenil 200mg take one half tablet once daily at 8:00am and documented as administered on 08/08/19 at 8:00am. -There was an entry for Keppra 750mg take two tablets twice daily at 8:00am and 8:00pm and it was documented as administered on 08/08/19 at 8:00am. -There was an entry for diphenoxylate with atropine 2.5-0.25mg one tablet four times a day ass needed for diarrhea; Albuterol Sulfate 0.083% - 1 ampule and Ventolin 90mcg - two puffs four times daily as needed for shortness of breath were documented as administered on 08/08/19. -There was an entry for Oxycodone-Acetaminophen 5-325mg one tablet every eight hours as needed for pain and it was documented as administered on 08/08/19. Interview with Resident #19 on 08/08/19 at 8:30am revealed: -She had taken the medications that were left on the napkin and she self-administered her Albuterol nebulizer once she got out of bed. -Staff usually left her medications with her because the staff trusted her, and she knew what medications to take. -She sometimes had problems swallowing pills and if staff had to wait to watch her take the medications "it could take a while". Interview with the MA on 08/08/19 at 8:32am revealed: -She did not normally watch Resident #19 take her medications and she left the nebulizer treatment for Resident #19 to do on her own. -She normally watched other residents take their medications, but she trusted Resident #19 to take her medications once she left the medications	D 366		

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D 366	Continued From page 92 with Resident #19. -She documented she administered Resident #19's medications on the MAR even though she did not witness Resident #19 actually take the medications. -She knew she was supposed to watch the residents take their medications before starting administration of another resident's medications. Interview with the Executive Director on 08/09/19 at 10:15am revealed: -She was responsible for monitoring the MAs. -She expected all medications to be administered by the MAs and the MAs should observe the residents while administering medications. -The MAs had been trained to watch the residents take their medications and document on the MARs after administration and before starting on another resident's medications. -No medications should be left with the residents at their bedside.	D 366		
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;	D 367		

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D 367	Continued From page 93 (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, interviews and record reviews, the facility failed to assure documentation on the medication administration records for 2 of 7 residents (#2 and #12) were accurate including a cholesterol lowering medication (#2) and a nutritional supplement, medication for a mood disorder, prostate enlargement medication, hypothyroid medication and a dementia medication (#12). The findings are 1. Review of Resident #12's current FL-2 dated 05/20/19 revealed diagnoses included Alzheimer's dementia, vascular dementia, essential hypertension, type II diabetes mellitus, chronic obstructive pulmonary disease, hypothyroidism, malignant neoplasm of the prostate and hyperlipidemia. Review of Resident #12's Resident Register revealed he was admitted to the facility on 05/21/19.	D 367		

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D 367	Continued From page 94 a. Review of Resident #12's current FL-2 dated 05/20/19 revealed there was an order for potassium chloride 20mEq daily (nutritional supplement). Observation of medication available for administration for Resident #12 on 08/13/19 at 1:00pm revealed: -There was a bubble pack with a prescription label which had Resident #12's name and instructions for potassium chloride 20mEq daily. -The prescription label indicated 30 tablets were dispensed on 06/28/19 and 10 tablets remained. Telephone interview with the General Manager at the facility's contracted pharmacy on 08/13/19 at 2:57pm revealed potassium chloride 30 tablets were dispensed on 05/22/19 and 06/28/19 for Resident #12. Review of Resident #12's May 2019 medication administration record (MAR) revealed: -There was a hand-written entry for potassium chloride 20mEq daily at 8:00am. -There was documentation 10 doses were administered from 05/22/19 through 05/31/19. Review of Resident #12's June 2019 MAR revealed: -There was a preprinted entry for potassium chloride 20mEq daily at 8:00am. -There was documentation 30 doses were administered from 06/01/19 through 06/30/19. Review of Resident #12's July 2019 MAR revealed: -There was a preprinted entry for potassium chloride 20mEq daily at 8:00am. -There was documentation 30 doses were administered from 07/01/19 through 07/31/19.	D 367		

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D 367	Continued From page 95 Review of Resident #12's August 2019 MAR revealed: -There was a preprinted entry for potassium chloride 20mEq daily at 8:00am. -There was documentation 13 doses were administered from 06/01/19 through 06/30/19. Based on review of Resident #12's May through August 2019 MARs, observation of medications available to administer and dispensing information for potassium chloride, there were 83 doses documented as administered on the MAR, 10 tablets on hand and 60 tablets dispensed resulting in a discrepancy in the documentation of 33 doses. b. Review of Resident #12's current FL-2 dated 05/20/19 revealed there was an order for Risperdal 0.5mg twice daily (used to treat mood disorders). Observation of medication available for administration for Resident #12 on 08/13/19 at 1:00pm revealed: -There was a bubble pack with a prescription label which had Resident #12's name and instructions for Risperdal 0.5mg twice daily. -The prescription label indicated 60 tablets were dispensed on 05/22/19 and 21 tablets remained. -There was a second bubble pack with a prescription label which had Resident #12's name and instructions for Risperdal 0.5mg twice daily. -The prescription label indicated 60 tablets were dispensed on 06/21/19 and 30 tablets remained. -There was a third bubble pack with a prescription label which had Resident #12's name and instructions for Risperdal 0.5mg twice daily. -The prescription label indicated 60 tablets were dispensed on 07/14/19 and 30 tablets remained.	D 367		

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D 367	Continued From page 96 Telephone interview with the General Manager at the facility's contracted pharmacy on 08/13/19 at 2:57pm revealed Risperdal 60 tablets were dispensed on 05/22/19, 06/21/19 and 07/14/19 for Resident #12. Review of Resident #12's May 2019 medication administration record (MAR) revealed: -There was a hand-written entry for Risperdal 0.5mg twice daily at 8:00am and 8:00pm. -There was documentation 21 doses were administered from 05/21/19 through 05/31/19. Review of Resident #12's June 2019 MAR revealed: -There was a preprinted entry for Risperdal 0.5mg twice daily at 8:00am and 8:00pm. -There was documentation 60 doses were administered from 06/01/19 through 06/30/19. Review of Resident #12's July 2019 MAR revealed: -There was a preprinted entry for Risperdal 0.5mg twice daily at 8:00am and 8:00pm. -There was documentation 62 doses were administered from 07/01/19 through 07/31/19. Review of Resident #12's August 2019 MAR revealed: -There was a preprinted entry for Risperdal 0.5mg twice daily at 8:00am and 8:00pm. -There was documentation 24 doses were administered from 08/01/19 through 08/13/19 at 8:00am. Based on review of Resident #12's May through August 2019 MARs, observation of medications available to administer and dispensing information for Risperdal, there were 167 doses	D 367		

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documented as administered on the MAR, 81 tablets on hand and 180 tablets dispensed resulting in a discrepancy in the documentation of 86 doses.

c. Review of Resident #12's current FL-2 dated 05/20/19 revealed there was an order for Flomax 0.4mg daily at bedtime (used to treat an enlarged prostate).

Observation of medication available for administration for Resident #12 on 08/13/19 at 1:00pm revealed:
-There was a bubble pack with a prescription label which had Resident #12's name and instructions for Flomax 0.4mg daily.
-The prescription label indicated 30 tablets were dispensed on 06/28/19 and 2 tablets remained.
-There was a second bubble pack with a prescription label which had Resident #12's name and instructions for Flomax daily.
-The prescription label indicated 30 tablets were dispensed on 08/12/19 and 30 tablets remained.

Telephone interview with the General Manager at the facility's contracted pharmacy on 08/13/19 at 2:57pm revealed Flomax 30 tablets were dispensed on 05/22/19, 06/28/19 and 08/12/19 for Resident #12.

Review of Resident #12's May 2019 medication administration record (MAR) revealed:
-There was a hand-written entry for Flomax 0.4mg daily at 8:00pm.
-There was documentation 11 doses were administered from 05/22/19 through 05/31/19.

Review of Resident #12's June 2019 MAR revealed:
-There was a preprinted entry for Flomax 0.4mg

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daily at 8:00pm.
-There was documentation 30 doses were administered from 06/01/19 through 06/30/19.

Review of Resident #12's July 2019 MAR revealed:
-There was a preprinted entry for Flomax 0.4mg daily at 8:00pm.
-There was documentation 31 doses were administered from 07/01/19 through 07/31/19.

Review of Resident #12's August 2019 MAR revealed:
-There was a preprinted entry for Flomax 0.4mg daily at 8:00pm.
-There was documentation 13 doses were administered from 08/01/19 through 08/12/19.

Based on review of Resident #12's May through August 2019 MARs, observation of medications available to administer and dispensing information for Flomax, there were 85 doses documented as administered on the MAR, 32 tablets on hand and 90 tablets dispensed resulting in a discrepancy in the documentation of 27 doses.

d. Review of Resident #12's current FL-2 dated 05/20/19 revealed there was an order for Synthroid 50mcg daily (used to treat hypothyroidism).

Observation of medication available for administration for Resident #12 on 08/13/19 at 1:00pm revealed:
-There was a bubble pack with a prescription label which had Resident #12's name and instructions for Synthroid 50mcg daily.
-The prescription label indicated 30 tablets were dispensed on 07/07/19 and 28 tablets remained.

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D 367	Continued From page 99 Telephone interview with the General Manager at the facility's contracted pharmacy on 08/13/19 at 2:57pm revealed Synthroid 30 tablets were dispensed on 05/22/19, 06/14/19, and 07/14/19 for Resident #12. Review of Resident #12's May 2019 medication administration record (MAR) revealed: -There was a hand-written entry for Synthroid 50mcg daily at 6:00am. -There was documentation 10 doses were administered from 05/22/19 through 05/31/19. Review of Resident #12's June 2019 MAR revealed: -There was a preprinted entry for Synthroid 50mcg daily at 7:00am. -There was documentation 30 doses were administered from 06/01/19 through 06/30/19. Review of Resident #12's July 2019 MAR revealed: -There was a preprinted entry for Synthroid 50mcg daily at 7:00am. -There was documentation 31 doses were administered from 07/01/19 through 07/31/19. Review of Resident #12's August 2019 MAR revealed: -There was a preprinted entry for Synthroid 50mcg daily at 7:00am. -There was documentation 12 doses were administered from 06/01/19 through 06/30/19. Based on review of Resident #12's May through August 2019 MARs, observation of medications available to administer and dispensing information for Synthroid, there were 83 doses documented as administered on the MAR, 28	D 367		

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tablets on hand and 90 tablets dispensed resulting in a discrepancy in the documentation of 21 doses.

e. Review of Resident #12's current FL-2 dated 05/20/19 revealed there was an order for Namenda 10mg twice daily

Observation of medication available for administration for Resident #12 on 08/13/19 at 1:00pm revealed:
-There was a bubble pack with a prescription label which had Resident #12's name and instructions for Namenda 10mg twice daily.
-The prescription label indicated 60 tablets were dispensed on 05/22/19 and 17 tablets remained.

Telephone interview with the General Manager at the facility's contracted pharmacy on 08/13/19 at 2:57pm revealed Namenda 60 tablets were dispensed on 05/22/19 and 06/28/19 for Resident #12.

Review of Resident #12's May 2019 medication administration record (MAR) revealed:
-There was a hand-written entry for Namenda 10mg twice daily at 8:00am and 8:00pm.
-There was documentation 21 doses were administered from 05/21/19 through 05/31/19.

Review of Resident #12's June 2019 MAR revealed:
-There was a preprinted entry for Namenda 10mg twice daily at 8:00am and 8:00pm.
-There was documentation 60 doses were administered from 06/01/19 through 06/30/19.

Review of Resident #12's July 2019 MAR revealed:
-There was a preprinted entry for Namenda 10mg

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D 367	Continued From page 101 twice daily at 8:00am and 8:00pm. -There was documentation 62 doses were administered from 07/01/19 through 07/31/19. Review of Resident #12's August 2019 MAR revealed: -There was a preprinted entry for Namenda 10mg twice daily at 8:00am and 8:00pm. -There was documentation 24 doses were administered from 07/01/19 through 07/31/19. Based on review of Resident #12's May through August 2019 MARs, observation of medications available to administer and dispensing information for Namenda, there were 167 doses documented as administered on the MAR, 17 tablets on hand and 120 tablets dispensed resulting in a discrepancy in the documentation of 64 doses. Interview with the medication aide (MA) on 08/14/19 at 1:00pm revealed she did not know why Resident #12 had extra Flomax and Risperdal on hand. Telephone interview with the General Manager at the facility's contracted pharmacy on 08/13/19 at 2:57pm revealed the facility was not an automatic cycle refill; refills had to be requested. Interview with a personal care aide (PCA) on 08/14/19 at 9:35am revealed: -Resident #12 would try to fight staff if they tried to wake him up in the morning so staff would just let him sleep until he woke up. -The MA would go down and wake Resident #12 up and give him medications. -Resident #12 would not get upset if staff did not try to get him out of the bed.	D 367		

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D 367	Continued From page 102 Interview with a second MA on 08/14/19 at 9:42am revealed: -Most of the time she was able to get Resident #12 to take his morning medications. -She would have the kitchen staff put aside a breakfast plate for Resident #12 because he slept late. Second interview with the first MA on 08/14/19 at 9:20am revealed: -When she worked, she would have the PCAs get Resident #12 up as soon as they finished the breakfast meal. -She needed to have all the residents up by 10:00am so she could finish the medication pass. -Most of the time, she would have a PCA go down with her in the morning to administer Resident #12 his Synthroid and Ativan. -Resident #12 was not always sleep when staff went in his room in the morning. -She would sit Resident #12 up and give him the Ativan and Synthroid and then let him go back to sleep. Interview with the Administrator on 08/14/19 at 10:42am revealed Resident #12 did not bring any medications with him on admission to the facility. Interview with Resident #12's PCP on 08/15/19 at 10:44am revealed: -It was not concerning that Resident #12 missed multiple doses of his morning medications due to sleeping late. -He should get his Synthroid, but it was not that high of a dose. -Staff had reported difficulty giving medications and Resident #12's irritability in the mornings so she ordered Ativan. -There had not been any discussion of changing Resident #12's medication times to assure	D 367		

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D 367	Continued From page 103 administration as ordered. Interview with the Administrator on 08/15/19 at 1:00pm revealed: -She did not know there was an excess of some medications for Resident #12. -She did not know some medications had only been dispensed twice for a 30 day supply since Resident #12 had been admitted to the facility on 05/21/19. -Staff were expected to administer medications as ordered by the PCP. -If medications were not given, staff were expected to document the medication was not given by circling their initials on the MAR and entering a note on the back of the MAR. -If there were three consecutive missed doses, the MA faxed a notification to the PCP and filed the notification in the resident's record. Based on observations, interviews and record reviews, it was determined Resident #12 was not interviewable. 2. Review of Resident #2's FL-2 dated 12/04/18 revealed: -Diagnoses included Parkinson's disease, dementia, hypertension, hyperlipidemia and constipation. -There was an order for Simvastatin (used to lower cholesterol and triglycerides in the blood) 20 mg daily. Review of Resident #2's July 2019 medication administration record (MAR) revealed there was documentation Simvastatin 20 mg was administered at 8:00pm from 07/01/19 - 07/31/19. Review of Resident #2's August 2019 MAR revealed there was documentation Simvastatin	D 367		

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D 367	Continued From page 104 20 mg was administered at 8:00pm from 08/01/19 - 08/07/19. Observation of Resident #2's medications on hand on 08/08/19 at 10:45am revealed there was no Simvastatin in the medication cart. Interview with a medication aide (MA) on 08/08/19 at 11:13am and 5:39pm revealed: -The MA was to order medication for residents when their prescriptions were out. -She would circle the MAR and document the medication was not available, if a resident were out of their medication. -She was not aware Resident #2 was out of her Simvastatin medication. Interview with Executive Director (ED) on 08/08/19 at 11:17am revealed: -The MAs were responsible to reorder medications for the residents in the facility. -The third shift staff verified medication orders. -The Resident Care Coordinator (RCC) was responsible for making sure the medication orders were placed. -The RCC was not available during the survey for an interview. -She was acting as the RCC in her absence. Interview with a second MA on 08/08/19 at 5:28pm revealed: -It is the responsibility of the MA to reorder medications for residents. -She would look in backup medication stock or send an order to the pharmacist. -She told the third shift MA the Simvastatin was out for Resident #2. -She would circle the MAR and document the reason the medication was not given, if a resident was out of their medication.	D 367		

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D 367	Continued From page 105 -She worked on 08/07/19 and documented the medication was administered because she borrowed medication from another resident with the same prescription as Resident #15. Interview with a third MA on 08/09/19 at 9:48am revealed: -She would circle the MAR and document the medication was not available, if a resident were out of their medication. -She was not aware Resident #2 was out of her Simvastatin medication. Interview with the ED on 08/09/19 at 1:06pm revealed: -The MAs should not borrow medications from other residents. -There was no way to document if medications were being borrowed. -The medications could not be borrowed because the medications are dispensed in pouches. -It was the responsibility of the MA to order medications when residents ran out of their medications. Telephone Interview with the pharmacist on 08/08/19 at 11:05am and 08/09/18 at 4:00pm revealed: -There were no backup medications of Simvastatin 20mg delivered to the facility for Resident #2. -Resident #2 was dispensed Simvastatin 20mg for a 30-day supply of tablets on 06/24/19 and 08/08/19. -Resident #2 was not dispensed Simvastatin 20mg in the month of July. -Resident #2 "could not have borrowed Simvastatin from another resident that would mean the resident in question should have been out of Simvastatin."	D 367		

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D 367	Continued From page 106 Observation of the medication cart on 08/12/19 at 3:49pm revealed residents in the facility with the same prescription as Resident #2 were not missing any medications. Based on observations, interviews, and record reviews, it was determined Resident #2 was not able to interview.	D 367		
D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10A NCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure compliance with the facility's policies and procedures for the self-administration of medications for 1 of 1 sampled resident (#1). The findings are: Review of the facility's policy and procedure for	D 376		

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medication management
revealed:
-A resident may be permitted to keep his own medications in a secure place in their locked apartment if the resident assessment has indicated that the resident is capable of self-administering medications and has been assessed by a licensed nurse of the facility as capable of self-administering.
-The self-administering assessment will include: identification of each medication, the reason for use, dosing instructions, frequency of the dose, ability to reorder medication independently, ability to open and close all original containers, read the labels of the medications, and instill eye drops and apply topical patches independently if ordered.
-The facility's assessment will occur every six months or more if indicated by a change in condition or suspicion/report of inaccurate self-administration.

Review of Resident #1's current FL-2 dated 05/03/2019 revealed diagnoses included coronary artery disease, post-percutaneous coronary intervention, severe aortic stenosis, post-transcatheter aortic valve replacement, Type II diabetes mellitus, chronic obstructive pulmonary disease (COPD), hypothyroidism, and paroxysmal atrial fibrillation.

Review of Resident #1's Resident Register revealed admission date of 05/06/19.

Review of Resident #1's medication clarification orders dated 05/07/19 revealed:
-There was an order for Atrovent 170mcg take two puffs four times a day (Atrovent is used to treat COPD and asthma).
-There was an order for Pro-Air 90mcg take two

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D 376	Continued From page 108 puffs every four hours as needed for shortness of breath (Pro-Air is used to treat bronchospasms). -There was an order for Albuterol Sulfate 0.083% mg/ml nebulizer treatment take inhale contents of one vial (30ml) via nebulizer twice a day and every six hours as needed for wheezing (Albuterol Sulfate is used to treat asthma). -There was an order for Lantus take inject 22 units once daily at bedtime (Lantus is used lower blood sugar). -There was an order for Percocet 5/325mg take one table three times a day as needed for pain (Percocet is a controlled substance used for pain management). -There was an order for Advair 230mg/21mcg take two puffs every morning and every evening (Advair is used to treat COPD). -Narcan 0.4mg was listed for medication clarification but not continued for medication administration. Review of Resident #1's physician's orders dated 05/20/19 revealed there was an order for Resident #1 to self-administer his medications including Lantus, Atrovent, Albuterol, Pro-Air, Percocet, and Advair. Review of Resident #1's care plan dated 05/28/19 revealed: -Resident #1 was "oriented and had adequate memory". -Resident #1 could self-administer Advair take two puffs twice daily, Atrovent 17mcg take two puffs four times a day, Pro-Air 90mcg take two puffs every four hours as need for shortness of breath, Albuterol 0.083%mg/ml take three milliliters via nebulizer twice daily and every six hours as needed for shortness of breath, and Percocet 5/325mg take one tablet three times a day as needed for pain.	D 376		

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D 376	Continued From page 109 -Lantus injection was not listed for Resident #1 to self-administer. Attempted review of Resident #1's May 2019 resident assessment for self-administration of medication revealed it was requested on 08/07/19 and 08/15/19 but not provided prior to survey exit. Review of Resident #1's physician's orders dated 07/02/19 revealed: -There was an order for Flonase 50mg take inhale two sprays in each nostril twice a day (Flonase is used to treat seasonal allergies). -There was an order for Atrovent 170mcg take two puffs four times a day. -There was an order for Pro-Air 90mcg take two puffs every four hours as needed for shortness of breath. -There was an order for Albuterol 0.083% mg/ml nebulizer treatment take inhale contents of one vial (30ml) via nebulizer twice a day and every six hours as needed for wheezing. -There was an order for Lantus take inject 22 units once daily at bedtime. -There was an order for Percocet 5/325mg take one table three times a day as needed for pain. -There was an order of Eliquis 2.5mg take one tablet twice daily (Eliquis is used to prevent blood clots). -There was an order for enteric coated aspirin 81mg take one tablet every night (Enteric coated aspirin is used treat pain and prevent blood clots). -There was an order for Toprol XL 25mg take one half tablet every night (Toprol is used to treat hypertension and heart failure). -There was an order for Altace 2.5mg take one tablet once daily (Altace is used to treat hypertension and heart failure). -There was an order for Lipitor 40mg take one tablet twice daily at bedtime (Lipitor is used to	D 376		

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D 376	Continued From page 110 treat high cholesterol). -There was an order for Advair 230mg/21mcg take two puffs every morning and every evening (Advair is used to treat COPD). -There was an order for Levothyroxine 137mcg take one tablet once daily one hour before breakfast (Levothyroxine is used to treat hypothyroidism). -There was an order for Tylenol 325mg take two tablets every six hours as need for pain (do not take with Percocet). -There was an order for Thera-tears take instill one drop into both eyes twice daily as needed (Thera-tears is used to relieve dry eyes). -There was an order for Systane Ultra take instill two drops in the affected eye daily as needed (Systane is used to relieve dry eyes). -There was an order for Flomax 0.4mg take one tablet once daily (Flomax is used to treat enlarged prostate benign prostatic hyperplasia). -There was an order for Sanctura 20mg take one tablet once daily (Sanctura is used to treat overactive bladder). -There was an order for Finasteride 5mg take one tablet once daily (Finasteride is used to enlarged prostate benign prostatic hyperplasia). -There was an order for Amitiza 24mcg take once tablet twice daily with meals for constipation (Amitiza is used to relieve constipation). -There was an order for Dulcolax 5mg take two tablets twice daily as needed for constipation (Dulcolax is used to relieve constipation). -There was an order for Miralax 17gm take one capful in six ounces of water once daily as needed for constipation (Miralax is used to relieve constipation). -There was an order for Senna 8.6mg tablet take one tablet once daily (Senna is used to relieve constipation).	D 376		

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D 376	Continued From page 111 Review of Resident #1's physician's orders dated 07/18/19 revealed there was an order for Resident #1 to self-administer his medications and keep medications at bedside. Attempted review of Resident #1's July 2019 resident assessment for self-administration of medication revealed it was requested on 08/07/19 and 08/15/19 but not provided prior to survey exit. Observation of Resident #1's room on 08/07/19 at 10:15am revealed: -There was another resident alone in Resident #1's room and the room door was unlocked. -The other resident was alert and oriented to person only. -There were seven boxes of Atrovent inhalers, four boxes of Pro-Air inhalers, two boxes of Narcan, three bottles of Flonase, and eleven boxes of Albuterol nebulizer ampules that contained 25 ampules each on the built-in shelves next to Resident #1's bed. -There was one Lantus insulin pen in the resident's refrigerator. -There was a Pro-Air inhaler and a tube of over-the-counter muscle rub cream on a bedside table next to the bed. -There was a prescription bottle of medication that contained Dulcolax pills on a table setting next to the chair in the room. Review of Resident #1's record revealed there was no order for the over-the-counter muscle rub cream found at Resident #1's bedside. Interview with Resident #1 on 08/07/19 at 11:35am revealed: -Those were his medications located on the shelves, refrigerator, and both tables in the room. -He self-administered his medications and he	D 376		

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kept his medications in a bottom drawer of his chest in the room.
-He kept his medication overstock on the shelves in his room and his room door was never locked.
-He refused to allow the survey team to see his remaining medications that he kept in the bottom drawer of his chest in the room.
-"That is none of your business, what medications I take are between the military base pharmacy, my doctor at the military base, and me."
-He denied keeping any controlled substances in the room and refused to answer additional questions.

Interview with a medication aide (MA) on 08/07/19 at 11:05am revealed:
-Resident #1 self-administered his medications but did not keep his room door locked.
-She did not know why Resident #1's did not lock the door of his room.
-She did not know if Resident #1 had any narcotics in his room since he self-administered his medications.
-Staff did not do anything dealing with Resident #1's medications.
-Resident #1 ordered his medications and refills from the military base pharmacy on his own.

Interview with a second MA on 08/12/19 at 3:30pm revealed:
-Staff did not assist Resident #1 with his medications prior to 08/09/19 since he self-administered.
-She was not trained on any self-administration of medication procedures and was not aware of any policy for that.

Interview with Resident #1's health care provider on 08/08/19 at 10:35am revealed:
-There was an order for self-administration of

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medications for Resident #1 because he wanted to self-administer his medications.
-She did not know if Resident #1 had any medication order for controlled substances and if they were kept in his room.

Interview with the Executive Director (ED) on 08/07/19 at 12:26pm revealed:
-She knew Resident #1 self-administered his medications, but she did not know the medications were left unsecured in his room.
-She did not know Resident #1 was taking controlled substances or had if he had controlled substances in the room.
-Staff should have alerted her that Resident #1 had medications not secured in his room because he was self-administering his medications.
-She was not sure what medications Resident #1 was prescribed and she would have to review his record to look for an assessment for self-administration of medication for Resident #1.

Review of a resident assessment for self-administration of medication for Resident #1 revealed:
-Resident #1 did not always have knowledge of what his medications were used for.
-Resident #1 was not able to recognize his medications and did not know the correct times to take his medications.
-Resident #1 could sometimes recognize his medications' containers but would not store his medications properly.
-Resident #1 could identify the common adverse reactions associated with his medications.
-It was dated 07/07/19 and signed by the facility's license health professional support (LHPS) nurse.

Review of a fax sent to Resident #1's health provider revealed:

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D 376	Continued From page 114 -The fax was dated 07/07/19 and had fax confirmation sheet dated 08/07/19. -The fax was sent by the LHPS nurse for a request for an order to discontinue Resident #1's self-administration of his medications because Resident #1 was not able to demonstrate that he was able to safely self-administer his medications. Interview with the LHPS nurse on 08/08/19 at 3:20pm revealed: -She had completed the resident assessment for self-administration of medication for Resident #1 on 08/07/19. -She must have put the wrong date on the assessment form and fax when she completed it. -She did not know if a resident assessment for self-administration of medication had previously been completed for Resident #1 prior to 08/07/19. -It was not safe for Resident #1 to self-administer his medications because he cognitively could not manage taking his medications independently. -She had sent the request to discontinue self-administration of medications for Resident #1 to his physician on 08/07/19.	D 376		
D 377	10A NCAC 13F .1006(a) Medication Storage 10a NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and	D 377		

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interviews, the facility failed to assure that medications were stored in a safe and secure manner for 1 of 1 resident sampled (#1) who had a roommate with a diagnosis of dementia, who had access to the resident's unsecured medications.

The findings are:

Review of Resident #1's FL-2 dated 05/03/2019 revealed diagnoses included coronary artery disease, post-percutaneous coronary intervention, severe aortic stenosis, post-transcatheter aortic valve replacement, Type II diabetes mellitus, chronic obstructive pulmonary disease (COPD), hypothyroidism, and paroxysmal atrial fibrillation.

Review of Resident #1's Resident Register revealed an admission date of 05/06/19.

Review of Resident #1's medication clarification orders dated 05/07/19 revealed:
-There was an order for Flonase 50mg take inhale two sprays in each nostril twice a day (Flonase is used to treat seasonal allergies).
-There was an order for Atrovent 170mcg take two puffs four times a day (Atrovent is used to treat COPD and asthma).
-There was an order for Pro-Air 90mcg take two puffs every four hours as needed for shortness of breath (Pro-Air is used to treat bronchospasms).
-There was an order for Albuterol Sulfate 0.083% mg/ml nebulizer treatment take inhale contents of one vial (30ml) via nebulizer twice a day and every six hours as needed for wheezing (Albuterol Sulfate is used to treat asthma).
-There was an order for Lantus take inject 22 units once daily at bedtime (Lantus is used lower blood sugar).

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-There was an order for Percocet 5/325mg take one table three times a day as needed for pain (Percocet is used for pain management).
-There was an order for Bisacodyl 5mg take two tablets twice daily as needed for constipation (Bisacodyl (Dulcolax) is used to treat constipation).
-There was an order for Advair 230mg/21mcg take two puffs every morning and every evening (Advair is used to treat COPD).
-Narcan 0.4mg was listed for medication clarification but not continued for administration.
-There was no order for the over-the-counter muscle rub cream.

Review of Resident #1's physician orders revealed:
-There was an order for Resident #1 to self-administer his medications including Lantus, Atrovent, Albuterol, Pro-Air, Percocet, and Advair dated 05/20/19.
-There was an order for Resident #1 to self-administer his medications and keep desired medications at bedside on 07/18/19.

Review of Resident #11's FL-2 dated 05/07/19 revealed:
-Diagnoses included dementia without behavior disturbances, Parkinson's disease, essential hypertension, hyperlipidemia, and constipation.
-Resident #11 was intermittently disoriented and ambulatory.

Review of Resident #11's care plan dated 05/08/19 revealed:
-Resident #11 was ambulatory.
-She was sometimes disoriented, forgetful, and needed reminders.

Observation of Resident #1's and Resident #11's

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D 377	Continued From page 117 on 08/07/19 at 10:15am revealed: -Resident #11 was alone in the room and the room door was unlocked. -Resident #11 was alert and oriented to person only. -There were four built-in shelves on the wall next to Resident #11's bed that were accessible to Resident #11 that included seven boxes of Atrovent inhalers, four boxes of Pro-Air inhalers, two boxes of Narcan, three bottles of Flonase, and eleven boxes of Albuterol nebulizer ampules that contained 25 ampules each. -There was one Lantus insulin pen in the residents' refrigerator. -There was a Pro-Air inhaler and a tube of over-the-counter muscle rub cream on a bedside table next to the bed. -There was a prescription bottle of medication that contained Dulcolax pills on a table setting next to the chair in the room. Interview with Resident #11 on 08/07/19 at 10:15am revealed: -She lived in the room and Resident #11 was not in the room. -Resident #11 kept responding "I don't know" when asked additional questions. Interview with Resident #1 on 08/07/19 at 11:35am revealed: -Those were his medications located on the shelves, refrigerator, and both tables in the room. -He self-administered his medications and he kept his medications in a bottom drawer of his chest in their room. -He kept his medication overstock on the shelves in his room and their room door was never locked. -He refused to allow the survey team to see his remaining medications that he kept in the room.	D 377		

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-"That is none of business, what medications I take are between the military pharmacy, my doctor at the military base, and me."
-He denied keeping any narcotics in the room.

Review of the facility's medication management plan revealed a resident may be permitted to keep his own medications in a secure place in their locked apartment.

Interview with a personal care aide on 08/07/19 at 11:10am revealed:
-Resident #11 and Resident #1 lived in the same room.
-Resident #11 had dementia and was left alone often in the room.
-Resident #1 self-administered his medications and he kept boxes of medications on the shelves in the room since he was admitted to the facility in May 2019.
-She knew medications were supposed to "locked up", but staff did not bother Resident #1's medications on the shelves because he self-administered his own medications.
-She did not know if Resident #1 kept medications anywhere else in the room or if Resident #1 had controlled medications in the room.
-It was possible for Resident #11 to had access to the medications on the shelves and on the tables in their room.

Interview with the Executive Director (ED) on 08/07/19 at 12:26pm revealed:
-Resident #1 and Resident #11 lived together in their room.
-The ED knew Resident #1 self-administered his medications, but she did not know the medications were left unsecured in his room.
-She did not know if Resident #1 was taking

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D 377	Continued From page 119 controlled medications or had controlled medications in the room. -If a resident had a medication self-administration order, all medications would be kept secured in the room. -She did not know Resident #1 had medications stored on the shelves in his room or left out on tables. -Staff should have alerted her that Resident #1 had medications not secured in his room. -It concerned her that Resident #1 had unsecured medications in the room because Resident #11 had dementia and could get into the medications when Resident #11 was not supervised. -She would have Resident #1's unsecured medications removed from his room. Interview with Resident #1's and Resident #11's health care provider on 08/08/19 at 10:35am revealed: -There was an order for self-administration of medications for Resident #1 because he wanted to self-administer his medications. -She was not sure if Resident #1 had any medication order for controlled substances and if they were kept in his room. -Resident #11 lived with Resident #1 in their room and Resident #11 had dementia. -Resident #11 did not have a history of rummaging through the things in the room and she did not think Resident #11 had the hand dexterity to open the medications that were left in the room.	D 377		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by	D 392		

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D 392	Continued From page 120 documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews, and record reviews, the facility failed to assure readily retrievable records and failed to account for the use and administration of controlled substances for 1of 6 residents (#1) sampled who had 270 Percocet tablets unaccounted for since admission on 05/06/19 and no controlled substance (CS) logs for May 2019, June 2019, July 2019, and August 2019 for Percocet administration. The findings are: Review of Resident #1's currentFL-2 dated 05/03/2019 revealed: -Diagnoses included coronary artery disease, post-percutaneous coronary intervention, severe aortic stenosis, post-transcatheter aortic valve replacement, Type II diabetes mellitus, chronic obstructive pulmonary disease, hypothyroidism, and paroxysmal atrial fibrillation. -There was an order for Percocet 5/325mg - 1 tablet three times a day as needed for (Percocet is a controlled substance used to treat moderate to severe pain.). Review of Resident #1's record revealed an admission date of 05/06/19. Review of pharmacy dispensing records dated	D 392		

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D 392	Continued From page 121 03/29/19 - 08/07/19 for Resident #1 revealed: -There were 90 tablets of Percocet 5/325mg (30-day supply) dispensed on 03/29/19. -There were 90 tablets of Percocet 5/325mg (30-day supply) dispensed on 05/15/19. -There were 90 tablets of Percocet 5/325mg (30-day supply) dispensed on 06/15/19. -There were 90 tablets of Percocet 5/325mg (30-day supply) dispensed on 07/20/19. Attempted review of Resident #1's admission's medication inventory list revealed it was requested 08/08/19, 08/09/19, 08/10/19, 08/13/19, 08/14/19, and 08/15/19 but not provided prior to survey exit. Interview with the Executive Director (ED) on 08/07/19 at 12:26pm revealed: -The previous Resident Care Coordinator (RCC) was supposed to do an inventory of all medications Resident #1 brought in to the facility when he was admitted. -She was not sure if the RCC had completed the inventory of Resident #1's medications when he was admitted. -She was not sure what medications Resident #1 was prescribed and she would have to review his record to look if a medication inventory had been completed for Resident #1. Review of Resident #1's May 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Percocet 5/325mg take 1 tablet three times a day as needed for pain. -Percocet was not documented as administered from 05/06/19 through 05/31/19. Review of Resident #1's June 2019 MAR revealed:	D 392		

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D 392	Continued From page 122 -There was a pre-printed entry for Percocet 5/325mg take 1 tablet three times a day as needed for pain. -Percocet was not documented as administered from 06/01/19 through 06/30/19. Review of Resident #1's July 2019 MAR revealed: -There was a pre-printed entry for Percocet 5/325mg take1 tablet three times a day as needed for pain. -Percocet was not documented as administered from 07/01/19 through 07/31/19 and Resident #1 began self-administering all of medications on 07/18/19. Review of Resident #1's August 2019 MAR on 08/08/19 revealed: -There was a pre-printed entry for Percocet 5/325mg take 1 tablet three times a day as needed for pain. -Percocet was not documented as administered from 08/01/19 through 08/07/19 and Resident #1 was self-administering his medications. Review of Resident #1's records revealed there were no controlled substances logs for Resident #1 to account for the number of Percocet tablets Resident #1 had upon admission to the facility on 05/06/19 or the Percocet tablets dispensed by the pharmacy on 05/15/19, 06/15/19, or 07/20/19. Observation of Resident #1's medications on hand on 08/12/19 at 3:30pm revealed there were no Percocet tablets found in the medication cart. Interview with a medication aide (MA) on 08/12/19 at 3:30pm revealed: -She did not realize that Resident #1 still had a medication order for Percocet. -She could not find any Percocet tablets or	D 392		

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control logs on the medication cart for Resident #1.
-If Resident #1 had a medication order for Percocet then there should be control logs for the controlled substances.

Interview with Resident #1 on 08/13/19 at 8:58am revealed:
-He reported that he had not taken Percocet in months and the prescription had been discontinued for several months.
-He could not remember when the Percocet prescription was discontinued.
-He could not remember when he had last taken Percocet or picked up Percocet from his pharmacy since he was admitted to the facility.

Interview with a second MA on 08/14/19 at 9:35am revealed:
-She had not seen any Percocet tablets for Resident #1 on the medication cart since he was admitted to the facility in May 2019.
-She had not seen any control logs for Percocet for Resident #1.
-Resident #1 picked up his own medications from the pharmacy and he had never given any Percocet tablets to be put in the medication cart.
-Staff never checked to see why Resident #1's Percocet was not on the medication cart.

Second interview with first MA on 08/14/19 at 10:20am revealed:
-There had not been any control logs for Resident #1's Percocet tablet since he was admitted to the facility.
-Staff had not checked to see if Resident #1 had any Percocet tablets because there was problem with Resident #1 self-administering his medications.
-Resident #1 told her when he was admitted to

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the facility that he had Percocet, but she never saw any Percocet tablets and the resident told her that he kept the Percocet in his room.
-She did not know where he kept the narcotics.
-She did not tell ED about Resident #1 having Percocet because she never saw any Percocet tablets.
-There had never been any Percocet on the medication cart for Resident #1 since admission.

Interview with the Executive Director (ED) on 08/13/19 at 3:45pm revealed:
-Resident #1 picked up all his medications from the pharmacy including the Percocet.
-Staff did not check Resident #1's medications when he brought them from the pharmacy.
-Resident #1 was supposed to give his medications to RCC or the medication aide when he brought them from the pharmacy.
-Staff was initially administering medications for Resident #1, but Resident #1 had been allowed to self-administer his medications at varying times since he was admitted to the facility because he complained about getting his medications on time.
-She did not know 270 tablets of Percocet had been dispensed to Resident #1 since he was admitted to the facility.
-She was unable to get the dispensing records from Resident #1's pharmacy.
-She could not find a medication inventory list for Resident #1 that noted if Resident #1 had Percocet when he was admitted to the facility or how many Percocet tablets Resident #1 had upon admission.
-She did not know if the facility had control logs for Resident #1 since he was admitted to the facility.

Observation of Resident #1 on 08/14/19 at

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D 392	Continued From page 125 1:05pm revealed: -Resident #1 removed a blue prescription bottle from his right front pants pocket. -Resident #1 refused to allow the survey team to see the label of the prescription bottle or the contents inside the prescription bottle. Interview with Resident #1 on 08/14/19 at 1:05pm revealed: -He had his prescription bottle of Percocet and he had six tablets left in the bottle. -He took Percocet for his back pain and he could take 1 tablet three times a day as needed for pain. -He kept his Percocet because he "did not think it was any business" of the staff to know how often he took his pain medication. -He did not lock up the Percocet tablets when they were in his room even though he had a lockbox. -He could administer his own pain medications as directed by his physician. -He could not explain why he only had six tablets left out of ninety tablets of Percocet dispensed on 07/20/19 since he took his pain medication as directed by his physician. -He last picked up his pain medication on 07/20/19 and he did not have any pain medication missing. if -He drove himself to the pharmacy to pick-up his medications including his Percocet. -His prescription for Percocet was from his physician at the pain clinic. Attempted telephone interview with Resident #1's pain clinic physician on 08/15/19 at 1:20pm was unsuccessful. _____ The facility failed to have an accurate accounting of the receipt, administration and disposition of	D 392		

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D 392	Continued From page 126 Resident #1's Percocet, a controlled substances resulted in 270 Percocet tablets being unaccounted for and allowed for unmonitored opportunities for potential drug diversion and risk for medication errors which was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/15/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 29, 2019.	D 392		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5-day requirements for 1 of 1 sampled resident (#7) who sustained a head injury and hip fracture of unknown origins.	D 438		

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D 438	Continued From page 127 The findings are: 1. Review of Resident #7's FL-2 dated 02/05/19 revealed diagnoses included unspecified dementia, hypertension, cerebral infarction, anxiety disorder, and rheumatoid arthritis. Review of Resident #7's record revealed an admission date of 03/15/18 and discharged from the facility on 06/07/19 to a rehabilitation center. Review of an accident/injury report dated 06/03/19 at 9:40am for Resident #7 revealed: -Staff documented "noticing a lump on the right side" of Resident #7's head "while getting her up". -Resident #7 complained of back pain (location not specified). -The Executive Director (ED) was notified of the lump to Resident #7's head at approximately 9:45am. -Resident #7 was sent to the hospital for a report of head and back injuries at approximately 9:56am. Review of a hospital physician's consult dated 06/03/19 at 4:50pm for Resident #7 revealed: -There was "a bump noticed on the forehead" of Resident #7 on the morning of 06/03/19 at the assisted living facility and Resident #7 was sent to the emergency room at the hospital. -The physician's assessment revealed Resident #7's right lower extremity was shortened but there was no bruising to the right hip. -A pelvic x-ray of Resident #7 revealed a displaced right hip fracture presumed secondary to a fall. Attempted telephone interviews with hospital physician on 08/15/19 at 9:11am, 9:15am, and	D 438		

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D 438	Continued From page 128 9:20am were unsuccessful. Telephone interview with a personal care aide (PCA) on 08/14/19 at 4:59pm revealed: -She bathed and dressed Resident #7 in the bed between 9:00am and 9:30am on 06/03/19. -Resident #7 required assistance to get out of bed from staff. -She asked another PCA to get Resident #7 out of bed because she could not Resident #7 out of bed without assistance. -When the other PCA attempted to get Resident #7 out of bed then she noticed the resident grimaced like she was in pain. -The other PCA got Resident #7 up in her wheelchair without any assistance and she noticed Resident #7 appeared to be leaning sideways in her wheelchair. -She was unable to remember to which side Resident #7 was leaning towards. -Resident #7 never complained about any pain but the resident looked like she was in pain because she was grimacing. -She began to comb Resident #7's hair and she found a "knot" on Resident #7's head. -She could not recall which side of Resident #7's head the "knot" was, what size it was, or there was any bruising to the "knot". -She immediately notified the medication aide (MA) about the "knot" on Resident #7's head and the medication aide also noticed Resident #7 was leaning in the wheelchair. -The MA notified the ED who came and looked at Resident #7. -The ED advised to send Resident #7 to the emergency room because of the "knot" to her head. -She did not know what happened to Resident #7's head or why Resident #7 appeared to be in pain.	D 438		

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D 438	Continued From page 129 Attempted review of Resident #7's Activities of Daily Living (ADL) Logs dated 06/02/19 and 06/03/19 revealed it was requested on 08/15/19 and 08/16/19 but not provided prior to survey exit. Telephone interview with a MA on 08/14/19 at 7:57pm revealed: -A PCA came to her on 06/03/19 between 9:00am and 10:00am and reported Resident #7 was complaining of pain to her lower right back. -The PCA brought Resident #7 to the nurse's station and she noticed Resident #7 was leaning to the side in her wheelchair. -She could not remember which side Resident #7 was leaning toward. -She noticed a palpable "knot" on backside of Resident #7's head above her right ear. -She was not sure what size the "knot" was and there was no bruising to the area. -She notified the ED; the ED told her complete and accident/injury report and send Resident #7 to the emergency room. -She did not know what happened to Resident #7's head or why Resident #7 was in pain and leaned in her wheelchair prior to the resident leaving the facility on 06/03/19. -She did not remember if she was questioned about the cause of Resident #7's injuries she found on 06/03/19 by the ED or any other management staff. Interview with a second PCA on 08/15/19 at 3:45pm revealed: -He had worked with Resident #7 on the morning of 06/03/19 and he had worked the memory care unit for third shift on 06/02/19. -Resident #7 was not part of his assignment during third shift on 06/02/19, but there had not been any injuries reported.	D 438		

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D 438	Continued From page 130 -He assisted another PCA to get Resident #7 out of bed and into her wheelchair on 06/03/19 at approximately 9:30am. -He remembered the other PCA reporting Resident #7 looked like she was in pain and the other PCA found the "knot" in Resident #7's head. -The other PCA notified the MA and the ED; and Resident #7 was sent to the emergency room. -He did not know how Resident #7 was injured. Telephone interview with a third PCA on 08/15/19 at 4:32pm revealed: -Resident #7 was sent to the emergency room on 06/03/19 -She worked with Resident #7 during second shift on 06/02/19 and the resident "did not have any knots or bruises" when she was put to bed. Telephone interview with Resident #7's family member on 08/09/19 at 12:35pm revealed: -He wanted to know what happened to Resident #7 that lead to the resident needing to be sent to the hospital on 06/03/19. -Staff at the facility had called him initially on 06/03/19, reported Resident #7 had "a knot on the side of her head", and was being sent to the hospital. -When he arrived at the hospital, the family member saw the "knot" located on the backside of Resident #7's head above her right ear and it was found that Resident #7 had fractured right hip. -It had not been reported to the family member that Resident #7 had fallen or any type of accident that could have resulted in Resident #7's right hip fracture. -He contacted the ED at the facility on 06/06/19 or 06/07/19 because he inquired about how Resident #7 was injured. -The ED told him an internal investigation was	D 438		

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D 438	Continued From page 131 being conducted. -The ED could not comment about how Resident #7 had gotten the hip fracture or the "knot" on her head until the facility's internal investigation was complete. -The family member still had not heard from the ED about the outcome of the facility's internal investigation regarding Resident #7's injuries on 06/03/19. Interview with the ED on 08/15/19 at 4:05pm revealed: -She did not know how Resident #7 got the "knot" on her head or the right hip fracture on 06/03/19. -She had staff send Resident #7 to the hospital when she saw the "knot" on 06/03/19. -There had not been any reports from staff of any accidents/incidents that could have resulted in Resident #7's right hip fracture or "knot" to her head. -She had not completed an initial report or a 5-day follow-up report for the Health Care Personnel Registry (HCPR) for Resident #7's injuries. -The previous regional compliance nurse was supposed to conduct the internal investigation regarding Resident #7's injuries which she thought was sufficient. -She did not know the outcome of the internal investigation and she did not follow-up with the regional compliance nurse regarding the internal investigation outcome or if the internal investigation was done. -The previous regional compliance nurse was no longer with the company and there was no documentation of the internal investigation about Resident #7's injuries on 06/03/19. The facility failed to completed Health Care Personnel Registry (HCPR) reporting and	D 438		

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D 438	Continued From page 132 investigation requirements for 1 of 1 sampled resident (#7) with head injury and hip fracture of an unknown origins. The facility's failure to report the injuries of unknown origins was detrimental to the health, safety and welfare of all the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/15/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 29, 2019.	D 438		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to immediately notify the department of social services and local law enforcement authorities as required by law for 1 of 1 resident sampled (#11) after staff reported an allegation of physical abuse from another resident. The findings are:	D 453		

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D 453	Continued From page 133 Review of Resident #11's current FL-2 dated 05/07/19 revealed diagnoses included dementia without behavior disturbances, Parkinson's disease, essential hypertension, hyperlipidemia, and constipation and Resident #11 was intermittently disoriented and ambulatory. Review of Resident #11's care plan dated 05/08/19 revealed: -Resident #11 was ambulatory. -She was sometimes disoriented, forgetful, and needed reminders. -Her hearing was adequate, and she had a speech impediment. Review of a nurse note for Resident #11 dated 07/24/19 revealed Resident #11 had bruise on her left forearm and Resident #11 reported another resident "grabbed her". Interview with a personal care aide (PCA) on 08/14/19 at 9:35am revealed: -She found a large dark purple/reddish colored bruise to Resident #11's left forearm on 07/24/19 when she was helping the resident with a shower. -Resident #11 reported another resident "grabbed her" her arm when she asked the resident about the bruise. -She showed Resident #11's bruise to the medication aide (MA) and the MA reported it to the Executive Director (ED). -Nothing was done when Resident #11's allegation was reported to the ED. -She did not know if the ED notified the county department of social services or the local law enforcement of Resident #11's allegation of abuse. Interview with a MA on 08/14/19 at 9:30am revealed:	D 453		

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D 453	Continued From page 134 -The PCA reported the bruise on Resident #11's forearm to her on 07/24/19 and she saw the bruise. -The bruise covered about half of Resident #11's outer lower left forearm. -Resident #11 told her another resident "grabbed her". -She reported the bruise to the ED on 07/24/19. -She did know if the county department of social services or the local law enforcement were notified about the allegation of another resident grabbing Resident #11. Review of the facility's elder abuse policy revealed: -Employees were mandatory reporters and were required to report all suspicions of abuse immediately to their supervisor. -The abuse must be reported to the county department of social services. Interview with the ED on 08/08/19 at 12:26pm revealed she had not seen any bruises to Resident #11's forearm or know anything about any allegation of Resident #11 being grabbed by another resident. Interview with the ED on 08/15/19 at 11:20am revealed: -Staff did report that Resident #11 had a bruise on her arm about two weeks ago. -An incident report was done and faxed to the county department of social services. -She was unable to locate the incident report or the fax confirmation of reporting Resident #11's allegation of being grabbed by another resident. Review of an accident/injury report for Resident #11 dated 07/24/19 at 11:30am revealed: -A bruise was observed on the left forearm of	D 453		

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D 453	Continued From page 135 Resident #11. -When staff asked Resident #11 what happened to her arm, Resident #11 reported she was grabbed by the other resident. -Staff documented they notified the ED about the report on 07/24/19 at 12:05pm. Interview with the ED on 08/15/19 at 3:15pm revealed: -There was no further investigation of Resident 11's allegation of being grabbed and bruised by the other resident. -She did not fax the accident/injury report to the local county department of social services or contact local law enforcement regarding Resident #11's allegation. -She was responsible to report the allegation, but she "must have dropped the ball" in reporting Resident #11's allegation. Based on observations, interviews, and record reviews, it was determined Resident #11 was not interviewable on 08/09/19 at 3:48pm and 08/13/19 at 3:10pm.	D 453		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure Resident #5 was treated with dignity and respect related to her bedroom door being kept locked by staff resulting	D911		

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D911	Continued From page 136 in restricted access to her bathroom. The findings are: Review of Resident #5's current FL-2 dated 01/29/19 revealed: -Diagnoses included dementia, Type II diabetes, benign hypertension, chronic interstitial cystitis, and chronic systolic congestive heart failure. -Resident #5 was intermittently disoriented. -Resident #5 was ambulatory. -Resident #5 was continent of bladder and bowel. Review of Resident #5's care plan dated 02/04/19 revealed: -Resident #5 was independent with toileting. -Resident #5 required supervision with grooming/personal hygiene. -Resident #5 resided on the locked assisted living side of the facility. Observation of Resident #5 on 08/01/19 between 1:45pm to 3:00pm revealed: - At 1:45pm Resident #5 smelled of urine. -The front and back of Resident #5's pants were saturated with urine. -Resident #5 attempted to enter her room but the door was locked. -Resident #5 paced back and forth up the hall. -No facility staff attempted to assist Resident #5 with personal care until it was brought to the personal care aides (PCA) attention at 3:00pm. Observation of Resident #5 on 08/07/19 at 9:58am to 10:04am revealed: -Resident #5 attempted to enter her room but the door was locked. -There were no observations of a PCA going to assist Resident #5 when she tried to enter into her room.	D911		

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D911	Continued From page 137 -Resident #5 sat back down in the common area. Interview with the medication aide (MA) on 08/07/19 at 10:04am revealed: -Resident #5's room door was kept locked to prevent her from "urinating all over the floor". -When the PCA's would see Resident #5 going to her bedroom they would go assist her to the bathroom. Interview with a PCA on 08/12/19 at 3:41pm revealed: -Resident #5 could tell the PCA's she needed to use the bathroom, but she did have accidents at times. -She was not sure why Resident #5's room door was locked. -The PCA would monitor Resident #5 and when she went to her room then she would go and assist her with toileting if needed. Observations of Resident #5 on 08/12/19 between 3:45pm and 3:55pm revealed: -Resident #5 walked to her room from the common area attempted to enter but the door was locked. -Resident #5 walked up the hall and then back to her room. -No PCA came to Resident #4's room to unlock the door. -Resident #5 stood in front of her room. -When the PCA was prompted at 3:55pm Resident #5's room door was unlocked. Observation on 08/13/19 between 4:17pm and 4:40pm revealed: -Resident #5's room door was locked. -When the PCA was prompted at 4:40pm she unlocked the door. -The PCA was not sure how long the room door	D911		

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D911	Continued From page 138	D911		

had been locked.

Interview with another PCA on 08/13/19 at 4:21pm revealed:
-Resident #5 and her roommate knew how to lock the room door from outside of the room.
-When Resident #5 needed the room door unlocked the resident would ask the facility staff to unlock the door.

Observations of Resident #5 on 08/07/19 at 9:58am, 08/12/19 between 3:45 and 3:55pm, 08/13/19 between 4:17pm and 4:40pm and on 08/14/19 at 10:30am revealed the resident had not asked staff to unlock the room door.

Observation on 08/14/19 at 10:30am revealed:
-Resident #5 stood at the entrance to her bedroom.
-Resident #5's room door was locked.
-Resident #5 sat back down in the common area.

Interview with Resident #5 on 08/14/19 at 10:30am revealed when asked how she locked the room door from the outside, Resident #10 stated, she opens it and puts the stuff in it".

Observations of Resident #5 on 08/07/19 at 9:58am, 08/12/19 between 3:45 and 3:55pm, 08/13/19 between 4:17pm and 4:40pm and on 08/14/19 at 10:30am revealed the resident did not know how to unlock the room door.

Interview with another PCA on 08/15/19 at 9:34am revealed:
-Resident #5 knew when she had to use the bathroom.
-Resident #5 would say it then walk to her room.
-The PCA would have to go to the bathroom with Resident #5 and assist her in making sure she

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D911	Continued From page 139 was clean and that her protective undergarment was not soiled. Observation on 08/15/19 at 10:10am revealed when Resident #5 went to her room the PCA went into the room behind her. Interview with the Administrator on 08/08/19 at 12:26pm revealed: -Every resident should have access to their room and bathroom. -The assisgned PCA was expected to provide toileting assistance to Resident #5 every two hours.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care, health care, controlled substances and Health Care Personnel Registry. The findings are:	D912		

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D912	Continued From page 140 1. Based on observations, interviews and record reviews, the facility failed to assure personal care assistance including toileting, incontinence care, nail care and turning and repositioning was done according to the needs of 3 of 9 sampled residents (#3, #4, and #13) which resulted in overgrown and ingrown toenails (#3), multiple pressure ulcers and a genital rash (#4 and #13) [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care (Type A2 Violation)]. 2. Based on interviews, observations, and record reviews, the facility failed to assure supervision was provided to 2 of 10 sampled residents (#8 and #16) who suffered multiple falls (#8) resulting in skin tears and head injuries (#16) [Refer to Tag 270 10A NCAC 13F .0901(b) Supervision (Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow up with the residents' primary care provider for 4 of 7 sampled residents (#3, #4, #10 and #18) including the follow up and podiatry referral for an ingrown toenail for 3 weeks (#3); home health referral for wound care for 3 weeks and a neurology referral for 6 weeks (#4); follow up with the orthopedic physician for discontinuation orders for an orthopedic boot (#10);and reporting a total of 11 pound weight loss in 6 weeks to the PCP (#18) [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 4. Based on observation, interviews, and record reviews, the facility failed to assure readily retrievable records and failed to account for the use and administration of controlled substances for 1of 6 residents (#1) sampled who had 270	D912		

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D912	Continued From page 141 Percocet tablets unaccounted for since admission on 05/06/19 and no controlled substance (CS) logs for May 2019, June 2019, July 2019, and August 2019 for Percocet administration [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5-day requirements for 1 of 1 sampled resident (#7) who sustained a head injury and hip fracture of unknown origins [Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: I. TYPE A2 VIOLATION Based on observation, interviews, and record review, the facility failed to assure 1 of 1 sampled resident (#11) was protected from abuse and injury which resulted in verbal abuse and bruising from another resident. The findings are: Review of Resident #11's current FL-2 dated 05/07/19 revealed:	D914		

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	HAL047011	A. BUILDING: _____ B. WING _____	R 08/15/2019

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D914	Continued From page 142 -Diagnoses included dementia without behavior disturbances, Parkinson's disease, essential hypertension, hyperlipidemia, and constipation. -Resident #11 was intermittently disoriented and ambulatory. Review of Resident #11's care plan dated 05/08/19 revealed: -Resident #11 was ambulatory. -She was sometimes disoriented, forgetful, and needed reminders. -Her hearing was adequate, and she had a speech impediment. Observation of Resident #11 on 08/07/19 at 10:15am revealed: -She was alert, oriented to person only, and had garbled speech. - She was dressed appropriately and used a rollator for ambulation. - She was observed trying to put on her shoes without staff assistance. Interview with Resident #11 on 08/07/19 at 10:15am revealed: -Resident #11 reported the other resident was not in the room. -Resident #11 did not know where the other resident had left, and she was looking for him. -Resident #11 kept responding "I don't know" when asked additional questions about the other resident and what type of care she received. Confidential interview with a staff member revealed: -Resident #11 had resided in the same room as another resident since May 2019. -The other resident was "very verbally abusive" toward Resident #11. -The other resident yelled and spoke harshly to	D914		

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D914	Continued From page 143 Resident #11 by saying to Resident #11 that "you act like you don't have any sense". -The other resident yelled at Resident #11 when Resident #11 did not move fast enough for the other resident. -The other resident did not understand that Resident #11's actions were from her dementia and Parkinson's disease. -Staff had complained several times to the Executive Director (ED) about how Resident #11 was spoken to by the other resident. -The staff could not remember the dates the staff had complained to the ED about the concerns, but nothing was done to address the concerns. -The staff was afraid for Resident #11 to reside in the same room as the other resident because the other resident did not have patience to deal with Resident #11's dementia. Interview with the other resident who resided in the room with Resident #11 on 08/08/19 at 11:23am revealed: -He had lived at the facility since May 2019 and he asked for Resident #11 to be moved into the room with him when he was admitted to the facility. -He wanted Resident #11 in the room with him so he could take care of her. -It was hard taking care of Resident #11 because of her dementia, but he wanted to take care of her. -He got frustrated with Resident #11 sometimes because she "did not understand a lot of things" because of her dementia. -He yelled sometimes at Resident #11 because she did not respond to him unless he yelled at her. -"It was hard to get her (Resident #11) to understand sometimes like last night, she would not go to sleep".	D914		

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D914	Continued From page 144 -He had to be up at 5:30am to go for a doctor's appointment and at one o'clock in the morning and Resident #11 would not stop talking and he was trying to get some sleep. -He finally told her "to shut the (expletive) up" to get Resident #11 go to sleep. -Resident #11 would not be quiet and go to sleep until he yelled at her. -He did not know what else to do to get her (Resident #11) to be quiet so that he could go to sleep. Confidential interview with a second staff member revealed: -The staff member was concerned about how the other resident treated Resident #11. -The staff member had reported that the other resident was verbally and physically aggressive towards Resident #11 to the ED several times within the last two months. -The staff had seen bruises to Resident #11's face when the other resident visited Resident #11 when she resided in the memory care unit. -Staff could not specify when the staff saw the bruises to Resident #11's face, but nothing was done about the bruises when it was reported to the ED. -Resident #11 was moved out the memory care unit to the assisted care unit at the request of the other resident when the he was admitted to the facility in May 2019. -Staff was afraid Resident #11 would be hurt by the other resident if they continued to reside in the same room together. -Resident #11 shrank away from the other resident when he came into their room and he "yelled a lot" at Resident #11 "for no reason". -The other resident yelled sometimes at Resident #11 "why are you acting like that", "I don't understand why you are acting like you don't have	D914		

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D914	Continued From page 145	D914		

any sense", "you need to come on and hurry up" and he sometimes used profanity when he yelled at Resident #11.
-Staff tried to intervene and explained to other resident that Resident #11 could not comprehend normally because of her dementia, but the other resident would become angrier and more frustrated with Resident #11.

Review of a nurse's note for Resident #11 dated 07/24/19 revealed Resident #11 had bruise on her left forearm and Resident #11 reported the other resident had grabbed her.

Review of an accident/injury report for Resident #11 dated 07/24/19 at 11:30am revealed:
-A bruise was observed on Resident #11's left forearm.
-When staff asked Resident #11 what happened to her arm, Resident #11 reported she was grabbed by the other resident.
-Staff documented they notified the ED about the report on 07/24/19 at 12:05pm.
-The accident/injury report was signed by the ED on 07/24/19.

Interview with a personal care aide (PCA) on 08/14/19 at 9:35am revealed:
-She found a large dark purple/reddish colored bruise to Resident #11's left forearm on 07/24/19 when she was helping the resident with a shower.
-When she asked Resident #11 about the bruise, she reported the other resident had grabbed her.
-She showed Resident #11's bruise to the medication aide and the medication aide reported it to the ED.
-The ED did not do anything when Resident #11's allegation was reported to the her.
-Resident #11 was afraid of the other resident and Resident #11 shrank away when the other

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D914	Continued From page 146	D914		

resident who lived in the room with her.
-The other resident yelled and used profanity sometimes at Resident #11.
-The other resident often became angry with Resident #11 because she did not move fast enough for him and he yelled at Resident #11.
-If the other resident told Resident #11 to stay in the room when he left the facility, then Resident #11 sat in the chair and looked out the window most of the time until the other resident returned.
-Staff could not get Resident #11 to leave the room because Resident #11 insisted the other resident told her to stay in the room and she had to stay in the room.
-Staff had reported their concerns about the other resident's interactions with Resident #11 to the ED several times in the two months.
-She was afraid the other resident could hurt Resident #11 because he would get so angry with Resident #11.

Interview with a medication aide (MA) on 08/14/19 at 9:30am revealed:
-The PCA reported the bruise on Resident #11's forearm to her on 07/24/19 and she saw it.
-The bruise covered about half of Resident #11's outer lower left forearm.
-Resident #11 told her the other resident had grabbed her arm.
-She reported the bruise to the ED and notified Resident #11's health care provider.
-The ED did not instruct the staff to do anything to protect Resident #11 after the allegation of the other resident grabbing Resident #11.
-She was afraid for Resident #11 to be alone in the room with the other resident.
-The other resident yelled and cursed at Resident #11 and he became angrier when the staff tried to intervene when he was verbally abusive to Resident #11.

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D914	Continued From page 147 -Staff had reported the verbally abusiveness to the ED several times since the other resident had been admitted to the facility in May 2019. -She was afraid Resident #11 would be hurt seriously if Resident #11 continued to stay in the room with the other resident. Interview with Resident #11's health care provider on 08/08/19 at 10:35am revealed: -Staff had reported to her about two weeks ago about Resident #11 having a bruise on arm from the other resident. -She was concerned about Resident #11 being in the room with the other resident because staff had reported the other resident was aggressive towards and spoke harshly to Resident #11. -She did not order any intervention because the other resident wanted Resident #11 to stay in the room together with Resident #11so he could take care of her. -Staff had reported that the other resident yelled "you need to come on now" when Resident #11 could not move fast enough for him "like she (Resident #11) intentionally tried to get his nerves". -The other resident did not understand Resident 11's dementia caused her respond to him differently and it frustrated the other resident. -It was difficult to communicate with Resident #11 sometimes because of her dementia. -Resident #11 had told her that the other resident had slapped Resident #11's face within the last two months (unable to specify the date). -She could not remember if she told the ED about the slapping. -She had spoken to the ED about two weeks ago about her concerns with how the other resident treated Resident #11 and about the bruise on Resident #11's arm. -She had discussed with the ED that the other	D914		

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D914	Continued From page 148 resident needed to be discharged from the facility because of how he treated Resident #11 and the other resident did not have any personal care needs that he could not manage independently. -She was concerned about Resident #11's safety when the other resident became frustrated, but she did not know what else to do after she spoke to the ED. -She did not believe it was a good idea for Resident #11 and other resident to live in the same room together. Interview with the ED on 08/08/19 at 12:26pm revealed: -Staff had reported to her that the other resident talked "hateful" to Resident #11 when Resident #11 was not moving fast enough for him and that was only reported to her one time. -Staff had not reported that Resident #11 shrank away from the other resident. -There had not been any reports from staff about the other resident hitting Resident #11 or that Resident #11 had been bruised by the other resident. -There had not been any discussion or concerns voiced to her from the staff or the health care provider about Resident #11's safety when she was with the other resident. -She had not put any interventions in place to protect Resident #11 from the other resident because she did not know of any reports of the other resident yelling at Resident #1 except for one time. Interview with a second MA on 08/14/19 at 10:20am revealed: -The other resident did not have patience to deal with Resident #11's dementia, but he insisted that he and Resident #11 live in the same room at the facility.	D914		

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D914	Continued From page 149 -She saw the bruise on Resident #11's forearm on 07/24/19 and Resident #11 told her that the other resident grabbed her arm. -An accident report had been done but nothing was done about the other resident grabbing Resident #11. Based on observations, record review, and interviews, it was determined Resident #11 was interviewable on 08/09/19 at 3:48pm and 08/13/19 at 3:10pm. Interview with the other resident on 08/14/19 at 1:05pm revealed he had never been verbally or physically abusive toward Resident #11. Telephone interview with Resident #11's mental health provider on 08/15/19 at 9:41am revealed: -She had observed the other resident being verbally aggressive to Resident #11 and she spoke with the ED about it in June 2019 and was she started seeing the other resident for mental health services. -The other resident did have some problems with adjustment and anxiety since he was admitted to the facility. -The other resident yelled and raised his voice at Resident #11 and the other resident was impatient in dealing Resident #11's dementia. -The other resident had anger issues and anxiety and there were problems with the other resident who complained of how he had to take care of the Resident #11. -The other resident was not capable to taking care of Resident #11 and that made the other resident frustrated with Resident #11 sometimes. -If the other resident told Resident #11 not to leave the room then Resident #11 stayed in the room until other resident returned to the room. -The other resident tried to isolate Resident #11	D914		

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D914	Continued From page 150	D914		

to stay in the room when he was gone.
-Staff had reported to her that Resident #11 was afraid of the other resident.
-It was hard to communicate with Resident #11 to find out if Resident #11 was afraid of the other resident.
-Resident #11 had a history of Parkinson's disease with occasional tremors, however, she noticed on several occasions that Resident #11 seemed to shake more when she was around the other resident.
-She told the ED in June 2019 that she did not think it was a good idea for the other resident to live together with Resident #11 because of the other resident's anxiety and anger issues would make living with Resident #11 could make the other resident more anxious because he could not understand what Resident #11 could and could not do.
-The ED did not make any interventions and Resident #11 remained in the same room with the other resident.
-She did expect staff to keep Resident #11 safe from the other resident and she did not know of any allegation of Resident #11 being grabbed by the other resident.
-If the other resident was physically abusive to Resident #11 then the two residents should be separated.

Interview with the ED on 08/15/19 at 3:15pm revealed:
-She did not follow-up with Resident #11's allegation with Resident #11 because of her dementia.
-She asked the other resident what happened, and he reported Resident #11's arm was bruised because he had to pull her up to stand.
-She did not remember speaking to Resident #11's mental health provider about concerns

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D914	Continued From page 151 about the other resident's anger issues or verbal abuse in June 2019. -She did not remember the mental health provider expressed concerns about Resident #11 living the other resident because of his anger issues and anxiety. -She would have taken actions if those concerns had been expressed to her sooner. The facility's failure to protect Resident #11 from physical and repeated verbal abuse by another resident resulted in Resident #11 sustaining a bruise to her left forearm. The facility's failure to protect Resident #11's physical and mental well-being resulted in substantial risk of serious injury and neglect which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-21 on August 8, 2019 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2019. II. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care and supervision, health care, controlled substances, health care personnel registry reporting and residents' rights. [Refer to Tag 980 G.S.131D-25 Implementation (Type A2 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation	D980		

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D980	Continued From page 152 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 A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care and supervision, health care, controlled substances, health care personnel registry reporting and residents' rights. The findings are: Interview with a medication aide (MA) on 08/09/19 at 4:41pm revealed: -New orders, referrals or sending residents out the hospital had to go through the Resident Care Coordinator (RCC) or Administrator. -The MA faxed new orders to the pharmacy and then notified the RCC or Administrator. -After hours the MA called the RCC or Administrator. -The RCC and/or Administrator had to know what was going on, the MA called about "anything" because the RCC or Administrator had to give the okay before the MA could do anything. Interview with an Executive Director (ED) from a sister facility on 08/07/19 at 2:32pm revealed: -She was instructed by her Supervisor to help on 08/06/19 and was scheduled to be at the facility two days every week.	D980		

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D980	Continued From page 153 -The Administrator was new and covering a lot of roles because "key staff" were out of work. Interview with the Administrator on 08/08/19 at 8:41am revealed there was one RCC for the building; the RCC had been out sick for one week and she was covering the role of RCC. Interview with the Administrator on 08/13/19 at 3:22pm revealed: -She started as the Administrator around the 3rd week of March 2019; she was the RCC prior to becoming the Administrator. -The Regional Director was at the facility for support when she first started as the Administrator. -The were EDs from a couple of other sister facilities who also provided support. -She did not know how long the RCC position was vacant before hiring a new RCC. -She covered as both the RCC and Administrator when she first started as the Administrator and again since the RCC was out sick. -She was in the process of assigning RCC responsibilities to a MA on the assisted living (AL) side and a second MA on the locked hall side. Interview with the Administrator on 08/15/19 at 3:41pm revealed: -MAs reported any concerns to the RCC or her. -She did a "walk through" of the facility every morning to make sure staffing was okay and breakfast was running smoothly. -She checked behind the RCC daily to make sure newly ordered medications were in the building. -She made random observations throughout the day of the common areas, meals and medication passes. Interview with the ED from a sister facility on	D980		

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D980	Continued From page 154 08/15/19 at 3:41pm revealed: -The Administrator had a "Daily Driver" sheet she was responsible for completing each day. -The Daily Driver sheet was a to do list which included supervision for what the RCC did such as medication management and referral and follow up. Interview with an ED from a sister facility on 08/13/19 at 3:22pm revealed she would be at the facility every Monday, Wednesday and Friday, a regional representative would cover the facility on Tuesdays and Thursdays. Non compliane was identified at the violation level in the following rule areas: 1. Based on observations, interviews and record reviews, the facility failed to assure personal care assistance including toileting, incontinence care, nail care and turning and repositioning was done according to the needs of 3 of 9 sampled residents (#3, #4, and #13) which resulted in overgrown and ingrown toenails (#3), multiple pressure ulcers and a genital rash (#4 and #13) [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care (Type A2 Violation)]. 2. Based on interviews, observations, and record reviews, the facility failed to assure supervision was provided to 2 of 10 sampled residents (#8 and #16) who suffered multiple falls (#8) resulting in skin tears and head injuries (#16) [Refer to Tag 270 10A NCAC 13F .0901(b) Supervision (Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow up with the residents' primary care provider for 4 of 7 sampled residents (#3,	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047011	A. BUILDING: _____ B. WING _____	R 08/15/2019

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D980	Continued From page 155 #4, #10 and #18) including the follow up and podiatry referral for an ingrown toenail for 3 weeks (#3); home health referral for wound care for 3 weeks and a neurology referral for 6 weeks (#4); follow up with the orthopedic physician for discontinuation orders for an orthopedic boot (#10);and reporting a total of 11 pound weight loss in 6 weeks to the PCP (#18) [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 4. Based on observation, interviews, and record reviews, the facility failed to assure readily retrievable records and failed to account for the use and administration of controlled substances for 1of 6 residents (#1) sampled who had 270 Percocet tablets unaccounted for since admission on 05/06/19 and no controlled substance (CS) logs for May 2019, June 2019, July 2019, and August 2019 for Percocet administration [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5-day requirements for 1 of 1 sampled resident (#7) who sustained a head injury and hip fracture of unknown origins [Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. 6. Based on observation, interviews, and record review, the facility failed to assure 1 of 1 sampled resident (#11) was protected from abuse and injury which resulted in verbal abuse and bruising from another resident. [Refer to Tag 914 G.S.131D-21(1) Residents' Rights (Type A2 Violation)].	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D980	Continued From page 156 The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing personal care, supervision, health care, controlled substances, health care personnel registry reporting and residents' rights. The Administrator's failure to implement rules and regulations resulted in pressure ulcers for two residents (#4 and #13); significant risk of harm for Resident #11 who experienced verbal and physical abuse by another resident. The Administrator's failure resulted in substantial risk of serious neglect and physical harm which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/14/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2019.	D980		