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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Brunswick County Department of Social Services conducted a complaint investigation from 02/19/20 - 02/21/20 and 02/24/20 - 02/25/20. The Brunswick County Department of Social Services initiated the complaint investigation on 02/10/20.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interviews the facility failed to assure 4 of 7 staff (Staff A, D, F, and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hiring, according to G.S. 131E-256. The findings are: 1. Review of Staff A's personnel record revealed: -The date of hire was 11/25/19 as a transportation assistant. -There was no documentation of a Health Care Personnel Registry (HCPR) check upon employment. The Administrator was not available for interview from 02/21/20 - 02/25/20. Refer to interview with the facility's Owner on	D 137		

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D 137	Continued From page 1 02/25/20 at 7:00pm. 2. Review of Staff D's personnel record revealed: -The date of hire was 02/10/20 as a transportation assistant. -There was no documentation of a Health Care Personnel Registry (HCPR) check upon employment. -There was documentation of a HCPR check completed on 02/11/20. The Administrator was not available for interview from 02/21/20 - 02/25/20. Refer to interview with the facility's Owner on 02/25/20 at 7:00pm. 3. Review of Staff F's personnel record revealed: -The date of hire was 10/08/19 as a personal care aide/medication aide (PCA/MA). -There was no documentation of a Health Care Personnel Registry (HCPR) check upon employment. -There was documentation of a HCPR check completed on 02/17/20. The Administrator was not available for interview from 02/21/20 - 02/25/20. Refer to interview with the facility's Owner on 02/25/20 at 7:00pm. 4. Review of Staff G's personnel record revealed: -The date of hire was 10/29/19 as a personal care aide (PCA). -There was no documentation of a Health Care Personnel Registry (HCPR) check upon employment. The Administrator was not available for interview	D 137		

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D 137	Continued From page 2 from 02/21/20 - 02/25/20. Refer to interview with the facility's Owner on 02/25/20 at 7:00pm. _____ Interview with the facility's Owner on 02/25/20 at 7:00pm revealed: -The Administrator was responsible for making sure the HCPR checks were completed upon hire for all staff. -Once staff was offered a position at the facility the Administrator should verify there were no substantiated findings on HCPR. -The job offer was contingent on the results of the HCPR. The facility provided documentation of a HCPR check performed on 02/25/20 for Staff A and Staff G which revealed there were no substantiated findings on the HCPR for both. _____ The facility failed to ensure 4 of 7 sampled staff (Staff A, D, F, and G) had a HCPR check completed prior to hire. This failure resulted in the facility not knowing if staff had substantiated findings on the HCPR which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/25/20 for this violation. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON FEBRUARY 26, 2020.	D 137		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment	D 255		

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D 255	Continued From page 3 (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may	D 255		

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be a need to use a restraint and there is no current restraint order for the resident.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure an assessment of a resident was completed within ten days following a change in the resident's condition for 1 resident sampled who had a significant decline in activities of daily living (#9).

The findings are:

Review of Resident #9's current FL-2 dated 08/07/19 revealed:
-Diagnoses included dementia, diabetes mellitus (DM), hypertension (HTN), hypertensive urgency, schizophrenia disorder depressed type, arthritis, and peripheral neuropathy.
-The resident was semi-ambulatory with the use of a wheelchair, required assistance of staff with bathing and dressing, and was incontinent of bowel and bladder.

Review of Resident #9's current care plan dated 03/15/19 revealed:
-The resident had limited range of motion and strength of her upper extremities and was incontinent of bowel and bladder.
-The resident was independent in ambulation with a walker and used a cane at times, required supervision from staff for eating, extensive assistance from staff for bathing, dressing, and grooming/personal hygiene, and was totally dependent upon staff for transfers and toileting.

Review of Resident #9's care plan revealed a significant change in condition care plan was not completed.

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Observation of Resident #9 on 02/25/20 at 10:35am revealed:
-She was sitting in a wheelchair located in the common living room in front of the patio door.
-Her body was snug fitting in the wheelchair.
-Her arms and hands were puffy and laid to her sides.
-Her buttocks were resting towards to edge of the wheelchair seat.
-Her legs were outstretched straight and heels resting on the floor.
-Her feet were swollen.
-Her bedroom shoe was half off her right foot.
-Another resident pushed her in the wheelchair to another location in the common living room.
-The resident slightly raised her feet when the other resident pushed her in the wheelchair.

Interview with Resident #9 on 02/25/20 at 10:35am revealed:
-She was not ambulatory and used a wheelchair for mobility.
-She received a shower two times a week.
-She was totally dependent upon staff for bathing, dressing and toileting.
-She required assistance from one or two staff for transfers.
-She was going to rehabilitation.
-She did not say why she was going to rehabilitation.

Interview with a personal care aide (PCA) on 02/25/20 at 12:00pm revealed:
-Resident #9 was totally dependent upon three staff for showers, transfers, and toileting.
-Resident #9 was dependent upon one staff for feeding.
-Resident #9 was dependent upon two staff for dressing.
-Resident #9 would stand by holding the grab bar

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in the bathroom, pulling up, and three staff would stand with the resident to help hold her up.
-It would take three staff members thirty minutes to shower, dress, and groom Resident #9.
-She assisted Resident #9 with personal care between 10 - 20 times a month.
-The shower book in the medication room would let her know what care to provide for Resident #9.
-The shower book would indicate if a resident needed assistance and the type of assistance needed. An example would be either hands on assistance or independent.
-She did not know who entered the information in the shower book.
-She did not know what a resident care plan was and had never seen Resident #9's care plan.

Observation of the PCA on 02/25/20 at 12:30pm revealed she searched the medication room for the shower book and was unable to locate it.

Interview with the Resident Care Director (RCD) on 02/25/20 at 12:40pm revealed:
-The care plans would indicate what type of assistance residents required.
-The care plans were completed by the Administrator.
-She could not answer if the PCAs or the nurse assistants (NAs) knew what services to provide for the residents because she did not know how they had been trained.
-She had been the RCD since December 2019.
-She could not "recall" if any PCAs had asked her what services residents needed.
-Staff provided personal care to Resident #9 daily.
-Resident #9 was "too heavy" and had not been able to stand in three weeks.
-She had told the Administrator Resident #9 needed "a lot of assistance for care" and could

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not stand.
-The Administrator was going to have Resident #9 placed in a skilled facility.
-She did not know the care plans needed to be changed if a resident had a significant change in condition.

Interview with the Owner on 02/25/20 at 1:20pm revealed:
-She was unaware Resident #9 had a significant change.
-She expected the PCAs to inform the supervisor of any needs of the residents when performing care.

Observation of Resident #9 on 02/25/20 at 1:30pm revealed:
-She was sitting in a standard wheelchair without leg rests in the common living room.
-Her head was leaned back against the back of the wheelchair.
-Her bottom was sitting on the edge of the wheelchair seat.
-Her legs were stretched out in front of the wheelchair with her heels resting on the floor.

On 02/25/20 at 1:30pm, the Owner was directed to Resident #9 in the common living room. When the owner was asked what she thought about Resident #9's appearance she did not respond and approached the resident.

Interview with a medication aide (MA) on 02/25/20 at 2:30pm revealed:
-The PCAs knew the resident's level of care by verbal report at shift change.
-The PCAs had an assignment sheet posted in the time clock room that included what hall they would staff, who would serve snacks, and who would perform feeding assistance.

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D 255	Continued From page 8 -The assignment sheet was completed by the third shift MA. Review of a laminated paper labeled "Shallotte Assisted Living Employee Handbook Page 25" on 02/25/20 revealed: -There was documentation "The following residents ARE 2-Person Assists". -There were five residents listed. -Resident #9 was not listed. Interview with a second MA on 02/25/20 at 4:15pm revealed: -Resident #9 was a large person -Resident #9 needed assistance of one staff for activities of daily living (ADLs) when she arrived at the facility March 2019 or April 2019. -Resident #9 needed assistance of two staff for ADLs about five months ago. -Resident #9 needed assistance of three staff for ADLs two weeks ago. -Two weeks ago, she told the Administrator Resident #9 had declined. -The Administrator told her to do what she could do for Resident #9. -She did not know if Resident #9's Primary Care Provider (PCP) had been informed. -Resident #9 was totally dependent on three staff for assistance in all ADLs other than feeding. -Resident #9 was dependent upon one staff for feeding. -Resident #9 smoked and could not hold her cigarette. -Staff would have to hold Resident #9's cigarette for her to smoke. -Resident #9 declined daily. -Resident #9 would "jerk" when staff tried to stand her. Staff were afraid the resident was going to fall.	D 255		

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A second interview with the RCD on 02/25/20 at 4:20pm revealed:
-Resident #9 had declined over the last three to four weeks.
-Resident #9 needed assistance of three staff for ADLs.
-Resident #9 needed the assistance of two staff for ADLs in October 2019.
-She did not know if Resident #9's PCP had been informed she had a decline in condition.
-Resident #9's PCP needed to be informed of resident changes in condition because he needed to be updated in all residents.

Interview with the Licensed Health Professional Support (LHPS) nurse on 02/25/20 at 4:30pm revealed:
-The Administrator was responsible for completing care plans.
-All residents with significant changes required a new care plan.
-An example given for a significant change would be if a resident normally walked independently then needed a walker.
-The Administrator should have contacted him if a resident had a significant change so he could have completed a new LHPS assessment.
-The Administrator did not notify him Resident #9 had a significant change in condition.

A third interview with the RCD on 02/25/20 at 5:20pm revealed:
-Staff would know what services to provide for residents by looking at the ADLs on the electronic medication administration record (MAR).
-When tasks were completed the PCAs would document on the eMAR.

A second interview with the Owner on 02/25/20 at 5:35pm revealed:

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D 255	Continued From page 10 -The Administrator was responsible for the care plans. -The Administrator or the RCD would do a new care plan for any residents with change in conditions. -The LHPS nurse would be notified that a new care plan had been completed for a change in condition and a new LHPS assessment would be completed. Telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm revealed: -He acknowledged he was the PCP for the residents who resided in the facility. -He would "try" to complete visits to the facility once a month but not greater than 90 days from his previous visit. -His last visit to the facility was in November 2019. -He was available "24/7" (twenty - four hours per day, seven days per week) and staff knew his availability. -A Nurse Practitioner (NP) was available to staff in his absence (when he was on vacation and not available). -He expected staff to contact him by text or phone for any concerns or changes in residents' status or condition at the time observed and to document the notification as they normally would (he was unsure of the documentation process). Reiew of Resident #9's progress notes and provider notes revealed there was no documentation the resident's PCP was notified of a significant change in condition for the resident.	D 255		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

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

Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up for 7 of 7 sampled residents who had four specialty referrals (#2), redness and weeping legs and thick, long toenails (#3), no nebulizer available for ordered nebulizer treatments (#4), blood sugars greater than 400, three emergency department visits, and thick yellow toenails (#5), chest pressure with shortness of breath (#6), and thyroid stimulating hormone labs and ophthalmology for macular degeneration (#7).

The findings are:

1. Review of Resident #6's current FL-2 dated 11/19/19 revealed:
-Diagnoses included unstable angina (A life threatening condition when the heart does not get enough blood flow and oxygen which could lead to a heart attack. Symptoms are chest pain/pressure, shortness of breath, and sweating.), congestive heart failure (CHF), coronary artery disease, and diabetes.
-There were medication orders for Plavix (a blood thinner) and Aspirin (used as a blood thinner). (Plavix can be used with Aspirin to prevent strokes and heart attacks, treat chest pain, and keep blood vessels open).

Interview with Resident #6 on 02/12/20 at 12:30pm revealed:
-She had informed "all the aides" she wanted to

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see her physician and her cardiologist, but she had not been able to do so.
-She had four stents in her heart and was supposed to see her cardiologist every year, but she had not been scheduled to see him in about two years.
-During a recent trip to the hospital, she was advised by the hospital provider she should see her physician as soon as possible because the muscle relaxer she was on may be causing damage to her heart.
-She had started trying to wean herself off the muscle relaxer since she could not speak with her physician.
-After repeated requests the staff finally obtained her hospital discharge summary.

Review of Resident #6's local emergency department (ED) notes dated 01/30/20 revealed:
-The resident was evaluated for generalized weakness.
-There was documentation Baclofen (Baclofen is a muscle relaxer) was a risk factor to the weakness.
-The resident had a history of coronary artery disease, three heart attacks, hyperlipidemia, hypertension, ischemic cardiomyopathy, and paroxysmal atrial fibrillation.
-The resident had a surgical history of cardiac catherization and cardiac stent placement.
-The resident was diagnosed with a urinary tract infection (Bacteria in the urinary tract) and generalized weakness.
-There was documentation the ED provider encouraged the resident's Baclofen to be decreased.
-The resident was discharged on antibiotics.
-The resident was to follow up with her primary care provider (PCP) who was not associated with the facility.

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D 273	Continued From page 13 Interview with Resident #6 on 02/24/20 at 9:40am revealed: -The resident had heart "fluttering" for one to two days. -She had left upper chest pain and "pressure" for three to four days. -She had chest pressure last night (02/23/20) while sitting on the bedside. -When she had chest pressure she would "get washed down in sweat". -The resident was "washed down in sweat" last night (02/23/20). -She would have increased shortness of breath when she had chest pressure and when she ambulated. -She did not tell anyone last night (02/23/20) she had chest pressure and was "washed down in sweat" because "it doesn't do any good". -She had not seen her cardiologist since January 2018. -The (named) transportation staff would not take the resident to the cardiologist because the staff told her she would not go if the appointment was made. -She would have gone to the cardiologist if an appointment had been made. -She did not know the name of her cardiologist. Interview with a third shift medication aide (MA) on 02/24/20 at 10:03am revealed: -She worked third shift on 02/23/20. -Resident #6 did not tell her on 02/23/20 she had chest pain, shortness of breath, and/or had sweaty skin. -Resident #6 had never told her she had chest pain, shortness of breath, and/or sweaty skin. -She had never seen Resident #6 with chest pain, shortness of breath, and/or sweaty skin. -She would have sent Resident #6 to the ED if the	D 273		

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D 273	Continued From page 14 resident had wanted to go. Interview with a personal care aide (PCA) on 02/24/20 at 10:18am revealed Resident #6 had never told her she had chest pain/pressure, shortness of breath, and/or sweaty skin. Interview with a second MA on 02/25/20 at 2:30pm revealed: -Resident #6 never complained of chest pain or pressure. -She had never been told by staff Resident #6 had complained of chest pain or pressure. -If Resident #6 had chest pain or pressure emergency services would have been called. Interview with the Resident Care Director (RCD) on 02/24/20 at 11:30am revealed: -She was unaware Resident #6 had chest pain until 1 week ago when a local Department of Social Services worker told her the resident was supposed to see a cardiologist. -She told the current Administrator Resident #6 needed to see a cardiologist and the Administrator said she would take care of it. -She did not know if the Administrator made Resident #6 an appointment with a cardiologist. -She did not know the name of Resident #6's cardiologist. -If a resident complained of chest pain to a PCA the PCA would tell the MA and the MA would call emergency services to transport the resident to the emergency department. -Facility staff members could not treat a resident with chest pain. -The PCAs or MAs would not tell her a resident complained of chest pain or require transfer to the emergency department unless they saw her in passing. -The PCAs or MAs would notify the Administrator	D 273		

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instead of her.

Telephone interview with a receptionist for Resident #6's cardiologist on 02/24/20 at 1:20pm revealed:
-Resident #6's cardiologist was not in the office.
-Resident #6's last visit was 01/30/18.
-She did not know the reason for the 01/30/18 visit.
-Resident #6 did not keep a follow up appointment scheduled for July 2018.
-She did not know why the appointment was not kept or what it was for.

Telephone interview with a nurse for Resident #6's cardiologist on 02/25/20 at 9:45am revealed:
-The resident's cardiologist was not in the office.
-Resident #6 had a significant cardiac history with several cardiac stent placements.
-It was important for the resident to keep follow up appointments because of her extensive cardiac history.
-The resident would need to be sent to the emergency department for diagnosis and treatment of active chest pain.
-The resident's cardiologist would call back regarding the possible outcome of the resident if not treated for active chest pain.

A second telephone interview with a nurse for Resident #6's cardiologist on 02/26/20 at 9:49am revealed:
-She had spoken with the resident's cardiologist regarding the resident.
-The resident had paroxysmal atrial fibrillation, chronic combined diastolic and systolic heart failure, and coronary artery disease.
-The resident also had a history of noncardiac chest pain.
-Any of the resident's diagnoses could contribute

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to symptoms of chest pressure, shortness of breath, and sweating.
-The resident's clinical outcomes at worse could include worsening CHF, heart attack, and death.
-The resident needed to be evaluated by the cardiologist.

Review of Resident #6's nurse notes dated from 07/23/19 - 12/18/19 revealed:
-There was no documentation the resident experienced chest pain/pressure, shortness of breath, and/or sweating.
-There was no documentation the resident had been evaluated by a provider for chest pain/pressure, shortness of breath, and/or sweating.
-There was no documentation the resident's PCP had been informed of the resident's chest pain/pressure, shortness of breath, and/or sweating.
-There was no documentation after 12/18/19.

Confidential staff interview revealed:
-The week of 02/09/20 Resident #6 said she had chest pain that woke her from sleep, and she was wet with sweat.
-The staff member told Resident #6 to tell the MA.
-The staff member told the MA Resident #6 had complained of chest pain and sweating.
-The MA told the staff member Resident #6 was sweating because she may have had a fever.
-The staff member did not know if the MA checked on Resident #6.
-The staff member did not know the process to follow when residents complained of chest pain.
-The staff member would go directly to the MA for a resident who reported chest pain.
-The staff member did not document Resident #6 reported chest pain awakening her from sleep

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and was wet with sweat.
-The staff member did not document the MA was told Resident #6 had chest pain that awoke her from sleep and was wet with sweat.
-The staff member never thought of documenting in a resident's notes.

Interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm revealed:
-The policy for health care referral and PCP notification was for the MAs, RCD, and/or Administrator to call or text the PCP at the time of a change in resident condition, orders needed, or any concerns.
-The process for PCP notification was as follows: when the MAs were notified or saw a resident change or concern, the MAs notified the PCP via text, fax, or phone at that time; notified the RCD and/or Administrator; the PCP notification (whether by text, fax, or phone) was documented; and new orders were implemented at the time received.
-The staff contacting the PCP should document on a physician's order sheet and/or nurses' note at the time of the PCP notification.

Refer to interview with the RCD on 02/10/20 at 11:56am.

Refer to interview with the Administrator on 02/10/20 at 12:30pm.

Refer to confidential staff interview.

Refer to a confidential interview with a second staff.

Refer to interview with the RCD on 02/12/20 at 11:30am.

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Refer to interview with the Administrator on 02/12/20 at 1:30pm.

Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm.

2. Review of Resident #3's FL-2 dated 12/04/19 revealed:
-Diagnosis included onychomycosis (fungal infection of the nail), cellulitis of lower extremity, poor circulation, atrial fibrillation, hyperlipidemia, arteriosclerotic coronary heart disease, iron deficiency anemia, heart failure, peripheral vascular disease, chronic obstructive pulmonary disease, brain injury.
-The resident was semi ambulatory with a wheelchair and required assistance from staff with bathing and dressing.

Review of Resident #3's care plan dated 02/27/19 revealed the resident was ambulatory with use of a wheelchair, independent in ambulation and grooming/personal hygiene, and required extensive assistance of staff for bathing and dressing.

a. Observation of Resident #3 on 02/19/20 at 10:17am revealed:
-He was sitting in a wheelchair in his room with his left foot soaking in a container of water.
-His toenails had a thick fluid seeping from behind the nail bed.
-His left leg and foot were covered in black and red blotches significant for restricted blood flow.
-His left ankle and leg were dry and scaly.
-On the top of the resident's left ankle was a patch of red scaly skin with raised blisters that were oozing a clear fluid.
-The skin over the blisters were yellow and crusty.

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D 273	Continued From page 19 Interview with Resident #3 on 02/19/20 at 10:18am revealed: -He had a diagnosis of eczema that was "really acting up" and was covering both legs, up to his hips. -He thought the blistered spot on his left ankle "must be infected" because he had shooting pains in that area "like electricity" and he had been having those pains for "at least a couple of weeks". -He had told "all the aides" he probably needed an antibiotic and they "just kept saying they would check on it". -He did not have a physician at the facility, but he had seen a physician a few months ago when he went to the hospital for swelling in his leg. -He "thought he remembered" seeing a physician at the facility "one time" and he was provided medication for "migraine headaches". -A few months ago, his eczema was so bad on both legs and his left ankle, he was "dripping down the hallway" as he rolled his wheelchair down the hallway by using his barefoot to propel the chair forward. -The staff started covering "the dripping areas" on his legs with a bandage. -He asked to speak with a physician and the staff sent him to the hospital to be checked. -He was treated with an oral antibiotic and went to a rehabilitation center for a short stay before returning to the facility. -His legs seemed better shortly after the antibiotic but were "very bad again". Review of Resident #6's Resident Register revealed his primary care physicain (PCP) was the facility's contracted PCP. A second interview with Resident #3 on 02/20/20 at 8:21am revealed:	D 273		

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-He had shooting pains "like electricity in his foot and ankle all night, especially around the area on his ankle where his eczema was inflamed.
-As far as he knew, no staff person had notified his physician about the poor condition of his skin.

Review of Resident #3's Accident/Incident reports revealed:
-On 11/04/19, the resident had symptoms of cellulitis of the leg and he was sent to the hospital and returned to the facility the same day with a prescription for an oral antibiotic and orders for wound care.
-There was an attached fax confirmation dated 11/04/19 showing the facility's physician was notified.
-On 11/11/19, the resident was still having cellulitis and drainage after taking the prescribed antibiotics and he was admitted to the hospital with a diagnosis of cellulitis.
-There was an attached fax confirmation dated 11/11/19 showing the facility's physician was notified by fax.

Review of a Resident #3's "chart note" dated 01/15/20 revealed:
-Resident #3 was sent to the emergency room for symptoms of pain and an extreme burning sensation in his lower leg.
-There was no documentation of notification to Resident #3's physician about the resident's symptoms or being sent to the emergency department (ED).

Interview with a medication aide (MA) on 02/21/20 at 1:00pm revealed:
-Resident #3 was "probably" sent to the ED because "you can never reach the doctor".
-She remembered Resident #3 "complaining a lot with having burning and shooting pains in his

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legs".
-She could not remember if she had attempted to notify the physician, but it would not have mattered, because "he never responded anyway".
-She knew Resident #3's skin "looked awful" but he "probably" needed to be seen by a dermatologist.
-It was hard to make specialist appointments because the staff could not reach the physician to get referrals.

Review of a "shift change condition" report dated 02/02/20 (no time) revealed Resident #3 had pain and burning in his lower leg.

Interview with Resident Care Director (RCD) on 02/21/20 at 1:30pm revealed:
-At the request of Adult Home Specialist (AHS), she would go and look at Resident #3's leg.
-She "had no idea" if the physician had been notified of his symptoms of shooting pains, oozing rash, and burning".

Observation of the RCD and Resident #3 on 02/21/20 at 1:31pm revealed:
-The RCD looked at Resident #3's leg, listened to him explain his symptoms of burning and pain, and asked "Do you want to have to be sent out to the hospital?".
-The RCD did not offer to notify Resident #3's physician.

A second interview with the RCD on 02/21/20 at 1:33pm revealed:
-At the request of AHS, she would notify Resident #3's physician but she needed to go to the Administrator's office before calling the physician.
-She did not say why she needed to go to the Administrator's office before calling the resident's physician.

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D 273	Continued From page 22 -She would "get with the AHS" later to notify the physician. Telephone interview with the transportation staff person on 02/21/20 at 2:10pm revealed: -She was told by the Administrator "a while back" that Resident #3 might have an upcoming specialist appointment, but an appointment had not been scheduled. -She did not know why the appointment had not been scheduled for Resident #3. Interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm revealed: -The policy for health care referral and primary care physician (PCP) notification was for the MAs, RCD, and/or Administrator to call or text the PCP at the time of a change in resident condition, orders needed, or any concerns. -The process for PCP notification was as follows: when the MAs were notified or saw a resident change or concern, the MAs notified the PCP via text, fax, or phone at that time; notified the RCD and/or Administrator; the PCP notification (whether by text, fax, or phone) was documented; and new orders were implemented at the time received. -The staff contacting the PCP should document on a physician's order sheet and/or nurses' note at the time of the PCP notification. Review of Resident #3's progress notes, physician's orders and correspondence revealed there was no documentation the PCP was notified about the resident's complaints of burning and shooting pain in his legs, or oozing blisters dated after 11/2019. Refer to interview with the RCD on 02/10/20 at 11:56am.	D 273		

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D 273	Continued From page 23 Refer to interview with the Administrator on 02/10/20 at 12:30pm. Refer to confidential staff interview. Refer to a confidential interview with a second staff. Refer to interview with the RCD on 02/12/20 at 11:30am. Refer to interview with the Administrator on 02/12/20 at 1:30pm. Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm. b. Observation of Resident #3 on 02/19/20 at 10:17am revealed: -He was sitting in a wheelchair in his room with his left foot soaking in a container of water. -His left foot toenails were uncut and were growing to the left of his foot overlapping adjoining toes. -His toenails had white, yellow, and black nail discoloration, a thick fluid seeping from behind the nail bed, and thickening of the nails. Interview with Resident #3 on 02/19/20 at 10:18am revealed: -His toenails had not been cut since "sometime last year" but an aide "came into my room this morning and attempted to cut them". -His toenails were so thick and hard the aide could not cut them and that was why she had his foot soaking in water. -The aide told him she would come back to cut them later. -He probably needed to see a foot doctor, but he	D 273		

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was just glad somebody was "finally cutting them".
-He had not been able to wear a shoe on his left foot for "a very long time" due to his eczema on his ankle "dripping" and his toenails being "in such bad shape".

Observation of Resident #3's feet on 02/20/20 at 8:21am revealed his toenails had been cut.

A second interview with Resident #3 on 02/20/20 at 8:21am revealed
-An aide had cut his toenails for him.
-As far as he knew, no staff person had notified his physician about the poor condition of his feet.

Interview with a medication aide (MA) on 02/21/20 at 1:00pm revealed:
-She knew Resident #3's toenails "looked awful."
-The resident needed to be seen by a podiatrist.
-It was hard to make specialist appointments because the staff could not reach the physician to get referrals.

Review of Resident #3's progress notes revealed:
-The last documentation of Resident #3 having contact with his physician was dated 11/14/18.
-The labeled "foot care" section of Resident #3's record was empty.

Reviews of a Resident #3's physician's order revealed:
-There was a physician's order dated 03/23/18 for podiatry services.
-There was no order to discontinue podiatry services.

Review of Resident #3's podiatry note date 01/07/19 revealed:
-The resident was diagnosed with

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onychomycosis, dystrophic nails, and calluses.
-All the resident's toenails were debrided with manual clippers for length and thickness.
-The resident's feet were to be kept clean and dry.
-There was documentation under "Care Plan Interventions" for nail debridement greater than every 61 days to minimize pain, pressure, and infection risk.
-There were no podiatry visit notes dated after 01/07/19.

Review of Resident #3's progress notes dated from 11/14/18 - 02/11/20 revealed there was no documentation the resident's primary care provider (PCP) or podiatrist had been notified the resident's toenails had grown past the tip of his toes, were yellow, thick and over his adjoining toes.

Interview with the Administrator on 02/10/20 at 12:30pm revealed:
-She used to have a contract with a company that provided podiatry services, but she canceled the contract in September 2019 due to the company only wanting to provide podiatry services for diabetics.
-Residents had not been seen by a podiatrist since the podiatry services contract ended.
-Aides should be cutting nails for those residents that are not considered to be high risk, like diabetics.
-She was making a list of residents who needed podiatry care.

Interview with the Resident Care Director (RCD) on 02/24/20 at 11:30am revealed:
-She had not seen podiatry in the facility since 10/2019.
-When asked if she knew if podiatry was seeing

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residents in the facility she responded, "I don't have an answer for that question".
-The process for podiatry referral was to call the PCP and request a referral to podiatry.
-One of her responsibilities as the RCD was to talk with the residents to see if they had any needs.
-She knew she needed to round on the residents to assess for needs but was not told to do so by the Administrator.
-She had asked the Administrator about one month ago when podiatry was going to the facility.
-The Administrator had told her she would contact podiatry but never did.

Observation of Resident #3 on 02/24/20 at 12:27pm revealed:
-He was sitting in a wheelchair located in his room.
-There was a sock on his left foot and the left foot was propped on his bedside.
-A personal care aide (PCA) removed the sock from his left foot.
-The residents sock stuck to the left foot as the PCA remove the sock.
-There was a foul, dirty foot smell when the PCA removed the residents sock from his left foot.
-There were flakes of skin adhered to the sock when the PCA removed the sock from the resident's left foot.
-The first, second, and fourth toenails were thick, dark yellow, elevated from the nail bed, and jagged.
-The first toenail was also dark gray at the base of the nail bed and around the edges and grew to the left towards the other toes.
-The left third toenail was thick and brownish gray with black spots to the middle and base of the nail bed. The skin under the end of the nail was bright pink and swollen. There was an open area

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approximately pencil tip size to the tip of the toe.
-The left fifth toenail was missing. The base of the nail bed was reddish brown and jagged.
-All the toes on the left foot had flaking skin around the nail beds and between the toes.
-The base of the toes was ruddy reddish brown in color and the joints to the left first toe were swollen.
-The right first through fifth toenails were thick, yellow, and elevated from the nail bed.
-The right first toe extended past the toe and was growing to the right towards the other toes.
-The right foot toes were swollen with thick, flaky, scaly skin and were ruddy brown in color from mid toes to the midfoot.
-The bottom of the right first toe had two circular areas that were dark yellow in the middle with a cream color perimeter. One was to the bottom tip of the toe and one was to the bottom left side of the toe.
-The residents left bottom heel, bottom side of the foot, foot pad, and toes were stained black.

Telephone interview with the manager of the previous contracted podiatry provider on 02/25/20 at 10:00am revealed:
-Podiatry was last at the facility October 2019.
-Podiatry would routinely see residents usually every 63 days because Medicare would not allow podiatry visits less than every 61 days
-On multiple occasions when the Nurse Practitioner (NP) went to the facility to see residents, the Administrator would reschedule the appointments because she did not expect podiatry in the building on those days.
-Podiatry was scheduled to return to the facility December 2019.
-The facility was made aware a NP was required for podiatry.
-There were multiple attempts to contact the

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Administrator via telephone and email regarding the need for resident orders to continue podiatry services, but they were not returned.
-The facility's contract with podiatry was canceled because the Administrator did not forward the orders for podiatry to the contracting provider.

A third interview with Resident #3 on 02/25/20 at 10:28am revealed:
-His toenails were thick, "like donkey hooves".
-He did not see a podiatrist.
-The PCA would wash his feet and cut his toenails with "little clippers" and a file.
-The PCA cut his toenails last week.
-It was going to take "two sessions" to cut his toenails because they were so thick and long.
-The PCA would wash his legs and feet one to two times a week depending on how much "doctoring" they needed.
-It hurt to wear a shoe on his left foot.

Interview with a PCA on 02/25/20 at 10:42am revealed:
-She had been performing resident nail care for two weeks.
-She saw about eight residents a day for nail care.
-She soaked the resident's feet in a basin of water and Epsom salt (Epsom salt is a chemical compound made up of magnesium, sulfur, and oxygen used as a home remedy to sooth aches and pains and exfoliate dead skin on the feet).
-She provided the supplies for resident nail care because the facility did not have the appropriate supplies.
-Resident #3's nails were thick and long, and they needed cutting "real bad".
-She called Resident #3's physician and obtained an order to cut the resident's toenails because the resident was a diabetic.

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-She did not remember the name of Resident #3's physician.
-She did not document the call with Resident #3's physician regarding cutting the resident's toenails.
-It was going to take her two times to cut Resident #3's toenails because they were so long and thick.
-She first cut Resident #3's toenails last week. She would cut them again this week.
-She soaked Resident #3's feet to soften the toenails before cutting.
-She cut Resident #3's toenails with big clippers and filed them after cutting the toenails.
-It took her 45 minutes to cut Resident #3's toenails because they were so long and thick.

A second interview with a PCA on 02/25/20 at 11:30am revealed:
-All the residents who wanted nail care told the RCD two weeks ago.
-The RCD wrote the residents name on a piece of paper and she made a mark by the names who were diabetics.
-The RCD gave her the list of resident names to perform nail care.
-She would provide cuticle clippers and emery boards for resident nail care.
-She would use the facility's nail clippers for resident nail care.
-She had not seen a provider in the facility to trim residents' toenails.

A second interview with the RCD on 02/25/20 at 12:40pm revealed:
-The contract for podiatry with the facility ended around October 2019 or November 2019 because the Administrator did not submit the required paperwork on time.
-Since October 2019 or November 2019 only one resident had been taken to a local podiatrist.

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-She had not seen podiatry in the building since October 2019.
-She had started making a list of all residents who needed podiatry care two weeks ago.
-She was going to ask the facility's PCP to give orders to send the residents to a local podiatrist.
-She gave the list of residents who she felt needed podiatry care to the Administrator, but the Administrator never did anything with the list of residents.
-She determined the residents who needed podiatry care based on the residents who "walked a lot" and who she felt needed podiatry services.
-Her goal was to have all the residents see podiatry.
-There was no process in place for resident podiatry care since October 2019 when services ended because she had not received directive from the Administrator.
-No one told the PCA which residents to perform nail care for.
-She had not seen any in-services or staff training on performing resident nail care since beginning work at the facility in October 2019.
-She knew the PCA had cut Resident #3's toenails.
-She did not remember if she put Resident #3 on a list of residents who needed toenails cut.
-She had not seen Resident #3's feet and nails until today (02/25/20) when the PCA was soaking the resident's feet.
-She "...can't answer ..." anything else about Resident #3.

Interview with the Owner on 02/25/20 at 1:20pm revealed:
-She expected podiatry referrals to have been made within 24 business hours.
-She expected all podiatry orders to have been signed by the facility's contracted PCP and sent

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to the facility's contracted podiatry provider.
-She expected residents with thick, yellowing nails to have received proper nail care and a podiatry referral.
-She thought the corporate Registered Nurse (RN) could provide podiatry services.
-She expected the corporate RN to have cut the residents toenails if podiatry referrals were not made.
-The RCD was expected to contact corporate for guidance if the Administrator did not give clear directive to the RCD.

Interview with the Corporate Administrator on 02/25/20 at 1:30pm revealed nail care training for staff was performed by the corporate RN yearly.

Telephone interview with a podiatrist for the facility's previous contracted podiatry provider on 02/25/20 at 3:40pm revealed:
-It was expected for residents in the facility to have been seen within 61 days after the last documented podiatry visits because residents needed to keep the toenails short as to not cause problems with the nail beds.
-She did not recommend the PCAs to cut the nails of residents with thick, yellow nails because the PCAs had not been trained.
-Residents with thick, yellow nails should only have their toenails cut by a NP, Physician's Assistant, or Podiatrist because they had been trained on treatment in decreasing infection when cutting nails.
-An injury from cutting a resident's thick, yellow toenails could lead to an infection.
-Peripheral vascular disease (PVD) caused an increase in compromised blood flow to the toes from the heart because the toes were already the furthest from the heart.
-Decreased blood flow caused less oxygenation

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to the tissues which could cause delayed healing.
-It was unacceptable for a PCA to cut Resident #3's toenails because of the diagnoses of PVD which placed the resident at risk from an infection if the residents skin integrity was broken during nail care.
-If a "nick" occurred to Resident #3 it could lead to an infection, loss of toe, foot or leg.
-She expected Resident #3 to have had a follow up podiatry visit after 01/07/19.

Telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm revealed:
-Orders for specialty referrals should be in the residents' records.
-He was unaware of any missed healthcare appointments such as podiatry; it would be in the resident's record.

Refer to interview with the RCD on 02/10/20 at 11:56am.

Refer to interview with the Administrator on 02/10/20 at 12:30pm.

Refer to confidential staff interview.

Refer to a confidential interview with a second staff.

Refer to interview with the RCD on 02/12/20 at 11:30am.

Refer to interview with the Administrator on 02/12/20 at 1:30pm.

Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm.

3. Review of Resident #4's current FL-2 dated

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06/19/19 revealed:
-Diagnoses included schizophrenia, psychotic affective, emphysema of lung, acute encephalopathy, edema onychomycosis, hypothyroidism, and extreme hypertension.
-An order for DuoNeb 0.5-3 (2.5) mg/3 ml use 1 vial three times a day via hand held nebulizer and every four hours as necessary (prn) shortness of breath (SOB)/wheezing [DuoNeb is used for the treatment of breathing problems with chronic obstructive pulmonary disease (COPD)].

Observation on 02/21/20 at 10:07am revealed there was no nebulizer machine in Resident #4's room.

Observation on 02/24/20 at 08:30am revealed there was no nebulizer machine in Resident #4's room.

Review of Resident #4's licensed health professional support review dated 03/22/19 revealed:
-The resident was on continuous oxygen for chronic obstructive pulmonary disease (COPD) and emphysema complications.
-The resident also used inhalers and nebulizer treatment to aid with the management of COPD as well.

Review of Resident #4's hospice electronic progress notes for September 2019 revealed:
-On 09/04/19, 09/16/19, 09/23/19, 09/24/19, and 09/30/19, Resident #4's respiratory assessment documented her breathing was labored, and she had dyspnea at rest.
-On 09/23/19, she was very SOB and took several minutes to recover enough to talk as she did not have her oxygen on. She remained with conversational dyspnea after resting several

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minutes.
-Her respiratory rate was 22 breaths per minute (bpm) (the normal respiratory rate is 12 to 20 breaths per minute).
-On 09/16/19, her oxygen saturation was 84% (normal oxygen saturation readings ranged from 95-100%) at rest on room air (RA).
-On 09/24/19, her oxygen saturation was 90% at rest on RA.

Review of Resident #4's hospice electronic progress notes for October 2019 revealed:
-On 10/09/19, 10/16/19, and 10/29/19, Resident #4's respiratory assessment documented her breathing was labored, and she had dyspnea at rest.
-Her respiratory rate was 22 bpm on 10/09/19 and 10/29/19.
-On 10/09/19 and 10/29/19, her oxygen saturation was 90% at rest on RA.
-On 10/16/19, her oxygen saturation was 91% at rest on RA.
-On 10/21/19, her oxygen saturation was 86% at rest on RA.

Review of Resident #4's hospice electronic progress notes for November 2019 revealed:
-On 11/05/19, 11/13/19, 11/18/19, and 11/25/19, Resident# 4's respiratory assessment documented her breathing was labored, and she had dyspnea at rest.
-On 11/18/19, she had dyspnea with minimal exertion, 3-5-word conversational dyspnea and resting RA oxygen saturations in the low 80's. She was oxygen dependent on 4 liters of continuous oxygen.
-Her respiratory rate was 22 bpm on 11/05/19 and 11/18/19.
-On 11/13/19, her oxygen saturation was 62-64% at rest on RA.

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D 273	Continued From page 35 Review of Resident #4's hospice electronic progress notes for December 2019 revealed: -On 12/02/19, 12/09/19, and 12/18/19, Resident #4's respiratory assessment documented she had dyspnea at rest. -On 12/31/19, Resident #4's respiratory assessment documented her breathing was labored, and she had dyspnea at rest. -Her respiratory rate was 22-28 bpm on 12/02/19, 12/18/19, 12/27/19, and 12/31/19. Review of Resident #4's hospice electronic progress notes for January 2020 revealed: -On 01/05/19, 01/13/20, 01/22/20, and 01/27/20, Resident #4's respiratory assessment documented she had dyspnea at rest. -On 01/06/19, Resident #4's respiratory assessment documented her breathing was labored, and she had dyspnea at rest. -On 01/16/20, she had dyspnea with minimal exertion, 3-5-word conversational dyspnea and resting oxygen saturations at 85% without oxygen. -Her respiratory rate was 22-24 bpm on 01/06/20, 01/13/20, and 01/22/20. -On 01/06/20, her oxygen saturation was 72% at rest on RA. Review of Resident #4's hospice electronic progress notes for February 2020 revealed: -On 02/03/20 and 02/10/20, Resident #4's respiratory assessment documented she had dyspnea at rest. -On 02/17/20, Resident#4's respiratory assessment documented her breathing was labored and she had dyspnea at rest. -Her respiratory rate was 22-24 bpm on 02/03/20, 02/10/20, and 02/17/20. -On 02/03/20, her oxygen saturation was 90% at	D 273		

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rest on RA.
-On 02/17/20, her oxygen saturation was 87% at rest on RA.

Review of 24-Hour Nursing/Change of Condition Report dated 02/23/20 revealed Resident #4 was given as needed (prn) Ativan for agitation and had no nebulizer machine for scheduled breathing treatment.

Interview with Resident #4 on 02/21/20 at 11:24am:
-She did not have a nebulizer machine.
-She had received nebulizer treatments previously but could not recall the last time or who had administered them to her.
-She did experience shortness of breath "often."

Interview with a first shift medication aide (MA) on 02/21/20 at 1:30pm revealed:
-The facility did not have a nebulizer machine for Resident #4.
-The machine was taken out of the facility for service, but she was not sure the date.
-The facility had let the hospice agency know but she was not sure of the date of notification.

Interview with the Resident Care Director (RCD) on 02/24/20 at 09:23am revealed:
-Resident #4 was on hospice for end stage COPD.
-She had been aware since October 7th or 8th, 2019, Resident #4 did not have a nebulizer machine to administer her DuoNeb ordered three times daily and as necessary for shortness of breath.
-She made the Administrator aware in October 2019, Resident #4 did not have a nebulizer machine.
-The Administrator was responsible for obtaining

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the nebulizer machine.
-She was never given "full reigns" from the Administrator when she assumed the position as RCD in the beginning of December 2019.
-She did not follow up on obtaining a nebulizer machine because she thought the Administrator was taking care of completing the task.
-She was not sure how Resident #4 was receiving her DuoNeb if she did not have a nebulizer machine.
-She did not contact the physician or hospice agency related to the unavailability of the nebulizer machine.

Interview with the hospice Registered Nurse on 02/24/20 at 09:45am revealed:
-She came to the facility to see Resident #4 twice a week on Monday and Fridays.
-Resident #4 was short of breath "every time" when she came to the facility and the documentation would be included in her nursing assessments.
-She was dependent on continuous oxygen except when smoking.
-She was not sure if the nebulizer machine was in Resident #4's room during her visit on 02/17/20.

Interview with a pharmacist from the facility's contracted pharmacy on 02/24/20 at 12:29pm revealed:
-In "overall terms" if a resident with end stage COPD was not receiving their scheduled and prn DuoNeb, the resident would have difficulty breathing, shortness of breath, worsening of COPD resulting in hospitalization.
-This would be the "progression" of the resident's symptoms.

Refer to interview with the RCD on 02/10/20 at 11:56am.

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Refer to interview with the Administrator on 02/10/20 at 12:30pm.

Refer to confidential staff interview.

Refer to a confidential interview with a second staff.

Refer to interview with the RCD on 02/12/20 at 11:30am.

Refer to interview with the Administrator on 02/12/20 at 1:30pm.

Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm.

4. Review of Resident #5's current FL-2 dated 10/01/19 revealed diagnoses included depression, hypothyroidism, type II diabetes mellitus, anxiety, insomnia, high cholesterol and restless leg syndrome.

Review of Resident #5's Care Plan dated 10/01/19 revealed the resident was oriented and her memory was adequate.

a. Review of an order dated 11/05/19 in Resident #5's record revealed finger stick blood sugar (FSBS) once daily at 6:30am notify Medical Doctor (MD) if blood sugar was below 60 or above 400.

Review of the December 2019 electronic medication administration record (eMAR) for Resident #5 revealed:
-There was documentation on 12/05/19 Resident #5's FSBS at 6:30am was 551; there was documentation the primary care physician (PCP)

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was notified, and no new orders received.
-There was documentation on 12/27/19 that Resident #5's FSBS at 6:30am was 415; there was documentation the PCP was notified.
-There was documentation on 12/28/19 that Resident #5's FSBS at 6:30am was 440; there was documentation the PCP was notified.
-There was documentation on 12/29/19 that Resident #5's FSBS at 6:30am was 417; there was documentation the PCP was notified.

Review of a fax confirmation report to PCP dated 12/19/19 revealed:
-There was documentation Resident #5's blood sugar levels had consistently been above 300.
-There was documentation she took Glipizide 10mg daily (Glipizide is used to lower blood sugars).
-There was documentation "please advise."

Review of the January 2020 eMAR for Resident #5 revealed:
-There was documentation on 01/11/20 that Resident #5's FSBS at 6:30am was 507; there was documentation the PCP was notified, and no new orders given.
-There was documentation on 01/03/20 that Resident #5's FSBS at 6:30am was 402; there was documentation the PCP was notified.
-There was documentation on 01/10/20 that Resident #5's FSBS at 6:30am was 427; there was documentation the PCP was notified.
-There was documentation on 01/14/20 that Resident #5's FSBS at 6:30am was 470; there was documentation the PCP was notified.
-There was documentation on 01/16/20 that Resident #5's FSBS at 6:30am was 436; there was no documentation the PCP was notified.
-There was documentation on 01/17/20 that Resident #5's FSBS at 6:30am was 412; there

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was no documentation the PCP was notified.
-There was documentation on 01/19/20 that Resident #5's FSBS at 6:30am was 447; there was documentation the PCP was notified.
-There was documentation on 01/22/20 that Resident #5's FSBS at 6:30am was 404; there was documentation the PCP was notified.
-There was documentation on 01/25/20 that Resident #5's FSBS at 6:30am was 437; there was documentation the PCP was notified.

Review of the February 2020 e MAR for Resident #5 revealed:
-There was documentation on 02/21/20 that Resident #5's FSBS at 6:30am was 573; there was no documentation the PCP was notified.
-There was documentation on 02/05/20 Resident #5's FSBS at 6:30am was 411; there was documentation the PCP was notified.
-There was documentation on 02/12/20 that Resident #5's FSBS at 6:30am was 452; there was documentation he PCP will be made aware.
-There was documentation on 02/13/20 that Resident #5's FSBS at 6:30am was 450; there was no documentation the PCP was notified.
-There was documentation on 02/19/20 that Resident #5's FSBS at 6:30am was 400; there was no documentation the PCP was notified.

Review of the 24-hour Nursing/Change of Condition Report on 02/21/20 revealed:
-There was documentation Resident #5's FSBS remained elevated.
-There was documentation Resident #5 remained noncompliant with her diet.

Review of the 24-hour Nursing/Change of Condition Report on 02/22/20 revealed there was documentation Resident #5 's 25 Units of Lantus was not on the eMAR.

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D 273	Continued From page 41 Review of the 24-hour Nursing /Change of Condition Report on 02/23/20 revealed: -There was documentation Resident #5 's 25 Units of Lantus was not on the eMAR. -There was documentation Resident #5's blood sugars continued to be high. -There was documentation Resident #5 continued to be noncompliant with her diet. Interview with Resident #5 on 02/20/20 at 8:29am revealed: -She had not seen the PCP in over 2 months. -She had been at the facility for four months and only seen the PCP one time. -She had never seen the PCP's physician assistant or nurse practitioner. -The medication aides (MA) told her they tried to contact the PCP, but he did not respond. -She was on insulin before she came to the facility. -She had not had any insulin since being at the facility. Interview with the Resident Care Director (RCD) on 02/20/20 at 1:55pm revealed: -She was aware the order was to notify PCP if Resident #5's FSBS was under 60 and over 400. -She faxed the PCP Resident #5's FSBS on 12/13/19 but got no response from the PCP. -She did not follow up with the PCP when she did not get a response. -The RCD was informed by the Administrator that she (the Administrator) would contact the PCP. Interview with the Administrator on 02/20/20 at 5:30pm revealed: -She had notified the PCP about Resident #5's FSBS being elevated. -She did not know dates she had notified PCP,	D 273		

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but it would be documented in the eMAR notes.
-Resident #5 was noncompliant with her diet and would drink soft drinks and eat sweet cakes.
-The PCP had never ordered any insulin because Resident #5 was noncompliant.
-If Resident #5 was found unresponsive, she would be sent to the emergency department.

A second interview with the Administrator on 02/20/20 at 5:48pm revealed she had called the PCP and obtained an order for Resident #5 to be administered insulin.

Interview with a MA on 02/21/20 at 1:34pm revealed:
-She faxed the PCP the FSBS that were greater than 400 on Resident #5.
-The PCP did not send any orders back.
-She never got a response from the PCP.
-She did not try to contact him a second time.

Interview with a second MA on 02/24/20 at 5:50am revealed:
-The MA took the order for Lantus 25 units am and pm and sent it to the pharmacy on 02/23/20 for Resident #5 after the PCP called and gave a verbal order
-The PCP had never ordered Resident #5 any insulin prior to 02/23/20 that she was aware of.
-The MA had faxed a copy of Resident #5's December 2019 eMAR with her blood sugars to the PCP on 12/19/19 and wrote a note about consistently elevated blood sugars and asked to please advise.
-The MA received no response from the PCP about the blood sugars.

Telephone interview with the facility's contracted Primary Care Provider (PCP) on 02/24/20 at 2:10pm revealed:

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-He expected staff to contact him by text or phone for any concerns or changes in residents' status or condition at the time observed.
-An example provided was if a resident had a high finger stick blood sugar (FSBS), they were expected to call or text him at the time of the increased FSBS, take the verbal order, and document the notification and verbal orders at that time.
-Which ever staff contacted him was expected to complete the documentation.

Refer to interview with the RCD on 02/10/20 at 11:56am.

Refer to interview with the Administrator on 02/10/20 at 12:30pm.

Refer to confidential staff interview.

Refer to a confidential interview with a second staff.

Refer to interview with the RCD on 02/12/20 at 11:30am.

Refer to interview with the Administrator on 02/12/20 at 1:30pm.

Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm.

b. Review of a discharge instruction sheet from an emergency department (ED) visit dated 10/12/19 for Resident #5 revealed:
-There was documentation Resident #5 was discharged at 6:22pm with pneumonia of both lower lobes due to an infectious organism.
-There was documentation Resident #5 was discharged with a prescription for Cefuroxime

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250mg take 1 capsule by mouth 2 times a day for 10 days. (Cefuroxime is an antibiotic used to treat infection.)
-There was documentation Resident #5 was to schedule an appointment in 4 days for a follow up with the primary care physician (PCP).

Review of a discharge instruction sheet from a second ED visit dated 12/15/19 for Resident #5 revealed:
-There was documentation Resident #5 was discharged at 4:26pm with hyperglycemia, dehydration, unsteady gait, and acute cystitis without hematuria.
-There was documentation Resident #5 was discharged with a prescription for Cephalexin 500mg take 1 capsule by mouth 2 times a day for 10 days. (Cephalexin is an antibiotic used to treat infection.)
-There was documentation Resident #5 was to schedule an appointment as soon as possible for a visit in 1 day with the PCP.

Review of a discharge instruction sheet from a third ED visit dated 01/25/20 for Resident #5 revealed:
-There was documentation Resident #5 was discharged at 10:12pm with a urinary tract infection (UTI) and elevated blood sugar.
- There was documentation Resident #5 was discharged with a prescription for Cephalexin 500mg take 2 capsules 2 times a day for 7 days. (Cephalexin is an antibiotic used to treat infections.)
-There was documentation Resident #5 was to see the PCP "as soon as possible."

Interview with Resident #5 on 02/24/20 at 11:18am revealed:
-She never saw a doctor for follow up after she

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went to any ED visits.
-She had only seen the PCP one time since coming to the facility.
-The Administrator would say the PCP would be here next week, but he would not show up.

Interview with a MA on 02/24/20 at 11:23am revealed:
-When a resident came back from the hospital, an incident report was filled out and faxed to Department of Social Service and the PCP.
-A copy of the report was given to the Administrator.
-The Resident Care Director (RCD) was responsible for making follow up appointments.

Interview with RCD on 02/24/20 at 6:16am revealed:
-She was instructed to give the referrals or follow up orders to the Administrator.
-She was "never given full range to do her job."
-She could not explain how follow up with the PCP could be done when he was not coming to the facility.
-She had never seen the PCP at the facility.

Interview with the Owner on 02/24/20 at 12:07pm revealed:
-The RCD and/or Administrator were responsible for ensuring orders were implemented.
-The PCP was supposed to be notified of any issues with orders.
-The system used to schedule resident visits with the PCP was prioritized by need and depended on follow up to hospital visits, refill requests for controlled substances, and referral needs.
-The residents were added to the schedule to see the PCP by the Administrator or RCD.
-An example provided was a diabetic with uncontrolled sugars would be added to the

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schedule to see the PCP on the next visit.
-Follow up appointments should be made the day the resident came back from the hospital or the next day.
-If the resident could not be seen in the follow up time frame ordered, then staff should make the next available appointment.
-It should have been documented in the resident record when the next appointment would be.

Refer to interview with the RCD on 02/10/20 at 11:56am.

Refer to interview with the Administrator on 02/10/20 at 12:30pm.

Refer to confidential staff interview.

Refer to a confidential interview with a second staff.

Refer to interview with the RCD on 02/12/20 at 11:30am.

Refer to interview with the Administrator on 02/12/20 at 1:30pm.

Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm.

c. Review of Resident #5's current FL-2 dated 10/01/19 revealed:
-There were diagnoses of diabetes mellitus (DM) and restless leg syndrome.
-There were medication orders for Neurontin (Neurontin is used to treat nerve pain such as diabetic neuropathy and restless leg syndrome), and Glipizide (used to lower blood sugar.)
-The resident was ambulatory with the use of a wheelchair and required staff assistance for

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bathing and dressing.

Review of Resident #5's care plan dated 10/01/19 revealed:
-The resident had a diagnosis of DM and restless leg syndrome.
-The resident was totally dependent on staff for grooming/personal hygiene, bathing, and dressing.

Review of Resident #5's skin assessment form dated 12/05/19 revealed the resident's toenails did not need to be cut.

Observation of Resident #5 on 02/24/20 at 9:20am revealed:
-She was laying on her bed in her room.
-She did not have on socks or shoes.
-The toes on her left foot were close together and toenails curled and formed towards the left.
-The toes on her right foot were close together and toenails curled and formed to the right.
-The left big toenail was dark yellow, jagged, approximately 4 millimeters (mm) thick, and elevated from the nail bed.
-On the side of the left big toe was a bright pink to reddish colored area approximately the size of a pencil eraser.
-The left fourth and fifth toenails were dark yellow, jagged, thick, and elevated from the nailbed.
-The left forth toe had a bright pink to reddish colored circular area approximately the size of a pencil eraser close to where the toe adjoined the foot.
-The left fifth toe had a bright pink to reddish colored circular area approximately half the size of a pencil eraser close to the base of the toe.
-The toes on the right foot were dark yellow, jagged, and thick.
-The right forth toe had a bright pink to reddish

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colored circular area approximately half the size of a pencil eraser on the joint closest to the foot.

Interview with Resident #5 on 02/24/20 at 9:20am revealed:
-She had not seen a podiatrist since being at the facility.
-A nursing assistant (NA) "sneaked around" and cut her toenails one month ago.
-The NA offered to cut her nails because she "felt sorry for me".
-Before the NA cut her toenails, she had to wear shoes a size larger than normal because they hurt her feet and left big toe and her toenails were thick.
-She had asked the Resident Care Director (RCD) three or four times to have her nails cut.
-The RCD did not do anything when she asked to have her nails cut.

Confidential staff interview revealed::
-She was told not to cut diabetic resident's nails.
-Resident #5's toenails were so long she felt sorry for the resident and could not let them go uncut.
-Resident #5's toenails were "growing over all the other toes and had to be cut".
-It took five to ten minutes to cut Resident #5's toenails with nail clippers the end of January 2020.
-Resident #5 was more at a risk when not having her toenails cut and the nail to be ripped off or an infection than cutting the toenails.
-She did not tell anyone she had cut Resident #5's nails because she was afraid she would get fired.
-The Administrator was never around to tell about Resident #5's toenails.
-She had told a medication aide (MA) Resident #5's toenails needed to be cut but the MA did not acknowledge her.

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-She had never seen podiatry at the facility.
-Diabetic resident nails were supposed to be cut by a MA or a podiatrist.
-She had cut other diabetic residents' toenails because they needed to be cut.
-She would take the nail equipment home (several small and large clippers) to sterilize because they were not being sterilized at the facility after use.
-She researched on the internet how to properly sterilize the equipment.

Interview with a MA on 02/24/20 at 10:30am revealed:
-She had told the Administrator one to two weeks ago Resident #5 needed to see podiatry for foot care.
-She had told the Administrator one or two weeks ago all diabetic residents needed foot care.
-The Administrator said she would "get on it" but never did.

Interview with the RCD on 02/24/20 at 11:30am revealed:
-She had not seen podiatry in the facility since October 2019.
-The process for podiatry referral was to call the primary care physician (PCP) and request a referral to podiatry.
-There were no specific diabetic residents that had been brought to her attention that needed nail care.
-Diabetic residents should automatically see podiatry for nail care " ...because they are brittle, and the smallest cut could turn deadly".
-One of her responsibilities as the RCD was to talk with the residents to see if they had any needs.
-She knew she needed to round on the residents to assess for needs but was not told to do so by

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the Administrator.
-She had asked the Administrator about one month ago when podiatry was going to the facility.
-The Administrator had told her she would contact podiatry but never did.
-Staff would not cut Resident #5's nails because she was a diabetic.
-No one had told her Resident #5's toenails needed to be cut.
-Resident #5 had not asked to have her nails cut.

Telephone interview on 02/25/20 at 10:00am with the manager of the facility's previous contracted agency for podiatry revealed:
-Podiatry was last at the facility October 2019.
-Podiatry would routinely see residents usually every 63 days because Medicare would not allow podiatry visits less than every 61 days
-Podiatry was scheduled to return to the facility December 2019.
-There were multiple attempts to contact the Administrator via telephone and email regarding the need for resident orders to continue podiatry services, but they were not returned.
-The facility's contract with podiatry was canceled because the Administrator did not forward the orders for podiatry to the contracting provider.

Interview with a personal care aide (PCA) on 02/25/20 at 10:42am revealed:
-She had been performing resident nail care for two weeks.
-She would not cut the nails of diabetic residents but would file their nails.
-She had not performed foot/nail care for Resident #5.
-She would file Resident #5's toenails instead of cut because the resident was a diabetic.
-She had not seen a podiatrist in the facility.

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D 273	Continued From page 51 A second interview with the PCA on 02/25/20 at 11:30am revealed: -She was not allowed to cut the toenails of diabetic residents. -Diabetic residents' toenails had to be cut by a provider. -She would soak diabetic residents' feet and file their toenails. A second interview with the RCD on 02/25/20 at 12:40pm revealed: -The contract for podiatry with the facility ended around October 2019 or November 2019 because the Administrator did not submit the required paperwork on time. -Since October 2019 or November 2019 only one resident had been taken to a local podiatrist. -She had not seen podiatry in the building since October 2019. -She had started making a list of all residents who needed podiatry care two weeks ago. -She was going to ask the facility's PCP to give orders to send the residents to a local podiatrist. -She gave the list of residents who she felt needed podiatry care to the Administrator, but the Administrator never did anything with the list of residents. -She determined the residents who needed podiatry care based on the residents who "walked a lot" and who she felt needed podiatry services. -There was no process in place for resident podiatry care since October 2019 when services ended because she had not received directive from the Administrator. Interview with the Owner on 02/25/20 at 1:20pm revealed: -She expected podiatry referrals to have been made within 24 business hours. -She expected all podiatry orders to have been	D 273		

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signed by the facility's contracted PCP and sent to the facility's contracted podiatry provider.
-She expected residents with thick, yellowing nails to have received proper nail care and a podiatry referral.
-She thought the Corporate Registered Nurse (RN) could provide podiatry services.
-She expected the Corporate RN to have cut the residents toenails if podiatry referrals were not made.
-The RCD was expected to contact corporate for guidance if the Administrator did not give clear directive to the RCD.

Interview with the Corporate Administrator on 02/25/20 at 1:30pm revealed:
-Nail care training for staff was performed by the corporate RN yearly.
-During the training staff were instructed not to cut diabetic resident's nails.

Telephone interview with a podiatrist for the facility's previous contracted podiatry provider on 02/25/20 at 3:40pm revealed:
-It was expected for residents in the facility to have been seen within 61 days after the last documented podiatry visits because residents needed to keep the toenails short as to not cause problems with the nail beds.
-She did not recommend the PCAs to cut diabetic residents or residents with thick, yellow nails because the PCAs had not been trained.
-Diabetic residents or residents with thick, yellow nails should only have their toenails cut by a Nurse Practitioner, Physician's Assistant, or Podiatrist because they had been trained on treatment in decreasing infection when cutting nails.
-An injury from cutting a diabetic resident or residents with thick, yellow toenails could lead to

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an infection.
-An infection in a diabetic resident could possibly lead to amputation of a toe, foot, or leg.

Interview with the Corporate RN on 02/25/20 at 4:30pm revealed:
-The MAs were told in diabetic training classes to not cut the nails of diabetic residents.
-The PCAs had been told not to cut the nails of diabetic residents when he provided training on high and low blood sugars to the PCAs.
-He did not know podiatry was not in the facility.
-The Administrator would have been responsible to notify him if there were podiatry concerns.
-It was expected all diabetics be referred to podiatry for services immediately on admission to the facility.
-He tried to assess residents' nails and feet when performing Licensed Health Professional Support (LHPS) assessments.
-He could not remember the residents or their names by looking at the LHPS assessment forms.

Telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm revealed:
-Orders for specialty referrals should be in the residents' records.
-He was unaware of any missed healthcare appointments such as podiatry; it would be in the resident's record.

Review of Resident #5's provider notes and progress notes revealed:
-There were no podiatry notes.
-There was no documentation the PCP or a podiatrist was notified of the resident's toenails being long past the toes, thick, and yellow.

Podiatry correspondence and/or notes for

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D 273	Continued From page 54 Resident #5 were not provided prior to survey exit on 02/25/20. Refer to interview with the RCD on 02/10/20 at 11:56am. Refer to interview with the Administrator on 02/10/20 at 12:30pm. Refer to confidential staff interview. Refer to a confidential interview with a second staff. Refer to interview with the RCD on 02/12/20 at 11:30am. Refer to interview with the Administrator on 02/12/20 at 1:30pm. Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm 5. Review of Resident #7's current FL-2 dated 04/04/19 revealed: -Diagnoses included borderline diabetes mellitus, mild mental retardation, and hypertension. -There was a medication order for metformin 1000mg daily (Metformin used to lower blood sugar). Review of Resident #7's care plan dated 04/03/19 revealed the resident required extensive assistance from staff with bathing, dressing, and grooming/personal hygiene. Review of Resident #7's skin assessment form dated 12/05/19 revealed: -The resident's toe nails needed to be cut. -There was handwritten documentation the	D 273		

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residents toe nails were to be cut by podiatry.

Review of Resident #7's podiatry visit note dated 10/01/19 revealed:
-The resident had diagnoses of diabetes mellitus, peripheral vascular disease, and onychomycosis.
-All the resident's toenails were debrided with manual clippers for length and thickness.
-The resident's feet were to be kept clean and dry.
-There was documentation under "Care Plan Interventions" of nail debridement greater than every 61 days to minimize pain, pressure, and infection risk.

Observation of Resident #7 on 02/25/20 at 10:42 am revealed:
-The resident was sitting in the activity room with a personal care aide (PCA).
-The resident had no socks or shoes on his feet.
-There was a white towel on the floor under the resident's feet.
-There was a 2x2 gauze pad with reddish brown colored spots that was laying on the towel.
-The resident was holding up his right foot.
-The tip of the residents right 4th toe had a laceration approximately 3 millimeters (mm) long.
-The laceration was bright pink in color and not closed.
-The first through third, and fifth toenails were thick, and yellow in color.
-The second and fourth toenails were elevated from the toes.
-The third toenail was past the tip of the toe and curved towards the left.
-The PCA was applying a band aid to the tip of the residents right fourth toe wound.

Interview with a PCA on 02/25/20 at 10:42am revealed:

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-She had "nicked" the tip of Resident #7's right fourth toe while cutting out an ingrown toenail this morning (02/25/20).
-The wound bled "a little" after cutting the resident's toe.
-She was going to put a band aid on Resident #7's toe wound.
-She had been performing resident nail care for two weeks.
-She soaked the resident's feet in a basin of water and Epsom salt (Epsom salt is a chemical compound made up of magnesium, sulfur, and oxygen used as a home remedy to sooth aches and pains and exfoliate dead skin on the feet).
-She provided the supplies for resident nail care because the facility did not have the appropriate supplies.

A second interview with the second PCA on 02/25/20 at 11:30am revealed:
-All the residents who wanted nail care told the Resident Care Director (RCD) two weeks ago.
-The RCD wrote the residents names on a piece of paper and she made a mark by the names who were diabetics.
-The RCD gave her the list of resident names to perform nail care.
-She would provide cuticle clippers and emery boards for resident nail care.
-She would use the facilities nail clippers for resident nail care.
-She was not allowed to cut the toenails of diabetic residents.
-Diabetic residents toenails had to be cut by a provider.
-She would soak diabetic residents' feet and file their toenails.
-Resident #7 told her he was not a diabetic when she asked.
-She did not look at Resident #7's diagnoses to

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see if he was a diabetic because she had asked the resident.
-Today (02/25/20) was the first time she had cut Resident #7's toe while performing nail care.
-She applied "styptic powder" on the cut located on the tip of Resident #7's fourth toe this morning (02/25/20) to stop the bleeding (Styptic powder is used in the veterinary trade to stop bleeding from nails or claws that are clipped to closely).
-She brought the styptic powder to the facility from home.
-The styptic powder stayed on Resident #7's wound for ten minutes this morning.
-She rinsed the styptic powder from Resident #7's wound with clean water, wiped the wound with an alcohol pad, and applied a band aid.
-She was going to check on Resident #7's wound in about forty minutes to be certain it had stopped bleeding.
-If the wound continued to bleed, she would tell the medication aide (MA) or a nursing assistant (NA).
-She would also tell the RCD if she was in the facility.

Interview with Resident #7 on 02/25/20 at 11:50am revealed:
-The resident was not a diabetic and did not take medications for diabetes.
-The PCA had cut his toenails last week and today (02/25/20).
-The PCA cut the callouses from the right and left big toes two weeks ago with toenail clippers. The right toe callouses were worse than the left.
-The PCA filed his toe callouses after cutting them with toenail clippers two weeks ago.
-Today (02/25/20) the PCA filed the callouses on the right and left big toes.
-Today (02/25/20) he had an ingrown toenail on his right fourth toe.

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D 273	Continued From page 58 -The PCA had to "cut out an ingrown toenail" on his right fourth toe this morning (02/25/20). -The PCA cut the tip of his right fourth toe while cutting out the ingrown toenail this morning (02/25/20). -Today (02/25/20) was the first time the PCA had cut his toe while performing nailcare. -He had seen podiatry in the near-by area two years ago before residing at the facility. -He had not been seen by podiatry at the facility. -He would like to see podiatry if he needed. Interview with the RCD on 02/25/20 at 12:40pm revealed: -The contract for podiatry with the facility ended around October 2019 or November 2019 because the Administrator did not submit the required paperwork on time. -She had started making a list of all residents who needed podiatry care two weeks ago. -She was going to ask the facility's primary care physician (PCP) to give orders to send the residents to a local podiatrist. -She gave the list of residents who she felt needed podiatry care to the Administrator, but the Administrator never did anything with the list of residents. -There was no process in place for resident podiatry care since October 2019 when services ended because she had not received directive from the Administrator. -No one told the PCA which residents to perform nail care. -She did not think the list of residents were diabetics based on her previous knowledge of the residents by administering mediations to the residents when she worked on the medication cart. -She did not know the PCA had cut Resident #7's toe until the PCA told her today (02/25/20).	D 273		

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D 273	Continued From page 59 -She did not know Resident #7 was a diabetic until the PCA told her today (02/25/20). Interview with the Owner on 02/25/20 at 1:20pm revealed: -She expected podiatry referrals to have been made within 24 business hours. -She expected all podiatry orders to have been signed by the facility's contracted PCP and sent to the facility's contracted podiatry provider. -She expected residents with thick, yellowing nails to have received proper nail care and a podiatry referral. -She thought the corporate Registered Nurse (RN) could provide podiatry services. -She expected the corporate RN to have cut the residents toenails if podiatry referrals were not made. -The RCD was expected to contact corporate for guidance if the Administrator did not give clear directive to the RCD. -She was told in a care meeting twenty minutes ago Resident #7's toe was cut during nail care this morning. -The PCA was not expected to cut out an ingrown toenail. -She expected to have been informed at the time the toe was cut so Resident #7's PCP would have been notified. -She did not know what styptic powder was. Telephone interview with the manager of the facility's previous contracted podiatry provider on 02/25/20 at 10:00am revealed: -Podiatry was last at the facility October 2019. -Podiatry would routinely see residents usually every 63 days because Medicare would not allow podiatry visits less than every 61 days -On multiple occasions when the Nurse Practitioner (NP) went to the facility to see	D 273		

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residents the Administrator would reschedule the appointments because she did not expect podiatry in the building on those days.
-Podiatry was scheduled to return to the facility December 2019.
-The facility's contract with podiatry was canceled because the Administrator did not forward the orders for podiatry to the contracting provider.

Telephone interview with a podiatrist for the facility's previous contracted podiatry provider on 02/25/20 at 3:40pm revealed:
-PVD caused an increase in compromised blood flow to the toes from the heart because the toes were already the furthest from the heart.
-Decreased blood flow caused less oxygenation to the tissues which could cause delayed healing.
-Styptic powder was used to stop bleeding.
-Resident #7's provider should have been notified when the resident's toe was cut due to impaired skin integrity and diagnoses of diabetes and PVD.
-It was not acceptable for a PCA to apply styptic powder to a wound without orders from a provider because the skin integrity had been impaired.
-If a diabetic resident's toe was cut while performing nail care, the toe should have been cleaned with betadine, an antibiotic ointment applied, and a dry dressing daily until the wound was healed.
-It was not acceptable for a PCA to cut out an ingrown toenail.
-It was expected for residents in the facility to have been seen within 61 days after the last documented podiatry visits because residents needed to keep the toenails short as to not cause problems with the nail beds.
-Diabetic residents or residents with thick, yellow nails should only have their toenails cut by a Nurse Practitioner, Physician's Assistant, or Podiatrist because they had been trained on

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treatment in decreasing infection when cutting nails.
-An injury from cutting a diabetic resident or residents with thick, yellow toenails could lead to an infection.
-An infection in a diabetic resident could possibly lead to amputation of a toe, foot, or leg.

Interview with the Corporate RN on 02/25/20 at 4:30pm revealed:
-The MAs were told in diabetic training classes to not cut the nails of diabetic residents.
-The PCAs had been told not to cut the nails of diabetic residents when he provided training on high and low blood sugars to the PCA's.
-He did not know podiatry was not in the facility.
-The Administrator would have been responsible to notify him if there were podiatry concerns.
-It was expected all diabetics be referred to podiatry for services immediately on admission to the facility.

Telephone interview with the facility's contracted primary care physician (PCP) on 02/24/20 at 2:10pm revealed:
-Orders for specialty referrals should be in the residents' records.
-He was unaware of any missed healthcare appointments such as podiatry; it would be in the resident's record.

Review of Resident #7's PCP orders, progress notes, podiatry visit notes and provider correspondence revealed there were no requests or orders for podiatry referral and no podiatry visit notes dated after 10/01/19.

Refer to interview with the RCD on 02/10/20 at 11:56am.

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D 273	Continued From page 62 Refer to interview with the Administrator on 02/10/20 at 12:30pm. Refer to confidential staff interview. Refer to a confidential interview with a second staff. Refer to interview with the RCD on 02/12/20 at 11:30am. Refer to interview with the Administrator on 02/12/20 at 1:30pm. Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm. 6. Review of Resident #1's current FL-2 dated 01/10/20 revealed diagnoses included Hashimoto's thyroiditis, adrenal insufficiency, psoriatic arthritis, chronic neck pain, depression, anxiety, diabetes mellitus, abdominal aortic aneurysm repair, hypertension, and obstructive sleep apnea. a. Review of Resident #1's lab results dated 01/24/19 revealed Resident #1's thyroid stimulating hormone (TSH) level was 0.23 mIU/L and flagged as low. (TSH levels are used to determine if the thyroid is functioning normally. The normal reference range for TSH is 0.45 - 5.33 mIU/L. A low TSH may indicate overactive thyroid or an overtreatment of underactive thyroid.) Review of Resident #1's physician's orders dated 04/29/19 revealed: -The resident' dosage of Armour Thyroid was changed to 105mg daily. (Armour Thyroid is used to treat hypothyroidism.)	D 273		

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-There was an order to recheck the resident's TSH level in 6 weeks.

Review of Resident #1's lab results, progress notes, and provider visit notes revealed no documentation the resident's TSH level had been rechecked as ordered on 04/29/19 after the medication dosage was changed.

Interview with Resident #1 on 02/25/20 at 12:45pm revealed:
-The last time his thyroid levels were checked about a year ago, the level was too low.
-He was taking Armour Thyroid 120mg daily until around June 2019 when the facility's contracted physician decreased the dosage by 15mg.
-The dosage had not been changed to his knowledge.
-He felt tired and depressed and he needed to have his thyroid levels rechecked.

Telephone interview with the receptionist at Resident #1's primary care provider's (PCP) office on 02/25/20 at 11:17am revealed:
-The last dosage they had on file for Resident #1's Armour Thyroid was 120mg daily and that order dated back to 11/09/18.
-There was no documentation in their records the dosage of Armour Thyroid had been changed.
-They were not aware the facility's contracted provider had changed the Armour Thyroid dosage on 04/29/19 or that a TSH level had been ordered.
-The last TSH level in the resident's record was done on 01/24/19 and it was low at 0.23 at that time.
-There was no other documentation in their records that she could find regarding the resident's TSH levels or Armour Thyroid dosage.
-The resident was scheduled for a routine visit

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 64 with their office on 03/31/20. Interview with the Resident Care Director (RCD) on 02/25/20 at 4:58pm revealed: -She just started working as the RCD in the middle of December 2019 and she was still in training. -The Administrator was responsible for coordinating labwork for residents. -She thought sometimes residents would go to the hospital to have labwork drawn and sometimes labwork was obtained at the facility by a lab company. -Prior to becoming RCD, she had helped transport residents to appointments. -She did not transport Resident #1 to have any labwork completed. -She did not know if Resident #1's TSH had been rechecked as ordered on 04/29/19. The Administrator was not available for interview from 02/21/20 - 02/25/20. Interview with the facility's Owner on 02/25/20 at 5:35pm revealed: -She did not know if Resident #1's TSH level had been checked as ordered on 04/29/19. -The Administrator and RCD were responsible for assuring labwork was obtained. -The Administrator was responsible for working with the RCD to ensure residents' labwork was obtained but that was not being done. Refer to interview with the RCD on 02/10/20 at 11:56am. Refer to interview with the Administrator on 02/10/20 at 12:30pm. Refer to confidential staff interview.	D 273		

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D 273	Continued From page 65 Refer to a confidential interview with a second staff. Refer to interview with the RCD on 02/12/20 at 11:30am. Refer to interview with the Administrator on 02/12/20 at 1:30pm. Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm. b. Review of Resident #1's physician's order dated 03/07/19 revealed an order for an ophthalmology referral for macular degeneration. (Macular degeneration is an eye disease caused by deterioration of the retina which overtime may cause blurred or no vision in the center of the visual field.) Review of Resident #1's most current assessment and care plan dated 01/11/19 revealed: -The resident's vision was limited (sees large objects) and the resident used glasses. -The resident would be seen by a contracted provider for vision care. Review of Resident #1's physician's order dated 01/11/19 by the facility's contracted primary care provider (PCP) revealed an order for an ophthalmic consult for the resident due to decreased vision and diabetes. Review of Resident #1's physician's order dated 03/07/19 revealed an order for an ophthalmology referral for macular degeneration. Review of Resident #1's progress notes and	D 273		

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provider visit notes revealed no documentation the resident had been seen by an ophthalmologist.

Interview with Resident #1 on 02/25/20 at 12:45pm revealed:
-He thought he was saw an optometrist (could not recall name) around June 2019, but he was supposed to see an ophthalmologist because he had macular degeneration.
-He had not seen an ophthalmologist and he was not aware of any appointments being made for him to see one.
-He needed to see an ophthalmologist because he had macular degeneration and his eyesight was getting worse.
-He could see a person's hair around their face but not a person's face because it was blurry.
-The center of his visual field was blurry.

Telephone interview with a manager of the facility's previous contracted agency for ophthalmic services on 02/25/20 at 10:00am revealed:
-They had not provided optometry services for the facility since February 2019 because they did not have an optometrist or an ophthalmologist.
-The facility had routinely referred residents to a local ophthalmologist before optometry services ended in February 2019.
-The facility should have referred Resident #1 to a local ophthalmologist.

A second telephone interview with a manager of the facility's previous contracted agency for ophthalmic services on 02/25/20 at 2:35pm revealed:
-Resident #1 was admitted to their services on 01/12/19.
-The facility was responsible for referring

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Resident #1 to an ophthalmologist.
-The facility never contacted their office for assistance with referring Resident #1 to an ophthalmologist.

Interview with the Resident Care Director (RCD) on 02/25/20 at 4:58pm revealed:
-She started working as the RCD in the middle of December 2019.
-The Administrator was responsible for coordinating referrals for residents.
-Prior to becoming RCD, she had helped transport residents to appointments.
-She did not transport Resident #1 to see an ophthalmologist.
-She did not know if Resident #1 had been seen by an ophthalmologist.

The Administrator was not available for interview from 02/21/20 - 02/25/20.

Interview with the facility's Owner on 02/25/20 at 5:35pm revealed:
-She did not know if Resident #1 had been seen by an ophthalmologist.
-The Administrator and RCD were responsible for assuring referrals were completed as ordered.
-The Administrator was responsible for working with the RCD to ensure a system for referrals but that was not being done.

Refer to interview with the RCD on 02/10/20 at 11:56am.

Refer to interview with the Administrator on 02/10/20 at 12:30pm.

Refer to confidential staff interview.

Refer to a confidential interview with a second

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staff.

Refer to interview with the RCD on 02/12/20 at 11:30am.

Refer to interview with the Administrator on 02/12/20 at 1:30pm.

Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm.

7. Review of Resident #2's current FL-2 dated 07/01/19 revealed diagnoses included depression, fibromyalgia, chronic obstructive pulmonary disease, irritable bowel syndrome, hypertension, essential tremors, and gastroesophageal reflux disease.

Review of Resident #2's Care Plan dated 07/01/19 revealed the resident was forgetful and needed reminding.

Review of an order dated 10/17/19 for Resident #2 revealed:
-Resident #2 was unable to have her dental visit completed due to being nervous.
-Resident #2 was referred to an oral surgeon.

Review of an order dated 11/25/19 for Resident #2 revealed there were referrals to an ear nose and throat doctor, gastroenterologist, and a dermatologist.

Interview with Resident #2 on 02/19/20 at 10:33 revealed:
-She had not seen a physician since the beginning of December 2019.
-She had not been sent to any of the referrals since coming to the facility in July 2019.
-She had a broken tooth sometime in December

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2019 the dentist referred her to an oral surgeon.
-She had not been to the oral surgeon.
-The Administrator would tell you she will get it done but nothing happened.

Interview with Resident Care Director (RCD) on 02/19/20 revealed:
-If there was a referral to a new physician you send the demographics sheet to the physician and they will make an appointment.
-She and the transportation staff were responsible for making the appointments.

A second interview with the RCD on 02/21/20 at 11:38 revealed:
-Resident #2 has never been to a referral that she was aware of.
-She was aware that Resident #2 was referred to an oral surgeon.
-Resident #2's oral surgeon was an hour and a half away because of her insurance.
-The Administrator would not let her make the appointment for Resident #2 with the oral surgeon because it was too far away.
-She did not notify anyone.

Interview with the facility's Owner on 02/24/20 at 12:07pm revealed:
-She was not aware appointments were never made for Resident #2's referrals.
-There should be "immediate action" on specialty referrals; the process for specialty referrals was as follows: the same day or next business day the resident received the referral or returned from the hospital with the referral, the MA, RCD or Administrator was supposed to call to schedule the appointment with the specialist; documentation was made of the appointment in nurses' notes; if there were any delays, the PCP was to be notified of the delays.

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D 273	Continued From page 70 -The earliest appointment should be obtained. -A fax should be sent to the PCP with the date of the appointment. -There should be documentation in the resident record this was completed. -Delays and PCP notifications were also documented in the nurses' notes. -There should be documentation of attempts to make appointments and any delays in appointments in nurses' notes. -The facility could take the residents an hour and a half away if needed. Refer to interview with the RCD on 02/10/20 at 11:56am. Refer to interview with the Administrator on 02/10/20 at 12:30pm. Refer to confidential staff interview. Refer to a confidential interview with a second staff. Refer to interview with the RCD on 02/12/20 at 11:30am. Refer to interview with the Administrator on 02/12/20 at 1:30pm. Refer to telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm. Interview with the Resident Care Director (RCD) on 02/10/20 at 11:56am revealed: -It was very difficult to reach the facility's primary care physician (PCP) because he never responded to staff's attempts to reach him. -She was aware staff were having difficulty reaching the physician.	D 273		

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D 273	Continued From page 71 -She was unsure if any of the staff had been able to successfully contact him lately. -If she needed to contact the physician, she would fax him and then tell the Administrator. -The Administrator had requested that all staff notify her if they needed to get information to the physician. -She heard he may be out of the country. -If residents needed medical care, they "could always send them to the hospital". Interview with the Administrator on 02/10/20 at 12:30pm revealed: -Staff had no problem reaching the facility's contracted PCP when they needed him. -The one area of care that she was sure was provided to the residents was the mental health services that was provided on-site. -No other on-site services had been provided to the residents recently, but she had just signed a contract a few days ago for audiology and optometry services to be added. -If any resident had gone to any outside provider for services, the documentation of the visit should be in the residents' records. -If there were no records of health care visits by the PCP or specialist, she had large bins of resident records in the previous RCD's office and she would go through the bins to try to locate records. -She had always been told by the facility's Owner that "less was more when it came to the information kept in resident records". -She did not know why the resident records would be "almost empty". -She was not aware of any residents that were overdue for specialty healthcare appointments except for those needing podiatry. Confidential staff interview revealed:	D 273		

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D 273	Continued From page 72 -It had been a long time since any staff member had been able to make contact with the facility's contracted PCP. -It was "almost impossible" to reach the contracted PCP. -He never responded to her attempts to contact him about resident's healthcare needs. -If residents asked to speak with the physician, residents were told staff did not know when he would be coming in. -She did not think any staff person had spoken to him in several months. -The Administrator had informed the staff to stop contacting the PCP directly, and to notify her if they needed anything from the PCP and she would take care of it. -She had never worked in a facility where the staff could not communicate with the physician. -The staff "don't really do chart notes" to document anything about the residents or their healthcare. -The Administrator had instructed staff during staff meetings "not to leave a paper trail" in the resident's records and to "chart as little as possible". -The new RCD had mentioned they might start documenting some narratives on the electronic medication administration records but this had not yet been started. Confidential interview with a second staff revealed: -Staff were instructed by the Administrator "not to leave a paper trail of any kind of information in the residents' records". -The staff "basically don't chart anything anywhere". -She thought the reason staff were told not to leave a paper trail was becuase it was easier to hide when residents did not get their healthcare if	D 273		

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there was "basically nothing" in the records.
-She was always taught at other facilities that if you didn't document it, it did not happen.
-She had been attempting to contact the PCP "since last fall" for various health issues for various residents.
-She received no response to text messages, faxes, or voicemails.
-She always informed the Administrator if she attempted unsuccessfully to reach the physician.
-She frequently ended up sending residents out to the hospital when the PCP did not respond.
-The Administrator had told the staff "a while back" not to try to contact the PCP, but to let her know if they needed something from him.
-Almost every physician order she saw in the resident's records, was written in the Administrator's handwriting with a stamped signature of the PCP's name.
-She had heard several staff speak about the Administrator possibly having the PCP's signature stamp.

Interview with the RCD on 02/12/20 at 11:30am revealed:
-As soon as she started working at the facility in December 2019, she noticed there was no documentation of anything in the resident's records.
-She heard from other staff that the Adult Home Specialist was asking for missing healthcare documentation.
-She had spoken to the Administrator about the lack of healthcare documentation and told her they needed to try to assure more documentation was in the resident's records for review.
-She had spoken to the MAs about starting to document some narrative information on the eMARs but this plan had not yet been implemented.

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-She was going to "go through storage bins" in her office and try to find health care information for the residents that needed to be placed in their records.
-She was not aware there were residents in need of primary and specialty healthcare services that had not received any.
-She would go to each resident "room to room" and would ask if they needed to see the PCP or any specialist and would schedule any needed appointments.
-She had not seen the facility's PCP in "quite a while".

Interview with the Administrator on 02/12/20 at 1:30pm revealed:
-She had always been told by the facility's Owner that "less was more" when it came to documentation of healthcare in residents' records.
-She felt sure the residents were getting their health care needs met and the documentation was probably in some large "bins of records" stored in the RCD's office.
-She would go through the bins to try to find health care records and would file them back in the resident's records.

Telephone interview with the facility's contracted primary care physician (PCP) on 02/24/20 at 2:10pm revealed:
-He acknowledged he was the PCP for the residents who resided in the facility.
-Staff were expected to notify him upon receipt of any specialty appointments that required referral.
-Staff called him when a resident returned from the hospital if a special referral was needed.
-He gave verbal orders for the specialty referral appointments at the time he was notified of the need and signed the order when he was onsite.

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D 273	Continued From page 75 -He was unaware of any delays in health care appointments or missed healthcare appointments; it would be in the record. -He would "try" to complete visits to the facility once a month but not greater than 90 days from his previous visit. -His last visit to the facility was in November 2019. -He was available "24/7" (twenty - four hours per day, seven days per week) and staff knew his availability. -A Nurse Practitioner (NP) was available to staff in his absence (when he was on vacation and not available). -He expected staff to contact him by text or phone for any concerns or changes in residents' status or condition at the time observed and to document the notification as they normally would (he was unsure of the documentation process). -He expected all notifications and orders to be kept in the residents' records. -When asked why there were only a few current notifications and orders being found in the residents' records, he did not respond. _____ The facility failed to assure a resident (#6) who had a history of three heart attacks and cardiac stents who was having chest pain and pressure that awoke her from sleep with shortness of breath and sweaty skin was referred to the emergency department and/or her cardiologist; Resident #4 who had end stage chronic obstructive pulmonary disease and was on oxygen had not received a nebulizer machine for ordered nebulizer treatments and had labored breathing and shortness of breath on exertion; Resident #5 was not referrred to the PCP for blood sugars greater than 400, two emergency department visits for urinary tract infections and 1 for pneumonia; Residents #3 and #5 were not	D 273		

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D 273	Continued From page 76 referred for podiatry services whose toenails had grown over the adjoining toes and nails which were thick and yellow; Thyroid labs were not obtained for Resident #1 who was diagnosed with an autoimmune thyroid disorder and had thyroid labs results out of the normal range when last checked over a year ago; Ophthalmology referral was not made for Resident #1 with macular degeneration and who complained of deteriorating eye sight and blurred vision; and Resident #2 who had a fractured tooth was not referred to an oral surgeon because it was too far of a drive nor to gastroenterology, and dermatology. The facility' failure resulted in serious physical harm and neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on February 20, 2020 for this violation. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON FEBRUARY 26, 2020.	D 273		
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: TYPE A2 VIOLATION	D 358		

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D 358	Continued From page 77 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policies for 2 of 3 residents observed (#1, #11) during the medication passes including errors with a medication used to treat heart failure and high blood pressure (#11), a medication for breathing problems (#11), and a medication for underactive thyroid (#1); and for 5 of 5 residents sampled (#1, #2, #3, #4, #5) for record review including errors with medications for heart/blood pressure (#1, #3), thyroid disease (#1, #4, #5), narcotic pain relievers (#1, #2), anxiety (#1, #4, #5), muscle relaxer (#1), antidepressants (#1, #4, #5), enlarged prostate (#1), inflammation and arthritis (#1), adrenal insufficiency (#1), acid reflux (#1, #5), cholesterol and triglycerides (#1, #4, #5), constipation (#1, #4), seasonal and year-round allergies (#4), fluid retention (#4), manic-depressive disorder (#4), chronic obstructive pulmonary disease (#3, #4), hormone for sleep-wake cycle (#4), antipsychotics (#4, #5), a medication used to reduce the risk of heart attack (#4), vitamin supplements (#1, #5), nerve pain and seizures (#5), expectorant for congestion (#5), and diabetes (#5). The findings are: 1. The medication error rate was 11% as evidenced by the observation of 3 errors out of 27 opportunities during the 8:00am/9:00am medication passes on 02/20/20. a. Review of Resident #11's current FL-2 dated 08/15/19 revealed diagnoses included dementia, major depressive disorder, generalized weakness, congestive heart failure,	D 358		

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non-rheumatic valve stenosis, hypertension, anxiety, aspiration pneumonia, cerebrovascular accident, and chronic obstructive pulmonary disease.

Review of a physician's order for Resident #11 dated 11/01/19 revealed change Coreg 6.25 mg to ½ tablet po twice daily with meals at 7:00am and 5:00pm (Coreg is used to treat heart failure and high blood pressure. According to the manufacturer, Coreg should be given with food to slow the rate if absorption and reduce the incidence of orthostatic effects, or low blood pressure when standing up).

Review of Resident #11's February 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for Coreg 6.25 mg twice daily with meals.
-Coreg was scheduled to be administered at 8:00am and 5:00pm.
-Instructions on the eMAR included giving Coreg with meals.

Observation of the morning medication pass on 02/20/20 revealed:
-Resident #11 was lying in bed in her room.
-The medication aide (MA) stated Resident #11 did not usually eat breakfast.
-The MA administered Coreg 6.25 mg to Resident #11 at 8:26am on an empty stomach.

Interview with Resident #11 on 02/20/20 at 1:41pm revealed:
-The resident "sometimes" ate breakfast, but staff did not ask her if she was going to eat breakfast.
-Her medication did not hurt her stomach.

Interview with the MA on 02/20/20 at 1:48pm

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revealed:
-It would not make a "difference" that if a medication was ordered to be administered before or with meals, she would administer the medication to the resident before the meal.
-Resident #7 did not eat breakfast.
-Snacks were given to residents at 10:00am and residents also had bedside snacks.
-She administered Coreg to the resident each morning when the resident received her other morning medications.

Interview with the Resident Care Director (RCD) on 02/20/20 at 2:09pm revealed:
-If a medication was ordered before meals, the medication should be administered 30 minutes before the resident ate.
-If a medication was ordered with meals, the medication should be administered right before the resident ate or when the resident was eating their meal.
-Her expectation for medications ordered with meals was for the MA to try to give the resident a little something to eat. For example, a mighty shake or yogurt.
-The MA should try to encourage the resident to drink a shake when medication(s) were ordered to be administered with meals.
-She was not aware Resident #11 was not eating breakfast and taking the Coreg on an empty stomach.
-The MAs should have notified the physician or the RCD so they could get the order clarified and changed.

Interview with the Administrator on 02/20/20 at 4:50pm revealed:
-Medications ordered with meals should be administered just before the resident was going into the dining room to start eating.

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-If there was a delay with getting the meal, the resident should be administered a snack such as a cracker with the medication.
-She was not aware Resident #11 did not eat breakfast.
-The MAs should have notified her or the RCD that Resident #11 did not eat breakfast so the primary care provider (PCP) could be contacted to change the order.

b. Review of a physician's order for Resident #11 dated 11/25/19 revealed DuoNeb 4 times daily (DuoNeb is used for the treatment of breathing problems associated with chronic obstructive pulmonary disease).

Review of Resident #11's February 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for DuoNeb 0.5 mg-3 mg/3 ml use 1 vial via handheld nebulizer 4 times daily.
-DuoNeb was scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm.

Observation of the 8:00am medication pass on 02/20/20 revealed:
-Resident #11 was lying in bed in her room.
-The medication aide (MA) did not prepare or offer Resident #11 the ordered DuoNeb.

Interview with Resident #11 on 02/20/20 at 1:41pm revealed:
-She did not have a nebulizer machine.
-She was never offered her DuoNeb.
-She sometimes wore oxygen therapy.
-She did not "usually" get short of breath.

Observation on 02/20/20 at 1:45pm revealed a nebulizer machine on the lower compartment of a bedside nightstand in Resident #11's room.

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D 358	Continued From page 81 Interview with the MA on 02/20/20 at 1:50pm revealed: -The facility was working on getting another nebulizer machine for Resident #11. -The nebulizer machine had been broken for about a week; the nebulizer machine was cracked. -She did not offer the DuoNeb to Resident #11 during the morning medication pass on 02/20/20 because "every time" it was offered to Resident #11 she would refuse. -She was sure the physician did not know Resident #11's nebulizer machine was broken, or she was refusing the DuoNeb medication. -She did not notify Resident #11's physician by phone or fax. -She believed the facility's policy to notify the physician of resident's medication refusals was after 3 days. -She had not noticed Resident #11 having any shortness of breath. Interview with the Resident Care Director (RCD) on 02/20/20 at 2:09pm revealed: -It was reported to her that Resident #11's nebulizer machine was broken on Monday (02/17/20). -She reported the broken nebulizer machine to the Administrator on the same day, 02/17/20. -The nebulizer machine was "supposed to be ordered." -She did not have an answer what Resident #11 should do in the meantime with no available nebulizer machine for use. -She had not contacted Resident #11's physician to notify them of the unavailability of a nebulizer machine. -She had heard the facility had backup nebulizer machines, but she had not tried to use a backup	D 358		

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nebulizer because she had not seen any.

Interview with the Administrator on 02/20/20 at 4:50pm revealed:
-She had not ordered a nebulizer for Resident #11 because she was not aware until now that the resident's nebulizer was broken.
-No one reported to her that Resident #11's nebulizer was broken.
-There was a new nebulizer kept in the facility's storage that did not belong to any resident.
-If she had known prior to now that Resident #11's nebulizer was broken, she would have gotten the new one from storage so staff could use it for the resident.
-The MAs should have reported the broken nebulizer to her, and they should have notified the resident's primary care provider (PCP) of any missed doses of DuoNeb.

A second interview with the Administrator on 02/21/20 at 9:50am revealed Resident #11 had a new nebulizer in her room today (02/21/20) to be used for her DuoNeb treatments.

c. Review of Resident #1's current FL-2 dated 01/10/20 revealed diagnoses included adrenal insufficiency, obstructive sleep apnea, Hashimoto's thyroiditis, psoriatic arthritis, hypertension, depression, anxiety, diabetes mellitus, abdominal aortic aneurysm repair, and chronic neck pain.

Review of Resident #1's current FL-2 dated 01/10/20 revealed:
-There was an order for Armour Thyroid 120 mg daily. (Armour Thyroid is used to treat underactive thyroid.)
-There was an order for Armour Thyroid 15 mg daily.

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D 358	Continued From page 83 Review of Resident #1's February 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Armour Thyroid 90 mg take 1 tablet daily take along with 15 mg tablet to equal 105 mg tablet. -The Armour Thyroid medications were scheduled to be administered at 9:00am. Review of physician's orders for Resident #1 revealed no documentation the physician was contacted to clarify the Armour Thyroid medication order. Observation of the morning medication pass on 02/20/20 revealed: -Resident #1 was standing in the hallway of the facility near the medication cart. -The medication aide (MA) administered Armour Thyroid 15 mg and Armour Thyroid 90 mg to Resident #1 at 8:43am. Interview with the MA on 02/20/20 at 1:48pm revealed: -She usually administered Armour Thyroid 90 mg and 15 mg to Resident #1 because that was the instructions on the eMARs. -She did not know if the resident's order for Armour Thyroid had changed. Interview with the Resident Care Director (RCD) on 02/20/20 at 2:09pm revealed: -She was not involved with the completion of the resident's FL-2. -She had not done any auditing of residents' FL-2s. -She was unaware of the discrepancy with Resident #1's Armour Thyroid order.	D 358		

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Interview with the Administrator on 02/20/20 at 4:50pm revealed she was not aware Resident #1's order for Armour Thyroid on the current FL-2 did not match the dosage being administered to the resident.

Interview with a pharmacist from the facility's contracted pharmacy on 02/25/20 at 12:10pm revealed:
-The last order she had on file for Resident #1's Armour Thyroid was the physician's order sheet dated 12/02/19 for 90 mg along with a 15 mg tablet to equal 105 mg.
-The pharmacy did not receive a copy of Resident #1's current FL-2 dated 01/10/20 that included orders for Armour Thyroid 120 mg and 15 mg once daily.
-She was not aware the orders on the current FL-2 did not match the orders the pharmacy had on file.

Interview with Resident #1 on 02/25/20 at 12:45pm revealed:
-The last time his thyroid levels were checked about a year ago, the level was too low.
-He was taking Armour Thyroid 120 mg daily until around June 2019 when the facility's contracted physician decreased the dosage by 15 mg.
-The dosage had not been changed to his knowledge.
-He felt tired and depressed and he needed to have his thyroid levels rechecked.

Telephone interview with the receptionist at Resident #1's primary care provider's (PCP) office on 02/25/20 at 11:17am revealed:
-The last dosage they had on file for Resident #1's Armour Thyroid was 120 mg daily and that order dated back to 11/09/18.
-There was no documentation in their records the

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dosage of Armour Thyroid had been changed.
-They were not aware the facility's contracted provider had changed the Armour Thyroid dosage on 04/29/19 or that a thyroid-stimulating hormone (TSH) laboratory test (a blood test used to measure TSH levels) had been ordered.
-The last TSH level in the resident's record was done on 01/24/19 and it was low at 0.23 (normal reference range is 0.4-4.0) at that time.
-There was no other documentation in their records that she could find regarding the resident's TSH levels or Armour Thyroid dosage.

2. Review of Resident #4's current FL-2 dated 06/19/19 revealed diagnoses included schizophrenia, psychotic affective, emphysema of lung, acute encephalopathy, edema onychomycosis, hypothyroidism, and extreme hypertension.

a. Review of Resident #4's current FL-2 dated 06/19/19 revealed an order for DuoNeb 0.5-3 (2.5) mg/3ml three times daily via hand held nebulizer and every 4 hours as necessary (prn) for shortness of breath (SOB)/wheezing [DuoNeb is used to treat chronic obstructive pulmonary disease (COPD)].

Review of Resident #4's December 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for DuoNeb 0.5-3 (2.5) mg/3ml use 1 vial in nebulizer three times daily.
-There was documentation DuoNeb was administered three times daily for 88 out of 93 opportunities from 12/01/19 to 12/31/19.
-On 12/09/19 at 2:17pm, it was documented the resident refused her DuoNeb.
-On 12/10/19 at 9:39am, it was documented the resident refused her DuoNeb.

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-On 12/10/19 at 2:25pm, it was documented the resident refused her DuoNeb.
-On 12/27/19, 12/28/19, DuoNeb 0.5-3(2.5) mg/3 ml was unavailable.
-There were no prn DuoNeb doses documented as administered from 12/01/19 to 12/31/19.

Review of Resident #4's January 2020 eMAR revealed:
-There was an entry for DuoNeb 0.5-3 (2.5) mg/3ml use 1 vial in nebulizer three times daily.
-There was documentation DuoNeb was administered three times daily for 85 out of 93 opportunities from 01/01/20 to 01/31/20.
-On 01/30/20 at 2:05pm, it was documented the resident refused her DuoNeb.
-On 01/31/20 at 2:22pm, it was documented the resident refused her DuoNeb.
-On 01/31/20 at 8:50pm, it was documented the resident refused her DuoNeb.
-There were no prn DuoNeb doses documented as administered from 01/01/20 to 01/31/20.

Review of Resident #4's February 2020 eMAR revealed:
-There was an entry for DuoNeb 0.5-3 (2.5) mg/3 ml use 1 vial in nebulizer three times daily.
-There was documentation DuoNeb was administered three times daily for 39 out of 58 opportunities from 02/01/20 to 02/20/20.
-Resident #4 refused her DuoNeb on 19 occurrences from 02/01/20 to 02/20/20.
-Her last administered dose was 9:00pm on 02/19/20.
-There were no prn DuoNeb doses documented as administered from 01/01/20 to 01/31/20.

Review of Resident #4's hospice electronic progress notes for December 2019 revealed:
-On 12/02/19, 12/09/19, and 12/18/19, Resident

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#4's respiratory assessment documented she had dyspnea at rest.
-On 12/31/19, Resident #4's respiratory assessment documented her breathing was labored, and she had dyspnea at rest.
-Her respiratory rate was 22-28 breaths per minute (bpm) (the normal respiratory rate is 12 to 20 bpm) on 12/02/19, 12/18/19, 12/27/19, and 12/31/19.

Review of Resident #4's hospice electronic progress notes for January 2020 revealed:
-On 01/05/19, 01/13/20, 01/22/20, and 01/27/20, Resident #4's respiratory assessment documented she had dyspnea at rest.
-On 01/06/19, Resident #4's respiratory assessment documented her breathing was labored, and she had dyspnea at rest.
-On 01/16/20, she had dyspnea with minimal exertion, 3-5-word conversational dyspnea and resting oxygen saturations at 85% without oxygen [normal oxygen saturation readings range from 95 - 100% at rest on room air (RA)].
-Her respiratory rate was 22-24 bpm on 01/06/20, 01/13/20, and 01/22/20.
-On 01/06/20, her oxygen saturation was 72% at rest on RA.

Review of Resident #4's hospice electronic progress notes for February 2020 revealed:
-On 02/03/20 and 02/10/20, Resident #4's respiratory assessment documented she had dyspnea at rest.
-On 02/17/20, Resident #4's respiratory assessment documented her breathing was labored and she had dyspnea at rest.
-Her respiratory rate was 22-24 bpm on 02/03/20, 02/10/20, and 02/17/20.
-On 02/03/20, her oxygen saturation was 90% at rest on RA.

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D 358	Continued From page 88 -On 02/17/20, her oxygen saturation was 87% at rest on RA. Interview with a pharmacist from the facility's contracted pharmacy on 02/24/20 at 12:30pm revealed: -In "overall terms" if a resident with end stage chronic obstructive pulmonary disease was not receiving their scheduled and prn DuoNeb, the resident would have difficulty breathing, shortness of breath, worsening of COPD resulting in hospitalization. -This would be the "progression" of the resident's symptoms. Observations on 02/24/20 at 4:02pm of medications on hand for Resident #4 revealed: -DuoNeb was dispensed from the facility's contracted pharmacy on 11/26/19 containing a total of 270 ml (one-month supply). -Each DuoNeb packet had 5 vials containing 15 mls in total. -There were 8 full packets (120 ml) and 1 open packet containing 3 additional doses (15 ml). -There was 135 ml remaining (a 9-day supply) of the 270 ml dispensed amount. Interview with Resident #4 on 02/21/20 at 11:24am revealed: -She did not have a nebulizer machine. -She had received nebulizer treatments previously but could not recall the last time or who had administered them to her in the facility. -She experienced shortness of breath "often." Interview with a first shift medication aide (MA) on 02/21/20 at 1:30pm revealed: -The facility did not have a nebulizer machine for Resident #4. -The machine was taken out of the facility for	D 358		

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service, but she was not sure the date.
-The facility had let the hospice agency know but she was not sure of the date of notification.
-When presented with Resident #4's February 2020 eMAR, she was not sure if Resident #4 was given her DuoNeb on 02/14/20 at 9:00am, 02/14/20 at 3:00pm, 02/16/20 at 9:00am, 02/16/20 at 3:00pm, and 02/17/20 at 3:00pm where her initials were documented to indicate administration of the medication.

Interview with the Hospice Registered Nurse (RN) on 02/24/20 at 09:45am revealed:
-She came to the facility to see Resident #4 twice a week on Mondays and Fridays.
-Resident #4 was short of breath "every time" when she came to the facility and the documentation would be included in her nursing assessments.
-Resident #4 was dependent on continuous oxygen except when smoking.
-She was not sure if the nebulizer machine was in Resident #4's room during her visit on 02/17/20.

Interview with a pharmacist from the facility's contracted pharmacy on 02/24/20 at 4:02pm revealed:
-Resident #4's DuoNeb was dispensed from the facility's contracted pharmacy on 11/26/19 for the 30-day scheduled dose.
-The facility staff did not initiate the re-order of the DouNeb medication through the eMAR.
-There was no documentation of any re-orders for Resident #4's DuoNeb per pharmacy records since November 2019.

Refer to interview with the Administrator on 02/19/20 at 12:12pm.

Refer to interviews with the Resident Care

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Director (RCD) on 02/19/20 at 10:40am and 02/25/20 at 4:58pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 02/24/20 at 2:10pm.

Refer to interview with a pharmacist at the facility's primary pharmacy on 02/25/20 at 11:45am.

Refer to interview with the facility's Owner on 02/25/20 at 5:35pm.

b. Review of Resident #4's current FL-2 dated 06/19/19 revealed:
-There was an order for Flonase 50 mcg take 2 sprays each nostril twice daily (Flonase is used to relieve seasonal and year-round allergic and non-allergic nasal symptoms).
-There was an order for Aldactone 25 mg twice daily (Aldactone is used to treat high blood pressure and fluid retention).
-There was an order for Lithium Carbonate 300 mg twice daily with meals (Lithium Carbonate is used to treat Manic-Depressive Disorder).
-There was an order for Synthroid 100 mcg before meals (Synthroid is used to treat an underactive thyroid).
-There was an order for Senna Plus 3 twice daily (Senna Plus is a laxative).
-There was an order for DuoNeb 0.5-3 (2.5) mg/3 ml three times daily via hand held nebulizer and every 4 hours as necessary (prn) shortness of breath (SOB)/wheezing (DuoNeb is used to treat chronic obstructive pulmonary disease).
-There was an order for Lasix 20 mg daily (Lasix is used to treat fluid retention).
-There was an order for Simvastatin 10 mg daily (Simvastatin is used to treat high cholesterol and

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triglycerides levels).
-There was an order for Trazodone 100 mg daily at bedtime (Trazadone is used to treat depression).
-There was an order for Buspar 10 mg three times daily (Buspar is used to treat anxiety).
-There was an order for Aspirin 81 mg daily (Aspirin is used to reduce the risk of heart attack).

Review of a physician order dated 08/22/19 revealed Loratadine 10 mg daily (Loratadine is used to treat allergy symptoms).

Review of a physician's order dated 09/12/19 revealed an order for Risperidone 3 mg three times a day (Risperidone is an antipsychotic).

Review of a physician's order dated 10/31/19 revealed Melatonin 10 mg every hour of sleep (Melatonin is used to regulate the sleep-wake cycle).

Review of Resident #4's December 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Flonase 50 mcg 2 sprays into each nostril twice daily scheduled for 9:00am and 9:00pm.
-On 12/27/19 and 12/28/19, Flonase 50 mcg spray was unavailable and not documented as administered.
-There was an entry for Aldactone 25 mg take 1 tablet twice daily scheduled for 9:00am and 9:00pm.
-On 12/27/19, 12/28/19, and 12/29/19, Aldactone 25 mg tablet was unavailable for scheduled twice daily dose and not documented as administered.
-On 12/30/19, Aldactone 25 mg tablet was unavailable at 9:54am and not documented as administered.

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D 358	Continued From page 92 -On 12/31/19, Aldactone 25 mg tablet was unavailable at 9:25am and not documented as administered. -There was an entry for Lithium Carbonate 300 mg take 1 capsule twice daily scheduled for 9:00am and 5:00pm. -On 12/27/19 and 12/28/19, Lithium Carbonate 300 mg capsule was unavailable for twice daily dose and not documented as administered. -There was an entry for Synthroid 100 mcg take 1 tablet once daily. -On 12/27/19, 12/28/19, 12/30/19, and 12/31/19, Synthroid 100 mcg tablet was unavailable and not documented as administered. -There was an entry for Senna Plus take 3 tablets twice daily scheduled for 9:00am and 9:00pm. -On 12/27/19, 12/28/19, 12/29/19, 12/30/19, and 12/31/19, Senna Plus tablet was unavailable for scheduled twice daily dose and not documented as administered. -There was an entry for DuoNeb 0.5-3 (2.5) mg/3 ml use 1 vial in nebulizer three times daily scheduled for 9:00am, 3:00pm, and 9:00pm. -On 12/27/19, 12/28/19, DuoNeb 0.5-3(2.5) mg/3 ml was unavailable and not documented as administered. -There was an entry for Lasix 20 mg take 1 tablet once daily scheduled for 9:00am. -On 12/27/19, 12/28/19, and 12/30/19, Lasix 20 mg tablet was unavailable and not documented as administered. -There was an entry for Loratadine 10 mg take 1 tablet daily scheduled for 9:00am. -On 12/27/19 and 12/28/19, Loratadine 10 mg was unavailable and not documented as administered. -There was an entry for Simvastatin 10 mg take 1 tablet daily scheduled for 5:00pm. -On 12/27/19, Simvastatin 10 mg tablet was unavailable and not documented as administered.	D 358		

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D 358	Continued From page 93 -There was an entry for Melatonin 10 mg take once daily at bedtime. -On 12/27/19, Melatonin 10 mg tablet was unavailable and not documented as administered. -There was an entry for Risperidone 3 mg take 1 tablet three times daily scheduled for 9:00am, 3:00pm, and 9:00pm. -On 12/27/19, Risperidone 3 mg was unavailable at 9:05pm and not documented as administered. -On 12/28/19, Risperidone 3 mg was unavailable at 10:03am and 8:58pm and not documented as administered. -On 12/29/19, Risperidone 3 mg was unavailable at 8:39pm and not documented as administered. -On 12/30/19, Risperidone 3 mg was unavailable at 9:54am and not documented as administered. -There was an entry for Trazodone 100 mg take 1 and 1/2 tablets at bedtime. -On 12/27/19 and 12/29/19, Trazodone 100 mg tablet was unavailable and not documented as administered. -There was an entry for Buspar 10 mg three times daily scheduled for 9:00am, 3:00pm, and 9:00pm. -On 12/28/19, Buspar 10 mg tablet was unavailable and not documented as administered. Review of Resident #4's January 2020 eMAR revealed: -There was an entry for Aldactone 25 mg take 1 tablet by mouth twice daily scheduled for 9:00am and 9:00pm. -On 01/01/20, Aldactone 25 mg tablet was unavailable at 9:18am and not documented as administered. -On 01/03/20, Aldactone 25 mg tablet was unavailable for the scheduled twice daily dose and not documented as administered. -There was an entry for Synthroid 100 mcg take 1 tablet once daily scheduled for 9:00am.	D 358		

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D 358	Continued From page 94 -On 01/01/20, Synthroid 100 mcg tablet was unavailable at 9:18am and not documented as administered. -On 01/03/20, Synthroid 100 mcg tablet was unavailable at 9:33am and not documented as administered. -There was an entry for Senna Plus take 3 tablets twice daily scheduled for 9:00am and 9:00pm. -On 01/01/20, Senna Plus tablet was unavailable at 9:18am and not documented as administered. -On 01/03/20, Senna Plus tablet was unavailable at 9:33am and not documented as administered. -There was an entry for Lasix 20 mg take 1 tablet daily scheduled for 9:00am. -On 01/03/20, Lasix 20mg was unavailable at 9:33am and not documented as administered. -There was an entry for Trazodone 100 mg take 1 and 1/2 tablets at bedtime. -On 01/03/20, Trazodone 100 mg tablet was unavailable and not documented as administered. -There was an entry for Aspirin EC once daily scheduled for 9:00am. -On 01/03/20, Aspirin EC 81 mg was unavailable at 9:33am and not documented as administered. Refer to interview with the Administrator on 02/19/20 at 12:12pm. Refer to interviews with the Resident Care Director (RCD) on 02/19/20 at 10:40am and 02/25/20 at 4:58pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 02/24/20 at 2:10pm. Refer to interview with a pharmacist at the facility's primary pharmacy on 02/25/20 at 11:45am.	D 358		

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Refer to interview with the facility's Owner on 02/25/20 at 5:35pm.

3. Review of Resident #1's current FL-2 dated 01/10/20 revealed diagnoses included Hashimoto's thyroiditis, adrenal insufficiency, psoriatic arthritis, chronic neck pain, depression, anxiety, diabetes mellitus, abdominal aortic aneurysm repair, hypertension, and obstructive sleep apnea.

a. Review of Resident #1's current FL-2 dated 01/10/20 revealed an order for Oxycodone 10mg 1 tablet 3 times a day. (Oxycodone is a narcotic used to treat moderate to severe pain.)

Review of a physician order form for Resident #1 revealed:
-There was handwritten information to discontinue Oxycodone 10mg.
-There was handwritten information for Oxycodone 5mg 1 by mouth every 6 hours as needed (prn) for pain.
-The order form was stamped with the facility's contracted physician's signature.
-There was a handwritten date of 02/13/20 in the same handwriting as the written orders.

Review of Resident #1's February 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone 10mg 1 tablet 3 times daily with scheduled administration times of 9:00am, 3:00pm, and 9:00pm.
-There were 45 of 45 doses of Oxycodone 10mg documented as administered from 02/01/20 - 02/15/20 and it was noted to be discontinued after 02/15/20.
-There was an entry for Oxycodone 5mg 1 tablet every 6 hours prn (as needed) for pain.

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-There were 20 doses of prn Oxycodone 5mg documented as administered from 02/16/20 - 02/24/20.
-The prn Oxycodone was documented as being administered too early, less than 6 hours apart, on 4 occasions.
-The prn Oxycodone was administered from 5 minutes to 2 hours and 39 minutes too early.
-Oxycodone 5mg was documented as administered at 11:14am on 02/22/20 and again at 2:39pm on 02/22/20, only 3 hours and 21 minutes apart (2 hours and 39 minutes before it was due).
-Oxycodone 5mg was documented as administered at 9:00am on 02/21/20 and again at 2:35pm on 02/21/20, 5 hours and 35 minutes apart.
-Oxycodone 5mg was documented as administered at 2:35pm on 02/21/20 and again at 8:26am, 5 hours and 51 minutes apart.
-Oxycodone 5mg was documented as administered at 2:39pm on 02/22/20 and again at 8:34pm on 02/22/20, 5 hours and 55 minutes apart.

Interview with a medication aide (MA) on 02/25/20 at 11:35am revealed:
-Resident #1 went to the hospital over this past weekend because he was complaining of pain all over.
-Resident #1's Oxycodone dosage was decreased after his medications were stolen (could not recall date).
-She was not sure why the dosage was decreased.
-The resident requested the prn Oxycodone more often than the every 6 hours it was ordered.
-She sometimes administered the prn Oxycodone more often than every 6 hours because the resident would complain and give the MA a "hard

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time" if she did not administer it to him when he asked for it.

Interview with Resident #1 on 02/25/20 at 12:45pm revealed:
-The resident had chronic neck pain that radiated down his spine.
-He took Oxycodone for the chronic pain.
-The Administrator recently had his Oxycodone decreased from 10mg to 5mg.
-He did not ask or request for the Oxycodone to be decreased.
-He now had to ask for the Oxycodone because he was no longer getting it on a scheduled basis.
-His pain had been worse since the dosage had been reduced.
-He went to the hospital yesterday, 02/24/20 and over this past weekend due to increased pain.

Interview with a pharmacist at the facility's contracted pharmacy on 02/25/20 at 4:20pm revealed:
-There were 90 Oxycodone 10mg tablets delivered to the facility for Resident #1 on 02/05/20.
-There were 60 of those 90 tablets that were missing on 02/13/20 so the Administrator wanted the pharmacist to replace the missing medications.
-The Administrator would not report it to the police because she did not want to be fined by the state.
-The pharmacist told the Administrator she could not dispense another supply of the Oxycodone 10mg tablets without a police report and the insurance would not pay for it again.
-The pharmacist told the Administrator she could dispense Oxycodone 5mg tablets if she had a prescription.
-The Administrator talked to Resident #1 and got an order for Oxycodone 5mg from the facility's

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contracted physician.

Interview with the Resident Care Director (RCD) on 02/25/20 at 4:58pm revealed:
-The MAs should administer Resident #1's prn Oxycodone as ordered.
-The prn Oxycodone should not be administered more frequently that every 6 hours as ordered.

b. Review of Resident #1's current FL-2 dated 01/10/20 revealed:
-There was an order for Amlodipine 5mg 1 tablet once daily. (Amlodipine lowers blood pressure.)
-There was an order for Docusate Sodium 100mg 1 capsule twice daily. (Docusate Sodium is a stool softener for constipation.)
-There was an order for Fish Oil 1,000mg 1 capsule once daily. (Fish Oil is used to lower triglycerides.)
-There was an order for Hydrocortisone 10mg once daily at bedtime. (Hydrocortisone is used to treat adrenal insufficiency.)
-There was an order for Ranitidine 150mg 1 tablet 3 times a day. (Ranitidine is for acid reflux.)
-There was an order for Sulfasalazine 500mg 2 tablets twice daily. (Sulfasalazine is for inflammation and arthritis.)
-There was an order for Terazosin 2mg 1 capsule twice daily. (Terazosin is for enlarged prostate.)
-There was an order for Venlafaxine ER 75mg 1 capsule once daily. (Venlafaxine ER is an antidepressant.)

Review of Resident #1's physician's orders dated 12/03/19 and clarification orders dated 02/21/20 revealed:
-There was an order for Baclofen 20mg 4 times a day. (Baclofen is a muscle relaxer.)
-There was an order for Clonidine 0.2mg twice daily. (Clonidine lowers blood pressure.)

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D 358	Continued From page 99 -There was an order for Preservision Areds 2 softgel 1 capsule twice daily. (Preservision Areds 2 is a vitamin supplement for macular degeneration.) Review of Resident #1's December 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Amlodipine 5mg 1 tablet once daily with a scheduled administration time of 9:00am. -Amlodipine was documented as not administered on 12/27/19 and 12/28/19 due to the medication being unavailable. -There was an entry for Baclofen 20mg 1 tablet 4 times daily with scheduled administration times of 9:00am, 1:00pm, 5:00pm, and 9:00pm. -Baclofen was documented as not administered at 1:00pm on 12/26/19 due to the medication being unavailable. -There was an entry for Clonidine 0.2mg 1 tablet twice daily with scheduled administration times of 9:00am and 9:00pm. -Clonidine was documented as not administered at 9:00am on 12/27/19 and 12/28/19 due to the medication being unavailable. -There was an entry for Docusate Sodium 100mg 1 capsule twice daily with scheduled administration times of 9:00am and 9:00pm. -Docusate Sodium was documented as not administered at 9:00am on 12/27/19 and 12/28/19 due to the medication being unavailable. -There was an entry for Fish Oil 1,000mg 1 capsule once daily with a scheduled administration time of 9:00am. -Fish Oil was documented as not administered on 12/27/19 and 12/28/19 due to the medication being unavailable. -There was an entry for Hydrocortisone 20mg ½ tablet (10mg) once daily at bedtime with a	D 358		

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scheduled administration time of 9:00pm.
-Hydrocortisone 20mg was documented as not administered on 12/27/19 due to the medication being unavailable.
-There was an entry for Preservision Areds 2 softgel 1 capsule twice daily with scheduled administration times of 9:00am and 9:00pm.
-Preservision Areds 2 softgel was documented as not administered for 3 doses from 9:00am on 12/27/19 through 9:00am on 12/28/19 due to the medication being unavailable.
-There was an entry for Ranitidine 150mg 1 tablet 3 times a day with scheduled administration times of 9:00am, 3:00pm, and 9:00pm.
-Ranitidine was documented as not administered at 9:00am on 12/10/19, 12/27/19, and 12/28/19, and at 3:00pm on 12/09/10 and 12/10/19 due to the medication being unavailable.
-There was an entry Sulfasalazine 500mg 2 tablets twice daily with scheduled administration times of 9:00am and 9:00pm.
-Sulfasalazine was documented as not administered for 3 doses from 9:00am on 12/27/19 through 9:00am on 12/28/19 due to the medication being unavailable.
-There was an entry Terazosin 2mg 1 capsule twice daily with scheduled administration times of 9:00am and 9:00pm.
-Terazosin was documented as not administered for 3 doses from 9:00am on 12/27/19 through 9:00am on 12/28/19 due to the medication being unavailable.
-There was an entry Venlafaxine ER 75mg 1 capsule once daily with a scheduled administration time of 9:00am.
-Venlafaxine ER was documented as not administered on 12/28/19 due to the medication being unavailable.

Review of Resident #1's January 2020 eMAR

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D 358	Continued From page 101 revealed: -There was an entry for Baclofen 20mg 1 tablet 4 times daily with scheduled administration times of 9:00am, 1:00pm, 5:00pm, and 9:00pm. -Baclofen was documented as not administered at 5:00pm on 01/08/20 due to the medication being unavailable. -There was an entry for Ranitidine 150mg 1 tablet 3 times a day with scheduled administration times of 9:00am, 3:00pm, and 9:00pm. -Ranitidine was documented as not administered at 3:00pm on 01/08/20 due to the medication being unavailable. Review of Resident #1's February 2020 eMAR revealed: -There was an entry for Baclofen 20mg 1 tablet 4 times daily with scheduled administration times of 9:00am, 1:00pm, 5:00pm, and 9:00pm. -Baclofen was documented as not administered at 9:00am on 02/23/20 due to the medication being unavailable. There was an entry for Dexilant DR 60mg 1 tablet once daily with a scheduled administration time of 9:00am. -Dexilant DR was documented as not administered on 02/23/20 due to the medication being unavailable. -There was an entry for Armour Thyroid 90mg 1 table once daily take along with 15mg tablet to equal 105mg with a scheduled administration time of 9:00am. -Armour Thyroid 90mg was not documented as administered on 02/23/20 due to the medication being unavailable. -There was an entry Venlafaxine ER 75mg 1 capsule once daily with a scheduled administration time of 9:00am. -Venlafaxine ER was documented as not administered on 02/23/20 due to the medication	D 358		

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being unavailable.

Refer to interview with the Administrator on 02/19/20 at 12:12pm.

Refer to interviews with the Resident Care Director (RCD) on 02/19/20 at 10:40am and 02/25/20 at 4:58pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 02/24/20 at 2:10pm.

Refer to interview with a pharmacist at the facility's primary pharmacy on 02/25/20 at 11:45am.

Refer to interview with the facility's Owner on 02/25/20 at 5:35pm.

4. Review of Resident #2's current FL-2 dated 07/01/19 revealed:
-The diagnoses included depression, fibromyalgia, chronic obstructive pulmonary disease, irritable bowel syndrome hypertension, essential tremors, and gastroesophageal reflux disease.
-There was an order for Oxycodone 5mg/325mg take 1 tablet by mouth 3 times a day. (Oxycodone is an opioid used to treat moderate to severe pain).

Review of Resident #2's December 2019 medication administration record (e MAR) revealed:
-There was a computer printed entry for Oxycodone 5mg/325mg take 1 tablet by mouth 3 times a day at 8:00am, 2:00pm, and 8:00pm.
-Oxycodone was not documented as administered on 12/17/19 at 8:00am, 12/17/19 at

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D 358	Continued From page 103 2:00pm, and 12/18/19 at 8:00am dose due to medication unavailable. Interview with Resident #2 on 02/19/20 at 10:33 reveled: -Sometime at the end of December 2019 her medications ran out. -She could not remember all the medications she ran out of. -She knew her Oxycodone was a medication she ran out of. -She ran out of medications frequently. Refer to interview with the Administrator on 02/19/20 at 12:12pm. Refer to interviews with the Resident Care Director (RCD) on 02/19/20 at 10:40am and 02/25/20 at 4:58pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 02/24/20 at 2:10pm. Refer to interview with a pharmacist at the facility's primary pharmacy on 02/25/20 at 11:45am. Refer to interview with the facility's Owner on 02/25/20 at 5:35pm. 5. Review of Resident #5's current FL-2 dated 10/01/19 revealed: -The diagnoses included depression, hypothyroidism, type II diabetes mellitus, anxiety, insomnia, high cholesterol and restless leg syndrome. -There was an order for Buspirone 10 mg take 2 tablets 3 times a day. (Buspirone is used to treat anxiety).	D 358		

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D 358	Continued From page 104 -There was an order for Atorvastatin 10mg take 1 tablet daily. (Atorvastatin is used to treat abnormal lipid levels). -There was an order for Quetiapine Fumarate 25mg take 1 tablet 2 times a day. (Quetiapine Fumarate is used to treat depression.) -There was an order for Folic Acid 1 mg take 1 tablet daily. (Folic Acid is a vitamin.) -There was an order for Gabapentin 600mg take 1 tablet 3 times a day. (Gabapentin is used to treat never pain). -There was an order for Venlafaxine 75 mg take 3 capsules daily. (Venlafaxine is used to treat depression and nerve pain.) -There was an order for Levothyroxine 50mcg take 1 tablet daily. (Levothyroxine is used to treat hypothyroidism.) -There was an order for Pantoprazole 40mg take 1 tablet daily. (Pantoprazole is used to treat gastroesophageal reflux disease.) -There was an order for Mucinex ER 600mg take 2 tablets 2 times a day. (Mucinex is used to thin mucus.) Review of a physician order on 11/08/19 revealed Glipizide was increased to 10 mg daily. (Glipizide is used to treat elevated blood sugar.) Review of Resident #5's December 2019 electronic medication administration record (eMAR) revealed: -There was a computer printed entry for Buspirone 10mg take 2 tablets 3 times a day at 6:00am, 12:00pm, and 6:00pm. -Buspirone was not documented as administered on 12/27/19 at 6:00am due to medication unavailable. -There was a computer printed entry for Atorvastatin 10mg take 1 tablet daily at 6:00am. -Atorvastatin was not documented as	D 358		

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administered on 12/25/19, 12/26/19, and 12/27/19 due to medication unavailable.
-There was a computer printed entry for Quetiapine Fumarate 25mg take 1 tablet 2 times a day at 6:00am and 12:00pm.
-Quetiapine Fumarate and was not documented as administered on 12/25/19, 12/26/19, and12/27/19 at 6:00am
-There was a computer printed entry for Folic Acid 1mg take 1 tablet daily at 6:00am.
-Folic Acid was not documented as administered on 12/25/19, 12/26/19, and 12/27/19 at 6:00am due to medication unavailable.
-There was a computer printed entry for Gabapentin 600mg take 1 tablet 3 times a day at 6:00am, 12:00pm, and 6:00pm.
-Gabapentin was not documented as administered on 12/27/19 at 6:00am due to medication unavailable.
There was a computer printed entry for Venlafaxine HCL ER 75 mg take 3 capsules daily at 6:00am.
-Venlafaxine was not documented as administered on 12/26/19 and 12/27/19 at 6:00am due to medication unavailable.
-There was a computer printed entry for Levothyroxine 50mcg take 1 tablet daily at 6:00am.
-Levothyroxine was not documented as administered on 12/27/19 at 6:00am due to medication unavailable.
-There was a computer printed entry for Pantoprazole 40mg take 1 tablet daily at 6:00am.
-Pantoprazole was not documented as administered on 12/27/19 due to medication unavailable.
-There was a computer printed entry for Mucinex ER 600mg take 2 tables 2 times a day at 6:00am and 6:00pm.
-Mucinex was not documented as administered

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on 12/25/19 and 12/26/19 at 6:00am and 12/27/19 and 12/28/19 at 6:00am and 6:00pm.
-There was a computer printed entry for Glipizide 10mg take 1 tablet daily at 6:00am.
-Glipizide was not documented as administered on 12/27/19 due to medication unavailable.
-There was documentation that Resident #5's finger stick blood sugar (FSBS) at 6:30am was 415.

Interview with Resident #5 on 02/21/20 at 1:45 revealed:
-She remembered running out of medication in December 2019.
-She remembered it was at the end of December 2019.
-She could not recall which medications she was out of.

Refer to interview with the Administrator on 02/19/20 at 12:12pm.

Refer to interviews with the Resident Care Director (RCD) on 02/19/20 at 10:40am and 02/25/20 at 4:58pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 02/24/20 at 2:10pm.

Refer to interview with a pharmacist at the facility's primary pharmacy on 02/25/20 at 11:45am.

Refer to interview with the facility's Owner on 02/25/20 at 5:35pm.

6. Review of Resident #3's current FL-2 dated 12/04/19 revealed:
-Diagnoses included onychomycosis (fungal

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infection of the nail), cellulitis of lower extremity, poor circulation, atrial fibrillation, hyperlipidemia, arteriosclerotic coronary heart disease, iron deficiency anemia, heart failure, peripheral vascular disease, chronic obstructive pulmonary disease, and brain injury.
-There was an order for Metoprolol Tartrate 50mg 1 tablet twice daily. (Metoprolol is for heart / blood pressure.)
-There was an order for Incruse Ellipta 62.5mcg inhaler 1 puff to once daily. (Incruse Ellipta is for breathing problems associated with chronic obstructive pulmonary disease.)

Review of Resident #2's December 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol Tartrate 50mg 1 tablet twice daily with scheduled administration times of 9:00am and 9:00pm.
-Metoprolol Tartrate was documented as not administered on 12/27/19 at 9:00am and 9:00pm and on 12/28/19 at 9:00am due to the medication being unavailable.
-There was an entry for Incruse Ellipta 62.5mcg 1 puff once daily with a scheduled administration time of 9:00am.
-Incruse Ellipta was documented as not administered on 12/27/19 and 12/28/19 at 9:00am due to the medication being unavailable.

Interview with Resident #3 on 02/20/20 at 8:30am revealed:
-He was unable to recall if he ever missed doses of medication.
-He just took "whatever the staff gave him" so he hoped it was what he was supposed to have.
-The only symptoms he could recall having in recent weeks was burning and shooting pains in his legs and ankles.

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D 358	Continued From page 108 Refer to interview with the Administrator on 02/19/20 at 12:12pm. Refer to interviews with the Resident Care Director (RCD) on 02/19/20 at 10:40am and 02/25/20 at 4:58pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 02/24/20 at 2:10pm. Refer to interview with a pharmacist at the facility's primary pharmacy on 02/25/20 at 11:45am. Refer to interview with the facility's Owner on 02/25/20 at 5:35pm. _____ Interview with the Administrator on 02/19/20 at 12:12pm revealed: -Within the last couple of weeks, she had talked with the medication aides (MAs) about not ordering medications in a timely manner. -When a MA noticed a medication was getting low (in the blue strip on the card - a 7 day supply) and there was none in the back up supply, the MA was supposed to contact the primary pharmacy. -The MAs had not been doing that and some medications had been unavailable at times. Interviews with the Resident Care Director (RCD) on 02/19/20 at 10:40am and 02/25/20 at 4:58pm revealed: -The MAs were responsible for ordering medications that were not delivered in the monthly cycle fills. -The MAs reordered medications through the computer or via fax to the pharmacy. -The primary pharmacy could also overnight	D 358		

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medication through the mail or they sometimes called a local back up pharmacy and the facility could pick the medication up from the back up pharmacy.
-She had noticed the residents had been running out of monthly cycle fill medications toward the end of the cycles; which was usually around the end of the month.
-The Administrator had contacted the RCD one night (could not recall date) and said they were going to meet with the pharmacist about changing from monthly dose packs to 7 day dose packs.
-They would be switching to the 7 day packs on 03/01/20.
-She had not notified the physician of any missed doses of medications for the residents.
-If the physician was notified, it should be documented in the progress notes.

Telephone interview with the facility's contracted primary care provider (PCP) on 02/24/20 at 2:10pm revealed:
-He expected all medications to be administered as ordered on the medication administration records (MARs).
-The process for medication orders was as follows: the medication order was received, the order was faxed to the pharmacy, the medication came in from the pharmacy, and then the medication was administered as ordered.
-Implementation of medication orders would sometimes take 24 hours.
-His expectation was for residents not to run out of medications.
-It was "not advisable" to borrow or share medications among residents (he did not provide an answer when questioned as to why this was not advisable).
-Refills were controlled by the pharmacy on the cycle fill.

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D 358	Continued From page 110 -He expected a staff person to go through the MARs and medications on hand periodically and send refill requests to the pharmacy so the refill requests could be completed before the residents ran out of the medications. -Staff kept "tab" on who was running low and what medications were running low and contacted the pharmacy to ask for a refill; then, the pharmacy sent him the refill requests and he signed "on the computer." Interview with a pharmacist at the facility's primary pharmacy on 02/25/20 at 11:45am revealed: -It was not unusual for the facility to run out of medications early before the end of the monthly cycle. -She thought maybe the facility staff were putting the new monthly cycle fills in the active medication carts and using them before they finished using the remainder of the previous month's cycle. -She thought the facility staff may be sending a few tablets left from the previous month back to the pharmacy, which would make the new cycle fill run short. -On one occasion, she could not recall when, the facility ran out of medications 14 days early. -The facility was starting a 7 day cycle fill this week that should help prevent medications running out too soon. Interview with the facility's Owner on 02/25/20 at 5:35pm revealed: -She just found out this week the facility was having some issues with monthly cycle fills for medications running out. -The facility was switching to a 7 day system this week and she heard that would help with the issue of medications being unavailable.	D 358		

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D 358	Continued From page 111 The facility failed to administer medications as ordered for 2 of 3 residents observed during the medication passes resulting in an 11% medication error rate with 3 errors out of 27 opportunities including Resident #11 who had chronic obstructive pulmonary disease (COPD) and had not received DuoNeb treatments in over a week due to the nebulizer being broken. Resident #4, a hospice patient with end stage COPD had not received DuoNeb treatments because she had no nebulizer machine for an undetermined amount of time. Resident #4 exhibited symptoms of worsening COPD including difficulty breathing, shortness of breath, and low oxygen saturation levels on multiple occasions. Residents # 1, #2, #3, #4, and #5 missed multiple doses of multiple medications due to the medications being unavailable. Missed medications included but were not limited to medications for heart/blood pressure, diabetes, narcotic pain relievers, anxiety, depression, adrenal insufficiency, fluid retention, antipsychotics, and thyroid disease. The failure of the facility to administer medications as ordered resulted in substantial risk of serious physical harm or death and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/20/20 for this violation. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON FEBRUARY 26, 2020.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances	D 392		

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D 392	Continued From page 112 (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 4 of 5 residents sampled (#1, #3, #4, #5) including three residents receiving pain medications (#1, #3, #4) and three residents receiving medications for anxiety and agitation (#1, #4, #5). The findings are: 1. Review of Resident #1's current FL-2 dated 01/10/20 revealed diagnoses included Hashimoto's thyroiditis, adrenal insufficiency, psoriatic arthritis, chronic neck pain, depression, anxiety, diabetes mellitus, abdominal aortic aneurysm repair, hypertension, and obstructive sleep apnea. a. Review of Resident #1's physician's orders dated 11/25/19 and 12/05/19 revealed orders for Oxycodone 10mg 1 tablet 3 times a day. (Oxycodone is a narcotic used to treat moderate to severe pain.) Review of Resident #1's current FL-2 dated 01/10/20 also revealed an order for Oxycodone 10mg 1 tablet 3 times a day.	D 392		

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D 392	Continued From page 113 Review of a physician order form dated 02/13/20 for Resident #1 revealed: -There was a handwritten note on the form, "per pt (patient) request". -There was handwritten information to discontinue Oxycodone 10mg. -There was handwritten information for Oxycodone 5mg 1 by mouth every 6 hours as needed (prn) for pain. -The order form was stamped with the facility's contracted physician's signature. -There was a handwritten date of 02/13/20 in the same handwriting as the written orders. Review of Resident #1's December 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone 10mg 1 tablet 3 times daily with scheduled administration times of 9:00am, 3:00pm, and 9:00pm. -There were 92 of 93 doses of Oxycodone 10mg documented as administered from 12/01/19 - 12/31/19. -One dose of Oxycodone was documented as not administered at 3:00pm on 12/27/19 due to the resident being out of the facility. Review of Resident #1's January 2020 eMAR revealed: -There was an entry for Oxycodone 10mg 1 tablet 3 times daily with scheduled administration times of 9:00am, 3:00pm, and 9:00pm. -There were 93 of 93 doses of Oxycodone 10mg documented as administered from 01/01/20 - 01/31/20. Review of Resident #1's February 2020 eMAR revealed: -There was an entry for Oxycodone 10mg 1 tablet	D 392		

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D 392	Continued From page 114 3 times daily with scheduled administration times of 9:00am, 3:00pm, and 9:00pm. -There were 45 of 45 doses of Oxycodone 10mg documented as administered from 02/01/20 - 02/15/20 and it was noted to be discontinued after 02/15/20. -There was an entry for Oxycodone 5mg 1 tablet every 6 hours prn pain. -There were 13 doses of prn Oxycodone 5mg documented as administered from 02/16/20 - 02/21/20 at 9:00am. Review of controlled substance (CS) logs for Resident #1's Oxycodone 10mg tablets revealed: -There was a CS count sheet with a stamped date of 11/04/19 at the top of the page and it was card 2 of 3 cards of 30 Oxycodone 10mg tablets. -The first dose of 30 for this page was documented on 11/16/19 at 2:00pm and the last of the 30 doses was documented on 11/26/19 at 9:00am. -There was no CS count sheet for card 3 of 3 with a stamp date of 11/04/19. -There was no CS count sheet for accurate reconciliation of 30 Oxycodone 10 mg tablets that should have been administered from 11/26/19 at 3:00pm through 12/06/19 at 9:00pm. -The next available CS count sheet had a stamp date of 12/05/19 at the top of the page and it was card 1 of 3 with 30 of 90 Oxycodone 10mg tablets dispensed. -The first dose was documented as administered on 12/07/19 at 9:00am and the last dose of the 30 tablets was documented on 12/16/19 at 2:03pm. -There was no CS count sheet for card 2 of 3 or card 3 of 3 with a stamp date of 12/05/19. -There was no CS count sheet for accurate reconciliation of 60 Oxycodone 10mg tablets that should have been administered from 12/16/19 at 9:00pm through 01/16/20 at 9:00am.	D 392		

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D 392	Continued From page 115 -The next CS count sheet was handwritten with no date stamp and no date or signature of when or who received the Oxycodone 10mg tablets. -The count on the sheet started at 30 tablets with the first dose documented on 01/16/20 at 3:15pm and the last dose on 01/26/20 at 8:50am. -The next CS count sheet was date stamped 01/04/20 and it was card 3 of 3 cards with 30 Oxycodone 10mg tablets. -The first dose was documented on 01/26/20 at 2:03pm and the last dose on 02/05/20 at 9:00am. -The next CS count sheet had a dispense date of 02/05/20 with 90 tablets dispensed. -Documentation started at 27 tablets on 02/06/20 at 8:43pm and the last of the 27 tablets on 02/15/20 at 2:16pm. -There was no dose documented for Oxycodone 10mg on 02/15/20 at 9:00pm but it was documented as administered on the eMAR. -The top 3 lines for tablets 28 - 30 were blank with no documentation to account for those 3 tablets. -There were no CS count sheets for cards 2 of 3 and 3 of 3 to accurately reconcile 60 of the 90 tablets dispensed on 02/05/20. -There were 29 Oxycodone 10mg tablets documented as administered on the CS count sheets, but 92 doses were documented as administered on the eMARs from 12/01/19 - 12/31/19. -There were 47 Oxycodone 10mg tablets documented as administered on the CS count sheets, but 93 doses were documented as administered on eMARs from 01/01/20 - 01/31/20. -There were 40 Oxycodone 10mg tablets documented as administered on the CS count sheets and 45 on the eMARs from 02/01/20 - 02/15/20.	D 392		

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D 392	Continued From page 116 Review of CS logs for Resident #1's prn Oxycodone 5mg tablets revealed: -There was one CS count sheet for Oxycodone 5mg tablets with a date stamp of 02/14/20 at the top of the page. -The first dose of 30 tablets was documented as administered on 02/16/20 at 8:00am and the last dose documented was on 02/21/20 at 9:00am leaving a balance of 15 tablets. -The prn Oxycodone was documented as administered 15 times on the CS log but only 13 times on the eMAR from 02/01/20 - 02/21/20 at 9:00am -The prn Oxycodone was documented as administered 3 times each on the CS log on 02/16/20 and 02/18/20 but only 2 times each of those days on the eMAR. Observation of Resident #1's medications on hand on 02/21/20 at 1:45pm revealed: -There were no Oxycodone 10mg tablets in the medication cart. -There were 15 of 30 Oxycodone 5mg tablets in the medication cart that were dispensed on 02/14/20. Review of Resident #1's pharmacy dispensing records for Oxycodone 10mg revealed: -There were 90 Oxycodone 10mg tablets dispensed on 11/04/19. -There were 90 Oxycodone 10 mg tablets dispensed on 12/05/19. -There were 90 Oxycodone 10 mg tablets dispensed on 01/04/20. -There were 90 Oxycodone 10 mg tablets dispensed on 02/05/20. Review of Resident #3's December 2019 - February 2020 eMARs, CS logs, and pharmacy dispensing records revealed:	D 392		

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D 392	Continued From page 117 -There were 90 Oxycodone 10mg tablets dispensed on 11/04/19 with 3 cards of 30 tablets. -There was no CS log for card 3 of 3 to accurately reconcile 30 of 90 tablets dispensed on 11/04/19. -There were 90 Oxycodone 10mg tablets dispensed on 12/05/19 with 3 cards of 30 tablets. -There was no CS log for cards 2 of 3 and 3 of 3 to accurately reconcile 60 of 90 tablets dispensed on 12/05/19. -There were 90 Oxycodone 10mg tablets dispensed on 01/04/20 with 3 cards of 30 tablets. -There was no CS log for 1 of the 3 cards to accurately reconcile 30 of 90 tablets dispensed on 01/04/20. -There were 90 Oxycodone 10mg tablets dispensed on 02/05/20 with 3 cards of 30 tablets. -There was no CS log for 2 of the 3 cards to accurately reconcile 60 of 90 tablets dispensed on 02/05/20. -The CS logs did not accurately reconcile with the eMARs or the quantities dispensed. Confidential staff interview revealed: -If controlled substances arrived in the evening, staff usually called the Resident Care Director (RCD) or Administrator and one of them would come in and lock the controlled substances in the RCD's office. -Sometime in December 2019, medications arrived to the facility via mail. -There were several packs of Oxycodone for Resident #1 in the shipment. -The staff was going to lock the medication in the medication cart and staff called the Administrator. -The Administrator instructed the staff to lock the medication in the water heater closet located "inside the chart room" and she (the Administrator) would take care of the medication the next morning when she came to work. -There were other medications in the box with	D 392		

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Resident #1's Oxycodone but the staff was not sure what other medications were in the box.
-The staff put the box of medications on the floor inside the water heater closet, the staff did not have a key to the water heater closet so the staff did not lock the door on the closet.
-The staff member only told one additional staff member that the medication was in the water heater closet.
-The staff "assumed" the Administrator got the medication from the hot water heater closet the next day and did not think anything else about it.
-About one to two weeks later, the Administrator asked the staff what ever happened to Resident #1's Oxycodone.
-There was a camera in the medication room where the hot water heater was located.
-The Administrator said she was going to check at the camera footage to see who had been in the closet, but she had not heard anything else about it.

Interview with the Administrator on 02/12/20 at 1:30pm revealed:
-She and the RCD checked in all controlled substances.
-Controlled substances that were not on the medication carts were stored in the RCD's office.

A second interview with the Administrator on 02/12/20 at 3:10pm revealed:
-She did not remember anything about Resident #1's Oxycodone being put into the water heater closet and then go missing.
-After prompting, she remembered that she had not known anything about it at the time.
-A MA had locked the Oxycodone in the water closet because she thought they would be safe there.
-She could not really remember any details about

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the incident and would ask the RCD about happened.

Interview with the RCD on 02/12/20 at 3:14pm revealed:
-She did not have anything to do with the Oxycodone being put in the hot water closet or the tablets being missing.
-She could not figure why the Administrator told the MA to put the Oxycodone in the water heater closet.
-She heard the Administrator was going to look at the camera footage to find out who had been in the hot water closet but she had not heard anything else about it.
-As far as she knew, no staff had a key to the water closet so the medications must have been left in with closet with the door unlocked.
-She or the Administrator were the only staff responsible for checking in controlled medication deliveries.

Interview with three MAs on 02/12/20 at 3:18pm revealed:
-The water heater closet was never locked because nobody had a key to the door.
-The water heater closet was not used for medication storage.

Confidential interview with a a second staff revealed:
-The Administrator was keeping the overstocked controlled substances in her office now.
-The Administrator was the only staff who had a key to the Administrator's office.
-On Tuesday or Wednesday of the previous week, another whole bubble pack of 10mg Oxycodone was missing for Resident #1.
-Resident #1's bubble pack of 10mg Oxycodone that was missing had to be replaced with 5mg

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D 392	Continued From page 120 Oxycodone that was ordered prn. Review of a local police report dated 02/20/20 revealed: -The facility Administrator reported 60 Oxycodone 10mg tablets for Resident #1 were missing. -The date found missing was 02/14/20 at 10:30am and the Oxycodone was last known secure on 02/13/20 at 3:00pm. -The Administrator reported she had 60 Oxycodone pills in a tote in the storage closet in her office. -It was discovered on the morning of 02/14/20 that the pills were missing. -The Administrator reported she had the only key to the door and there appeared to be no damage to the door. -The Administrator reported she did an investigation but had no suspects. The Administrator was not available for interview from 02/21/20 - 02/25/20. Interview with a pharmacist at the facility's contracted pharmacy on 02/25/20 at 4:20pm revealed: -There were 90 Oxycodone 10mg tablets delivered to the facility for Resident #1 on 02/05/20. -There were 60 of the 90 tablets missing on 02/13/20 so the Administrator wanted the pharmacist to replace the missing medications. -The Administrator would not report it to the police because she did not want to be fined by the state. -The pharmacist told the Administrator she could not dispense another supply of the Oxycodone 10mg tablets without a police a report and the insurance would not pay for it again. -The pharmacist told the Administrator she could dispense Oxycodone 5mg tablets if she had a	D 392		

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prescription.
-The Administrator talked to Resident #1 and got an order for Oxycodone 5mg from the facility's contracted physician.

Interview with a MA on 02/25/20 at 11:35am revealed:
-Resident #1 went to the hospital over this past weekend because he was complaining of pain all over.
-Resident #1's Oxycodone dosage was decreased after his medications were stolen (could not recall date).
-She was not sure why the dosage was decreased.
-The resident requested the prn Oxycodone more often than every 6 hours it was ordered.
-She sometimes administered the prn Oxycodone more often than every 6 hours because the resident would complain and give the MA a "hard time" if she did not administer it to him when he asked for it.

Interview with Resident #1 on 02/25/20 at 12:45pm revealed:
-The resident had chronic neck pain that radiated down his spine.
-He took Oxycodone for the chronic pain.
-The Administrator recently had his Oxycodone decreased from 10mg to 5mg.
-He did not ask or request for the Oxycodone to be decreased.
-He now had to ask for the Oxycodone because he was no longer getting it on a scheduled basis.
-His pain had been worse since the dosage had been reduced.
-He went to the hospital yesterday, 02/24/20 and over this past weekend due to increased pain.
-He did not recall missing any doses of his pain medication.

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D 392	Continued From page 122 Refer to interview with a MA on 02/19/20 at 10:40am. Refer to interview with the RCD on 02/19/20 at 11:20am. Refer to interview with the Administrator on 02/19/20 at 1:42pm. Refer to interview with a second MA on 02/24/20 at 5:50am. Refer to telephone interview with the facility's Consultant Pharmacist on 02/24/20 at 3:26pm. Refer to interview with the facility's Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to interview with the RCD on 02/25/20 at 2:15pm. b. Review of Resident #1's physician's orders dated 11/19/19 and 12/03/19 revealed an order for Fentanyl 100mcg/hr apply 1 patch every 3 days, remove old patch and rotate site. (Fentanyl is a topical narcotic patch used to treat moderate to severe pain.) Review of Resident #1's current FL-2 dated 01/10/20 also revealed an order for Fentanyl 100mcg/hr apply 1 patch every 3 days Review of Resident #1's physician's order dated 02/03/20 revealed an order to increase Fentanyl to 125mcg/hr every 72 hours to include Fentanyl 100mcg patch and Fentanyl 25mcg patch every 72 hours. Review of Resident #1's December 2019	D 392		

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electronic medication administration record (eMAR) revealed:
-There was an entry for Fentanyl 100mcg/hr patch, apply 1 patch topically every 72 hours (3 days); remove old patch and rotate site with a scheduled administration time of 4:00pm.
-There were 9 of 10 patches documented as administered from 12/01/19 - 12/31/19.
-One Fentanyl 100mcg/hr patch was documented as not administered on 12/27/19 due to the resident being out of the facility.

Review of Resident #1's January 2020 eMAR revealed:
-There was an entry for Fentanyl 100mcg/hr patch, apply 1 patch topically every 72 hours (3 days); remove old patch and rotate site with a scheduled administration time of 4:00pm.
-There were 10 of 10 patches documented as administered from 01/01/20 - 01/31/20.

Review of Resident #1's February 2020 eMAR revealed:
-There was an entry for Fentanyl 100mcg/hr patch, apply 1 patch topically every 72 hours (3 days); remove old patch and rotate site with a scheduled administration time of 4:00pm.
-There were 6 of 6 Fentanyl 100mcg/hr patches documented as administered from 02/01/20 - 02/16/20 with this entry noted as discontinued on 02/18/20.
-There was second entry for Fentanyl 100mcg/hr patch give 100mcg patch with the 25mcg patch to equal 125mcg with a scheduled administration time of 4:00pm.
-Two Fentanyl 100mcg/hr patches were documented as administered on 02/19/20 and 02/22/20.
-There was a third entry for Fentanyl 25mcg/hr patch apply 1 patch topically every 72 hours (3

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days), remove old patch, rotate site, and use with 100mcg patch to equal total dose of 125mcg.
-The original date or date written noted on the eMAR for the Fentanyl 25mcg patch was 02/03/20 but the first documented 25mcg patch administered was 02/07/20.
-There were 6 Fentanyl 25mcg patches documented as applied with the 100mcg patch from 02/07/20 - 02/22/20.

Review of Resident #1's pharmacy dispensing records for Fentanyl 100mcg patches revealed:
-There were 10 Fentanyl 100mcg patches dispensed on 11/19/19.
-There were 10 Fentanyl 100mcg patches dispensed on 12/17/19.
-There were 10 Fentanyl 100mcg patches dispensed on 01/04/20.
-There were 10 Fentanyl 100mcg patches dispensed on 01/27/20.

Review of controlled substance (CS) logs for Resident #1's Fentanyl 100mcg patches revealed:
-There was a CS count sheet with a stamped date of 10/16/19 at the top of the page with 10 patches dispensed.
-The first patch was documented on 10/25/19 and the last of the 10 patches was documented on 11/21/19.
-The next available CS count sheet was for 10 patches dispensed on 12/17/19.
-The first patch documented was on 12/24/19 and the last patch was on 01/19/20.
-There was no CS count sheet for any patches administered from 11/24/19 - 12/21/19 for a total of 10 patches that could not be accurately reconciled.
-The next available CS count sheet was for 10 patches dispensed on 01/04/20.

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-The first patch was documented on 01/26/20 and the last patch on 02/19/20 leaving a balance of 1 patch.
-There was no CS count sheet for any patches administered from 01/20/20 - 01/25/20 but the eMAR documented 2 patches were administered during that time frame.
-There was a CS count sheet for 10 patches dispensed on 01/27/20 and no patches were documented as used, leaving a balance of 10 patches.
-There were 10 Fentanyl 100mcg patches dispensed on 11/19/19 but there was no CS log to accurately reconcile those 10 patches.
-There was no CS count sheet with documentation for 6 of 9 Fentanyl 100mcg patches documented as administered on the December 2019 eMAR.
-There was no CS count sheet with documentation for 1 of 10 Fentanyl 100mcg patches documented as administered on the January 2020 eMAR.
-The CS logs did not accurately reconcile with the eMARs or the quantities dispensed.

Review of CS logs for Resident #1's Fentanyl 25mcg patches revealed:
-There was one CS count sheet for 10 patches with the first dose started on 02/07/20 and the last dose on 02/19/20.
-There was a balance of 5 Fentanyl 25mcg patches on the CS count sheet.

Observation of Resident #1's medications on hand on 02/21/20 at 1:45pm revealed:
-There was 1 of 10 Fentanyl 100mcg patches dispensed on 01/04/20 and 5 of 10 Fentanyl 100mcg patches dispensed on 02/03/20 in the medication cart for a total of 11 patches.
-There were 5 Fentanyl 25mcg patches in the

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medication cart.

Observation of Resident #1's used Fentanyl patches on 02/21/20 that had been removed after 72 hours to be returned to the pharmacy for disposal revealed:
-There were 9 used Fentanyl 100mcg patches in small envelopes stapled to medication disposition sheets with dates ranging from 12/06/19 - 02/19/20.
-There were 3 used Fentanyl 25mcg patches in small envelopes stapled to medication disposition sheets with dates ranging from 02/13/20 - 02/19/20.

Review of CS logs and eMARs and observation of medications prepared for disposition revealed:
-There were 25 Fentanyl 100mcg patches documented as administered and removed from 12/01/19 - 02/16/20 but only 9 of the 25 used patches were accounted for and in the medication room to be returned to the pharmacy for disposal.
-There were 5 Fentanyl 100mcg patches documented as administered and removed from 02/07/20 - 02/19/20 but only 3 of the 5 used patches were accounted for and in the medication room to be returned to the pharmacy for disposal.

Interview with a medication aide (MA) on 02/19/20 at 10:20am revealed:
-Resident #1 was the only resident in the facility with orders for Fentanyl patches.
-The MAs put the used Fentanyl patches when they were removed in small envelopes and stapled a medication disposition form to it.
-She usually put the envelopes with attached forms in a box in the medication room so they could be returned to the pharmacy.
-She was not sure who was responsible for sending the used Fentanyl patches back to the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 127 pharmacy. Interview with a second MA on 02/20/20 at 5:25pm revealed: -The MAs used medication disposition sheets to document Resident #1's Fentanyl patches when they were removed. -They put the used patches in small manila envelopes and staple them to the disposition sheets. -They either gave the used patches and disposition sheet to the Resident Care Director (RCD) or put them in the RCD's box in the medication room. -She did not know if any had been sent back to the pharmacy. Interview with a third MA on 02/20/20 at 5:30pm revealed: -The MAs put used Fentanyl patches in small envelopes and filled out medication disposition forms and stapled them together. -The MAs put the used patches in the RCD's box in the medication room. -She did not know if any patches had been sent back to the pharmacy. Interview with the RCD on 02/21/19 at 1:00pm revealed: -The facility's policy was to put all used Fentanyl patches in small manila envelopes, fill out a medication disposition form, staple the envelope to the form, and send them back to the contracted pharmacy to be destroyed. -The MAs usually put the envelopes and disposition forms in the RCD's box hanging on the wall in the medication room. -She had not sent any of the Fentanyl patches back to the pharmacy because she had not been told to send them.	D 392		

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D 392	Continued From page 128 -She started working as the RCD in December 2019. -She had not checked the Fentanyl patches so she did not realize any were missing. Interview with Resident #1 on 02/25/20 at 12:45pm revealed: -He was currently receiving a Fentanyl 100mcg patch and a Fentanyl 25mcg patch. -The MAs usually applied both patches at the same time. -The MAs would remove the old patches prior to apply the new ones. -The MAs would put the old patches they removed in small envelopes and took the envelopes with them. -He did not know what the MAs did with the old patches after they were put in the envelopes. -He did not recall missing doses of his pain medication. Interview with a pharmacist at the facility's contracted pharmacy on 02/25/20 at 11:45am revealed: -Resident #1 was the only resident at the facility with orders for Fentanyl patches. -No Fentanyl patches had been returned to the pharmacy for disposal in December 2019, January 2020, or February 2020. A second interview with the RCD on 02/25/20 at 4:58pm revealed: -The Administrator made staff open and check all sharp's containers in the facility last Friday, 02/21/20 for any used Fentanyl patches. -Staff found only 2 Fentanyl patches that were not dated in the sharp's containers. -She did not know the strength of the patches found.	D 392		

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D 392	Continued From page 129 The Administrator was not available for interview from 02/21/20 - 02/25/20. Refer to interview with a MA on 02/19/20 at 10:40am. Refer to interview with the RCD on 02/19/20 at 11:20am. Refer to interview with the Administrator on 02/19/20 at 1:42pm. Refer to interview with a second MA on 02/24/20 at 5:50am. Refer to telephone interview with the facility's Consultant Pharmacist on 02/24/20 at 3:26pm. Refer to interview with the facility's Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to interview with the RCD on 02/25/20 at 2:15pm. c. Review of Resident #1's physician's orders dated 09/24/19 and 12/03/19 revealed orders for Clonazepam 2mg 1 tablet 3 times a day. (Clonazepam is a narcotic used to treat anxiety.) Review of Resident #1's current FL-2 dated 01/10/20 revealed an order for Clonazepam 2mg 1 tablet 3 times a day. Review of Resident #1's December 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Clonazepam 2mg 1 tablet 3 times daily with scheduled administration times of 9:00am, 3:00pm, and 9:00pm. -There were 92 of 93 doses of Clonazepam 2mg	D 392		

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documented as administered from 12/01/19 - 12/31/19.
-One dose of Clonazepam was documented as not administered at 3:00pm on 12/27/19 due to the resident being out of the facility.

Review of Resident #1's January 2020 eMAR revealed:
-There was an entry for Clonazepam 2mg 1 tablet 3 times daily with scheduled administration times of 9:00am, 3:00pm, and 9:00pm.
-There were 93 of 93 doses of Clonazepam 2mg documented as administered from 01/01/20 - 01/31/20.

Review of Resident #1's February 2020 eMAR revealed:
-There was an entry for Clonazepam 2mg 1 tablet 3 times daily with scheduled administration times of 9:00am, 3:00pm, and 9:00pm.
-There were 61 of 61 doses of Clonazepam 2mg documented as administered from 02/01/20 - 02/21/20 at 9:00am.

Review of controlled substance (CS) logs for Resident #1's Clonazepam 2mg tablets revealed:
-There was a CS count sheet with a stamped date of 10/30/19 at the top of the page and it was card 2 of 3 cards of 30 Clonazepam 2mg tablets.
-The first dose of 30 for this page was documented on 11/21/19 at 8:18pm and the last of the 30 doses was documented on 12/01/19 at 2:00pm.
-There were 2 doses documented on this page for December 2019.
-There was no CS count sheet for card 3 of 3 with a stamp date of 10/30/19.
-There was no CS count sheet for accurate reconciliation of 30 Clonazepam 2mg tablets that should have been administered from 12/01/19 at

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D 392	Continued From page 131 9:00pm through 12/11/19 at 3:00pm. -The next available CS count sheet had a stamp date of 11/29/19 at the top of the page and it was card 1 of 3 with 30 of 90 Clonazepam 2mg tablets dispensed. -The first dose was documented as administered on 12/11/19 at 8:29pm and the last dose of the 30 tablets was documented on 12/21/19 at 2:00pm. -There was no CS count sheet for card 2 of 3 or card 3 of 3 with a stamp date of 11/29/19. -There was no CS count sheet for accurate reconciliation of 60 Clonazepam 2mg tablets that should have been administered from 12/21/19 at 9:00pm through 01/10/20 at 9:00pm. -The next available CS count sheet had a stamp date of 01/04/20 at the top of the page and it was card 1 of 3 with 30 of 90 Clonazepam 2mg tablets dispensed. -The first dose was documented as administered on 01/11/20 at 9:00am and the last dose of 30 tablets was documented on 01/20/20 at 2:00pm. -The next dose documented on page 2 of 3 was on 01/21/20 at 2:09pm. -There was no documentation on the CS count sheets for a dose being administered on 01/21/20 at 9:00am. -The last dose of 30 tablets on page 2 of 3 was documented on 01/30/20 at 2:03pm. -The CS count sheet for card 3 of 3 stamp dated 01/04/20 had the first dose documented on 01/30/20 at 8:26pm with the last dose on 02/09/20 at 2:00pm. -The next CS count sheet was card 1 of 3 with 30 of 90 tablets and a date stamp of 02/06/20. -The first dose was documented on 02/09/20 at 9:00pm and the last of the 30 tablets was documented as administered on 02/19/20 at 2:23pm. -The next CS count sheet was card 2 of 3 with 30 of 90 tablets and a date stamp of 02/06/20.	D 392		

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D 392	Continued From page 132 -The first dose documented was 02/20/20 at 8:41am and the last dose documented was 02/21/20 at 9:00am leaving a balance of 26 tablets. -There was no documentation on the CS count sheets for a dose being administered on 02/19/20 at 9:00pm. -There were 32 Clonazepam 2mg tablets documented as administered on the CS count sheets, but 92 doses were documented as administered on the eMARs from 12/01/19 - 12/31/19. -There were 63 Clonazepam 2mg tablets documented as administered on the CS count sheets, but 93 doses were documented as administered on eMARs from 01/01/20 - 01/31/20. -There were 61 Clonazepam 2mg tablets documented as administered on the CS count sheets and 60 on the eMARs from 02/01/20 - 02/21/20 at 9:00am. Observation of Resident #1's medications on hand on 02/21/20 at 1:45pm revealed there were 26 Clonazepam 2mg tablets in the medication cart. Review of Resident #1's pharmacy dispensing records for Clonazepam 2mg revealed: -There were 90 Clonazepam 2mg tablets dispensed on 11/20/19. -There were 90 Clonazepam 2mg tablets dispensed on 12/19/19. -There were 90 Clonazepam 2mg tablets dispensed on 01/04/20. -There were 90 Clonazepam 2mg tablets dispensed on 02/06/20. Review of Resident #3's December 2019 - February 2020 eMARs, CS logs, and pharmacy	D 392		

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dispensing records revealed:
-There were 90 Clonazepam 2mg tablets dispensed on 10/24/19 with 3 cards of 30 tablets.
-There was no CS log for card 3 of 3 to accurately reconcile 30 of 90 tablets dispensed on 10/24/19.
-There were 90 Clonazepam 2mg tablets dispensed on 11/20/19 with 3 cards of 30 tablets.
-There was no CS log for cards 2 of 3 and 3 of 3 to accurately reconcile 60 of 90 tablets dispensed on 11/20/19.
-There were 90 Clonazepam 2mg tablets dispensed on 12/19/19 with 3 cards of 30 tablets.
-There was no CS log for any of the 3 cards to accurately reconcile 90 of 90 tablets dispensed on 12/19/19.
-The CS logs did not accurately reconcile with the eMARs or the quantities dispensed.

Interview with Resident #1 on 02/25/20 at 12:45pm revealed:
-He took Clonazepam for severe anxiety and post-traumatic stress disorder.
-The Clonazepam helped with those symptoms.
-He did not recall missing any doses of Clonazepam.

The Administrator was not available for interview from 02/21/20 - 02/25/20.

Refer to interview with a MA on 02/19/20 at 10:40am.

Refer to interview with the RCD on 02/19/20 at 11:20am.

Refer to interview with the Administrator on 02/19/20 at 1:42pm.

Refer to interview with a second MA on 02/24/20 at 5:50am.

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D 392	Continued From page 134 Refer to telephone interview with the facility's Consultant Pharmacist on 02/24/20 at 3:26pm. Refer to interview with the facility's Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to interview with the RCD on 02/25/20 at 2:15pm. 2. Review of Resident #4's current FL-2 dated 06/19/19 revealed diagnoses included schizophrenia, psychotic affective, emphysema of lung, acute encephalopathy, edema onychomycosis, hypothyroidism, and extreme hypertension. a. Review of Resident #4's current FL-2 dated 06/19/19 revealed an order for Morphine 15 mg Extended Release (ER) two times daily (Morphine is a narcotic pain reliever). Review of Resident #4's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Morphine Sulfate ER 15 mg tablet twice daily. -There was documentation Morphine Sulfate ER 15 mg was administered twice daily for 61 out of 62 opportunities from 10/01/19 to 10/31/19. Review of Resident #4's November 2019 eMAR revealed: -There was an entry for Morphine Sulfate ER 15 mg tablet twice daily. -There was documentation Morphine Sulfate ER 15 mg was administered twice daily for 57 out of 60 opportunities from 11/01/19 to 11/30/19. Review of Resident #4's December 2019 eMAR	D 392		

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revealed:
-There was an entry for Morphine Sulfate ER 15 mg tablet twice daily.
-There was documentation Morphine Sulfate ER 15 mg was administered twice daily for 62 out of 62 opportunities from 12/01/19 to 12/31/19.

Review of Resident #4's January 2020 eMAR revealed:
-There was an entry for Morphine Sulfate ER 15 mg tablet twice daily.
-There was documentation Morphine Sulfate ER 15 mg was administered twice daily for 59 out of 62 opportunities from 01/01/20 to 01/31/20.

Review of Resident #4's February 2020 eMAR revealed:
-There was an entry for Morphine Sulfate ER 15 mg tablet twice daily.
-There was documentation Morphine Sulfate ER 15 mg was administered twice daily for 39 out of 39 opportunities from 02/01/20 to 02/20/20.

Review of Resident #4's controlled substance (CS) count sheet dated 09/26/19-10/11/19 for Morphine 15 mg ER take 1 tablet twice a day revealed 30 tablets were administered.

Review of Resident #4's CS count sheet dated 10/12/19-10/26/19 for Morphine 15 mg ER take 1 tablet twice a day revealed 30 tablets were administered.

Review of Resident #4's CS count sheet dated 10/27/19-11/11/19 for Morphine 15 mg ER take 1 tablet twice a day revealed 30 tablets were administered.

Review of Resident #4's CS count sheet dated 11/12/19-11/27/19 for Morphine 15 mg ER take 1

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tablet twice a day revealed 30 tablets were administered.

There was no documentation of Resident #4's CS count sheet dated 11/28/19-12/12/19 for Morphine 15 mg ER take 1 tablet twice a day.

Review of Resident #4's CS sheet dated 12/13/19-12/27/19 for Morphine 15 mg ER take 1 tablet twice a day revealed 30 tablets were administered.

There was no documentation of Resident #4's CS count sheet dated 12/28/19-01/12/20 for Morphine 15 mg ER take 1 tablet twice a day.

Review of Resident #4's CS count sheet 01/13/20-01/27/20 for Morphine 15 mg ER take 1 tablet twice a day revealed 30 tablets were administered.

Review of Resident #4's CS count sheet dated 01/28/20-02/12/20 for Morphine 15 mg ER take 1 tablet twice a day revealed 30 tablets were administered.

Interview with the Resident Care Director (RCD) on 02/12/20 at 3:11pm revealed:
-She was unable to locate CS logs for December 2019 and January 2020.
-She would keep looking for them and would notify Adult Home Specialist (AHS) if they were found.

The facility was unable to provide documentation of the CS count sheets for December 2019 and January 2020 at time of survey exit.

The Administrator was not available for interview from 02/21/20 - 02/25/20.

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D 392	Continued From page 137 Refer to interview with a MA on 02/19/20 at 10:40am. Refer to interview with the RCD on 02/19/20 at 11:20am. Refer to interview with the Administrator on 02/19/20 at 1:42pm. Refer to interview with a second MA on 02/24/20 at 5:50am. Refer to telephone interview with the facility's Consultant Pharmacist on 02/24/20 at 3:26pm. Refer to interview with the facility's Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to interview with the RCD on 02/25/20 at 2:15pm. b. Review of a physician's order dated 09/12/19 revealed an order for Ativan 1 mg every 8 hours as necessary (prn) anxiety or agitation (Ativan is used to treat anxiety). Review of Resident #4's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Ativan 1 mg every 8 hours prn for anxiety or agitation. -There was documentation Ativan 1 mg was administered 7 times from 10/01/19 to 10/31/19. Review of Resident #4's November 2019 eMAR revealed: -There was an entry for Ativan 1 mg every 8 hours prn for anxiety or agitation. -There was documentation Ativan 1 mg was	D 392		

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D 392	Continued From page 138 administered 15 times from 11/01/19 to 11/30/19. Review of Resident #4's December 2019 eMAR revealed: -There was an entry for Ativan 1 mg every 8 hours prn for anxiety or agitation. -There was documentation Ativan 1 mg was administered 5 times from 12/01/19 to 12/31/19. Review of Resident #4's January 2020 eMAR revealed: -There was an entry for Ativan 1 mg every 8 hours prn for anxiety or agitation. -There was documentation Ativan 1 mg was administered 3 times from 01/01/20 to 01/31/20. Review of Resident #4's February 2020 eMAR revealed: -There was an entry for Ativan 1 mg every 8 hours prn for anxiety or agitation. -There was documentation Ativan 1 mg was administered 1 time from 02/01/20 to 02/17/20. Review of Resident #4's controlled substance (CS) count sheet dated 12/19/19-02/17/20 for Ativan 1 mg every 8 hours prn anxiety or agitation revealed 14 tablets were administered to Resident #4. There were no CS count sheets for Ativan 1 mg observed or provided for Resident #4 prior to 12/19/19. Interview with the Resident Care Director (RCD) on 02/12/20 at 3:11pm revealed: -She was unable to locate controlled medication logs for December 2019 and January 2020. -She would keep looking for them and would notify Adult Home Specialist (AHS) if they were found.	D 392		

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D 392	Continued From page 139 The facility was unable to provide documentation of the CS count sheets for December 2019 and January 2020 at time of survey exit. The Administrator was not available for interview from 02/21/20 - 02/25/20. Refer to interview with a MA on 02/19/20 at 10:40am. Refer to interview with the RCD on 02/19/20 at 11:20am. Refer to interview with the Administrator on 02/19/20 at 1:42pm. Refer to interview with a second MA on 02/24/20 at 5:50am. Refer to telephone interview with the facility's Consultant Pharmacist on 02/24/20 at 3:26pm. Refer to interview with the facility's Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to interview with the RCD on 02/25/20 at 2:15pm. c. Observation of Resident #4's hospice comfort box (a prescribed set of medications that are used in a medical crisis) in the medication room on 02/19/20 at 10:52am revealed: -The doses administered were documented on the top of the comfort box. -Morphine Sulfate Oral Solution 0.25 ml was administered on 09/25/19. (Morphine Sulfate Oral Solution is a narcotic used for moderate to severe pain or for shortness of breath.) -Morphine Sulfate Oral Solution 0.25 ml was	D 392		

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administered on 10/05/19.
-Morphine Sulfate Oral Solution 0.25 ml was administered on 10/30/19.

Observation on 02/19/20 at 10:58am revealed there was no documentation of controlled substance (CS) count sheets for Resident #4's Morphine Sulfate Oral Solution 100 mg per 5 ml (20mg/ml) - Take 0.25 ml (5 mg) by mouth or under the tongue every 3 hours as needed for pain or shortness of breath.

Observation of Resident #4's comfort box on 02/19/20 at 10:58am revealed there was 4 ml of 15 ml remaining in the bottle of Morphine Sulfate Oral Solution in the facility's medication room.

Review of Resident #4's hospice electronic progress notes from September 2019 to February 2020 revealed there was no documentation of the administration of any medications from her hospice comfort pack.

There were no CS count sheets for Morphine Sulfate Oral Solution observed or provided for Resident #4 documenting the administered doses of 0.75 ml or to account for the 10.25 ml (41 doses) out of the bottle.

Interview with a medication aide (MA) on 02/19/20 at 10:02am revealed:
-During shift change, the MAs completed a shift report and a narcotic count.
-The MA reporting off shift would call off the name of the narcotic and the oncoming MA would complete the narcotic count for each resident's medication.
-If the narcotic count matched the CS count sheets, the MAs would hand off the keys to the medication cart and the medication room.

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D 392	Continued From page 141 -There had not been any narcotic discrepancies since she had been back to work in December 2019. -The MAs did not complete shift counts of the hospice comfort box. Interview with the Resident Care Director (RCD) on 02/19/20 at 11:21am revealed: -She did not know why there was not a CS count sheet for Resident #4's hospice comfort box. -She did not check the hospice comfort box. Interview with the Administrator on 02/19/20 at 1:39pm revealed she did not know the facility staff was not keeping a CS count sheet for Resident #4's hospice comfort box. Interview with Resident #4 on 02/19/20 at 1:52pm revealed: -She received her medications from the facility staff, and she did not think they had run out of any of her medications. -She did not have any pain. -She did not "normally" take any liquid medication. -The last time she took the liquid Morphine was about 6 months ago. Interview with the hospice Registered Nurse (RN) on 02/19/20 at 3:42pm revealed: -Her last visit to the facility was 02/17/20. -The hospice agency did not administer any medications to the residents. -The only time the hospice agency administered medications to the residents was on an "emergency basis" with a witness. -The administration of any medications from the comfort box would be included in the nursing assessment notes. -Comfort boxes are initiated for residents upon	D 392		

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admission to the hospice services.
-It was the facility's responsibility to maintain the CS count sheets for any residents that had hospice comfort boxes.
-It was her understanding; the facility should document the administration of any medication from the comfort box.
-The facility had been instructed to call the hospice agency before the administration of any medication from the comfort box.
-For her memory, the on-call hospice service was "seldomly" used by the facility because Resident #4's pain was managed by her Morphine Extended Release 15 mg tablets that she received twice daily.
-She could not recall that she had not been notified about any breakthrough pain for Resident #4.

Interview with a MA on 02/20/20 at 4:35pm revealed:
-She did not remember giving any medications from the hospice comfort box to Resident #4.
-If she gave any medications from the comfort box, she would have documented the administration of medications on the top of the comfort box.

Refer to interview with a MA on 02/19/20 at 10:40am.

Refer to interview with the RCD on 02/19/20 at 11:20am.

Refer to interview with the Administrator on 02/19/20 at 1:42pm.

Refer to interview with a second MA on 02/24/20 at 5:50am.

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D 392	Continued From page 143 Refer to telephone interview with the facility's Consultant Pharmacist on 02/24/20 at 3:26pm. Refer to interview with the facility's Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to interview with the RCD on 02/25/20 at 2:15pm. 3. Review of Resident #3's current FL-2 dated 12/04/19 revealed diagnoses included onychomycosis (fungal infection of the nail), cellulitis of lower extremity, poor circulation, atrial fibrillation, hyperlipidemia, arteriosclerotic coronary heart disease, iron deficiency anemia, heart failure, peripheral vascular disease, chronic obstructive pulmonary disease, and brain injury. Review of Resident #3's physician's order dated 12/05/19 revealed an order for Oxycodone 5mg 1 tablet every 4 hours as needed for pain. (Oxycodone is a narcotic used to treat moderate to severe pain.) Review of Resident #3's December 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone 5mg 1 tablet every 4 hours as needed for pain. -Oxycodone was documented as administered on 24 occasions from 12/14/19 - 12/31/19. Review of Resident #3's January 2020 eMAR revealed: -There was an entry for Oxycodone 5mg 1 tablet every 4 hours as needed for pain. -Oxycodone was documented as administered on 30 occasions from 01/01/20 - 01/31/20. Review of Resident #3's February 2020 eMAR	D 392		

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D 392	Continued From page 144 revealed: -There was an entry for Oxycodone 5mg 1 tablet every 4 hours as needed for pain. -Oxycodone was documented as administered on 15 occasions from 02/01/20 - 02/20/20. Review of controlled substance (CS) logs for Resident #3's Oxycodone 5mg tablets revealed: -There was no CS count sheet for any doses of Oxycodone for December 2019. -There was a CS count sheet with a stamped date of 12/31/19 at the top of the page with 30 Oxycodone 5mg tablets. -The first dose of 30 for this page was documented on 01/03/20 at 9:05pm and the last of the 30 doses was documented on 01/27/20 at 3:26pm. -The next available CS count sheet had a stamp date of 01/04/20 at the top of the page with 30 Oxycodone 5mg tablets. -The first dose was documented as administered on 02/17/20 at 9:00am and the last dose of the 30 tablets was documented on 02/20/20 at 4:55am. -There was no CS log to document one dose administered on the eMAR on 01/28/20 and two doses on 01/29/20. -There was no CS count sheet for accurate reconciliation of 24 Oxycodone 5mg tablets documented as administered on the eMAR from 02/01/20 - 01/12/20. -There were no Oxycodone 5mg tablets documented as administered on the CS count sheets, but 24 doses were documented as administered on the eMARs from 12/14/19 - 12/31/19. -There were 30 Oxycodone 5mg tablets documented as administered on the CS count sheets and on the eMARs from 01/01/20 - 01/31/20 but the dates and times did not match each time.	D 392		

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D 392	Continued From page 145 -There were 3 Oxycodone 5mg tablets documented as administered on the CS count sheets but 15 on the eMARs from 02/01/20 - 02/15/20. Review of Resident #3's pharmacy dispensing records for Oxycodone 5mg revealed: -There were 30 Oxycodone 5mg tablets dispensed on 12/05/19. -There were 30 Oxycodone 5mg tablets dispensed on 12/31/19. -There were 90 Oxycodone 5mg tablets dispensed on 01/02/20. -There were 90 Oxycodone 5 mg tablets dispensed on 01/04/20. Review of Resident #3's December 2019 - February 2020 eMARs, CS logs, and pharmacy dispensing records revealed: -There were 240 Oxycodone 5mg tablets dispensed from 12/05/19 - 01/04/20. -There were 69 Oxycodone 5mg tablets documented as administered from 12/05/19 - 02/20/20. -There were 27 Oxycodone 5mg tablets on hand on 02/20/20. -There were 144 Oxycodone 5mg tablets that could not be accurately reconciled. Interview with Resident #3 on 02/20/20 at 8:30am revealed: -He was unable to recall if he ever missed doses of medication. -He just took "whatever the staff gave him" so he hoped it was what he was supposed to have. -The only symptoms he could recall having in recent weeks was burning and shooting pains in his legs and ankles. Confidential staff interview revealed:	D 392		

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-Resident #3's CS logs for December 2019 and the first page of February 2020 were not in the CS log book.
-December 2019 had probably been thinned out of the book but she "had no idea" where the February 2020 CS log would be.
-CS logs seemed to "disappear easily" at the facility.
-She reviewed the amount of Oxycodone pills dispensed since the December 2019 order was written and agreed that the amount of Oxycodone on hand was not accurate and pills were missing.
-She could not explain why Resident #3 was missing Oxycodone medication.

Interview with the RCD on 02/21/20 at 2:53pm revealed:
-She could not locate Resident #3's CS logs for December 2019 and the first page of February 2020.
-She could not explain why the amount of Oxycodone on hand for Resident #3 was less than the number of pills that should be available.

The Administrator was not available for interview from 02/21/20 - 02/25/20.

Refer to interview with a MA on 02/19/20 at 10:40am.

Refer to interview with the RCD on 02/19/20 at 11:20am.

Refer to interview with the Administrator on 02/19/20 at 1:42pm.

Refer to interview with a second MA on 02/24/20 at 5:50am.

Refer to telephone interview with the facility's

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D 392	Continued From page 147 Consultant Pharmacist on 02/24/20 at 3:26pm. Refer to interview with the facility's Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to interview with the RCD on 02/25/20 at 2:15pm. 4. Review of Resident #5's current FL-2 dated 10/01/19 revealed diagnoses included depression, hypothyroidism, type II diabetes mellitus, anxiety, insomnia, high cholesterol and restless leg syndrome. Review of an order dated 11/26/19 for Lorazepam 0.5mg 1 tablet 4 times a day.(Lorazepam is used to treat anxiety.) Review of an order dated 12/12/19 for Lorazepam 0.5mg 1 tablet 3 times a day. Hold for Sedation. Review of Resident #5's electronic medication administration record (eMAR) dated December 2019 revealed: -There was a computer printer entry for Lorazepam 0.5mg 1 tables 4 times a day scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was a total of 49 doses of Lorazepam documented as administered from 12/02/19 - 12 /14/19. -There was no Lorazepam documented as administered on 12/01/19 and 12/02/19 for 8:00am and 12:00pm dose. -There was a computer printed entry for Lorazepam 0.5mg take 1 tablet 3 times a day, hold for sedation, scheduled to be given at 6:00am, 1:00pm, and 6:00pm. -There was a total of 50 doses of Lorazepam documented as administered from 12/15/19 -	D 392		

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D 392	Continued From page 148 12/31/19. Review of Resident #5's eMAR dated January 2020 revealed: -There was a computer printed entry for Lorazepam 0.5mg take 1 tablet 3 times a day, hold for sedation, scheduled to be given at 6:00am, 1:00pm, and 6:00pm. -There was a total of 93 doses of Lorazepam documented as administered from 01/01/20 - 01/1/20. Review of controlled substance (CS) logs for Resident #5's Lorazepam 0.5mg tablets revealed: -There was no CS sheet with a stamped date on 11/26/19 at the top of the page for card 1 of 5. -There was a CS count sheet with a stamped date of 11/26/19 at the top of the page and it was card 2 of 5 cards with 30 of 131 tablets of Lorazepam 0.5mg tablets. -The first dose of 30 for this page was documented on 12/10/19 at 4:13pm and the last of the 30 was documented on 12/19/19 at 6:15pm. -The next available CS count sheet had a stamped date of 12/26/19 at the top of the page and it was card 3 of 5 with 30 of 131 tablets of Lorazepam 0.5mg tablets. -There was no CS count sheet for card 4 of 5 with a stamped date of 11/26/19. -There was no CS count sheet for card 5 of 5 with a stamped date of 11/26/19. -There next available CS count sheet had a stamped date of 01/04/20 at the top of the page and it was card 1 of 3 cards with 30 of 90 tablets of Lorazepam 0.5mg tablets. -The first dose of 30 for this page was documented on 01/09/20 at 6:24am and the last of the 30 was documented on 01/18/20 at 6:00pm.	D 392		

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D 392	Continued From page 149 -There was a CS count sheet with a stamped date of 01/04/20 at the top of the page and it was card 2 of 3 cards with 30 of 90 tablets of Lorazepam 0.5mg tablets. -The first dose of 30 for this page was documented on 01/19/20 at 6:13am and the last of the 30 was documented on 01/28/20 at 6:00pm. -There was a CS count sheet with a stamped date of 01/04/20 at the top of the page and it was card 3 of 3 cards with 30 of 90 tablets of Lorazepam 0.5mg tablets. -The first dose of 30 for this page was documented on 01/29/20 at 4:50am and the last of the 30 was documented on 02/07/20 at 6:00pm. -There was a CS count sheet with no stamped date at the top of the page but there was a typed prescription label with the dispense date of 02/03/20 and it was card 1 of 3 with 30 of 70 tablets of Lorazepam 0.5mg tablets. -The first dose of 30 for this page was documented on 02/08/20 at 6:22am and the last of the 30 was documented on 02/17/20 at 5:28pm. -There was no CS count sheet for card 2 of 3 with a typed prescription label or stamped date of 02/03/20. -There was no CS count sheet for card 3 of 3 with a typed prescription label or stamped date of 02/03/20. Review of Resident #5's pharmacy dispensing records for Lorazepam 0.5mg revealed: -There were a 120 Lorazepam 0.5mg tablets dispensed on 11/26/19. -There were 90 Lorazepam 0.5mg tablets dispensed on 12/19/19. -There were 90 Lorazepam 0.5mg tablets dispensed on 01/04/20.	D 392		

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D 392	Continued From page 150 Review of Resident #5's December 2019 - February 2020 eMARs, CS logs, and pharmacy dispensing records revealed: -There were 300 Lorazepam 0.5mg tablets dispensed from 11/26/19 - 01/04/20. -There were 255 Lorazepam 0.5mg tablets documented as administered from 12/01/19 - 02/20/20. -There were 20 Lorazepam 0.5mg tablet on hand on 02/21/20. The Administrator was not available for interview from 02/21/20 - 02/25/20. Refer to interview with a MA on 02/19/20 at 10:40am. Refer to interview with the RCD on 02/19/20 at 11:20am. Refer to interview with the Administrator on 02/19/20 at 1:42pm. Refer to interview with a second MA on 02/24/20 at 5:50am. Refer to telephone interview with the facility's Consultant Pharmacist on 02/24/20 at 3:26pm. Refer to interview with the facility's Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to interview with the RCD on 02/25/20 at 2:15pm. _____ Interview with a medication aide (MA) on 02/19/20 at 10:40am revealed: -The MAs did controlled substance (CS) shift counts each time they changed shifts.	D 392		

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D 392	Continued From page 151 -One MA would call out the number on the CS logs and the other MA would check the cards in the cart to make sure the numbers matched. -If the CS logs did not match the count on hand, they would compare the CS log with the eMAR to make sure someone did not forget to sign out a dosage administered. -The CS count was always correct when she was on duty and checked it. -If everything matched during shift counts, the MA going off duty would give the keys to the medication cart to the oncoming MA. Interview with the Resident Care Director (RCD) on 02/19/20 at 11:20am revealed: -She sometimes checked behind the MAs by standing by the medication cart during shift counts. -She had not noticed any discrepancies with the CS logs and the medications on hand. -The Administrator also helped audit the medication carts but she was not sure how often. Interview with the Administrator on 02/19/20 at 1:42pm revealed: -There should be CS logs for all narcotic medications in the facility. -She did random checks on narcotics but she could not recall when she last audited them. Interview with a second MA on 02/24/20 at 5:50am revealed: -Medications arrive from the pharmacy on second or third shift. -The MA had to count the meds with the pharmacy when they arrived. -The MA that counted with the pharmacy signed the delivery receipt. -The facility got a delivery receipt and the pharmacy got a copy of the delivery receipt.	D 392		

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-If the medications were on the eMAR the medications would go in the drawer.
-If the medications were controlled medications the CS log would go in the control log book and the controlled medications would be put in the control drawer and locked up.
-Every MA did not follow that process.
-Some MAs would leave them in the tote they came in until the next day.
-The MA was also supposed to call the RCD or the Administrator when controlled medications arrived.
-Sometimes the controlled medications run short.
-The pharmacy only sent a 30-day supply of the controlled medications.
-Controlled medications usually got missing before the medications get put on the cart.
-When controlled medications came in when she was on duty; she would lock them in the control drawer.

Telephone interview with the facility's Consultant Pharmacist on 02/24/20 at 3:26pm revealed:
-She was responsible for completing quarterly medication regimen reviews at the facility.
-She did random audits of controlled substances when she was at the facility.
-She saw a few times that the documentation on the eMARs did not match the CS logs but the number on hand always matched the remaining balance on the CS logs.
-She had talked with the Administrator about having a system for storage of narcotics so the correct CS logs was stored and used for the correct medication card.
-She talked to the Administrator and the RCD after some narcotics were stolen in January 2020.
-She talked to them about not keeping as much back up supply of narcotics on hand at the facility.
-The Administrator told her that the back up

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narcotics were now being kept locked in the Administrator's office under double lock in a closet.
-She had not received any reports on any missing narcotics since the doses that were stolen in January 2020.

Interview with the facility's Owner and Corporate Administrator on 02/24/20 at 12:08pm revealed:
-The facility's policy for the disposition of controlled substances was in accordance with the rule which was as follows: when controlled substances were delivered from the pharmacy, the MAs placed them under double lock; the Administrator or RCD were responsible for ensuring the controlled substance counts received matched the controlled substance counts on the pharmacy dispense sheets; the control substances were then stocked on the medication cart by the Administrator or RCD, if needed, or placed in overstock if not needed on the medication cart.
-Double lock meant locking controlled substances in a drawer or cabinet with a lock and then locking the room where located.
-Controlled substances were always expected to be kept under double lock and counted at the end of every shift by the on-coming and off-going MAs.
-If there was a discrepancy during the counting of the controlled substances, the MAs were supposed to notify the supervisor (RCD or Administrator) and were not to leave until it was found out what happened in relation to the discrepancy.
-The Administrator was responsible for keeping a record of the controlled substances in overstock and ensuring they were kept under double lock.
-The Owner did not know why the overstocked controlled substances were stored in the

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D 392	Continued From page 154 Administrator's office, but the corporate policy did not state where overstocked controlled substances were to be stored as long as they were under double lock. -The Corporate Administrator had provided training on controlled substances and provided an optional form for maintaining the disposition of overstocked controlled substances that the Administrator signed, and MA signed when controlled substances were taken out of overstock and placed on the medication cart. -The Administrator had not utilized the corporate form to account for the disposition of overstock-controlled substances. -On 01/02/20 or 01/03/20, the Administrator called the Owner to report approximately 3,000 controlled substances went missing during a break in at the facility on that same date (01/02/20 or 01/03/20) and the Owner instructed the Administrator to follow the policy for missing controlled substances. -The policy for missing controlled substances was to contact the following: first, call the police; second call the Owner; third call the primary care provider (PCP); fourth call the pharmacy; and fifth, notify health care personnel registry (HCPR) within 24 hours, all of which was the responsibility of the Administrator. -The Owner was "almost 100% sure" the PCP and pharmacy were notified when the approximately 3,000 controlled substances went missing but did not know if HCPR was notified. -The Corporate Administrator and Owner had no knowledge of additional missing and unaccounted for controlled substances after the break in when the approximately 3,000 controlled substances went missing on 01/02/20 or 01/03/20. -They expected the Administrator to follow the policy if/when additional controlled substances were found to be unaccounted for at the time the	D 392		

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D 392	Continued From page 155 discrepancy was found. Interview with the RCD on 02/25/20 at 2:15pm revealed she had been unable to locate any other CS count sheets for any of the residents. _____ The facility's failure to assure controlled substance (CS) logs for 4 sampled residents (#1, #3, #4, #5) accurately reconciled the administration, receipt and disposal of controlled substances. Resident #1 had multiple doses of Oxycodone that were not accurately reconciled including 60 tablets that were discovered missing from the Administrator's office resulting in the resident's dosage being lowered on 02/13/20 to Oxycodone 5mg prn and the resident going to the emergency room on two occasions afterwards due to complaints of pain. Resident #1 had 19 Fentanyl patches that had been removed and packaged for destruction that could not be located and had not been sent back to the pharmacy. There was no CS log for Resident #4's Morphine Sulfate Oral Solution with 41 doses that could not be reconciled for the hospice resident. The facility's failure resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/19/20 for this violation. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON FEBRUARY 26, 2020.	D 392		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel	D 438		

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D 438	Continued From page 156 Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to report an allegation of misappropriation of a resident's personal money to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours for 1 of 1 sampled resident (#12) and failed to ensure allegations of drug diversion were reported to HCPR within 24 hours and 5-day follow-up reporting was completed. The findings are: 1. Review of an Incident/Investigation Report from a local police department dated 02/18/20 at 9:30am revealed: -Resident #12 told police he had placed an order at a local department store and when he checked his wallet for his debit card it was missing; the resident also reported $8.00 missing from the wallet. -The resident reported that a few people knew his pin password to the debit card because they would run errands for him. -Resident #12 contacted his financial institution and was told by a representative that his debit card had been used for two transactions earlier that day. -The first transaction was a withdrawal of $40.00 from an automatic teller machine (ATM) at 7:00am on 02/18/20. -The second transaction was a withdrawal of $200.00 from a second ATM at 7:36am on	D 438		

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D 438	Continued From page 157 02/18/20. -The resident stated he had not made these two transactions and canceled the debit card. -Resident #12 told the police officer he suspected Staff E, personal care aide (PCA), had taken and used the debit card without his permission because Staff E had been in her room the previous night (02/17/20). -Review of "Supplement #2" to the Incident/Investigation Report dated 02/20/20 revealed a local police detective had received pictures of the two fraudulent withdrawals from the ATM using Resident #12's debit card. -The detective went to the facility and spoke with Resident #12 who reported Staff E took $7.00 or $8.00 out of his wallet which was "fine" but he did give Staff E with permission to use his debit card. -The detective spoke with Staff E who admitted to using Resident #12's debit card, but said the resident had given her permission to use it. -Staff E told the detective she knew it was wrong to ask the resident for money. -Staff E told the detective she used the $240.00 to purchase Suboxone "but not from a pharmacy." (Suboxone is a controlled substance used to treat pain which has a high risk for addiction and dependency). -Staff E was arrested for financial card fraud and taken to the local jail. Interview with a law enforcement detective on 02/20/20 at 11:17am revealed: -He was currently at the facility investigating an incident where a staff person had stolen a resident's debit card and withdrew money from two ATMs on 02/18/20. -The Administrator was aware the resident's debit card had been stolen by a staff member when the detective came to the facility that morning on 02/20/20.	D 438		

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D 438	Continued From page 158 Staff E was not available for interview after arrest on 02/20/20. Refer to the interview with the Administrator on 02/12/20 at 3:15pm. Refer to the telephone interview with a North Carolina Health Care Personnel Registry (NC HCPR) Nurse Consultant on 02/17/20 at 9:05am. Refer to interview with the Administrator on 02/19/20 at 12:25pm. Refer to the interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to telephone interview with a representative from the NC HCPR on 02/24/20 at 2:25pm. 2. Review of an Incident/Investigation Report from a local police department dated 01/03/20 revealed: -An officer was dispatched to the facility in reference to a breaking and entering. -The Administrator reported that more than 3000 controlled substances were stolen from an office where medications were stored was broken into. -There was an itemized list of the stolen medications and quantities which included but was not limited to 510 Oxycodone tablets, 10 Fentanyl patches, 60 Morphine tablets, and 120 Hydrocodone tablets. -The officer checked the window in the office and noted the lock was broken and there was a pry mark on the window. -The Administrator told the officer the medication cart had been loaded with medications on 01/02/20 and had been locked and locked in the office.	D 438		

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D 438	Continued From page 159 -The Administrator told the officer whoever broke into the cart had found a key in the office and had only emptied the tray containing controlled substances, then locked the cart back. Interview with a law enforcement detective on 02/14/20 at 2:15pm revealed: -He was the detective assigned to a break in at the facility occurring on 01/03/20, at which time over 3000 controlled substance medications were stolen. -When the investigation was initiated, the Administrator had recently become estranged from her spouse, who had been the Resident Care Coordinator (RCD) at the facility. -The RCD was fired from employment just before the facility break-in, due to the Administrator getting a domestic violence protection order against him. -The facility break-in occurred when someone entered the RCD's office though a window, used a key to open a drawer where the controlled medications were stored, and exited through a window. -At the time of the break-in, the Administrator repeatedly told the detective her estranged spouse (former RCD) was the one that broke into the office and took the controlled medications. -The person that broke into the office was wearing gloves, therefore it was going to be difficult to prove the source of the break-in. -The Administrator had recently changed her story and stated one of her husband's girlfriends was probably the one that broke into the facility and took the medications. Interview with a North Carolina Health Care Personnel Registry (HCPR) Nurse Consultant on 02/17/20 at 9:05am revealed she had not received any report related to over 3000	D 438		

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controlled medications being stolen or about any other drug diversions.

Interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm revealed:
-On 01/02/20 or 01/03/20, the Administrator called the Owner to report approximately 3000 controlled substances went missing during a break in at the facility on that same date (01/02/20 or 01/03/20) and the Owner instructed the Administrator to follow the policy for missing controlled substances.
-The Owner was "almost 100% sure" the PCP and pharmacy were notified when the approximately 3000 controlled substances went missing but did not know if HCPR was notified.
-The Administrator was responsible for reporting allegations of drug diversion to HCPR.

Copies of the HCPR reports regarding the missing controlled substances for allegations of drug diversion were requested on 02/24/20 at 12:08pm but were not provided prior to survey exit.

Refer to the interview with the Administrator on 02/12/20 at 3:15pm.

Refer to the telephone interview with a North Carolina Health Care Personnel Registry (NC HCPR) Nurse Consultant on 02/17/20 at 9:05am.

Refer to interview with the Administrator on 02/19/20 at 12:25pm.

Refer to the interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm.

Refer to telephone interview with a representative from the NC HCPR on 02/24/20 at 2:25pm.

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D 438	Continued From page 161 3. Review of an Incident/Investigation Report from a local police department dated 02/20/20 at 8:39am revealed: -A police officer was dispatched to the facility and met with the Administrator regarding 60 Oxycodone tablets found to be missing from tote located in a storage closet in her office on 02/14/20. (Oxycodone is a controlled substance used to treat pain that has a high risk for addiction and dependency). -The Administrator reported to police that she had the only key to the storage closet but there appeared to be no damage to storage closet door. -The Administrator advised police there were no security cameras in her office or the storage closet where the Oxycodone tablets were located. -The Administrator also reported that she had completed a five-day internal investigation but had no suspects. Interview with a pharmacist at the facility's contracted pharmacy on 02/25/20 at 4:20pm revealed: -There were 90 Oxycodone 10mg tablets delivered to the facility for Resident #1 on 02/05/20. -The Administrator called the pharmacist on 02/13/20 and reported 60 of those 90 tablets were missing. -The Administrator wanted the pharmacist to replace the missing medications. -The Administrator would not report it to the police because she did not want to be fined by the state. -The pharmacist told the Administrator she could not dispense another supply of the Oxycodone 10mg tablets without a police report and the insurance would not pay for it again. -The pharmacist told the Administrator she could	D 438		

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dispense Oxycodone 5mg tablets if she had a prescription.
-The Administrator talked to Resident #1 and got an order for Oxycodone 5mg from the facility's contracted physician on 02/13/20.

Interview with the RCD on 02/19/19 at 9:46am revealed:
-She was not aware of any missing narcotics except the incident in January 2020 when 3,000 narcotics were stolen.
-She did not know if any missing medications had been reported to the HCPR.
-She had not taken part in any internal investigations of missing narcotics at the facility.
-The Administrator would be responsible for reporting to the HCPR.

Interview with the Administrator on 02/19/20 at 12:25pm revealed:
-She had not reported any missing drugs to the HCPR.
-She denied having knowledge of any missing drugs other than an incident on 01/03/20 when over 3,000 narcotics were stolen.

Copies of the HCPR reports regarding the missing controlled substances for allegations of drug diversion were requested on 02/24/20 at 12:08pm but were not provided prior to survey exit.

Refer to the interview with the Administrator on 02/12/20 at 3:15pm.

Refer to the telephone interview with a North Carolina Health Care Personnel Registry (NC HCPR) Nurse Consultant on 02/17/20 at 9:05am.

Refer to interview with the Administrator on

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D 438	Continued From page 163 02/19/20 at 12:25pm. Refer to the interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to telephone interview with a representative from the NC HCPR on 02/24/20 at 2:25pm. 4. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/21/20 at 5:23pm revealed: -She received a phone call a few minutes ago from the facility's Resident Care Director (RCD) who reported the Administrator had been arrested and no one at the facility had a key to get into the back up narcotic storage area. -The RCD reported to the pharmacist they were out of Resident #13's Hydrocodone/Acetaminophen 5/325mg tablets and they needed to get his overstock supply from the narcotic back up storage area. -She received a second call from the RCD a couple of minutes ago and the RCD reported staff was able to break into the storage area for the back-up narcotics but Resident #13's Hydrocodone tablets were not in the storage area. -There should have been a card of 30 Hydrocodone tablets in the back up storage area for Resident #13. -According to the RCD, Resident #13's Hydrocodone tablets were missing. -The pharmacy dispensed 60 Hydrocodone/Acetaminophen 5/325mg tablets on 02/03/20 which was a 30 days supply for Resident #13. -There should have been one card of 30 tablets in the back up supply at the facility left from the amount dispensed on 02/03/20.	D 438		

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D 438	Continued From page 164 Interview with the RCD on 02/25/20 at 10:20am revealed: -Resident #13's Hydrocodone tablets were not in the back up supply when she checked it on 02/21/20. -She assumed he was out of the medication. -She did not investigate or report the missing Hydrocodone to the police or the HCPR because she did not remember the pharmacist telling her that the resident should have 30 tablets on hand. Interview with a pharmacist at the facility's contracted pharmacy on 02/25/20 at 11:45am revealed: -The pharmacy sent another supply of 30 Hydrocodone tablets for Resident #13 to the facility on 02/21/20. -She again discussed with the RCD and told her 30 tablets from the supply dispensed on 02/03/20 should have been in the back up supply. -The RCD was aware on 02/21/20 that 30 Hydrocodone tablets for Resident #13 were missing. Interview with the facility's Owner on 02/25/20 at 10:25am revealed: -She was not aware of any missing Hydrocodone for Resident #13. -They would report it to the police and the HCPR. Refer to the interview with the Administrator on 02/12/20 at 3:15pm. Refer to the telephone interview with a North Carolina Health Care Personnel Registry (NC HCPR) Nurse Consultant on 02/17/20 at 9:05am. Refer to interview with the Administrator on 02/19/20 at 12:25pm.	D 438		

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D 438	Continued From page 165 Refer to the interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm. Refer to telephone interview with a representative from the NC HCPR on 02/24/20 at 2:25pm. _____ Interview with the Administrator on 02/12/20 at 3:15pm revealed: -She could not remember when she last reported anything to the HCPR. -She had not reported any drug diversions to HCPR. Telephone interview with a North Carolina Health Care Personnel Registry (HCPR) Nurse Consultant on 02/17/20 at 9:05am revealed: -She was the assigned investigator for all HCPR reports for the facility's home county. -She searched her data base and confirmed no HCPR reports had been received from the facility since 2017. Interview with the Administrator on 02/19/20 at 12:25pm: -She did not report the break in at the facility occurring on 01/03/20 to HCPR because the Department of Social Services "took over" the case and would contact the applicable agencies. -She was not aware she had to report findings to HCPR the same day they were discovered. -She was now aware of the HCPR regulation when the Adult Home Specialist informed her of the regulation last week. Interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm revealed: -The policy for missing controlled substances was to contact the following: first, call the police; second call the Owner; third call the primary care provider (PCP); fourth call the pharmacy; and	D 438		

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D 438	Continued From page 166 fifth, notify health care personnel registry (HCPR) within 24 hours, all of which was the responsibility of the Administrator. -They expected the Administrator to follow the policy if/when controlled substances were found to be unaccounted for at the time the discrepancy was found. -The Corporate Administrator and Owner had no knowledge of additional missing and unaccounted for controlled substances after the break in when approximately 3,000 controlled substances went missing on 01/02/20 or 01/03/20. -The Administrator had been provided with policies and attended training conducted by the Corporate Administrator and/or Corporate RN on the disposition of controlled substances, documentation, health care personnel registry reports, and "multiple trainings" on other policies and procedures (no dates provided). -It was the Administrator's responsibility to ensure staff working in the facility were trained and received the information on policies and procedures. Telephone interview with a representative from the NC HCPR on 02/24/20 at 2:25pm revealed they had not received any HCPR reports from this facility in January 2020 or February 2020. _____ The facility failed to report allegations of misappropriation of a resident's money and debit card and multiple allegations of drug diversion within the 24 hour and 5 -day time frame to North Carolina Health Care Personnel Registry (HCPR). The facility's failure resulted in an increased risk of drug diversion and misappropriation of other resident's personal money. The facility had at least three incidents of alleged drug diversion which were not reported to HCPR resulting in multiple residents having incidents of missing	D 438		

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D 438	Continued From page 167 controlled substances which was not investigated and placed the residents at substantial risk for serious neglect and exploitation which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/22/20 for this violation. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON FEBRUARY 26, 2020.	D 438		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect and exploitation related to other staffing qualifications, health care, medication administration, contolled substances, health care personnel registry, and implementation. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up for 7 of 7 sampled residents who had four specialty referrals (#2), redness and weeping legs and thick, long toenails (#3), no nebulizer available for ordered nebulizer treatments (#4), blood sugars greater than 400, three emergency department visits, and thick yellow toenails (#5), chest pressure with	D914		

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shortness of breath (#6), and thyroid stimulating hormone labs and ophthalmology for macular degeneration (#7). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policies for 2 of 3 residents observed (#1, #11) during the medication passes including errors with a medication used to treat heart failure and high blood pressure (#11), a medication for breathing problems (#11), and a medication for underactive thyroid (#1); and for 5 of 5 residents sampled (#1, #2, #3, #4, #5) for record review including errors with medications for heart/blood pressure (#1, #3), thyroid disease (#1, #4, #5), narcotic pain relievers (#1, #2), anxiety (#1, #4, #5), muscle relaxer (#1), antidepressants (#1, #4, #5), enlarged prostate (#1), inflammation and arthritis (#1), adrenal insufficiency (#1), acid reflux (#1, #5), cholesterol and triglycerides (#1, #4, #5), constipation (#1, #4), seasonal and year-round allergies (#4), fluid retention (#4), manic-depressive disorder (#4), chronic obstructive pulmonary disease (#3, #4), hormone for sleep-wake cycle (#4), antipsychotics (#4, #5), a medication used to reduce the risk of heart attack (#4), vitamin supplements (#1, #5), nerve pain and seizures (#5), expectorant for congestion (#5), and diabetes (#5). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

3. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records that accurately reconciled the receipt, disposition, and administration of

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controlled substances for 4 of 5 residents sampled (#1, #3, #4, #5) including three residents receiving pain medications (#1, #3, #4) and three residents receiving medications for anxiety and agitation (#1, #4, #5). [Refer to Tag D392, 10A NCAC 13F .1008(a) Controlled Substances (Type A2 Violation)].

4. Based on record reviews and interviews, the facility failed to report an allegation of misappropriation of a resident's personal money to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours for 1 of 1 sampled resident (#12) and failed to ensure allegations of drug diversion were reported to HCPR within 24 hours and 5-day follow-up reporting was completed. [Refer to Tag D338, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)].

5. Based on record review and interviews the facility failed to assure 4 of 7 staff (Staff A, D, F, and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hiring, according to G.S. 131E-256. [Refer to Tag D137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)].

6. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, total operations, and policies and procedures of the facility were implemented to maintain each residents' right to be free of serious neglect and exploitation as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, medication administration, controlled substances, reporting to health care personnel registry, and other staff

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D914	Continued From page 170 qualifications, all of which are the responsibility of the Administrator. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, total operations, and policies and procedures of the facility were implemented to maintain each residents' right to receive adequate and appropriate care and services and to be free of serious neglect and exploitation as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, medication administration, controlled substances, reporting to health care personnel registry (HCPR), and other staff qualifications, all of which are the responsibility of the Administrator. The findings are: 1. Confidential staff interview revealed: -Controlled medications had been disappearing out the facility "for a long time". -When the Administrator's spouse was the Resident Care Director (RCD) he often pulled the	D980		

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last few doses of controlled medications off the medication carts and would replace the packs with new ones.
-Since the facility break-in on 01/03/20 when over 3,000 controlled medications were stolen, there had been additional controlled medications that had "gone missing.".

Confidential interview with a second staff revealed:
-"All kinds" of controlled substances had "disappeared" several times and there was a break in when "a bunch were stolen" (the staff did not know the dates of the incidents when controlled substances went missing).
-The staff did not know if any controlled substances had gone missing after the break in.
-Most of the controlled substances that went missing were "whole cards" of medications and not just single doses.
-The staff felt like controlled substances were being stolen by "multiple" staff but would rather not say who, "I need my job."

Interview with a law enforcement detective on 02/14/20 at 3:25pm revealed:
-He was not aware controlled medications were continuing to go missing in the facility and had not received any additional reports of theft of medications since the break in that occurred on 01/03/20.
-He was not aware the Administrator had all controlled medications locked inside her office and she was the only person with a key.

Confidential staff interview on 02/18/20 revealed:
-The Administrator was keeping the overstocked controlled substances in her office now.
-The Administrator was the one staff who had a key to the Administrator's office.

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D980	Continued From page 172 -On Tuesday or Wednesday of the previous week, another whole bubble pack of Oxycodone 10mg had gone missing for Resident #1. Interview with the Administrator on 02/19/20 at 12:25pm revealed: -During the first or second week of January 2020, the Administrator and the RCD had put some controlled medications in the bottom drawer of the overstock medication cart in the RCD's office. -The medications were from the monthly cycle fill and there were 3,070 narcotic pills and 10 Fentanyl patches. -Nothing else would fit in the bottom drawer of the overstock cart because it was full. -The overstock medication cart was kept locked and the RCD's office was kept locked. -The Administrator and the RCD were the only ones with keys to the RCD's office. -The keys to the overstock medication cart were kept in an unlocked desk drawer inside of the RCD's office. -The overstock medication cart and the RCD's office door were kept locked anytime the RCD was not in the office. -She discovered all the narcotics in the overstock medication cart were missing on the next day and she contacted the police. -The police asked the Administrator to write a list of the missing medications so she shared a list of medications with the police. -The lock on the window to the RCD's office was popped and the window was partially opened. -The Administrator called the facility's contracted physician to make him aware of the stolen medications. -The facility's policy for any drug diversion was to drug test all staff but not on the same day as the diversion. -The Administrator did not drug test any staff after	D980		

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the controlled medications were stolen in January 2020 because she first suspected it was done by an outsider but later she suspected two former staff were involved.
-She interviewed staff on duty at the time the medications were stolen to see if anyone was seen going into the RCD's office, but no one saw anything.
-One staff reported changing a burned-out light bulb in an outside light near the RCD's office.
-The Administrator denied any knowledge of any other missing narcotics.

Interview with the Administrator on 02/19/20 at 1:42pm revealed she did random checks on narcotics but she could not recall when she last audited them.

Review of a local police report dated 02/20/20 revealed:
-The facility's Administrator reported 60 Oxycodone 10mg tablets for Resident #1 were missing.
-The date found missing was 02/14/20 at 10:30am and the Oxycodone was last known secure on 02/13/20 at 3:00pm.
-The Administrator reported she had 60 Oxycodone pills in a tote in the storage closet in her office.
-It was discovered on the morning of 02/14/20 that the pills were missing.
-The Administrator reported she had the only key to the door and there appeared to be no damage to the door.
-The Administrator reported she did an investigation but had no suspects.

Interview with a pharmacist at the facility's contracted pharmacy on 02/19/20 at 4:15pm revealed:

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D980	Continued From page 174 -The Administrator called the pharmacist on Friday, 01/03/20, and reported the facility had been broken into and controlled substances had been stolen. -The Administrator told her they needed "everything", all controlled substances for all residents. -The pharmacy had just sent a monthly batch fill of scheduled medications to the facility on 12/24/19 and that batch should have started on 12/29/19. -She told the Administrator that she needed a copy of a signed police report before she could replace the medications. -The pharmacy did not send anyone to check the facility's controlled substances on hand after the reported break in because it was a 4.5 hour drive from the pharmacy to the facility. -She printed controlled drug re-evaluation forms from the eMAR system and faxed them to the Administrator at 2:10pm on 01/03/20 so orders could be obtained to dispense the medications again. -The facility's contracted physician usually sent orders that were electronically signed to the pharmacy. -She received the controlled drug re-evaluation forms for all residents with the physician's stamped signature via fax from the facility's Administrator on 01/03/20 at 4:45pm. -She used these signed controlled drug re-evaluation forms to replace and dispense the scheduled controlled medications for the residents. -She had not noticed there were no quantities noted, refill information, or provider DEA number noted for any of the controlled substances re-evaluation forms she received back from the facility. -She dispensed a 30-day supply of the controlled	D980		

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substances because that was what the facility's contracted physician would have wanted her to do.
-The physician would not have wanted her to dispense a smaller quantity like a 7-day supply because they would have to get new orders again in 7 days if that was done.
-She did not talk to the physician regarding the orders because the Administrator handled getting the orders.
-She then changed the information provided earlier in the interview and stated she probably used prescriptions that had refills remaining for the scheduled III and IV narcotics.
-There would not be any refills on file for the scheduled II narcotics because they were not allowed to have refills.
-She would have to check her files and she would have the physician to add the quantities to the orders.
-When questioned about having the physician to add quantities to orders for controlled medications that had already been dispensed and sent to the facility, the pharmacist did not reply.
-There was another incident recently when the current RCD and the Administrator called the pharmacy and reported there was only 1 card of 30 tablets of Hydrocodone/Acetaminophen for one of the residents sent via mail to the facility from the pharmacy.
-The pharmacy sent 60 tablets of Hydrocodone/Acetaminophen via mail to the facility on 02/12/20 and there should have been 2 cards of 30 tablets in the mail received by the facility.
-She knew the pharmacy had sent 60 tablets of Hydrocodone/Acetaminophen to the facility because the pharmacist checked the pharmacy's controlled substance count sheets and the medication in stock and 60 tablets were mailed to

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D980	Continued From page 176 the facility. -She told the Administrator the pharmacy would never mail any controlled substances to the facility again. -She replaced the missing 30 tablets of Hydrocodone/Acetaminophen that the Administrator said were not in the mailed box on 02/12/20 and they were delivered to the facility on third shift later that night (02/13/20). -The Administrator reported another incident of 60 missing Oxycodone 10mg tablets on 02/13/20 to the pharmacy. -She told the Administrator that the Administrator needed to do drug testing on staff at the facility, but the Administrator reported she had already done that. A second interview with a pharmacist at the facility's contracted pharmacy on 02/25/20 at 4:20pm revealed: -There were 90 Oxycodone 10mg tablets delivered to the facility for Resident #1 on 02/05/20. -There were 60 of those 90 tablets that were missing on 02/13/20 so the Administrator wanted the pharmacist to replace the missing medications. -The Administrator would not report it to the police because she did not want to be fined by the state. -The pharmacist told the Administrator she could not dispense another supply of the Oxycodone 10mg tablets without a police report and the insurance would not pay for it again. -The pharmacist told the Administrator she could dispense Oxycodone 5mg tablets if she had a prescription. -The Administrator talked to Resident #1 and got an order for Oxycodone 5mg from the facility's contracted physician.	D980		

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D980	Continued From page 177 Telephone interview with the facility's Consultant Pharmacist on 02/24/20 at 3:26pm revealed: -She was responsible for completing quarterly medication regimen reviews at the facility. -She did random audits of controlled substances when she was at the facility. -She saw a few times that the documentation on the eMARs did not match the CS logs but the number on hand always matched the remaining balance on the CS logs. -She talked to the Administrator and the RCD after some narcotics were stolen in January 2020. -She talked to them about not keeping as much back up supply of narcotics on hand at the facility. -The Administrator told her that the back up narcotics were now being kept locked in the Administrator's office under double lock in a closet. -She had not received any reports on any missing narcotics since the doses that were stolen in January 2020. Interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm revealed: -The facility's policy for the disposition of controlled substances was in accordance with the rule which was as follows: when controlled substances were delivered from the pharmacy, the medication aides (MAs) placed them under double lock; the Administrator or RCD were responsible for ensuring the controlled substance counts received matched the controlled substance counts on the pharmacy dispense sheets; the controlled substances were then stocked on the medication cart by the Administrator or RCD, if needed, or placed in overstock if not needed on the medication cart. -Double lock meant locking controlled substances in a drawer or cabinet with a lock and then locking the room where located.	D980		

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D980	Continued From page 178 -Controlled substances were always expected to be kept under double lock and counted at the end of every shift by the on-coming and off-going MAs. -If there was a discrepancy during the counting of the controlled substances, the MAs were supposed to notify the supervisor (RCD or Administrator) and were not to leave until it was found out what happened in relation to the discrepancy. -The Administrator was responsible for keeping a record of the controlled substances in overstock and ensuring they were kept under double lock. -The Owner did not know why the overstocked controlled substances were stored in the Administrator's office, but the corporate policy did not state where overstocked controlled substances were to be stored as long as they were under double lock. -The Corporate Administrator had provided training on controlled substances and provided an optional form for maintaining the disposition of overstocked controlled substances the Administrator signed and MA signed when controlled substances were taken out of overstock and placed on the medication cart. -The Administrator had not utilized the optional corporate form to account for the disposition of overstock-controlled substances. -On 01/02/20 or 01/03/20, the Administrator called the Owner to report approximately 3,000 controlled substances went missing during a break in at the facility on that same date (01/02/20 or 01/03/20) and the Owner instructed the Administrator to follow the policy for missing controlled substances. -The policy for missing controlled substances was to contact the following: first, call the police; second call the Owner; third call the primary care provider (PCP); fourth call the pharmacy; and	D980		

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fifth, notify health care personnel registry (HCPR) within 24 hours, all of which was the responsibility of the Administrator.
-The Owner was "almost 100% sure" the PCP and pharmacy were notified when the approximately 3,000 controlled substances went missing but did not know if HCPR was notified.
-The Corporate Administrator and Owner had no knowledge of additional missing and unaccounted for controlled substances after the break in when the approximately 3,000 controlled substances went missing on 01/02/20 or 01/03/20.
-They expected the Administrator to follow the policy if/when additional controlled substances were found to be unaccounted for at the time the discrepancy was found.

Review of data in the law enforcement criminal history data base on 02/14/20 at 2:45pm revealed:
-The data system contained eight different names that had been used by the Administrator to identify herself.
-The Administrator had a previous felony conviction for forgery.
-The Administrator was under an active probation by law enforcement beginning on 12/09/19 and to end on 12/09/21.
-Terms for the Administrators probationary period included: parole officer for 24 months; surrender driver's license; must not possess or use controlled substances; submit to drug screening; complete substance abuse assessment; comply with substance abuse treatment; and
submit to warrantless search.

Review of an Incident/Investigation Report from a local police department dated 02/21/20 at 3:00pm revealed:

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D980	Continued From page 180 -An officer and detective from the local police department responded to assist a probation officer in conducting a search of the Administrator's residence (located on facility property) and vehicle; the Administrator consented to the search. -Officers found a gun, marijuana, prescription medications belonging to residents of the facility. (The medications were not controlled substances). -The Administrator was arrested for "possession of stolen firearm, possession of stolen firearm by convicted felon, simple possession of marijuana, and possession of marijuana paraphernalia" and received a $40,000 bond with her charges and probation violation. Telephone interview with a law enforcement detective on 02/21/20 at 3:05pm revealed: -During the search of the Administrator's residence conducted by law enforcement today (02/21/20), medications were found under her bed that belonged to residents who resided in the facility. -The search led to the Administrator being arrested. Telephone interview with the RCD on 02/21/20 at 4:25pm revealed: -She was notified by local law enforcement that the Administrator had been arrested. -She had spoken with the Owner by phone and had been authorized by the Owner to manage the facility until the Owner could come from out of town. -A detective brought her the facility keys, keys to the Administrator's office, and keys to the closet where controlled substances were stored. Review of a Domestic Violence Order of	D980		

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D980	Continued From page 181 Protection with documentation of electronic filing dated 12/12/19 revealed: -The Administrator was the petitioner and reported the former RCD who was her spouse committed acts of domestic violence towards her. -The box was checked that the Administrator was "placed in fear of imminent serious bodily injury" by the former RCD on 12/05/19. -The incident was described as the former RCD grabbed the Administrator by the arm, pushed her, and told her "the only way you leave this relationship is in a body bag." -The Administrator was "very afraid" of the former RCD due to "numerous threatening, aggressive, and assaultive behaviors during the marriage." -The box was checked that former RCD had "made threats to seriously injure or kill" the Administrator. -The former RCD owned and/or had in his possession two firearms and ammunition. -There were boxes checked to indicate the former RCD shall stay away from the Administrator's residence and work and shall have no contact with the Administrator. -The Domestic Violence Order of Protection was signed by a judge and dated 12/12/19. -The term of the Domestic Violence Order of Protection was effective until 12/10/20. Confidential staff interview revealed: -One to two months ago, the Administrator and former RCD had a "fist fight" in the facility's parking lot and there had been residents who observed the incident. -The incident had "upset" at least one resident. -The police responded to the incident and the former RCD left. -The Administrator told staff she had taken out a "restraining order" on the former RCD. -The staff had not observed the former RCD back	D980		

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D980	Continued From page 182 inside the facility since the incident but did not know if he was back the residence located on facility premises. Observation on 02/25/20 at 4:45pm revealed there was a residence located on the same property as the facility approximately 50 yards from the facility. Interview with the Owner on 02/24/20 at 12:08pm revealed the residence located on the facility's premises that the Administrator and former RCD live in was located close enough to the facility that it met the rule requirement of an Administrator being within 500 feet of the facility. Interview with a law enforcement detective on 02/14/20 at 2:15pm revealed if the Domestic Violence Order of Protection was still active, the Administrator's spouse (former RCD) was not supposed to be at the home or the facility, which were both on the same premises. Review of an Incident/Investigation Report from a local police department dated 02/21/20 at 3:00pm revealed: -An officer and detective from the local police department and a probation officer were conducting a search of the Administrator's residence and vehicle when the former RCD arrived at the residence. -The former RCD admitted to living in the residence with the Administrator even though a Domestic Violence Protection Order was active. -The former RCD was arrested for violation of the Domestic Violence Protection Order and was also charged with "possession of stolen firearm, simple possession of marijuana, and possession of marijuana paraphernalia."	D980		

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D980	Continued From page 183 Telephone interview with the Owner on 02/21/20 at 4:33pm revealed: -She had removed the Administrator's license from the wall of the facility and replaced it with her own Administrator's license. -She had placed the current RCD in charge of the facility. Interview with the current RCD on 02/24/20 at 6:30am revealed she was hired in October 2019 as a transporter and medication aide (MA) and became RCD after the former RCD left in December 2019. Interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm revealed: -The Administrator's employment was terminated on 02/21/20 after she was arrested and placed in jail. -The only criminal charges the Owner was told about by the Administrator was that she had been charged with "drunk driving", had an attorney, went to court and it was "resolved" (no dates provided). -The Owner was not aware of the Administrator having any other criminal charges at any time. -They acknowledged the Administrator was married to the former RCD. -The Owner was aware of incidents of arguing and fighting between the Administrator and the former RCD occurring at the residence in which the two resided that is located on the facility's property. -The Owner had asked the Administrator if there had been any incidents between her and the former RCD (spouse) on facility property or in front of the residents (no dates provided) and was told by the Administrator the incidents had only occurred inside their residence. -When the Administrator and former RCD were	D980		

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"having problems" at the residence, the former RCD did not report to work and was terminated for being "no call, no show" (no dates provided).
-The former RCD's termination was not related to missing medications or missing controlled substances.

Interview with the Owner on 02/25/20 at 10:00am revealed:
-She was not aware of the Administrator's probation status.
-She was aware the Administrator had a charge for driving under the influence (DUI) and the Administrator went to court, got a lawyer and was supposed to go back to court in April 2019.
-She thought the Administrator had taken care of it.
-She was also aware of an incident about 5 or 6 years ago when the Administrator had some medications in her car that belonged to residents at a different facility the Administrator used to work.
-The Administrator was taking the medications, which were controlled substances, to a veteran's hospital to meet the facility's contracted physician for disposal of the medications.
-The Administrator got a lawyer and went to court.
-The Administrator told the Owner that the case was dismissed.
-When the Administrator reported 3,000 narcotics were stolen from the facility (in January 2020), the Administrator said it was "an outside community" person and they were clever because they wore gloves.
-She did not think about drug testing the Administrator because she believed the Administrator when she said the medications were stolen by an outside person.
-The Administrator only reported the 3,000 missing narcotics to the Owner; no other missing

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D980	Continued From page 185 medications were reported to the Owner. Review of the agency's Certified Administrator file for the facility Administrator revealed: -A letter dated 8/10/2017 from the Division of Health Service Regulation Adult Care Licensure Section to the Administrator regarding Suspension of the Administrator's Assisted Living Administrator Certification, for reasons including charges filed by the Concord Police Department in January 2016 for Driving Under the Influence, two felony counts of trafficking heroin/opium, one count of possession of a Schedule II drug, and one count of possession of a Schedule IV drug. -An email dated 8/15/2017 to the Owner, notifying her of the Suspension of Assisted Living Administrator Certification of the Administrator including the reasons for the suspension. Interview with the Owner on 02/25/20 at 4:50pm revealed: -The Corporate Nurse and the Corporate Administrator were to oversee the operations of the facility (no specific time frames were given). -The facility's Corporate Nurse had been coming to the facility "quite a lot" providing training to staff. -We were trying to "uncover" the break in at the facility occurring on 01/03/20. -The Corporate Nurse was going to do a narcotic audit at the facility after the 3,000 controlled substances were stolen in January 2020, but that had not been done yet (no reason given). -The facility's Corporate Nurse lived within proximity of the facility. -The Corporate Administrator and Corporate Nurse would be responsible for auditing charts and verifying the medication administration records were in compliance; however, this had not taken place yet.	D980		

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D980	Continued From page 186 Interview with a law enforcement detective on 02/26/20 at 10:25am revealed: -The previous RCD had bonded out of jail and showed up on the "premises" again this morning (02/26/20) and was arrested. -He would be going back to jail for another forty-eight hours. The Administrator was not available for interview from 02/21/20 - 02/25/20. 2. Confidential staff interview revealed: -The primary care physician (PCP) did visit the facility, but staff did not know how often or when he would be in the facility. -Residents asked to see the PCP but staff did not know when he would be onsite so the staff told the residents that they did not know when the PCP would be there. -In the past (no dates provided), the staff had texted or called the PCP when needed, an example given was when a (named) resident's finger stick blood sugar (FSBS) was outside of the parameters; the PCP was not prompt in responding to the staff "in the past" (no dates provided). -When the staff did not get a response from the PCP, the staff notified the Administrator who said she would "handle it." -Staff did not document when the PCP was notified because staff was told by the Administrator not to document in the residents' records. -There was a report sheet in the medication room that the staff wrote on for communication. -Even though documentation was not in the residents' records staff knew what was going on by the communication sheet in the medication room.	D980		

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D980	Continued From page 187 -The staff recalled an incident that occurred after 01/17/20 when staff had texted the PCP about a resident's FSBS and the Administrator sent out a "group text" to all medication aides (MAs) not to contact the PCP anymore and to contact her (the Administrator) until further notice (instead of the PCP). Confidential interview with a second staff revealed: -The Administrator had instructed staff (no date provided) to let her know when they needed something from the PCP. -Many staff thought the Administrator had the PCP's signature stamp. -Almost every order was in the Administrator's handwriting with the PCP's stamped signature. Telephone interview with the Owner on 02/21/20 at 4:33pm revealed: -The facility's PCP was always responsive to requests by staff and residents. -The PCP visited the facility and saw the residents on a regular basis. -As far as she knew, none of the staff ever had trouble getting what they needed from the facility's PCP. -The Administrator traveled to the town near where the PCP lived on weekends and met with him to obtain signatures for orders. -The Administrator did not have the PCP's signature stamp that she used to sign orders. -She did not know why almost all orders in the residents' records were in the Administrator's handwriting with the PCP's stamped signature. -She did not know how the Administrator was able to provide orders to staff upon request that were in the Administrator's handwriting and stamped with the PCP's signature.	D980		

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Telephone interview with the Resident Care Director (RCD) on 02/21/20 at 4:52pm revealed:
-She would search the Administrator's office to try to locate the PCP's signature stamp.
-If she located the stamp, she would lock it in a safe place until the department of social services (DSS) returned to the facility and notify DSS.

A second telephone interview with the RCD on 02/22/20 at 9:40am revealed she had not located the PCP's signature stamp in the Administrator's office.

Telephone interview with a law enforcement detective on 02/22/20 at 12:28pm revealed:
-A staff person called the police department and gave a tip that the facility's PCP's signature stamp had been located "yesterday" (02/21/20) and a staff person instructed the maintenance director of the facility to "get rid of it".
-The maintenance director threw the signature stamp into the woods behind the facility.
-The signature stamp was in a bag and was caught on something when it was thrown into the woods and it was hanging in the bag.
-The staff person wanted to remain anonymous but had given the detective their name.
-He was on his way to try to retrieve the PCP's stamp out of the woods.

Telephone interview with a law enforcement detective on 02/22/20 at 12:53pm revealed:
-He had located PCP's signature stamp in a plastic bag, hung-up on a tree in the woods behind the facility.
-The stamp was wet and there was ink all inside the bag.

Telephone interview with a law enforcement detective on 02/22/20 at 1:38pm:

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D980	Continued From page 189 -The anonymous staff member who gave the tip to the police about the PCP's stamp was now at the police department wanting to make a formal statement about what happened with the signature stamp. -The staff was afraid of being arrested, so was coming forward to tell the truth about their involvement. Confidential telephone interview with the staff who contacted the local police about the PCP's signature stamp revealed: -The staff was calling from a detective's office and had just given a statement. -On 02/21/20 when the RCD was given the key to the Administrator's office, the staff, along with the RCD, other staff, and the maintenance director, went into the Administrator's office together. -A staff located the physician's signature stamp inside the Administrator's desk drawer. -A staff put the signature stamp in a plastic bag and told the maintenance director to "get rid of it". -The RCD, other staff, and the maintenance director were all present and agreed to get rid of the stamp and now they were trying to "lie and deny it happened." Telephone interview with a law enforcement detective on 02/22/20 at 3:37pm revealed: -He had just interviewed the Administrator at the jail. -She admitted the facility's PCP had given her his signature stamp to use because he hardly ever came to the facility to provide healthcare to the residents. -She hand-wrote prescriptions for the residents and stamped the prescriptions with the PCP's signature stamp. Review of an Incident/Investigation Report from a	D980		

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local police department dated 02/21/20 at 3:00pm revealed:
-On 02/23/20, (the police report was incorrect; the actual date was 02/22/20) police received information that the Administrator had been in possession of the PCP's signature stamp.
-The signature stamp had been thrown into the woods by a (named) maintenance staff member.
-The police went to the facility and found the signature stamp in a plastic bag stuck in a tree in the woods behind the facility; the stamp was recovered by police from where it was found.
-The police spoke with the maintenance staff and Resident Care Director (RCD, who had been put in charge of the facility upon the Administrator's arrest on 02/21/20) about the stamp.
-Both the maintenance staff and RCD denied knowledge of the physician's signature stamp.
-Police then went to the county jail to talk with the Administrator about the signature stamp.
-The Administrator acknowledged having the signature stamp and told police the PCP had given her the stamp to stamp prescriptions when he was not there to sign the prescriptions.

Review of video camera coverage on 02/24/20 revealed:
-The RCD and a MA entered the Administrator's office at 3:56pm on 02/21/20 followed by the Maintenance Director.
-The RCD and the MA left the Administrator's office at 4:54pm on 02/21/20.
-The Maintenance Director left the Administrator's office at 4:55pm with a clear bag in his hand.

Interview with the RCD on 02/24/20 at 6:16am revealed:
-She was told by other staff that a MA (named) found the PCP's signature stamp.
-She was told by other staff the stamp had been

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thrown across the fence into the woods.
-She was not involved in the finding of the stamp or the disposing of it.

Interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm revealed:
-There was never really a time when staff could not get in touch with the PCP.
- "Most of the time", the PCP would call, email, or text staff back on the same date he was contacted.
-If staff were unable to reach the PCP, it could be because he was out of the country.
-There was a Nurse Practitioner (NP) available when the PCP was not available; staff should know to contact the NP if the PCP was unavailable.
-The Administrator was supposed to let staff know when the PCP was unavailable.
-They were "unsure" how often the PCP came to the facility, but "guess" it was once a month.
-It was corporate policy that the Administrator and RCD were responsible for completing 5 to 10 record reviews audits each week day (Monday-Friday); the audits were split between the Administrator and RCD.
-The record review audits were done to ensure no orders were missed, follow up was done, orders were complete, and verbal orders were signed.
-The Corporate Nurse was also in the facility at least once a month to conduct staff trainings, tuberculosis testing, and record reviews.
-Over the last 6 months, the Corporate Nurse had been at the facility at least twice per month.
-The Corporate Administrator and Owner did not know if the record review audit policy had been followed at the facility.
-The Administrator had never been given the directive to tell staff not to contact the PCP; that should not happen.

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D980	Continued From page 192 -It was corporate policy for all orders to have a "wet" signature by the provider; a signature ink stamp should not be used to sign orders. -Verbal orders were supposed to have a "wet" signature also and not be stamped. -There had been "many times" (no dates provided) when the Corporate Nurse transported orders to the PCP to be signed; the Owner thought the Administrator had asked the Corporate Nurse to do this. -The Administrator had also told the Owner she met with the PCP to have orders signed because the PCP lived in the same city in which the Administrator was visiting family (no dates provided). -The Administrator had last reported to the Owner that she had went to visit her family on a recent weekend, but the Owner could not say if she had taken orders for the PCP to sign that weekend. -The Corporate Administrator and Owner did not know anything about an ink stamp with the PCP's signature being used by facility staff to sign PCP orders. -The Owner first heard about the stamp with the PCP's signature "this weekend" because she heard staff talking about it; staff said police found the signature stamp (no other details provided). -Staff should not have access to a signature stamp or use the PCP's signature stamp. -The Administrator had been provided with policies and attended training conducted by the Corporate Administrator and/or Corporate RN on the disposition of controlled substances, documentation, accidents and incidents, health care personnel registry reports, and "multiple trainings" on other policies and procedures (no dates provided). -It was the Administrator's responsibility to ensure staff working in the facility were trained and received the information on policies and	D980		

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D980	Continued From page 193 procedures. Telephone interview with the facility's contracted PCP on 02/24/20 at 2:10pm revealed: -He acknowledged he was the PCP for the residents who resided in the facility. -He would "try" to complete visits to the facility once a month but not greater than 90 days from his previous visit. -His last visit to the facility was in November 2019. -He was available "24/7" (twenty - four hours per day, seven days per week) and staff knew his availability. -A Nurse Practitioner (NP) was available to staff in his absence (when he was on vacation and not available). -He had no knowledge of staff being unable to reach him. -He had no knowledge of staff being instructed by the Administrator not to contact him and to contact her (the Administrator) first; he never gave that order. -Staff texted or called him "all the time"; it was not just the Administrator who contacted him, it was all staff. -He was notified by the pharmacy and "staff" of a break in at the facility in which 3,000 controlled substances went missing (he was unsure of the date the incident occurred or date he was notified). -A (named) Pharmacist or "someone" at the pharmacy told him the controlled substances needed to be refilled after being lost during the break in. -He used his computer and was "online" to sign the prescriptions for the refills to replace the controlled substances lost during the break in; he did not use a physical signature on those prescriptions.	D980		

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D980	Continued From page 194 -He did not use a signature stamp to sign the prescriptions for refills of the controlled substances lost during the break in. -The pharmacy would not fill prescriptions for controlled substances without a "hard" prescription. -He was "unsure" how the pharmacy got the hard prescriptions for controlled substances and referred questions to the pharmacy. -He referred questions related to how and why the pharmacy filled prescriptions for controlled substances signed with a signature stamp to the named contracted pharmacy. -He had not been notified of any additional missing controlled substances after the break in. -He acknowledged he had an ink type stamp with his signature that he used when onsite. -He brought the signature stamp to the facility and left it locked in the room he used while onsite. -He did not answer questions related to what staff (if any) had access to the room where the signature stamp was kept when he was not at the facility. -He described the location of the room he used when onsite as being located down the left hall (upon entrance to the facility), past the medication room, on the left side of the hallway. -The room was always kept locked; he had a key to the room. (He did not answer a question related to other staff that had a key to the room). -When he visited the facility, the door to the room was locked; he used his key to unlock the door. -When he left the facility, he locked the door to the room when he was leaving so he "assumes" the door was kept locked, but he could not say for sure. -Staff had used his signature stamp upon his approval after calling him in "certain situations." -He had authorized staff to use the signature	D980		

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stamp on orders when an "immediate signature is needed."
-When asked for an example of when an immediate signature was needed, he gave this example: staff called him and asked, "Can we get this signed" and he would tell them to use the stamp to sign the order.
-If he decided it was okay to use the signature stamp, he would give authority to whoever called.
-He would tell who ever called to go to his office to get the signature stamp and put it back after used.
-In certain situations, if a circumstance needed his signature then and could not wait, he would authorize the Administrator to use his signature stamp.
-It was "not often" that he gave staff approval to use the signature stamp.
-He was "unsure" of the last time he gave staff approval to use the signature stamp.
-It was a "concern" that his signature stamp was used on medication orders; he would not expect staff to use the signature stamp on any medication orders.
-He had not approved the use of the signature stamp for "any medication" or for "any type" of controlled substance.
-He was told by the Owner (no date provided) that his signature stamp had been found by police "outside" over the weekend.
-He provided no other information about the signature stamp being found outside by police.
-It "baffled" him that the signature stamp was "thrown away"; unless it was being used "inappropriately."
-He hoped that was not the case. If it was, "it would be bad" (no further details provided).
-He acknowledged authorizing the Administrator to use the signature stamp but did not answer questions related to other staff he had authorized

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to use the signature stamp.
-In September, October, or November 2019, he had met the Corporate Registered Nurse off site to sign orders in a (named) city in which they both resided.
-When questioned on meeting the Administrator to sign orders off site, he did not respond.

The Administrator was not available for interview on 02/21/20 - 02/25/20.

3. Observations of a wooded area approximately 50 yards from the Administrator's residence (located on the left side of the facility) on 02/24/20 at 2:56pm revealed:
-The ground was covered with pine needles and there was a pile of burned debris that contained burned black plastic trash style bags and multiple blister packs of medications and at least one multi-pack of medication in individual clear vials.
-There were still medications intact in at least two blister packs and in multiple small, clear, vials.
-One of the medication blister packs that was not completely burned was in a goldish colored blister pack and had a label on it that was yellow and white in color. The label on this blister pack was not completely burned, therefore, the label was legible.
-The medication in that blister pack was determined to Pantoprazole. (Pantoprazole is a medication use to treat gastro-esophageal reflux disease).
-There was evidence that additional medications had been burned; however due to the extensive damage it was undetermined the amount burned.

Review of "Supplement #2" to an Incident/Investigation Report from a local police department dated 02/24/20 at 3:33pm revealed:
-Detectives were on site at the Administrator and

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former RCD's residence (located on facility property) to search the former RCD's vehicle.
-After searching the vehicle, the police began to canvas the woods near their residence and located a "burn pile of blister pill packs" within "30 to 50 yards" of the residence.
-It appeared to detectives that it was "probable" well over a hundred blister packs had been burned and covered up with dirt and brush.
-The pill packs resembled the same types of pills packs found in the Administrator's residence but were so burned that detectives could not ascertain who the pills belonged to.

Interview with the Owner and Corporate Administrator on 02/24/20 at 12:08pm revealed:
-Medications that were no longer needed such as discontinued or the resident was deceased were supposed to be returned to the pharmacy within 30 days.
-The RCD was responsible for making sure the medications were returned to pharmacy and for returning the medications to the pharmacy

Observations on 02/24/20 at 3:53pm revealed:
-The Owner and Corporate Administrator were in the wooded area where the burned medications had been located.
-They observed the area and took pictures of the burn pile.

Interview with the Owner and Corporate Administrator on 02/24/20 at 3:53pm revealed:
-They were not aware of the burn pile of medications near the residence until it was brought to their attention today, 02/24/20.
-The label on the Pantoprazole did not look like a label used by the facility's current contracted pharmacy; the labels on the medications from the current contracted pharmacy had blue on them.

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D980	Continued From page 198 The Administrator was not available for interview on 02/21/20 - 02/25/20. 4. Non-compliance was identified at violation level in following rule areas: A. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up for 7 of 7 sampled residents who had four specialty referrals (#2), redness and weeping legs and thick, long toenails (#3), no nebulizer available for ordered nebulizer treatments (#4), blood sugars greater than 400, three emergency department visits, and thick yellow toenails (#5), chest pressure with shortness of breath (#6), and thyroid stimulating hormone labs and ophthalmology for macular degeneration (#7). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. B. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policies for 2 of 3 residents observed (#1, #11) during the medication passes including errors with a medication used to treat heart failure and high blood pressure (#11), a medication for breathing problems (#11), and a medication for underactive thyroid (#1); and for 5 of 5 residents sampled (#1, #2, #3, #4, #5) for record review including errors with medications for heart/blood pressure (#1, #3), thyroid disease (#1, #4, #5), narcotic pain relievers (#1, #2), anxiety (#1, #4, #5), muscle relaxer (#1), antidepressants (#1, #4, #5), enlarged prostate (#1), inflammation and arthritis (#1), adrenal insufficiency (#1), acid reflux (#1, #5), cholesterol and triglycerides (#1, #4, #5), constipation (#1,	D980		

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#4), seasonal and year-round allergies (#4), fluid retention (#4), manic-depressive disorder (#4), chronic obstructive pulmonary disease (#3, #4), hormone for sleep-wake cycle (#4), antipsychotics (#4, #5), a medication used to reduce the risk of heart attack (#4), vitamin supplements (#1, #5), nerve pain and seizures (#5), expectorant for congestion (#5), and diabetes (#5). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

C. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 4 of 5 residents sampled (#1, #3, #4, #5) including three residents receiving pain medications (#1, #3, #4) and three residents receiving medications for anxiety and agitation (#1, #4, #5). [Refer to Tag D392, 10A NCAC 13F .1008(a) Controlled Substances (Type A2 Violation)].

D. Based on record reviews and interviews, the facility failed to report an allegation of misappropriation of a resident's personal money to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours for 1 of 1 sampled resident (#12) and failed to ensure allegations of drug diversion were reported to HCPR within 24 hours and 5-day follow-up reporting was completed. [Refer to Tag D338, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)].

E. Based on record review and interviews the facility failed to assure 4 of 7 staff (Staff A, D, F, and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry

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D980	Continued From page 200 (HCPR) prior to hiring, according to G.S. 131 E-256. [Refer to Tag D137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)]. _____ The Administrator failed to ensure residents were scheduled and went to specialty health care appointments as ordered resulting in diabetic residents (#3 #5) not having access to podiatry services for foot and toenail care which placed them at risk for skin breakdown, a resident (#6) with diagnoses including coronary artery disease and unstable angina who had recurrent chest pain not being evaluated by cardiology as ordered, and a resident (#2) with tooth pain not being referred to an oral surgeon as ordered, leaving the resident in chronic tooth pain for four months. The Administrator instructed staff not to maintain documentation related to the residents' health care status and needs, to contact her and not to notify the residents' primary care provider (PCP) to address the residents' acute and chronic health care needs and used a signature stamp of the PCP's signature to sign orders which resulted in residents not having access to a PCP for their acute and chronic health care needs. The Administrator failed to ensure residents were administered their medications as ordered resulting in Resident #4, a hospice patient with end stage COPD not receiving DuoNeb treatments because she had no nebulizer machine for an undetermined amount of time and the resident exhibited symptoms of worsening COPD including difficulty breathing, shortness of breath, and low oxygen saturation levels on multiple occasions; and Residents # 1, #2, #3, #4, and #5 missed multiple doses of multiple medications due to the medications being unavailable including medications for heart/blood pressure, diabetes, narcotic pain relievers,	D980		

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D980	Continued From page 201 anxiety, depression, adrenal insufficiency, fluid retention, antipsychotics, and thyroid disease. The Administrator failed to investigate and notify health care personnel registry (HCPR) and failed to notify and/or delayed notifying law enforcement when controlled substances were unaccounted for on at least three different occasions resulting in residents missing doses of controlled substances, continued risk for ongoing drug diversion, and exploitation of residents who did not realize they missed doses of their controlled substance medications. The Administrator allowed her spouse who was the former Resident Care Director (RCD) and had a history of domestic violence, owned weapons, and made threats on her life to live in her residence which was located on the premises of facility property after obtaining a Domestic Violence Protection Order against him, placing the residents at risk of serious physical harm. The Administrator's failure resulted in residents not receiving the medical services and medications necessary to maintain their health and well-being which constitutes a Type A1 Violationin for serious neglect and exploitation. _____ The facility provided a plan of protection in accordance with G.S. 131-D 34 on 02/25/20 for this violation. A SUMMARY OF SUSPENSION OF LICENSE WAS ISSUED ON FEBRUARY 26, 2020.	D980		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.	D992		

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D992	Continued From page 202 (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 7 sampled staff (B) prior to hire. The findings are:	D992		

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D992	Continued From page 203 Review of Staff B's, personal care aide/medication aide (PCA/MA) personnel record revealed: -Staff B was hired in September 23, 2019. -There was no documentation Staff B completed the examination and screen for the presence of controlled substance. -There was no consent for a drug screening and examination. Interview with Staff B on 12/11/19 at 4:29pm revealed: -She was hired in October 2019; she was on medical leave for 6 weeks; and returned to work on 12/05/19. -She provided personal care to residents including bathing, toileting, and feeding. Interview with the facility's Owner on 02/25/20 at 7:00pm revealed: -The controlled substances examination screening should be completed before a new employee started working on the floor. -Some controlled substances examination screenings were completed by the Administrator or the facility's contracted Registered Nurse (RN). -The Administrator was responsible for completing the paperwork when Staff B was hired. -She did not have documentation of Staff B's drug screen or results and she was unable to retrieve documentation of Staff B's drug screen from the paper file onsite.	D992		