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D 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey and complaint investigation from 12/09/19 - 12/13/19 and 12/16/19.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 2 residents sampled (#4, #7) with multiple falls resulting in serious physical injuries to include an acute care hospitalization for a subdural hematoma (#7) and a head laceration requiring staples and a laceration of the resident's finger requiring stitches (#4). The findings are: Review of the facility's Fall Management Program revealed: -A fall assessment tool was completed for all residents admitted to determine factors that may contribute to possible falls.	D 270		

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-Staff would receive formal training on Fall Prevention Awareness.
-Staff were reminded of fall prevention techniques during staff meetings.
-Staff completed an Incident Report in its entirety for any falls.
-The Executive Director and or the Care Managers should determine any immediate interventions required, based on circumstances of the fall.
-Staff were responsible for completing a 72 hour Follow Up on resident falls to investigate possible circumstances contributing to the fall and documents observations for the period of 72 hours after the fall.
-72 hours after incident documentation included vital signs initially and every 72 hours, additional vital signs may be taken.
-Assessment of possible risk/contribution factors for falls included where the resident fell, was the area cluttered, and pathways and furniture, if the fall was in bathroom, use of proper shoes, if the resident was receiving any psychotropic medications, if the resident was a diabetic, was the resident utilizing an assisted device and were there any medication changes.
-If the resident had two falls within a 4 week period the primary care provider (PCP) was contacted to request a physical therapy evaluation to other treatment interventions.
-The resident was placed on a HOT BOX/ALERT CHARTING for 72 hours for follow up and monitoring.
-The Healthcare Team/QA Team would review incident reports on a monthly basis.

1. Review of Resident #7's current FL-2 dated 07/06/19 revealed:
-Diagnoses included gastroesophageal reflux disease, anemia, muscle weakness, difficulty

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walking, major depressive disorder, disorientation and hyperlipidemia.
-Resident #7 was non-ambulatory, constantly confused and wandered.

Review of Resident #7's current care plan dated 07/06/19 revealed:
-Resident #7 was ambulatory with a wheelchair and wandered.
-Resident #7 was always disoriented, forgetful and needed reminders.
-Resident #7 required limited assistance with ambulation and transfers.

Review of an accident/incident report dated 10/12/19 at 5:30am for Resident #7 revealed:
-Resident #7 was found on the floor in her room bleeding.
-Resident #7 had bruising and swelling.
-Resident #7 was sent to the emergency room (ER) and diagnosed with a head injury and bruise of face, neck or scalp.

Review of emergency room notes dated 10/12/19 for Resident #7 revealed there was documentation Resident #7 was found on the floor from falling out of bed and per the emergency medical services (EMS) it was not known how long Resident #7 was on the floor.

Upon request Care notes for Resident #7 dated prior to 10/13/19 revealed the notes were not available for review on 12/12/19, 12/13/19 and 12/16/19.

Interview with a personal care aide (PCA) on 12/16/19 at 12:28pm revealed:
-Resident #7 had a "bad fall" in October 2019 where she had bruises on her face and got increasingly confused.

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-Resident #7 was a resident that staff had to be supervised at all times because Resident #7 would try to stand and fall.
-She was never told Resident #7 was on every 15 minute checks.
-She was told last week that residents were supposed to be on every 15 minute checks after a fall; she was never told during her training in October 2019.
-Resident #7 had a chair alarm staff attached to the back of her wheelchair and placed on top of the accent chairs in the common area; Resident #7 liked to sit in the accent chairs in the common area.
-The alarm would fall from the top of the accent chair, detach from the resident if she tried to get up and the alarm would sound.
-The alarm box did not have to be secured to the accent chair.

Telephone interview with the Hospice Director of Operations on 12/16/19 at 10:16am revealed:
-Resident #7 was admitted to Hospice on 10/20/19; there were 3 falls documented in Resident #7's Hospice record: 11/18/19, 11/28/19 and 12/02/19.
-Hospice had a fall mat and electric hospital bed delivered on 10/25/19 and a pull tab alarm delivered on 10/29/19.

Review of a care note dated 11/18/19 at 6:32pm revealed Resident #7 leaned forward in a chair and fell onto the floor; Resident #7 was not injured.

Review of a care note dated 11/28/19 at 2:06pm revealed Resident #7 slid out of her wheelchair and landed on her bottom without injury.

Review of an accident/incident report dated

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D 270	Continued From page 4 12/02/19 at 7:04pm for Resident #7 revealed: -Resident #7 was sitting in a chair in the common area across from the dining room with the alarm attached to her. -Resident #7 "rolled up" the alarm, attempted to get up and hit the floor also hitting her head. -Resident #7 was sent to the ER. Review of a care note dated 12/02/19 at 7:07pm revealed -Resident #7 was sitting in a chair in the common area across from the dining room with the alarm attached to her. -Resident #7 "rolled up" the alarm, attempted to get up and hit the floor also hitting her head. Interview with a medication aide (MA) on 12/16/19 at 1:10pm revealed: -On 12/02/19, Resident #7 was in the common area across from the dining room when she fell; the PCA had "just walked away" from the common area. -Resident #7's fall was unwitnessed, and no alarm went off when she fell. -Resident #7 had been sitting in one of the accent chairs prior to the fall on 12/02/19. -She did not assist Resident #7 into the accent chair and did not know where the alarm was at the time of the fall. -Resident #7 was able to reach back, grab and hold the alarm in her hands. -She did not know of any interventions put in place after 12/02/19 to decrease falls and injury for Resident #7. -Resident #7 was wheelchair bound and had an alarm on her wheelchair and bed. -PCAs and MAs monitored Resident #7 "closely when she was in the day room." -Staff had to "keep an eye on" Resident #7 because she would try to get up on her own.	D 270		

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-She was not sure if Resident #7 was on every 15 minute checks.
-She learned in the last week or two, that residents were automatically placed on every 15 minute checks after a fall.
-She was not told when she started and had to verify the policy with the Resident Care Coordinator (RCC); she had been told by another staff.

Interview with the RCC on 12/16/19 at 12:43pm revealed:
-Resident #7 was placed on the 72 hour post fall monitoring after the fall on 12/02/19; the MAs were responsible for checking the resident's vital signs each shift.
-Resident #7 was not on every 15 minute checks after she fell on 12/02/19.

Review of an accident/incident report dated 12/09/19 at 8:56am revealed:
-Resident #7 was found at 6:50am lying on the floor in the hallway bleeding from her forehead.
-Resident #7 had a laceration and was sent to the ER.

Interview with a second PCA on 12/09/19 at 11:00am revealed:
-Resident #7 fell before breakfast at about 6:45am and went to the hospital this morning (12/09/19).
-There was "gushing blood" from the right side of the resident's head.
-The resident used a wheelchair and would try to get out of the wheelchair.
-Staff tried to watch Resident #7 every moment they could.
-She (PCA) was with another resident this morning when she heard an alarm and a "boom".
-Resident #7 had "maybe 3 falls in the last two

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months".

Review of hospital records for Resident #7 revealed:
-Resident #7 was admitted on 12/09/19 with a subdural hematoma and laceration of the forehead after a fall.
-The forehead laceration was closed with 6 sutures.
-Resident #7 was transferred to inpatient hospice.

Interview with the Assistant RCC on 12/16/19 at 12:19pm revealed:
-She was working as a MA on the locked section on 12/09/19.
-She had arrived to work early at 6:45am and was counting medications at the medication cart with the outgoing MA when she heard a "loud thud" and an alarm sound.
-Resident #7 was on the floor in the hallway at the entrance of the locked side between the common area and the dining room.
-She was not sure if there was a PCA at the front common area with residents; normally a PCA was there.
-Resident #7 was bleeding from a wound on her head; none of the staff on duty witnessed the resident fall.

Telephone interview with Resident #7's family member on 12/16/19 at 9:46am revealed:
-Resident #7 had 4 falls at the facility; one in her room and the remaining falls in the common area.
-Resident #7 spent most of her time in the front area.
-Resident #7 did not get a fall mat until Hospice was involved.
-Resident #7 had an alarm, but the cord was so long she would be on the floor before it set off.
-He was not aware of any increased supervision

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being provided for Resident #7.
-Resident #7 fell on 12/09/19 and had a subdural hematoma; the resident had been transferred to inpatient Hospice from the hospital.

Telephone interview with Resident #7's primary care provider (PCP) on 12/13/19 at 4:00pm revealed:
-Resident #1 had declined and was put on Hospice at the facility.
-Resident #7 was weak, wheelchair bound and was not able to stand without falling.
-There were medication changes by the emergency room and Hospice; those medications increased Resident #7's fall risk.

Interview with the Executive Director (ED)/Administrator on 12/16/19 at 3:09pm revealed:
-Resident #7 was not on 15 minute checks during her time at the facility 06/17/19 through 12/09/19.
-Staff had educated Resident #7 on use of the call bell and shortened the length of the chair alarm cord to decrease injury and falls for the resident.
-She did not think 15 minute checks were warranted for Resident #7 on the smaller locked side with 20 residents and 3 PCAs.
-She did not know staff had been placing the chair alarm on the top back of accent chairs in the common area where there was risk the alarm may not disconnect and sound and where the resident was known to grab and hold the alarm.

Second interview with the ED/Administrator on 12/16/19 at 4:08pm revealed:
-Staff did not have to do every 15 minute checks as part of the fall prevention monitoring.
-The 72 hour monitoring documented on the electronic medication administration record

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(eMAR) was part of the fall prevention monitoring.
-She, the Assistant RCC and RCC collaboratively decided when a resident needed every 15 minute checks depending on the individual circumstances.
-She conducted random rounds throughout the building each day; she checked documentation randomly and assured staff were doing what they were supposed to be doing.
-A PCA was expected to be within sight of the locked side common area across from the dining room at all times when residents were there.

2. Review of Resident #4's current FL-2 dated 07/08/19 revealed:
-Diagnoses included Alzheimer's disease, unspecified dementia without behavioral disturbances, acute myocardial infarction, unspecified atrial fibrillation, heart failure, unspecified dementia with behavioral disturbance, cerebral infarction unspecified, atherosclerotic heart disease of a native coronary artery, unspecified osteoarthritis, muscle weakness, unsteady on feet and difficulty in walking.
-There was documentation the resident was constantly disoriented and wandered.

Review of Resident #4's Resident Register revealed an admission date of 07/10/19.

Review of Resident #4's Hospice Comprehensive Assessment and Plan of Care dated 11/27/19 revealed:
-The resident had impaired cognitive function and was very forgetful which made communication difficult.
-The resident was hard of hearing.
-The resident required maximum assistance with all activities of daily living including pivoting from

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the wheelchair to the bed.
-The resident was unable to lift his legs into the bed.
-The resident had increased drowsiness and often requested to return to bed to rest throughout the day.
-The resident had a history of frequent falls and continued anxiety.
-The resident had recent medication changes to reduce the falls and drowsiness.

Review of Resident #4's Quarterly Licensed Health Professional Support (LHPS) review dated 11/18/19 revealed:
-The resident had multiple medical problems and was receiving hospice care.
-The resident was wheelchair bound and unable to propel himself and required staff assistance to transfer and propel his wheelchair.
-The resident was unable to feed himself.
-Personal care tasks included transferring and assistive devices from staff.

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

a. Interview with a personal care aide (PCA) on 12/09/19 at 11:10 am revealed:
-Resident #4 was a fall risk.
-Resident #4 attempted "a lot" to get up without staff assistance.
-Staff would remind Resident #4 not to get up without assistance but the resident could not remember and would forget "very easily".

Confidential interview revealed:
-Resident #4 had fallen "a dozen times".
-Resident #4 had required stitches in the back of his head because of a fall due to hitting his head

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on a shelf in his room.
-Resident #4 was weak and would fall when sitting up with no support.
-Some staff kept Resident #4's bed raised at the foot.
-The confidential interview saw Resident #4 sitting on the edge of the bed with this bed alarm sounding and the resident yelling "help, help" with no staff response to the resident.
-The confidential interview saw 4 to 5 call alarms going off around Resident #4's room when he was calling for help.

A second confidential telephone interview revealed Resident #4 had falls and some of the staff rarely came when the resident hollered out for help when he was in his room.

Observation in the hallway on the unlocked section of the facility on 12/12/19 between 2:34pm and 2:54pm revealed:
-At 2:34pm Resident #4 could be heard yelling "help, help" from his room.
-Resident #4 was seated at the edge of the bed with both feet on a fall mat on the floor and was observed repeatedly raising himself slightly off the bed and sitting back down.
-There was no audible bed alarm heard.
-At 2:35pm two medication aides (MAs) were sitting behind the nurse's station and were informed Resident #4 was yelling for help, sitting on the edge of the bed and was attempting to stand up.
-One of the MAs reported "he was probably ready to get up".
-The two MAs remained in a seated position at 2:35pm.
-At 2:37pm one of the MAs who had been prompted concerning Resident #4 was observed walking down the hall, entered the the dining

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room, then back down the hallway toward the nurse's station.
-At 2:46pm, Resident #4 was still seated on the side of the bed with his feet on the fall matt.
-Resident #4 stated that he wanted to get up.
-Resident #4's bed alarm was unplugged, and the alarm box was lying on the bedside table.
-Resident #4 stated "I don't know" when asked what the call bell string was for.
-Resident #4 had multiple discolored areas on his arms and a plastic bandage.
-At 2:50pm the call string chord for the call bell was pulled for staff assistance.
-At 2:54pm a PCA entered the room and stated the he heard Resident #4's call bell going off when he stepped out of another resident's room.
-There was a 20 minute delay and only after prompting before staff responded to Resident #4.

Observations of four staff in the unlocked section of the facility on 12/12/19 from 2:45pm to 2:55pm revealed:
-The MA was standing at the medication cart in front of the staff desk.
-There were two PCAs standing in front of the staff desk talking to each other.
-There was one PCA seated behind the staff desk talking to staff standing at the desk.

Observation of the PCA on 12/12/19 at 2:55pm who was sitting behind the staff desk revealed the PCA went down the hall and entered the door toward Resident #4's room.

Interview with a PCA on 12/12/19 at 2:45pm revealed:
-She could have a conversation with Resident #4 periodically.
-Sometimes Resident #4 yelled.
-When Resident #4 yelled, the resident wanted

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someone to talk to him.
-Resident #4 would yell out a name, and she did not know who the person was the resident was calling out to.
-She provided incontinent care for Resident #4 and made sure he was dry.
-Fifteen minute checks were done and documented for Resident #4.

Interview with the PCA that entered Resident #4's room on 12/12/19 at 3:00pm revealed:
-No staff told him to check on Resident #4 (12/12/19) at 2:54pm.
-He came to Resident #4's room after he stepped out of another resident's room which was located beside the nurse's station and saw Resident #4's call bell on at the call bell hub at the nurse's station.
-He usually could hear call bells in the other resident's room beside the nurse's station but did not hear Resident #4's call bell because he was using an electric razor in the room.
-It was a routine occurrence for Resident #4 to try to get up out of bed without staff assistance.
-There were some days that Resident #4 could get up by himself and some days he could not because he would not be stable on his feet.
-Resident #4 had a "couple of falls" in the past.
-Resident #4 was very confused.
-Resident #4 would unplug his bed alarm.
-If Resident #4's bed alarm had not been unplugged he would have heard the alarm and possibly had known the resident needed help sooner.
-Resident #4 was on a 2-hour check by staff but because Resident #4 kept on calling out and trying to get up he tried to keep more of a close eye on him by checking him more often.
-He did not document when Resident #4's checks were done.

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D 270	Continued From page 13 -After assisting Resident #4, the resident did not get up and wanted to lay back down. Observation in the hallway on 12/12/19 at 3:15pm revealed Resident #4 was yelling "help, help", I need some help". Observation of a MA on 12/12/19 at 3:18pm revealed a MA entered Resident #4's room. Interview with the MA that entered Resident #4's room at 3:18pm on 12/12/19 at 3:20pm revealed: -Resident #4 could not walk by himself but would sit on the side of the bed. -Staff would know when Resident #4 raised off the bed, because his alarm would go off. -If Resident #4's bed alarm was unplugged then the bed alarm would not sound. Interview with a PCA on 12/12/19 at 3:24pm revealed she never saw and was not aware Resident #4 unplugged his bed alarm. Telephone interview with Resident #4's Hospice Nurse on 12/13/19 at 3:09pm revealed: -The resident was seen by a Hospice nurse twice weekly. -The resident had some falls over the last 2 months, some falls occurred because the resident would slide out of bed. -The resident's skin was paper-thin and a skin tear could occur very easily. -The resident was very confused and could not follow simple commands. -A bed alarm, fall pad and ½ rails were ordered because the resident was a fall risk. -The resident's bed alarm was set so when pressure was released off the bed when he stood the bed alarm would activate and would hopefully alert staff before he got up out of bed.	D 270		

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-It was important to keep the resident's bed alarm on at all times.
-She had never observed the bed alarm disconnected when she visited the resident, but she thought the resident could disconnect the alarm.
-The resident had additional bleeding risks when he fell because he was on an anticoagulant (a medication to thin the blood).

Review of Resident #4's every 15 minute, Increased Supervision and Accountability Check List for December 2019 revealed:
-There was no documentation 15 minute checks were done from 12/01/19 from 7:00pm through 6:45pm on 12/02/19.
-There was no documentation 15 minute checks were done from 5:00pm through 6:45pm on 12/03/19.
-There was no documentation 15 minute checks were done on 12/07/19 from 7:00am through 6:45pm.
-There was no documentation 15 minute checks were done on 12/08/19 from 7:00am through 6:45pm.
-There was no documentation 15 minute checks were done on 12/12/19 from 7:00am through 5:45pm.
-On 12/12/19, 15 minute interval checks were documented as started at 6:00pm with instructions to confirm "that alarm is functioning and that resident is safe".

Interview with the Executive Director (ED)/Administrator on 12/12/19 at 5:40pm revealed she expected staff to respond immediately when Resident #4 was attempting to get up.

Interview with the ED/Administrator on 12/13/19

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D 270	Continued From page 15 at 8:35am revealed: -A care plan meeting was held today (12/13/19) for the best method for additional interventions for Resident #4 due to his attempts to get up out of bed without assistance and disconnecting his bed alarm. -She had spoken with the two MAs that were prompted that Resident #4 was attempting to get up on 12/12/19 and the MAs reported that they did not interpret that he needed staff assistance immediately. -One of two MAs was "clocked out" and was going on break, the other MA had the medication cart keys on her and told a PCA (named PCA that was observed entering the resident's room on 12/12/19 at 2:54pm) to check on Resident #4. -Resident #4 had not always been on 15-minute checks and was on 15-minute checks at intervals. -Resident #4 was placed on 15-minute checks when he had an incident, increased agitation, or when he was observed trying to get out up without staff. -The MAs assessed for the need for increased 15-minute checks and the Resident Care Coordinator (RCC), Assistant and herself determined if 15-minute checks needed to be implemented based on the resident's needs. Interview with one of the MAs prompted to assist Resident #4 on 12/12/19 on 12/16/19 at 9:47am revealed: -Resident #4 required assistance with bathing, incontinent care, and eating. -Resident #4 could get up and stand or "somewhat stand" and was dependent on his leg strength that day if he was able to stand. -Resident #4 was a "moderate" risk for falling and had fallen approximately 3 to 4 times since she started working at the facility in August 2019. -The resident could not follow directions due to	D 270		

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his disorientation.
-When she was prompted on 12/12/19 that Resident #4 needed help she understood that the resident was hollering for help and that he needed help.
-On 12/12/19, she and another MA had been counting medication "carts" and were putting in their passwords for the computer.
-The other MA at the desk on 12/12/19 was going to lunch.
-As soon as she walked away from the nurse's desk, she saw a PCA coming down the hallway and told him the resident needed help.
-She knew that someone needed to help Resident #4 because he would have tried to get up on his own without staff.
-Resident #4's bed alarm was used to help prevent the resident from falling and alerted staff that the resident was attempting to get up.
-Resident #4 was able to disconnect his bed alarm.
-She had not reported to the ED/Administrator that Resident #4 could disconnect the bed alarm.
-Resident #4 received the bed alarm approximately 1 to 1 ½ months ago.
-Staff were informed verbally by the Resident Care Coordinator (RCC) or the Assistant RCC when Resident #4 was placed on 15-minute checks and verbally told when the 15-minute checks ended.
-Resident #4 should have been on 15-minute checks on 12/12/19.

Interview with the second MA that was prompted to assist Resident #4 on 12/12/19 on 12/16/19 at 10:15am revealed:
-Resident #4 mostly yelled all day.
-When Resident #4 stood up, he was very shaky.
-Resident #4's mental status "comes and goes", but the resident could not follow directions.

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-On 12/12/19, she understood that Resident #4 needed help and he was at the end of the bed.
-She remembered that she verbalized that her and the other MA would "handle it".
-After she and the other MA finished putting their passwords into the computer, she then asked the other MA if she needed to go to Resident #4's room, however, the other MA said she would have a PCA go to the resident's room.
-As she was leaving for her break the named PCA was not in her sight.
-Resident #4 had a bed alarm to make sure he did not fall.
-Resident #4's bed alarm was to remain in place and on at all times.
-Resident #4 could not take off his bed alarm by himself.
-Resident #4 was placed on 15 minutes monitoring checks by the RCC when the resident had any issues or concerns.
-The RCC tried to keep all residents with bed alarms on 15-minute checks.

Interview with the ED/Administrator on 12/16/19 at 4:03pm revealed:
-Staff were expected to respond to all of the residents' needs and it could not always be immediate but within a reasonable time.
-She would have expected staff to respond to Resident #4 on 12/12/19 quicker than 19 to 20 minutes.

Telephone interview with Resident #4's primary care provider (PCP) on 12/13/19 at 3:40pm revealed:
-The resident was a "huge" fall risk.
-The resident would attempt to get out of bed and stand without staff assistance, but the resident was too weak to do that safely and it was a concern if the resident was sitting on the edge of

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the bed making motions to stand and the staff had a delay in response to that.
-The facility had placed the resident on 15-minute checks and thought the facility would know that the resident could remove his bed alarm.
-She had spoken with Hospice a couple of months ago that the resident needed increased supervision and to consider possibly a sitter or upgrading the resident to a higher level of care.
-The resident's bed alarm should stay in place at all times.
-The resident was on a medication to thin his blood and this placed the resident at an increased risk bleeding each time a fall occurred.

b. Review of an emergency room (ER) visit note for Resident #4 dated 09/29/19 revealed:
-The reason for the visit was a fall.
-The resident was diagnosed with a fall from ground level.
-The resident had a Computed Tomography (CT) scan of his cervical spine and head and an x-ray of his chest, elbow, hip/pelvis. (A CT scan is series of x-rays used to detect bone and joint problems such as injuries and bleeding).

Review of Resident #4's Hospice "Client Occurrence Report" documented by the Hospice nurse with an occurrence dated 09/29/19 revealed:
-The facility reported that the resident was found in his room on the floor.
-The resident's head hit a wooden shelf which cracked the shelf.
-The resident was seen in the ER and the CT scan was negative for a fracture.
-The resident sustained multiple contusions and was also diagnosed with a urinary tract infection.

Review of Resident #4's Hospice "Client

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Occurrence Report" documented by the Hospice Nurse with an occurrence dated 09/30/19 revealed:
-The nature of the occurrence was documented as a fall resulting with no injury.
-The facility reported the resident was found in the floor sitting on his bottom.
-There was no new injury noted.

Review of Resident #4's Hospice "Client Occurrence Report" documented by the Hospice Nurse with an occurrence dated 10/01/19 revealed:
-The nature of the occurrence was documented as a fall resulting with no injury.
-A named medication aide (MA) was walking down the hallway and heard the resident hollering and found the resident seated on the floor.
-The resident denied any pain or injury; no bleeding and no new injuries were noted.

Review of an Accident/incident Report for Resident #4 dated 10/04/19 at 4:30am revealed:
-The incident occurred in the bathroom with no injury and no witness to the incident.
-The resident was on the bathroom floor up against the toilet and reported his back was hurting.
-The resident was sent to the ER at 5:00am but, was not hospitalized.
-In the "Evaluation" section of the report "Educated on slow gradual position changes and staff assistance options".

Review of an ER visit note for Resident #4 dated 10/04/19 revealed the reason for the visit was a fall and a pelvic x-ray was done.

Telephone interview on 12/15/19 at 9:28pm with a PCA that discovered Resident 4's fall on 10/04/19

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revealed:
-Resident #4 was not always oriented, very weak and when he stood up he was unable to walk requiring staff to transfer him.
-Resident #4 sat on the side of the bed at times and would yell "help".
-When the resident raised off the bed, his bed alarm would go off.
-When Resident #4 called for help he usually wanted juice and when given to him he would lay back down and go back to sleep.
-The resident was checked on every 2 hours to monitor incontinent needs and to make sure he was breathing.
-All residents were checked on by staff every 2 hours.
-Resident #2 had a bed alarm that was tucked underneath his mattress.
-She was not aware of the resident disconnecting the bed alarm.
-When she monitored the resident, she made sure the bed alarm was on the resident and connected.
-She was not sure how the resident got into the bathroom on 10/04/19, but, knew that he was found on the floor with his back against the toilet.
-The MA was responsible for documenting the residents' incident reports.
-The resident had been on 15- minute checks for approximately a month or two in addition to every 2-hour checks.
-The 15-minute checks were documented when they were done for Resident #4.

Review of Resident #4's every 15 minute, Increased Supervision and Accountability Check List for October 2019 revealed there was no documentation 15 minute checks were done from 10/01/19-10/27/19.

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Review of an Accident/incident Report for Resident #4 dated 10/16/19 at 10:40pm revealed:
-There was documentation the incident occurred in the resident's bedroom with injury and there was no witness to the incident.
-The resident was on the floor bleeding from his head and an injury to his finger.
-The resident was taken to the ER by an ambulance and was not hospitalized.
-The resident had a head injury, an open wound to a finger and acute cystitis without hematuria.
-There was an entry in the "Evaluation" section of the report "follow up initiated".

Review of an ER visit note for Resident #4 dated 10/16/19 revealed:
-The reason for the visit was for a major fall and a head laceration.
-The resident was diagnosed with a head injury, cut in the skin on the top or back of the head and acute cystitis.
-There were instructions to remove all staples and stitches in the next 7 days to the resident's scalp and left thumb.
-The resident had an CT of the cervical spine and the head.

Review of Resident #4's "Resident Notes" documented the Hospice Nurse dated 10/19/19 revealed:
-The resident was being seen for a routine Hospice visit.
-The resident had sutures to his left thumb and staples to his posterior scalp.

Review of Resident #4's electronic "Progress Notes" dated 10/19/19 at 11:22pm documented by a MA revealed;
-The resident was observed lying on the floor beside the bed.

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-The resident had a skin tear to the upper right arm above the elbow.
-There were no other injuries found.
-The resident did not express pain verbally or by visual cues during range of motion and palpitation.
-The resident's skin tear was cleaned with normal saline and triple antibiotic ointment and a bandage was applied.
-The Resident Care Coordinator (RCC), the primary care provider (PCP) and the "POC" was notified.

Review of an Accident/incident Report for Resident #4 dated 10/21/19 at 12:10pm revealed:
-There was documentation the incident occurred in the resident's bedroom with a skin tear injury below the left eye and there was no witness to the incident.
-The resident was lying beside his bed
-The resident was taken to the ER and was not hospitalized.
-The resident had no new orders.
-There was an entry in the "Evaluation" section of the report that a "bed alarm ordered".

Review of an ER visit note for Resident #4 dated 10/21/19 revealed:
-The reason for the visit was a fall.
-The resident had a CT scan of the facial bones and head and an x-ray of his hip.

Review of a PCP visit note for Resident #4 dated 10/23/19 revealed:
-The resident was being seen for a hospital follow-up.
-The resident had dementia.
-There was documentation the resident had numerous falls.
-The resident had difficulty ambulating and was in

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a wheelchair, however tried to get up and ambulate.
-In the "Planof Care" section of the visit note there was documentation the resident was had frequent falls and needed a sitter or upgrade to a skilled nursing facility.

Review of Resident #4's every 15 minute, Increased Supervision and Accountability Check List for October 2019 revealed:
-There was no documentation 15 minute checks were done from 10/01/19 -10/27/19.
-There was no documentation 15 minute checks were done from 10/30/19 from 7:00am through 6:45pm.

Review of Resident #4's Hospice "Client Occurrence Report" documented by the Hospice nurse with an occurrence dated 11/20/19 revealed:
-The nature of the occurrence was documented as a fall with no injury.
-A named MA called to report the resident was found lying on the floor this morning with his bed alarm sounding.
-The MA reported there were no visible injuries.
-The MA reported that the resident was at his baseline and no visit was requested at this time.

Review of Resident #4's electronic "Progress Notes" dated 11/21/19 at 9:24pm documented by a MA revealed:
-The resident's bed alarm was going off.
-The Executive Director (ED)/Administrator came and advised that she found the resident on the floor in his room and she needed assistance to get the resident up.
-The resident had sat up in the bed and had slid to the floor.
-The resident was found sitting straight up with

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D 270	Continued From page 24 his back against the bed. Review of Resident #4's every 15 minute, Increased Supervision and Accountability Check List for November 2019 revealed: -There was no documentation 15 minute checks were done from 11/04/19 from 7:00am through 6:45pm. -There was no documentation 15 minute checks were done from 11/05/19 from 7:00am through 6:45pm. -There was no documentation 15 minutes were done from 11/07/19 at 7:00am through 11/08/19 at 6:45pm. -There was no documentation 15 minutes were done from 11/09/19 at 7:00am through 6:45pm. -There was no documentation 15 minutes were done from 11/10/19 at 7:00am through 6:45pm. -There was no documentation 15 minutes were done on 11/12/19 from 5:30pm - 6:45pm and on 11/13/19 from 6:00pm - 6:45pm. -There was no documentation 15 minute checks were done on 11/14/19 from 7:00am through 6:45pm. -There was no documentation 15 minute checks were done on 11/19/19 from 1:00am -1:45am. -There was no documentation of the 15 minute checks on 11/19/19 from 7:00am- 6:45pm. -There was no documentation 15 minutes were done on 11/22/19 from 5:15pm - 6:45pm. -There was no documentation 15 minute checks were done on 11/23/19 from 7:00am through 6:45pm. -There was no documentation 15 minute checks were done on 11/24/19 from 7:00am through 11/25/19 at 6:45am. Review of Resident #4's electronic "Progress Notes" dated 12/08/19 at 10:02pm documented by a MA revealed:	D 270		

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-The resident was found on the floor by a PCA.
-The resident stated that he was okay, had no pain and no injuries were noted.

Review of Resident #4's every 15 minute, Increased Supervision and Accountability Check List for December 2019 revealed:
-There was no documentation 15 minute checks were done from 12/01/19 from 7:00pm through 6:45pm on 12/02/19.
-There was no documentation 15 minutes were done on 12/03/19 from 5:00pm through 6:45pm.
-There was no documentation 15 minute checks were done on 12/07/19 from 7:00am through 6:45pm.
-There was no documentation 15 minute checks were done on 12/08/19 from 7:00am through 6:45pm.

Interview with two medication aides (MAs) on 12/09/19 at 11:22am revealed:
-There were 3 residents on the assisted living (AL) side staff had "to keep an eye on".
-The 3 residents were not on 15 or 30 minute checks; staff just needed to keep an eye the residents due to fall risk and having been recently hospitalized.
-Resident #4 was not listed as a resident on increased frequency of checks and was not one of the three residents staff had to keep an eye on.

Interview with the ED/Administrator on 12/13/19 at 8:35am revealed:
-Resident #4 had not always been on 15-minute checks and was on 15-minute checks at intervals.
-Resident #4 was placed on 15-minute checks when he had an incident, increased agitation, or when he was observed trying to get out up without staff.
-The MAs assessed for the need for increased

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D 270	Continued From page 26 15-minute checks and the Resident Care Coordinator (RCC), Assistant RCC and herself determine if 15-minute checks needed to be implemented based on the resident's needs. Interview with the ED/Administrator on 12/16/19 at 4:03pm revealed: -The 15-minute resident checks did not have to be done with the the fall prevention program. -The 15-minute checks were done as a collaborative effort with herself, the RCC and the Assistant RCC. -The 15-minute resident checks did not really work for Resident #4 because of his personality. -She periodically performed physical walk through's to monitor the residents 15-minute checks but might not actually visualize staff doing the resident checks but would review the 15-minute check documents randomly throughout the day. Telephone interview with Resident #4's PCP on 12/13/19 at 3:40pm revealed: -The resident was a "huge" fall risk. -She had spoken with Hospice a couple of months ago that the resident needed increased supervision and to consider possibly a sitter or upgrading the residents care. -The resident was on a medication to thin his blood and placed the resident at an increased risk bleeding each time a fall occurred. Attempted telephone interview with Resident #5's family member on 12/13/19 at 3:08pm and 12/16/19 at 2:44pm was unsuccessful. Attempted interview with the RCC was unsuccessful on 12/16/19 at 3:57pm. The facility failed to provide supervision for 2 of 2	D 270		

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D 270	Continued From page 27 residents in accordance with the facility's policies and procedures and each residents' assessed needs and current symptoms which resulted in Resident #4 having 10 unwitnessed falls between 09/30/19 and 12/08/19 which resulted in one head laceration requiring staple closure and an open finger injury which required stitches and an observed delayed response to the residents attempts to get out of his bed without staff assistance for up to 20 minutes by staff on 12/12/19; and failure to implement interventions and increase supervision for Resident #7 who suffered 5 falls between 10/12/19 and 12/09/19 resulting in injuries including a head injury and facial bruising on 10/12/19, and a subdural hematoma on 12/09/19 with hospitalization and transfer to inpatient Hospice. The facility's failure resulted in serious physical harm to the residents which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/12/19 with an addendum dated 12/16/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 15, 2020.	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 of residents.	D 273		

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This Rule is not met as evidenced by:
Non-compliance continues resulting in detriment to health, safety and welfare.

THIS IS A TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to assure follow up with the primary care provider (PCP) for 3 of 7 sampled residents one of who complained of worsening right hip pain following radiation treatment to the pelvic area for more than 3 weeks and required a home health referral for Vitamin B12 injections (#1); had abnormal chest x-ray results from 2 emergency room visits with instructions to follow up with the PCP and needed a home health referral for Procrit injections and physical and occupational therapy evaluations for falls (#7); and had blood pressures results outside of written parameters (#5).

The findings are:

1. Review of Resident #1's current FL-2 dated 05/09/19 revealed diagnoses included hemorrhoids, edema, hemorrhagic thrombocytopenia and hypokalemia.

a. Interview with Resident #1 on 12/09/19 at 10:26am revealed:
-She had been having a lot of (right) hip pain; she had asked staff to get in touch with her primary care provider (PCP) about the pain, but nothing was done.
-She had experienced 7 months of vaginal

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bleeding and was told she had a urinary tract infection in March 2019.
-She continued to have vaginal bleeding after antibiotics and asked to see a gynecologist, but no appointment was made.
-Her family member had to make the appointment in June 2019 and take her to the gynecologist.
-The gynecologist found a mass in her uterus; she had a hysterectomy in August 2019 for uterine cancer followed by radiation therapy in October/November 2019.
-She completed the radiation in mid-November 2019 and started having right hip pain.
-She had reported her right hip pain to the medication aides (MAs) and asked to see an orthopedic physician; the MAs said they would need to contact her PCP.
-She was given Tylenol for the pain which helped, but she was concerned because she had not had hip pain prior to the hysterectomy and radiation.
-She had also spoken to the Assistant Resident Care Coordinator (RCC) two weeks ago (11/25/19) who said she would contact her PCP.
-She had seen her PCP on 12/06/19 and was told staff had not contacted her prior to 12/06/19.
-She was afraid the staff would ignore her complaints of hip pain the way the staff ignored her vaginal bleeding.

Telephone interview with Resident #1's family member on 12/10/19 at 12:50pm revealed:
-Resident #1 had right hip pain for weeks and nothing had been done.
-She feared a repeat of the delays in a getting a gynecological (GYN) referral for 3 months of vaginal bleeding, so she had scheduled an orthopedic appointment for Resident #1 on 12/13/19.
-Resident #1 had internal pelvic radiation

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treatments which involved manipulation and positioning of the resident's hip and legs; she was afraid there might have been an injury which was causing the pain.
-She was afraid of the possibility of a spread of the cancer.

Review of a Physician's Order form dated 12/03/19 for Resident #1 revealed:
-The Assistant RCC documented Resident #1 complained of severe hip pain, had not had any recent fall and was requesting a referral to an orthopedic physician.
-Resident #1's PCP documented she would see the resident today and signed the form 12/06/19.

Review of Resident #1's October 2019 electronic medication administration record (eMAR) revealed there was an entry for Tylenol 500mg 2 tablets every 8 hours PRN for pain; there were no doses documented as administered.

Review of Resident #1's November 2019 eMAR revealed:
-There was an entry for Tylenol 500mg 2 tablets every 8 hours PRN for pain.
-There was documentation Tylenol was administered on 11/11/19 at 10:32am, 11/12/19 at 9:59am and 11/29/19 at 5:46pm.
-There was documentation the Tylenol was administered for pain and was effective.
-There was an asterisk next to the reason and effectiveness codes for 11/11/19 and 11/29/19; the information key indicated there were comments for entries with an asterisk.

Review of Resident #1's December 2019 eMAR revealed:
-There was an entry for Tylenol 500mg 2 tablets every 8 hours PRN for pain.

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-There was documentation Tylenol was administered on 12/02/19 at 1:17pm for pain and was somewhat effective.
-There was documentation Tylenol was administered on 12/03/19 at 7:14pm for pain and was "other" for effectiveness; there was an asterisk next to other.
-There was documentation Tylenol was administered on 12/04/19 at 7:20pm for pain and was effective; there was an asterisk next to pain.
-There was documentation Tylenol was administered on 12/05/19 at 8:48am for pain and was effective.
-There was an entry for Tylenol 500mg 2 tablets twice daily PRN for pain.
-There was documentation Tylenol was administered on 12/07/19 at 8:28pm and 12/08/19 at 9:18pm for pain and was effective.
-There was documentation Tylenol was administered on 12/09/19 at 8:42am for pain and was somewhat effective; there was an asterisk next to somewhat effective.

Resident #1's eMAR reasons and comments report for November 2019 and December 2019 was not available for review on 12/10/19, 12/11/19 and 12/12/19.

Interview with a MA on 12/10/19 at 11:25am revealed:
-She had administered Tylenol to Resident #1 on 11/11/19 and 11/12/19.
-Resident #1 had hip pain which had been "ongoing off and on."
-Resident #1 did not have the hip pain for a while and then last week started having the hip pain again.
-She did not report Resident #1's hip pain to the PCP because the resident had an order for Tylenol for pain.

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D 273	Continued From page 32 -She reported resident complaints of pain to the next shift MA for monitoring. Second interview with the MA on 12/10/19 at 5:10pm revealed: -Resident #1's hip pain was not new. -If the resident's hip pain had been new following a hysterectomy and radiation therapy, she would have reported it. -Resident #1 had hip pain and would have generalized pain (pain in general areas of the body). -Resident #1 did not have any complaints when she was getting radiation therapy. Second interview with Resident #1 on 12/10/19 at 12:50pm revealed: -She did not go to the dining room for breakfast and lunch because her hip was "really bothering" her. -She had reported having hip pain to the Assistant RCC that morning (12/10/19) when she brought morning medications. -She did not specifically ask for Tylenol and did not get any; she had asked to see an orthopedic physician, but no appointment had been made with the orthopedic physician. -She had been to the Assistant RCC's office 2-3 times since her hip started asking for follow up with a physician. -The Assistant RCC would say she had not heard back from the PCP, that she had sent a fax notification and did not know if the PCP got the fax or not. -She had told the Executive Director (ED)/Administrator about her hip pain about 2 weeks ago. -Her family member was trying to coordinate getting an appointment for her with an orthopedic physician.	D 273		

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D 273	Continued From page 33 Interview with the Assistant RCC on 12/10/19 at 4:53pm revealed: -Resident #1 had told her she still had hip pain the morning of 12/10/19. -Resident #1's hip pain had already been reported to the PCP on 12/06/19. -The PCP changed the Tylenol from as needed to scheduled and ordered a physical therapy referral on 12/06/19. -A physical therapy referral was sent to the home health agency on 12/06/19. -She was not sure if Resident #1 had hip pain prior to having pelvic radiation therapy. -New pain, worsened pain or pain not relieved by prescribed medication should be reported to the PCP. -She, the MAs and the RCC were responsible for notifying the PCP; "any of us who were aware." -She would have expected the MA to notify her of Resident #1's hip pain on 11/11/19 and 11/12/19. Interview with the ED/Administrator on 12/10/19 at 1:52pm revealed: -She was aware of Resident #1's hip pain; the resident reported the pain to her directly on 12/03/19. -She had notified Resident #1's PCP last week and today (12/10/19). -Notification to the PCP was documented in Resident #1's record. Review of care notes dated 11/20/19 through 12/10/19 for Resident #1 revealed there was no documentation of Resident #1 completing radiation treatment in November 2019, experiencing new hip pain beginning in mid November 2019 and experiencing worsened hip pain on 12/09/19.	D 273		

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Third interview with Resident #1 on 12/11/19 at 12:13pm revealed:
-She was still having right pain and did not go to the dining room for breakfast or lunch on 12/11/19 nor dinner on 12/10/19.
-She was experiencing new right knee pain as well.
-She contacted the nurse at the radiation treatment office.
-She had been checked on frequently by the ED/Administrator, Assistant RCC and MA on 12/11/19; she told them she continued to have pain.

Telephone interview with Resident #1's PCP on 12/11/19 at 11:57am revealed:
-She had a note dated 12/03/19 in her folder at the facility when she arrived on 12/06/19 that Resident #1 wanted to be seen for hip pain.
-Resident #1 said she had throbbing right hip pain that radiated down her leg and requested extra strength Tylenol.
-Resident #1 declined an x-ray due to recent radiation therapy.
-The ED/Administrator and Assistant RCC reported Resident #1's pain started last week (12/03/19).
-The ED/Administrator and Assistant RCC showed her Resident #1's eMAR with Tylenol not being administered until December 2019.
-She did not think the right hip pain was a spread of the cancer because it was localized to one hip.
-Staff had not notified her Resident #1's pain was worse since 12/06/19 and had kept her from walking to the dining room for meals from 12/09/19 through 12/11/19.
-She would have wanted staff to contact her so she could order immediate imaging of the hip to see what was going on and rule out any pathology.

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D 273	Continued From page 35 Interview with the ED/Administrator on 12/11/19 at 3:30pm revealed: -She had contacted Resident #1's PCP on 12/11/19 about the resident having increased pain. -The PCP may not have checked her fax prior to 11:57am. Interview with the Assistant RCC on 12/12/19 at 3:32pm revealed: -She was first told about Resident #1's right hip pain on 12/03/19; she was with the ED/Administrator when Resident #1 reported "pretty severe right hip pain." -She faxed a notification to Resident #1's PCP the same day (12/03/19) and the PCP saw Resident #1 on 12/06/19. -She did not have the fax confirmation for the PCP notification of Resident #1's hip pain dated 12/03/19. -None of the MAs had reported "anything out of the ordinary" to her for Resident #1; none of the staff had reported Resident #1 had previous right hip pain. -Resident #1 told her she had chronic pain and had reported increased pain on 12/03/19. Interview with the ED/Administrator on 12/12/19 at 4:39pm revealed: -Resident #1 brought her hip pain to the ED's/Administrator's attention on 12/03/19; the resident had not notified her prior to 12/03/19. -She was not sure if the notification to the PCP dated 12/03/19 was faxed. -It was not unusual for the PCP not to respond to faxes. -Resident #1's right hip pain following radiation treatments was not concerning because the resident had previous orthopedic problems.	D 273		

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-She expected staff to notify her, the Assistant RCC or the RCC of any increased pain or if pain medication was not working so they could ensure the PCP was notified.
-If a resident had a PRN order for Tylenol for pain, she did not expect further action by the MA.
-It was not unusual for Resident #1 to not go to the dining room for meals.
-The general rule was to notify the PCP within 48 hours of the change in condition; the first line was to use PRN medications and if the PRN medication was not effective notify the PCP.

Attempted telephone interview with Resident #1's radiation physician on 12/11/19 at 11:51am was unsuccessful.

Refer to the interview with the ED/Administrator on 12/16/19 at 11:02am.

b. Review of Resident #1's current FL-2 dated 05/09/19 revealed there was an order for Vitamin B12 1000mcg intramuscularly (IM) every month. (Vitamin B12 is a medication used to supplement Vitamin B12 which is essential to cell growth, cell reproduction and the formation of the bloods cellular components.)

Review of Physician's Orders dated 09/25/19 for Resident #1 revealed there was an order for Vitamin B12 1000mcg IM every month.

Review of a Licensed Health Professional Support (LHPS) evaluation dated 10/16/19 for Resident #1 revealed:
-There was a recommendation for a home health (HH) referral for monthly Vitamin B12 IM injections.
-There was documentation a HH referral was requested on 10/16/19.

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D 273	Continued From page 37 Review of a Physician's Order form dated 10/21/19 for Resident #1 revealed there was an order for a HH referral for monthly Vitamin B12 IM injections. Review of Resident #1's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin B12 1000mcg IM every month scheduled at 8:00am. -There was documentation on 10/06/19 the dose was not administered and was to be given by HH. -There was no dose documented as administered. Review of Resident #1's November 2019 eMAR revealed: -There was an entry for Vitamin B12 1000mcg IM every month scheduled at 8:00am. -There was documentation on 11/06/19 the dose was not administered and was to be given by HH or the physician. -There was no dose documented as administered. Review of Resident #1's December 2019 eMAR revealed: -There was an entry for Vitamin B12 1000mcg IM every month scheduled at 8:00am. -The box for 12/06/19 was blank; there was no documentation the Vitamin B12 was administered. Interview with Resident #1 on 12/09/19 at 10:26am revealed: -She was supposed to get Vitamin B12 injections every month. -The home health nurse (HHN) was there to give the injection the last week of November and the	D 273		

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Vitamin B12 was not in the facility.
-She talked to the Executive Director (ED)/Administrator and was told the injection was not due until 12/06/19.
-She was supposed to get the Vitamin B12 shots to help with anemia.

Review of laboratory results dated 11/27/19 for Resident #1 revealed:
-The hemoglobin result was 10.9 with the reference range 12.0 to 16.0.
-The hematocrit result was 32.7 with the reference range 37.0 to 47.0.

Interview with a medication aide (MA) on 12/10/19 at 11:25am revealed:
-The HHN administered Vitamin B12; HH had been set up for Resident #1.
-The HHN did not show up the day Resident #1 was supposed to get the Vitamin B12 shot for November 2019; the Assistant Resident Care Coordinator (RCC) contacted the HH agency.
-If the HHN did not administer the Vitamin B12 shot, she would let the Assistant RCC know or mark the eMAR not given and the Assistant RCC would see it on the eMAR exception report.

Second interview with Resident #1 on 12/10/19 at 12:50pm revealed:
-She had not received a Vitamin B12 shot since coming to the facility in September 2018 until October 2019.
-She was feeling run down and tired and had a 2 point drop in her hemoglobin.

Telephone interview with the Clinical Team Manager at the HH agency on 12/10/19 at 4:17pm revealed:
-The HH agency processed a referral for Resident #1 on 10/25/19; there was no prior

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referral.
-The home health nurse (HHN) administered the first Vitamin B12 injection on 10/30/19.
-HHN documented care and treatments provided in the resident's record at the facility.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 12/10/19 at 5:27pm revealed:
-The pharmacy dispensed single doses of Vitamin B12 for Resident #1 on 10/27/19 and 11/26/19.
-Vitamin B12 was not automatically refilled each month, staff had to request a dose from the pharmacy by fax or by phone.

Observation on 12/10/19 at 5:08pm revealed:
-There was a plastic bag with a pharmacy label on it which had Resident #1's name and instructions for Vitamin B12 SQ every month.
-The Vitamin B12 was dispensed on 11/26/19 for Resident #1.
-There was a vial of Vitamin B12 inside the plastic bag.

Interview with the HHN on 12/10/19 at 5:40pm revealed:
-She had administered the first Vitamin B12 injection to Resident #1 on 10/30/19.
-She could not administer the second dose on 11/25/19 because the Vitamin B12 was not in the facility.
-She had notified the MA on duty the Vitamin B12 was not in the facility and instructed the MA to contact her when the medication arrived.
-She checked back with the MA on duty on 11/27/19 and 11/29/19; each time staff said the Vitamin B12 was not in the facility.
-She was asked by the Clinical Team Manager on 12/10/19 to follow up Resident #1's Vitamin B12

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shot and was at the facility at 5:00pm to administer the Vitamin B12.

Review of an electronic HHN visit note dated 10/30/19 for Resident #1 revealed Resident #1 was given a Vitamin B12 IM injection.

Review of an electronic HHN visit note dated 11/25/19 for Resident #1 revealed the HHN was unable to administer Resident #1's Vitamin B12 injection because the medication was not available.

Review of care notes dated 11/20/19 through 12/10/19 for Resident #1 revealed there was no documentation of follow up with the HHN for Resident #1's Vitamin B12 injection.

Interview with Resident #1 on 12/12/19 at 3:30pm revealed she felt better today and thought it might be due to receiving a Vitamin B12 shot on 12/10/19.

Telephone interview with Resident #1's PCP on 12/11/19 at 11:57am revealed:
-Staff had contacted her on 12/11/19 about Resident #1's not receiving her November 2019 Vitamin B12.
-Resident #1 was receiving Vitamin B12 for anemia; she monitored the resident's anemia through monthly laboratory work.
-Resident #1's last hemoglobin was 10.2 which was down from 12; the resident had just had major surgery and radiation which might lower the count.

Interview with the Assistant RCC on 12/13/19 at 3:32pm revealed:
-She did not know about the LHPS recommendations for the HH referral for Vitamin

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B12 injections.
-LHPS recommendations for HH referrals were given to the PCP for a signed order and then she faxed to the HH agency.
-MAs were responsible for making sure medications were in the building; MAs brought any problems getting medications to her attention.
-HH was responsible for returning to the facility to make sure medications by injection were administered.
-The MA did not report any issue with Resident #1 getting the Vitamin B12 shot; it should have been reported so she could have contacted the pharmacy and followed up.

Interview with the ED/Administrator on 12/12/19 at 4:39pm revealed:
-She, the Assistant RCC and RCC were responsible for reviewing and follow up on LHPS recommendations.
-Recommendations for HH were forwarded to the PCP for a signed order and then forwarded to the HH agency.
-The Assistant RCC and RCC followed up with the HH agency liaison followed up on assuring referrals were done.
-She was "pretty sure" there was a hold order for the Vitamin B12 shots that may not have been faxed to the pharmacy.
-She did not know what the reason was for holding the Vitamin B12.
-Once an order was sent to the pharmacy, the MA was responsible for making sure the medication was in the facility.

Refer to the interview with the ED/Administrator on 12/16/19 at 11:02am.

2. Review of Resident #7's current FL-2 dated

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07/06/19 revealed diagnoses included gastroesophageal reflux disease, anemia, muscle weakness, difficulty walking, major depressive disorder, disorientation and hyperlipidemia.

a. Review of a Licensed Health Support Professional (LHPS) evaluation dated 07/29/19 for Resident #7 revealed:
-There was documentation of a recommendation for a referral for physical and occupational therapy evaluations.
-There was notation at the bottom of the page dated 08/16/19 the primary care provider (PCP) was notified, awaiting response.

Review of a Physician's Order dated 10/22/19 for Resident #7 revealed there was an order for physical and occupational therapy.

Telephone interview with the Branch Manager of the home health (HH) agency on 12/16/19 at 2:37pm revealed there was no record of a referral for Resident #7.

Review of Resident #7's record revealed the resident suffered 5 falls between 10/12/19 and 12/09/19 resulting in injuries including a head injury and facial bruising on 10/12/19, and a subdural hematoma on 12/09/19 with hospitalization and transfer to inpatient Hospice.

Telephone interview with Resident #7's family member on 12/16/19 at 9:46am revealed:
-Resident #7 had a long history of falls; the fall on 12/09/19 was the residents 11th fall in 2019.
-Only 4 of the falls happened at the facility; one in her room and the remaining falls in the common area.
-He wished there was something like a wheelchair that tilted back or mattress that sunk

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in was available to keep Resident #7 from trying to get up on her own and falling.

Telephone interview with the Hospice Director of Operations on 12/16/19 at 10:16am revealed:
-Resident #7 was admitted to Hospice on 10/20/19 there were 3 falls documented in Resident #7's Hospice record: 11/18/19, 11/28/19 and 12/02/19.
-Physical and occupational therapy would have been approved for evaluation of fall prevention devices including a tilt wheelchair, geriatric chair and concave mattress.

Interview with the Resident Care Coordinator (RCC) on 12/16/19 at 12:43pm revealed:
-She did not remember making a referral for physical and occupational therapy for Resident #7 for possible fall and injury prevention devices including a geriatric chair and concave mattress.
-She was responsible for making referrals; she would fax referrals to the HH agency when she received the referral.

Interview with the Executive Director (ED)/Administrator on 12/16/19 at 3:09pm revealed:
-The RCC was responsible for notifying the PCP of concerns, following up on LHPS recommendations and making referrals for residents on the locked side.
-She did not know there was a referral for physical and occupational therapy for Resident #7.
-She reviewed LHPS recommendations weekly to see that the Assistant RCC and RCC have followed up on any needed orders from the PCP.
-The MAs, Assistant RCC and RCC were expected notify the PCP and document either by fax notification sheets or in the care notes.

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D 273	Continued From page 44 Refer to the interview with the ED/Administrator on 12/16/19 at 11:02am. b. Review of a emergency room (ER) "Follow Up Radiology" form for Resident #7 dated 10/14/19 revealed: -There was documentation ER staff contacted the facility by phone on 10/13/19 and 10/14/19 and faxed the form on 10/14/19. -There was an abnormal chest x-ray result attached to the notification. -There were instructions to follow up with the primary care provider (PCP) by the end of the week (10/18/19). -There was no signature or initials by Resident #7's PCP on the notification. Review of a PCP visit note dated 10/29/19 for Resident #7 revealed there was no documentation of notification of an abnormal chest x-ray from the ER. Review of a ER "Follow Up Radiology" form for Resident #7 dated 11/08/19 revealed: -There was documentation ER staff contacted the facility by phone on 11/08/19 and faxed the form on 11/08/19. -There was documentation nodular density, cardiomegaly and pulmonary vascular congestion were found on a chest x-ray dated 11/07/19. -There were instructions to forward the results to the PCP. -There was an abnormal chest x-ray result attached to the notification. -There was no signature or initials by Resident #7's PCP on the notification. Review of a PCP visit note dated 11/13/19 for Resident #7 revealed there was no	D 273		

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documentation of notification of an abnormal chest x-ray from the ER.

Telephone interview with the Hospice Director of Operations on 12/16/19 at 10:16am revealed there was a Hospice nurse (HN) visit on 11/07/19 and 11/12/19; there was no documentation of notification from the emergency room dated 11/08/19 related to an abnormal chest x-ray result.

Interview with the Resident Care Coordinator (RCC) on 12/16/19 at 12:43pm revealed:
-She thought Resident #7's PCP was aware of the abnormal chest x-ray results because the PCP signed off on the initial ER discharge instructions.
-She did not notify Resident #7's PCP of the additional contact from the ER.

Interview with the Executive Director (ED)/Administrator on 12/16/19 at 3:09pm revealed the RCC was responsible for notifying the PCP of concerns for residents on the locked section.

Continued Interview with the ED/Administrator on 12/16/19 at 4:08pm revealed:
-She did not know if the PCP had been notified of the abnormal chest x-rays on 10/14/19 and 11/08/19 for Resident #7.
-The MAs, Assistant RCC and RCC were expected notify the PCP and document either by fax notification sheets or in the care notes.

Attempted interview with Resident #7's PCP on 12/16/19 at 2:43pm was unsuccessful.

Refer to the interview with the ED/Administrator on 12/16/19 at 11:02am.

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c. Review of Resident #7's current FL-2 dated 07/06/19 revealed an order for Procrit 40,000 units subcutaneously on Monday every 2 weeks. (Procrit is used to treat anemia.)

Review of a Physician's Order form dated 07/18/19 for Resident #7 revealed an order to hold Procrit injection until a complete blood count (CBC) was completed and the results were returned. (A CBC measures the amount of cells in blood.)

Review of a Licensed Health Support Professional (LHPS) evaluation dated 07/29/19 for Resident #7 revealed:
-There was documentation of a recommendation for a referral for home health (HH) for Procrit injections.
-There was notation at the bottom of the page dated 08/16/19 the primary care provider (PCP) was notified, awaiting response.

Review of a Physician's Order dated 10/22/19 for Resident #7 revealed there was an order for a HH referral for Procrit injections.

Review of hospital records for Resident #7 revealed:
-On 10/12/19, there was a hemoglobin result of 9.2; the reference range was 11.5 to 15.3.
-There was a hematocrit result of 27.7; the reference range was 34.0 to 46.0.
-On 12/09/19, there was a hemoglobin result of 9.6 and hematocrit of 28.5.

Telephone interview with Resident #7's family member on 12/16/19 at 9:46am revealed:
-Resident #7 had a long history of anemia and had been getting Procrit injections at an oncology

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office.
-The last appointment was on 11/07/19, but he could not take her due to agitation.
-He could not remember when her last appointment was prior to 11/07/19.
-He did not know a home health agency could administer the injections at the facility.

Review of a care noted dated 11/07/19 at 6:13pm for Resident #7 revealed the resident was agitated and would not go with her family member for her physician's appointment.

Telephone interview with Resident #7's PCP on 12/13/19 at 4:00pm revealed:
-She had not ordered Procrit for Resident #7; it had probably been discontinued by Hospice.
-Procrit was used to treat anemia; Resident #7 had issues with anemia.
-She did not have access to Resident #7's laboratory results at the time of the call.

Telephone interview with the Hospice Director of Operations on 12/16/19 at 10:16am revealed Resident #7 was admitted to Hospice on 10/20/19; there was no information in the Hospice records related to Procrit injections.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 12/16/19 at 11:20am revealed:
-On 07/17/19, the pharmacy received a refill request for Resident #7's Procrit but were unable to fill because the pharmacy needed laboratory results.
-A pharmacist faxed a request for laboratory results to the facility; the staff usually contacted the PCP for the laboratory results.
-The pharmacy did not receive the laboratory results and did not dispense any Procrit for

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Resident #7.
-The pharmacy did not receive an order to discontinue the Procrit for Resident #7.

Interview with the Resident Care Coordinator (RCC) on 12/16/19 at 12:43pm revealed:
-She contacted the PCP's office on 12/16/19 to follow up on the results for a complete blood count for Resident #7.
-She had not followed up on getting the CBC results before 12/16/19.
-The PCP had told her Resident #7's family member would have to take the resident to the physician's office who prescribed the Procrit to administer the injections.
-She did not follow up with Resident #7's family member.
-She did not follow up with Hospice about Procrit injections for Resident #7.
- LHPS recommendations were given to her by the Executive Director (ED)/Administrator and she faxed the evaluations to the primary care provider's PCP's office.

Interview with the ED/Administrator on 12/16/19 at 3:09pm revealed:
-She was not sure about follow up for Procrit injections; she knew Resident #7's family member had taken the resident to several doctor appointments.
-The RCC was responsible for notifying the PCP of concerns, following up on LHPS recommendations and making referrals for residents on the locked section.
-She reviewed LHPS recommendations weekly to see that the Assistant RCC and RCC have followed up on any needed orders from the PCP.

Second interview with the ED/Administrator on 12/16/19 at 4:08pm revealed the medication

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aides (MAs), Assistant RCC and RCC were expected notify the PCP and document either by fax notification sheets or in the care notes.

Based on observations, interviews and record reviews, it was determined Resident #7 was not interviewable.

Refer to the interview with the ED/Administrator on 12/16/19 at 11:02am.

3. Review of Resident #5's current FL-2 dated 10/22/19 revealed:
-Diagnoses included dementia, dysphagia, obesity, chronic pain, anorexia, muscle weakness, history or seizures, diabetes and abnormal weight loss.
-There was documentation the resident was intermittently disoriented.
-There was an order to obtain blood pressures (BPs) twice daily.
-There was an order to notify the primary care provider (PCP) if the systolic BP was greater than 180 mm Hg or less than 100 mm Hg. (The systolic BP is the top number of a BP and refers to the amount of pressure in the arteries when the heart contracts).
-There was an order to notify the PCP if the diastolic BP was greater than 100 mm Hg or less than 50 mm Hg. (the diastolic BP is the bottom number of a BP and refers to the pressure in the arteries between beats).
-There was an order for Metoprolol 25mg daily and Valsartan 40mg daily. (Metoprolol and Valsartan is a medication used to treat high blood pressure and heart failure).

Review of Resident #5's previous orders dated 10/03/19 and 9/25/19 revealed there were orders for BPs twice daily, notify the PCP if the systolic

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BP was greater than 180 mm Hg or less than 100 mm Hg and if the diastolic number was greater than 100 mm Hg or less than 50 mm Hg.

Review of Resident #5's Cardiologist visit note dated 08/20/19 revealed:
-The resident had a history of coronary artery disease with a heart attack, stent placement and hypertension.
-There was documentation the resident's blood pressure was stable during the visit and the resident should continue the on the current BP management and "follow" with the PCP.

Review of Resident #5's electronic medication record (eMAR) for October 2019 revealed:
-There was a computer printed entry for BPs twice daily, notify the PCP if the systolic BP was greater than 180 mm Hg or less than 100 mm Hg and if the diastolic number was greater than 100 mm Hg or less than 50 mm Hg with a scheduled time at 8:00am and 8:00pm.
-On 10/05/19, there was an entry at 8:00am the resident's BP was 190/89 mm Hg.
-On 10/14/19, there was an entry at 8:00am the resident's BP was 181/78 mm Hg.
-On 10/19/19, there was an entry at 8:00am the resident's BP was 223/117 mm Hg.
-On 10/22/19, there was an entry at 8:00am the resident's BP was 183/117 mm Hg.
-On 10/23/19, there was an entry at 8:00am the resident's BP was 191/96 mm Hg.
-On 10/24/19, there was an entry at 8:00am the resident's BP was 192/104 mm Hg.
-There was a total of 6 times the resident's BP was documented out of the ordered parameters with no documentation Resident #5's PCP had been notified.

Review of Resident #5's eMAR for November

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D 273	Continued From page 51 2019 revealed: -There was a computer printed entry for BPs twice daily, notify the PCP if the systolic BP was greater than 180 mm Hg or less than 100 mm Hg and if the diastolic number was greater than 100 mm Hg or less than 50 mm Hg with a scheduled time at 8:00am and 8:00pm. -On 11/01/19, there was an entry at 8:00am the resident's BP was 189/103 mm Hg. -On 11/06/19, there was an entry at 8:00am the resident's BP was 168/100 mm Hg. -On 11/10/19, there was an entry at 8:00am the resident's BP was 158/49 mm Hg. -On 11/12/19, there was an entry at 8:00am the resident's BP was 182/98 mm Hg. -On 11/13/19, there was an entry at 8:00am the resident's BP was 189/87 mmHg. -On 11/15/19, there was an entry at 8:00am the resident's BP was 180/104 mm Hg. -On 11/17/19, there was an entry at 8:00am the resident's BP was 95/76 mm Hg. -On 11/26/19, there was an entry at 8:00am the resident's BP was 194/108 mm Hg. -There was a total of 8 times the resident's BP was documented out of the ordered parameters and no documentation Resident #5's PCP had been notified. Review of Resident #5's eMAR for December 2019 revealed: -There was a computer printed entry for BPs twice daily, notify the PCP if the systolic BP was greater than 180 mm Hg or less than 100 mm Hg and if the diastolic number was greater than 100 mm Hg or less than 50 mm Hg with a scheduled time at 8:00am and 8:00pm. -On 12/01/19, there was an entry at 8:00am the resident's BP was 187/98 mm Hg. -On 12/04/19, there was an entry at 8:00am the resident's BP was 80/55 mm Hg.	D 273		

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D 273	Continued From page 52 -There was a total of 2 times the resident's BP was documented out of the ordered parameters with no documentation Resident #5's PCP had been notified. Review of Resident #5's Progress notes from October 2019 - December 2019 revealed there was no documentation the PCP was notified when the resident's the BP results were documented out of the ordered parameters. Based on observations, interviews, and record reviews Resident #5 was not interviewable. Telephone interview on 12/16/19 at 4:07pm with a medication aide (MA) who documented Resident #5's BP results at 8:00am on 10/14/19, 10/19/19, 10/23/19, 10/24/19, 11/01/19, 11/06/19, 11/12/19, 11/15/19, 11/17/19, 11/26/19 and 12/04/19 revealed: -The MAs were responsible for notifying the PCP if a residents' BP readings were out of the ordered parameters by calling the PCP or by leaving a message. -The MAs were responsible to document the residents BP results on the resident's eMARs. -The MAs were responsible to document when the PCP was notified regarding the BP results in the comment section on the eMAR or in the Progress notes. -She would either document when she contacted the PCP regarding BP readings that were out of the ordered parameters or let the next oncoming MA know. -She was aware Resident #5 had an order for BPs to be done twice daily. -When Resident #5 had a BP result out of the ordered parameters, she took the resident's BP again, but did not document when the resident's BP was retaken.	D 273		

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D 273	Continued From page 53 -She was aware that Resident #5's BPs had been out of the ordered parameters but did not call the PCP because Resident #5's BPs fluctuated, and she thought it was an "option" whether to notify the PCP for Resident #5 BP out of parameter results. Attempted interview with the Resident Care Coordinator (RCC) on 12/16/19 at 3:37pm was unsuccessful. Attempted telephone interview with Resident #5's PCP on 12/16/19 at 2:43pm was unsuccessful. Interview with the Executive Director (ED)/Administrator on 12/16/19 at 4:10pm revealed she expected staff to follow the order BP parameters and document each time the PCP was contacted. Refer to the interview with the ED/Administrator on 12/16/19 at 11:02am. _____ Interview with the Executive Director (ED)/Administrator on 12/16/19 at 11:02am revealed: -The PCP had a folder kept in the RCC and Assistant RCC offices. -MAs, the Assistant RCC and RCC placed questions, concerns and any needed follow up in the folder for the PCP address when at the facility. -The PCP placed any new orders following visits in the folder and the Assistant RCC and RCC followed up on the orders. _____ The facility failed to notify a resident's primary care provider (PCP) regarding a resident's worsening hip pain that was endured for 3 weeks following radiation to the pelvic area that	D 273		

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D 273	Continued From page 54 progressed to increased hip pain which resulted in the resident not being able to ambulate to the dining room for her meals due to the pain and failed to coordinate a home health referral for the administration of a Vitamin B12 intramuscular injection (#1); failed to assure a resident followed up with PCP after a resident was seen in the emergency room (ER) twice and found to have two abnormal chest x-ray results and had written instructions after each ER visit to follow up with the PCP and failed to assure the resident had been referred to a home health agency for the administration of Procrit injections and physical and occupational therapy evaluations for falls (#7). The facility's failure to assure the residents' referral and follow-up needs was detrimental to the overall health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 30, 2020.	D 273		
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: TYPE B VIOLATION Based on observations, interviews, and record	D 338		

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reviews, the facility failed to assure 1 of 7 residents sampled received care and services that was adequate, appropriate and at the safest method possible related to a resident who had been recommended by the primary care provider for a higher level of care in order to meet the resident's personal care and transferring needs (#5).

The findings are:

Review of Resident #5's current FL-2 dated 10/22/19 revealed:
-Diagnoses included dementia, dysphagia, obesity, chronic pain, anorexia, muscle weakness, history or seizures, diabetes and abnormal weight loss.
-There was documentation the resident was intermittently disoriented, required total care assistance with her personal care needs.
-There was documentation the resident bruised easily and had thin skin.

Review of Resident #5's Resident Register revealed an admission date of 11/15/17.

Telephone interview with Resident #5's primary care provider (PCP) on 12/13/19 at 3:40pm revealed:
-Resident #5 needed to be in a skilled nursing facility and an order was written for that approximately 6 months ago, however, the family had been resistant to increasing the resident's level of care.
-There had been meetings and discussions with the facility, family and Executive Director (ED)/Administrator recently concerning the residents personal care needs.
-The resident required total assistance from staff and needed maximum assistance with

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transferring.
-A three- person transfer was not enough when transferring Resident #5.
-The resident needed a mechanical lift to safely transfer her so the resident or the staff would not get hurt.
-Resident #5 was getting some bruising from her personal care.
-The resident was not at the level of care that she needed to be, the facility did not use mechanical lifts and that would be the only way the resident could be transferred safely.
-The facility kept the PCP informed that the facility had reached out in order to attempt to find a facility for the resident, but there had not been any bed offers.

Review of Resident #5's Assessment and Care Plan dated 03/29/19 revealed:
-There was documentation the resident was always disoriented with a significant memory loss requiring direction.
-There was documentation the resident was non-ambulatory with limited strength and limited range of motion in her upper extremities.
-There was documentation the resident required extensive staff assistance with toileting, dressing, bathing and grooming and was totally dependent on staff for transferring and ambulation.
-There was no additional information for the resident's transferring needs.

Interview with a personal care aide (PCA) on 12/09/19 at 11:10 am and 11:20am revealed:
-Resident #5 required total assistance from staff.
-Resident #5 was unable to bear any weight on her legs and required 2 staff to assist with transferring.
-The facility did not use mechanical lifts. (A mechanical lift is a device used to transfer

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individuals by placing a sling under the body and connecting the sling to the mechanical lift).

Interview with a second PCA on 12/11/19 at 10:45am revealed:
-Resident #5 could not stand and was dependent on staff for transferring.
-Usually there were 2 to 3 staff to transfer Resident #5, but when she saw only two staff transferring the resident, she would go in and assist.
-During Resident #5's transfers one staff was needed to stand behind the resident's wheelchair to steady the chair for safety and the other two staff placed their arms underneath the resident's arms and "grab" the back of the resident's pants to stand and pivot the resident.
-Resident #5 had to be transferred like that because she was non weight bearing.
-She was trained how to transfer the resident by PCAs.

Based on observations, interviews and record review Resident #5 was not interviewable.

Interview with Resident #5's family member on 12/09/19 at 3:35pm revealed the resident continued to get bruised areas all over her body at the waistline, stomach area and down the resident's legs.

Telephone interview with Resident #5's second family member on 12/09/19 at 7:18pm revealed:
-The family member was aware that the resident required heavy care from staff.
-The family member noticed a bruised area under the resident's right arm "like someone was grabbing her".

Observation of Resident #5 on 12/10/19 at

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D 338	Continued From page 58 10:33am revealed: -The resident was sitting in her wheelchair in the hallway. -The resident had a circular bruise approximately the size of a fifty-cent coin on her right inner arm above her wrist. Telephone interview with Resident #5's third family member on 12/10/19 at 11:04am revealed: -A mechanical lift was needed for the resident's transfers, however, the facility did not use mechanical lifts. -In late October 2019, the facility and the resident's family had a care plan meeting to discuss transfer needs and the facility was "pushing" for skilled nursing care for the resident because the facility did not have what was needed to care for the resident. -The family member was told by the Executive Director (ED) that the facility did not use mechanical lifts and that staff were not trained to use a lift. -Resident #5 required a 3-person transfer, however the family member had observed that 3 staff were not always available to transfer the resident. -The family member was concerned that with one person assisting with the resident's transfers it would result in an injury to staff and or "hurt" the resident. -She had talked to the ED/Administrator regarding safe transfer techniques for the resident and had a major concerns there could be an injury. -Staff grabbed the resident by her pants when transferring her and thought there would be some type of assistive device that would help with the resident's transfers. Confidential interview with a staff revealed:	D 338		

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-There was not enough staff available at the facility to transfer Resident #5.
-The facility did not use mechanical lifts.
-Staff had a difficult time transferring Resident #5 and other named residents which had been discussed with the current ED/Administrator.
-Staff tried to be careful with Resident #5 during transfers but staff had to grab hold of the resident by the back of her pants and lift the resident because the resident was unable to bear any weight.
-The facility did not allow the use of gait belts to assist with resident transfers.
-Management at the facility had watched staff struggling to transfer Resident #5.
-The staff member thought it was a safety risk for both the resident and staff when lifting Resident #5.
-The staff had an incident when transferring the resident where the staff had to fall down on the resident on the bed to keep the resident from falling hard on the bed. The staff member could not remember an exact date when the staff fell down on the resident.
-It was difficult to transfer Resident #5 and when the resident started sliding "you got to grab something besides clothing to keep her from falling".

Observation in Resident #5's room on 12/11/19 at 12:45pm revealed:
-The resident was seated in her wheelchair with family members present in her room.
-Two PCAs entered the room to provide care for the resident.
-The two staff positioned Resident #5 at an angle close to the edge of the bed.
-A family member stood behind the resident's wheelchair to steady the chair.
-The two staff placed one arm underneath the

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resident's arms and used their other hand gripping the back of the resident's pants as they lifted the resident up out of the chair and positioned on the bed.
-The resident was unable to bear any weight which resulted in the resident's pants being pulled, rolled and stretched tightly upward on her body during the total weight lift transfer done by the two staff.
-The resident's family commented on a raised darkened area on the resident's left groin.
-Staff performed the same total weight lift transfer to assist the resident back into the wheelchair by supporting the resident under her arms and holding on to the resident's pants causing the clothing to be pulled, rolled and stretched upward against the residents body.

Interview with one of the PCAs observed transferring Resident #5 at 12:45pm on 12/11/19 at 1:15pm revealed:
-She had worked at the facility for 1 ½ years.
-Resident #5 was able to "barely stand".
-Resident #5 required two staff assistance when transferring.
-Each time she assisted with transferring Resident #5 the same technique observed today, (12/11/19) was used.
-She had never been told of any other way to transfer Resident #5 and had not discussed Resident #5's transfers in any staff meetings.
-She had not noticed Resident #5 having any bruises.

Interview with the second PCA observed transferring Resident #5 on 12/11/19 at 12:45pm on 12/12/19 at 3:24pm revealed:
-She had been working at the facility since August 2019.
-She had previous experience providing personal

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care and transferring residents.
-Resident #5 required 3 persons to transfer her and the resident was a total lift and could not assist with transferring.
-She had spoken with the ED/Administrator approximately one month ago about the resident transfers and possible equipment that would make it easier to transfer the resident was and was told by the ED/Administrator "they were working on it" but had not heard any feedback yet.

Review of Resident #5's "Resident Notes" revealed:
-There was an entry signed by a Physical Therapist (PT) dated 07/01/19, the resident was seen for a physical therapy start of care secondary to recent falls, and a decline in function.
-The resident would not be "picked up" for services due to her cognition level and inability to follow commands to work toward goals.

Review of Resident #5's "Resident Agreement" dated 11/15/17 revealed:
-In the "Resident Service Plans" section, there was documentation the Community would provide services that were needed or requested by the resident to assist with the resident's activity of daily living and to improve the resident's quality of life.
-The services that were available to the resident based on the resident's service plan included assistance with dressing, bathing and transferring.
-If the level of services the resident was receiving changed during the term of the Agreement, a written notice of such a change would be provided to the resident or responsible party.
-In the Termination, Transfer and Discharge

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section of the agreement, there was documentation, the Community could discharge the resident when the resident required skilled nursing care beyond what the community provided and for the health safety, of the resident or employees was endangered by the residents' condition or behavior.
-Whether the Community could handle a resident need and whether the health or the safety of the resident was endangered were questions to be determined by the sole judgement and discretion of the ED.
-There was a copy of the "Resident Bill of Rights" that included the resident was to receive care and services that were adequate and appropriate.

Interview with a medication aide (MA) 12/16/19 at 9:47am revealed:
-She had been working at the facility since August 2019.
-Resident #5 required 3 staff to assist with her transferring needs.
-She knew that "someone" watched her transfer Resident #5 with other staff when she first started and was told they were doing "fine" with the transfer.
-She was unsure if it was the LHPS nurse that observed her transfer Resident #5.
-She was aware that Resident #5 would have random bruises on her arms and legs and thought those areas could have occurred from transfers.
-Resident #5 was hard to lift and could not assist during transfers.

Interview with the LHPS nurse for the facility on 12/16/19 at 10:10am revealed:
-Resident #5 required a total lift transfer.
-Resident #5 required 3 staff to transfer her.
-One Staff would be responsible to hold the

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wheelchair and the other 2 staff would transfer Resident #5 at the closest point possible to pivot the resident while supporting the resident under the arms with their other hand supporting the resident's back.
-She had observed staff transfer Resident #5 last week and the staff did well with the transfer.
-Resident #5 was a "dead weight" transfer and unable to assist most days.
-Holding on to or grabbing Resident #5's pants was not proper technique and not safe when transferring Resident #5.
-She thought pulling on Resident #5's clothing during transfers could have injured the resident by bruising the resident's skin, injure the resident's perineal area and could bruise the resident's skin.

Interview with a second MA on 12/16/19 at 10:15am revealed It was "hard" to transfer Resident #5 because she was a total lift transfer with 3 staff assisting and had told the current ED/Administrator her concerns.

Review of a Physician's Order form dated 12/11/19 for Resident #5 revealed:
-A request for a physical therapy order for the resident for education and assisted transfer techniques signed by the Resident Care Coordinator (RCC).
-There was no signature for the resident's PCP.

Interview with the ED/Administrator on 12/16/19 at 11:00am revealed:
-The facility had been working on placement for Resident #5, however, there had been no bed offers.
-Resident #5 needed increased level of care due to her level of care and difficult transferring needs of the resident.

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D 338	Continued From page 64 -She had observed staff transfer Resident #5 but staff did not pull on the resident's pants. -She would provide additional staff training for Resident #5's transferring techniques going forward. -A request had been sent to Resident #5's PCP last week on 12/11/19 for a physical therapist (PT) to evaluate the resident for safe transfer techniques, however, an approval had not been provided yet. -She was aware that Resident #5 had PT evaluations in the past, however, was not sure what the evaluations were for. -Since she had worked in her current position as the ED, she had not reached out for a PT referral to asses for transfer techniques for the resident until 12/11/19. _____ The facility failed to assure appropriate care and services was provided to Resident #5 who was totally dependent on staff for transferring needs and had been recommended by the primary care provider for a higher level of care in order to meet the resident's personal care needs as evidenced by unsafe transferring techniques used by staff for the resident which resulted in bruising of the residents skin and placed the resident's safety at risk as well as risks of other injuries. The facility's failure 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 12/12/19 with an addendum dated 12/11/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 30, 2020.	D 338		

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to administer medications as ordered for 1 of 7 residents (#3) sampled including errors with medications used to prevent blood clots, for urine retention, high potassium levels and allergies. The findings are: Review of Resident #3's current FL-2 dated 07/06/19 revealed diagnoses included gastroesophageal reflux disease, acute kidney failure, unspecified anemia, essential (primary) hypertension, chronic kidney disease, unspecified renal osteodystrophy, dehydration, and hypermagnesemia. Review of a pharmacy review dated 07/31/19 revealed additional diagnoses for Resident #3 included benign prostatic hypertrophy, hyperlipidemia, gout and dementia.	D 358		

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D 358	Continued From page 66 Review of a pharmacy review dated 10/29/19 revealed additional diagnoses for Resident #3 included deep vein thrombosis (DVT). a. Review of physician orders for Resident #3 dated 07/06/19 revealed a medication order for Xarelto (used in treatment for prevention of blood clot formation) 15mg tablet two times a day for 21 days. Review of a subsequent physician's order for Resident #3 dated 07/25/19 and 09/25/19 revealed a medication order for Xarelto 20mg tablet every day. Review of the October 2019 electronic medication administration records (eMARs) for Resident #3 revealed: -There was an entry for Xarelto 20mg tablet take one tablet every day scheduled at 8:00am. -There were parentheses around the staff initials for documenting administration for the Xarelto from 10/03/19 through 10/14/19. -There was an "information key" printed on the eMARs for "initial parenthesized = [equal] not administered or not charted, see reasons/comments". Review of the Administration Compliance Report for 10/01/19 - 10/31/19 for Resident #3 revealed there was documentation of "not administered: drug/item unavailable" for 12 doses beginning on 10/03/19 through 10/14/19 at 8:00am. Telephone interview with a Pharmacy Technician on 12/16/19 at 11:11am from the contracted pharmacy provider for the facility revealed: -Resident #3's Xarelto 20mg tablet daily was dispensed to the facility in the MDP (cycle fill/multi	D 358		

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dose packaging) system.
-A 7-day supply of Xarelto 20mg tablets was delivered to the facility on 09/28/19.
-No Xarelto was delivered to the facility in the MDP on 10/04/19 because the pharmacy needed a refill prescription from the PCP.
-The pharmacy sent a printed report, with the weekly cycle fill medications, to the facility every week notifying of which residents needed medication refill prescriptions.
-The facility was faxed on 10/02/19 notifying Resident #3 needed a refill prescription for the Xarelto.
-The facility was responsible to obtain the medication refill prescription.
-The facility did not get a refill prescription for the pharmacy.
-Resident #3 would have had a gap in Xarelto for 10/03/19 -10/14/19.
-A supply of Xarelto was delivered to the facility on 10/15/19 at 1:56am.

Interview with the Primary Care Provider (PCP) on 12/16/19 at 2:51pm revealed:
-She was not aware Resident #3 had gone without the Xarelto 20mg tablet daily from 10/03/19 - 10/14/19.
-The resident needed to be on Xarelto because of a blood clot.
-The resident was nearing the six-month mark of being on the Xarelto so might be coming off the Xarelto.
-There had not been any hospitalizations related to DVTs to her knowledge.
-She did not know if the resident had seen another provider to prescribe the Xarelto.

Interview with the Executive Director (ED)/Administrator on 12/16/19 at 3:33pm revealed:

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-The MAs performed a weekly medication cart audit.
-She expected medications to be reordered by the MAs when there was less than a week supply on hand.

Refer to the interview with the Resident Care Coordinator dated 12/12/19 at 4:00pm

Refer to the interview with the Assistant Resident Care Coordinator dated 12/12/19 at 5:19pm.

Refer to the interview with the ED/Administrator dated 12/16/19 at 8:35am.

b. Review of physician orders for Resident #3 dated 07/25/19 revealed a physician's order for Flomax (used in treatment for urinary retention in men) 0.4mg tablet every day at bedtime.

Review of the October 2019 electronic medication administration records (eMARs) for Resident #3 revealed:
-There was an entry for Flomax 0.4mg capsule take one capsule at bedtime scheduled at 9:00pm.
-There were parentheses around the staff initials for documenting administration for the Flomax from 10/09/19 through 10/11/19.
-There was an "information key" printed on the eMARs for "initial parenthesized = [equal] not administered or not charted, see reasons/comments".

Review of the Administration Compliance Report for 10/01/19 - 10/31/19 for Resident #3 revealed there was documentation of "not administered/refused" on 10/09/19 and "not administered: drug/item unavailable" for 10/10/19 and 10/11/19 for 9:00pm.

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D 358	Continued From page 69 Telephone interview with a Pharmacy Technician on 12/16/19 at 10:43am from the contracted pharmacy provider for the facility revealed: -A 7-day supply of Flomax 0.4mg capsule was delivered to the facility on 10/04/19 at 1:34am and 10/12/19 at 2:35am. -There should have been Flomax for administration in October 2019. Interview with the Primary Care Provider (PCP) on 12/16/19 at 2:51pm revealed: -She was not aware Resident #3's Flomax 0.4mg capsule was unavailable for administration on 10/10/19 and 10/11/19. -The resident had not experienced any worsening symptoms of urinary retention to her knowledge. Interview with the Executive Director (ED)/Administrator on 12/16/19 at 3:33pm revealed: -The MAs performed a weekly medication cart audit. -She expected medications to be reordered by the MAs when there was less than a week supply on hand. Refer to the interview with the Resident Care Coordinator dated 12/12/19 at 4:00pm Refer to the interview with the Assistant Resident Care Coordinator dated 12/12/19 at 5:19pm. Refer to the interview with the ED/Administrator dated 12/16/19 at 8:35am. c. Review of physician orders for Resident #3 dated 10/17/19 revealed a physician's order for Veltassa (used to treat high levels of potassium in the blood) 8.4gm (one) packet daily.	D 358		

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D 358	Continued From page 70 Review of the October 2019 electronic medication administration records (eMARs) for Resident #3 revealed: -There was an entry for Veltassa powder in packet 8.4 gram take one packet every day scheduled at 8:00am. -There was documentation for administration of the Veltassa 8.4gm packet daily beginning 10/22/19 at 8:00am. -There was no documentation for administration of the Veltassa 8.4gm packet daily for 10/17/19 through 10/21/19. -There was an "information key" printed on the eMARs for "initial parenthesized = [equal] not administered or not charted, see reasons/comments". Review of the Administration Compliance Report for 10/01/19 - 10/31/19 for Resident #3 revealed there was no documentation to provide a reason why the Veltassa was not administered for 5 doses beginning on 10/17/19 through 10/21/19 for the 8:00am scheduled medication administration time. Interview with the Resident Care Coordinator (RCC) on 12/12/19 at 4:25pm revealed: -She would have to look at the reason selected by the MA on the eMAR to determine why the Veltassa was not started until 10/22/19, five days after the 10/17/19 order date. -Resident #3 would refuse medications but would take the medications when she went back later. Interview with the Assistant Resident Care Coordinator on 12/12/19 at 5:19pm revealed: -She was aware of times when Resident #3 did not have medication available. -She did not provide specific medications she	D 358		

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D 358	Continued From page 71 was aware of being unavailable. Telephone interview with a Pharmacy Technician on 12/16/19 at 11:45am from the contracted pharmacy provider for the facility revealed: -The pharmacy received the Veltassa order dated 10/17/19 by fax from the facility on 10/21/19 at 1:17pm. -The pharmacy filled the prescription for the Veltassa on 10/21/19 and sent the medication to the facility on 10/21/19. -She did not know why the facility did not fax the 10/17/19 Veltassa order until 10/21/19. -Veltassa was a specialty drug, but the pharmacy documentation she was able to access did not note the need for a prior authorization. -The need for prior authorization would be a reason for a delay in starting the Veltassa. Interview with the Primary Care Provider (PCP) on 12/16/19 at 3:00pm revealed: -Veltassa was used to treat high levels of potassium and high potassium levels could cause heart arrhythmias. -Medications ordered for the resident were important. -She was not notified the Veltassa was started late and did not know if another provider had been notified of the late start. -She had never prescribed Veltassa for Resident #3. Interview with the Executive Director (ED)/Administrator on 12/16/19 at 3:33pm revealed she was not sure of the reason for Veltassa being started late. Refer to the interview with the Resident Care Coordinator dated 12/12/19 at 4:00pm	D 358		

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D 358	Continued From page 72 Refer to the interview with the Assistant Resident Care Coordinator dated 12/12/19 at 5:19pm. Refer to the interview with the ED/Administrator dated 12/16/19 at 8:35am. d. Review of physician orders for Resident #3 dated 11/01/19 revealed a physician's order for Claritin (used to treat allergies) 10mg tablet daily. Review of the November 2019 electronic medication administration record (eMAR) for Resident #3 revealed: -There was an entry for loratadine (generic for Claritin) 10mg tablet take one tablet every day scheduled at 8:00am. -There was a second entry for loratadine 10mg tablet take one tablet every day as needed. -There was documentation for administration of the loratadine 10mg tablet daily beginning 11/17/19 at 8:00am. -There was no documentation for administration of the loratadine 10mg tablet as needed for the month of November 2019. -There was no documentation for administration of the loratadine 10mg tablet daily for 11/01/19 through 11/16/19. Review of the Administration Compliance Report for 11/01/19 - 11/30/19 for Resident #3 revealed there was no documentation to provide a reason why the loratadine was not administered for 16 doses beginning on 11/01/19 through 11/16/19 at 8:00am. Interview with the RCC on 12/12/19 at 4:05pm revealed: -Resident #3 was seen by another physician who wrote an order for "Claritin 10mg" only on the back of the visit form.	D 358		

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-The visit form was faxed to the pharmacy.
-The pharmacy needed a prescription before the medication could be dispensed.
-The facility had to request another order from the provider for the Claritin.
-She had "no idea" why the Claritin was not started until 11/17/19, and she "guess"[ed] that was when the pharmacy entered the Claritin order on the eMAR.

Interview with the RCC on 12/12/19 at 4:54pm revealed:
-The physician's order for the Claritin was faxed from the facility to the pharmacy.
-She did not know when the Claritin order was received at the facility.
-She checked the fax machine for physician orders during the day every time she walked up to the front of the facility which was 2-4 times per day.

Telephone interview with a Pharmacy Technician on 12/16/19 at 10:50am from the contracted pharmacy provider for the facility revealed:
-The pharmacy received a verbal order for loratadine 10mg tablet daily as needed for allergies dated 10/31/19 on 10/31/19.
-The pharmacy filled the prescription for the loratadine 10mg daily as needed for allergies on 10/31/19 for a quantity of 30 tablets and delivered the medication to the facility on 11/01/19.
-The pharmacy received a prescription on 11/15/19 by fax for loratadine 10mg tablet daily dated 11/01/19 but did not dispense the loratadine per those instructions because the previous prescription for loratadine 10mg tablet as needed had just been dispensed and delivered to the facility.
-The pharmacy entered the 11/01/19 loratadine 10mg tablet daily in the eMAR on 11/16/19, and

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discontinued the loratadine 10mg daily as needed order on 11/16/19 because of the routine order for loratadine.

Interview with the physician's office medical assistant on 12/16/19 at 2:25pm revealed:
-A prescription was printed for loratadine 10mg tablet daily on 11/01/19, quantity 30 with three refills and faxed to the facility on 11/01/19 after receiving a telephone call from the facility staff (name unknown) requesting clarification for the loratadine.
-The medical assistant did not have any other documentation regarding the loratadine order.

Interview with the Executive Director (ED)/Administrator on 12/16/19 at 3:33pm revealed:
-She was not sure why the loratadine was started late.
-The RCC was responsible to ensure prescribed medications were in the facility.
-The MAs performed a weekly medication cart audit.

Refer to the interview with the Resident Care Coordinator dated 12/12/19 at 4:00pm

Refer to the interview with the Assistant Resident Care Coordinator dated 12/12/19 at 5:19pm.

Refer to the interview with the ED/Administrator dated 12/16/19 at 8:35am.

_____

Interview with the Resident Care Coordinator (RCC) on 12/12/19 at 4:00pm revealed:
-Resident #3's medications were dispensed and delivered to the facility from the pharmacy every seven days.
-Medications that were dispensed in a quantity

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greater than a 7 day supply should be ordered when there was a seven day supply left.
-The MAs performed an audit of the medication cart daily.
-Whoever was working as the MA and saw a low supply of medication could reorder the medication.
-The medication aides (MA) or the RCC were responsible for reordering medications.
-The parentheses around her initials on the eMARs meant the medication was not administered.
-There were different reasons why the medications would not be administered, including drug unavailable.
-The medication might be unavailable because it was ordered but had not been delivered from the pharmacy to the facility at the time the medication was scheduled for administration.
-Sometimes medication was not delivered from the pharmacy for insurance reasons because it was too early for a refill of the medication.
-She pulled a drug unavailable report "most of the time".
-She was responsible for reviewing the drug unavailable report prior to the Assistant RCC's employment.
-The Assistant RCC pulled the drug unavailable report now since starting work at the facility sometime last month.
-Medication orders that were received by fax were picked up from the fax by "whoever goes to the fax machine".
-She "might" find orders received by fax mixed in with other papers if the orders did not come to her.

Interview with the Assistant RCC on 12/12/19 at 5:19pm revealed:
-She was a medication aide and administered

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medication to residents on the locked unit when needed.
-She pulled a drug unavailable report every day.
-She was responsible to find out why medications were unavailable and provide a solution.
-Her corrective action depended on why the medication was not available.
-She usually notified the RCC about unavailable medications for residents in the locked unit.
-She could not say she followed up with the RCC after notifying her regarding residents listed on the unavailable drugs report in the locked unit.
-Once she reported to the RCC about unavailable medications for a resident, the RCC was responsible to reorder the medication and find out the reason the medication was unavailable.
-The MAs would be the first person to notice when a medication was unavailable.
-The MAs were responsible to either reorder an unavailable medication or notify the RCC or Assistant RCC.

Interview with the Executive Director (ED)/Administrator on 12/16/19 at 8:35am revealed:
-She had been in her current position as the ED since 09/24/19.
-She was aware that there had been some issues with residents' medications not being available to administer at the facility.
-The Resident Care Coordinator (RCC) pulled a report for the residents' medication refills and she reviewed that report.
-She saw that there had been issues with residents' medications not being available, and at times this was related to needing a medication refilled.
-The medication aides (MAs) were primarily responsible for ordering the residents' medications from the contracted pharmacy

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D 358	Continued From page 77 provider. -The MAs were responsible for performing a weekly medication cart audit by reviewing 3 to 4 residents' medications per shift. -MAs were responsible for ordering the residents medication when there was less than one-week supply which was done by faxing the medication refill request to the pharmacy. -Keeping the fax confirmation page attached to the residents' medication refill request was something she had put into place but questioned how consistent the MAs were about doing that. -She saw some improvement with residents' medications being available to administer but it was not 100% yet. -The contracted pharmacy delivered the resident medications to the facility. -There had been a recent issue with the contracted pharmacy providers phone service being down which caused an issue with medication availability for some residents. -When medications were not at the facility to administer, the RCC or the Assistant RCC called the residents' PCP, however, probably most of the notification was not documented.	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by:	D 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R-C 12/16/2019

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D 406	Continued From page 78 Based on observations, interviews and record reviews, the facility failed to assure follow up on recommendations on the quarterly pharmacy review for 1 of 7 sampled residents (#7). The findings are: Review of Resident #7's current FL-2 dated 07/06/19 revealed diagnoses included gastroesophageal reflux disease, anemia, muscle weakness, difficulty walking, major depressive disorder, disorientation and hyperlipidemia. Review of a quarterly pharmacy review dated 10/24/19 for Resident #7 revealed there was a recommendation to update the resident's record with complete blood count results. Interview with the Resident Care Coordinator (RCC) on 12/16/19 at 12:43pm revealed: -She had contacted the primary care provider's (PCP's) office on 12/16/19 to follow up on the results for a complete blood count for Resident #7. -She had had not followed up on getting the complete blood count results before 12/16/19. -Pharmacy review recommendations were given to her by the Executive Director (ED) and she faxed the recommendations to the PCP office. -She had not seen the pharmacy review dated 10/24/19 for Resident #7. Interview with the Executive Director (ED)/Administrator on 12/16/19 at 11:02am revealed Resident #7's PCP did not have a complete blood count result for the resident. Interview with the ED/Administrator on 12/16/19 at 3:09pm revealed: -The RCC was responsible for following up on	D 406		

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D 406	Continued From page 79 pharmacy review recommendations for residents on the locked section. -She did not know about the pharmacy review recommendation for a complete blood count result for Resident #7 until 12/16/19. -She did a random review of 3 to 5 pharmacy reviews to assure recommendations had been followed up on by the Assistant RCC and/or RCC.	D 406		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, supervision and residents' rights. The findings are : 1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 2 residents sampled (#4, #7) with multiple falls resulting in serious physical injuries to include an acute care hospitalization for a	D912		

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D912	Continued From page 80 subdural hematoma (#7) and a head laceration requiring staples and a laceration of the resident's finger requiring stitches (#4). [Refer to Tag 270 10A NCAC 13F .0901(b) Supervision (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure 1 of 7 residents sampled received care and services that was adequate, appropriate and at the safest method possible related to a resident who had been recommended by the primary care provider for a higher level of care in order to meet the resident's personal care and transferring needs (#5). [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure follow up with the primary care provider (PCP) for 3 of 7 sampled residents one of who complained of worsening right hip pain following radiation treatment to the pelvic area for more than 3 weeks and required a home health referral for Vitamin B12 injections (#1); had abnormal chest x-ray results from 2 emergency room visits with instructions to follow up with the PCP and needed a home health referral for Procrit injections and physical and occupational therapy evaluations for falls (#7); and had blood pressures results outside of written parameters (#5). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		