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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey, complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit date on 01/06/21 and a desk review survey on 01/07/21 to 01/08/21, 01/11/21 to 01/15/21, 01/19/21 to 01/22/21, and a telephone exit on 01/22/21.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure staff provided personal care assistance to 1 of 6 sampled residents (Resident #2) with bathing and incontinence care. The findings are: Observation from the hallway outside of Resident #2's room on 01/06/21 at 12:44pm revealed: -The personal care aide (PCA) helped Resident #2 sit up in the bed. -The PCA adjusted the resident's nasal cannula around her ear and nose. -Resident #2's hair looked disheveled. Review of Resident #2's current FL-2 dated 12/29/20 revealed: -Diagnoses included Alzheimer's Disease,	D 269		

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COVID-19 pneumonia, migraines, osteoporosis, and primary progressive aphasia.
-Resident #2 was incontinent of bladder and bowel.
-Resident #2 was constantly disoriented.
-Resident #2 was ambulatory.

Review of Resident #2's Resident Register revealed an admission date of 04/17/19.

Review of Resident #2's Care Plan dated 07/21/20 revealed:
-Resident #2 was totally dependent for eating, toileting, ambulation, and transfers.
-Resident #2 needed limited assistance with bathing, dressing, and grooming.

Review of facility's list of COVID-19 positive residents revealed Resident #2 tested positive on 12/25/20.

Telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm revealed:
-She found Resident #2 "covered" in urine on 12/30/20.
-She had checked on Resident #2 before she went to the hospital on 12/27/20.
-She was "mortified" at the condition in which she had found Resident #2.
-Resident #2 had on no underwear and she had a bowel movement sometime that day, and no one provided incontinence care.
-She put clean clothes on the resident and tried to clean her, but the feces was stuck to the skin.
-She told the Administrator the next time she saw her about the condition she had found Resident #2.
-She had found Resident #2 "covered" in urine again on 01/05/21.
-She was "usually" independent going to the

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restroom but was having some accidents while she was sick.

Telephone interview with a PCA on 01/08/21 at 2:15pm revealed:
-The PCAs were responsible for checking on all the residents every
-Resident #2 was having trouble getting up and going to the bathroom.
-Resident #2 had "accidents" and needed to be assisted with incontinent care.

Telephone interview with a second PCA on 01/12/21 at 1:02pm revealed:
-She knew a MA on first shift had found Resident #2 needing incontinent care.
-The facility had been "ridiculously" short staffed over the past several weeks.
-It was hard to care for all the residents with only two PCAs working.
-They have had several staff quit including two on third shift.
-Management was helping pass medications but they do not help provide personal care to the residents.

Telephone interview with a MA on 01/11/21 at 1:16pm revealed:
-She was having trouble getting the PCAs to check on Resident #2 more frequently since she had returned from the hospital.
-The PCAs were not use to Resident #2 requiring frequent incontinent care.
-She had to keep reminding the PCAs to check on Resident #2 between rounds to make sure she did not need additional incontinent care.

Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:48am revealed:

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-She had no concerns related to the personal care of Resident #2.
-She was not working on 12/27/20 when Resident #2 was transported to the local hospital.
-The PCAs were responsible for completing rounds to provide continence care every two hours.

Telephone interview with a paramedic from the local emergency medical services (EMS) on 01/11/21 at 3:13pm revealed:
-EMS arrived "a little after" 3:00pm on 12/27/20 to transfer Resident #2 to the local hospital.
-There were clothes and food wrappers all over the floor of Resident #2's room and the floor was sticky.
-Resident #2 appeared to have "greasy hair that had not been washed in several days."
-The entire room smelled of body odor, urine, and feces.
-Resident #2 looked like she had not been provided incontinent care or bathed in several days.

Telephone interview with a consultant nurse from a local home health agency on 01/11/21 at 12:45pm revealed:
-She had visited Resident #2 at the facility to complete an initial assessment on 01/05/21 around 1:30pm.
-She did not notice any strange smells when she entered the room.
-Resident #2 needed to be assisted with incontinent care when she assessed the resident.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed:
-She did not know that Resident #2 needed increased assistance with eating, transfers, and personal care.

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D 269	Continued From page 4 -Resident #2 was ambulating "normally" the last time she had been in the facility many months ago before COVID-19. -The staff were responsible for providing "some" prompting to remind Resident #2 to go to the bathroom or to eat. Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed: -The PCAs were responsible for completing rounds every two hours to check on the residents and provide incontinent care. -Showers were scheduled for twice weekly for each resident. -No one had brought it to her attention that Resident #2 was not being cared for. -When Resident #2 was diagnosed with COVID-19, she was having trouble walking to the restroom.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 4 of 8 sampled residents (#2, #4, #5, and #13) as related to delay in responding to a low heart rate and oxygen saturation (#5), bruising on resident thighs discovered three days	D 273		

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before sending the resident (#13) for hospital evaluation and diagnosed with a hip fracture, a resident who fell and had a head injury while taking Eliquis (#4) and was not sent out for evaluation, a resident taking aspirin with a fall and impact to the left eye causing bruising and swelling (#5) not being sent out for evaluation, and significant weight loss not being reported to the PCP for residents (#2, #4, #5, and #13).

The findings are:

1. Review of Resident #5's current FL2 dated 01/05/21 revealed:
-Diagnoses included vascular dementia, sepsis secondary to cellulitis, heart failure with preserved ejection fraction, stage II chronic kidney disease, hypertension, and lower extremity cellulitis with deep ulcer.
-The resident was ambulatory and intermittently disoriented.

Review of Resident #5's Care Plan dated 10/10/20 revealed:
-The resident was ambulatory with use of a walker.
-The resident required supervision with toileting, dressing, grooming, and transfers.
-The resident required limited assistance with eating and bathing.

Observation of Resident #5 on 01/06/21 at 9:54am revealed:
-The colored dot on the resident's name plate outside the room indicated the resident was COVID-19 positive.
-The resident was seated in a chair with her eyes closed and a rollator walker in front of the chair.
-There was a 1 inch wide by 1 inch long purple and green colored bruise visible over the corner

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of Resident #5's left eye.
-There was an uneaten plate of food on the seat of the rollator walker pulled up in front of the resident's chair.
-The resident's left elbow was propped on the arm of her chair and she grasped an empty 10 oz. cup in her left hand held up to the right side of her face.

a. Observation of a Medication Aide (MA) on 01/06/21 at 12:46pm revealed:
-The MA dressed in full personal protective equipment (PPE) delivered a lunch plate and beverage to Resident #5 and placed it on the set of the rollator walker pulled up in front of the resident's chair.
-The MA spoke to Resident #5 to try to wake the resident, but was unsuccessful.

Interview with the second MA on 01/06/21 at 1:16pm revealed Resident #5 had been "combative" with her that morning and was "not eating."

Observation of the second MA on 01/06/21 at 1:17pm revealed she asked a third MA to provide feeding assist to Resident #5.

Observation of the third MA on 01/06/21 from 1:20pm to 1:42pm revealed:
-The third MA was dressed in full PPE and was inside Resident #5's room.
-At 1:20pm, the MA offered Resident #5 a sip of water by putting the straw to the resident's lips.
-From 1:21pm to 1:28pm, the MA worked with Resident #5 and her roommate to encourage both residents to wake up and eat lunch but was unsuccessful.
-At 1:29pm, the MA leaves the resident room to go get equipment to check Resident #5's vitals.

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-At 1:36pm, the MA returns with the equipment to check vital signs for Resident #5.
-At 1:41pm, the Residents vitals are temperature of 96.3, oxygen saturation 95%, pulse 45, and the blood pressure was 103/57.
-At 1:42pm, the MA removed the PPE and left the room.

Interview with the third MA on 01/06/21 at 1:47pm revealed:
-He was going to contact the Administrator to let her know Resident #5 was "hard to arouse", had a low pulse, and had a low blood pressure.
-The call to the Administrator went to voicemail.
-The Divisional Director of Clinical Services (DDCS) who was a Registered Nurse (RN) was in the building and he alerted her as to Resident #5's condition.

Interview with the second MA on 01/06/21 at 1:50pm revealed Emergency Medical Services (EMS) had been notified to come to take Resident #5 to the hospital for evaluation.

Observation of the DDCS on 01/06/21 at 1:56pm and 2:00pm revealed:
-She was appropriately dressed in full PPE.
-She listened to Resident #5's breath sounds with a stethoscope.
-She encouraged Resident #5 to wake up and assisted the resident to drink sips of a beverage through a straw.

Interview with the DDCS on 01/06/21 at 1:57pm revealed:
-Resident #5 had just returned from the hospital on 01/05/21.
-The resident's blood pressure was low and her pulse was "rapid".
-The resident was "probably dehydrated".

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-The MA was letting the Nurse Practitioner (NP) know about the resident's vitals and condition.

Interview with the DDCS on 01/06/21 at 2:09pm revealed:
-The second MA was "now calling EMS."
-The MA had "misunderstood me" the first time and had called Resident #5's NP who had been unable to respond for 5 minutes.
-"I told her to go ahead and call" EMS and not to wait for a return call from the NP.

Observation of the arrival of EMS to the facility on 01/06/21 revealed they arrived at 2:19pm.

Interview with the second MA on 01/06/21 at 2:30pm revealed:
-EMS checked Resident #5 and her "pulse was strong" and oxygen saturations were "good."
-They decided Resident #5 did not need to be taken to the hospital for evaluation.

Telephone interview with the NP on 01/14/21 at 2:58pm revealed:
-Facility staff had paged her on 01/06/21 about Resident #5's low heart rate in the 40's and low oxygen level.
-She had told the staff "to get oxygen on her."
-If EMS had "checked" Resident #5 out and was able to get the resident's oxygen saturation back up to 94% by getting the resident up and moving around, she was satisfied with them not having sent the resident to the hospital for evaluation.

Review of the facility's Accident/Falls/Emergency & Fire Safety Policy revealed:
-An emergency is any situation which arises suddenly and calls for prompt action.
-Staff should assess the resident.
-If injury is apparent or possible, do not move the

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resident.
-Determine if resident is breathing and check for pulse.
-Administer CPR (check for DNR status) and first aide as appropriate.
-Continue emergency intervention until EMS arrives.
-Send appropriate information with resident.
-Call the resident's physician and responsible party.

b. Review of Resident #5's FL2 dated 01/05/21 revealed there was an order for aspirin (used as a blood thinner) 81mg 1 tablet daily.

Review of Resident #5's Event Report dated 01/01/21 revealed:
-The resident was laying on the floor by her bed.
-The resident hit her right eye on night stand.
-The eye was swollen and bruised.
-The resident was not taken to the hospital for evaluation.

Review of Resident #5's Event Report dated 01/02/21 revealed:
-The resident had an unwitnessed fall.
-The resident was found face down on the floor.
-The resident had a bump and swelling on the left side of forehead above the eye.
-The resident was sent to the hospital for evaluation.

Review of Resident #5's hospital discharge summary dated 01/05/21 revealed:
-The resident's arrival date was 01/02/21.
-The discharge diagnoses included fall, closed head injury, pneumonia, and urinary tract infection.

Telephone interview with a medication aide (MA)

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on 01/13/21 at 1:05pm revealed:
-When a resident fell and hit their head, the MA checked the resident's vitals and assessed the resident for injury.
-The MA notified the manager.
-The MA sent the resident out for hospital evaluation.

Telephone interview with Resident #5's Nurse Practitioner on 01/14/21 at 2:58pm revealed:
-She had not been made aware of the resident's fall on 01/01/21.
-The resident could bruise and bleed "a little worse" while taking aspirin.
-Residents who hit their head should be sent out for hospital evaluation.

Telephone interview with the Administrator on 01/13/21 at 2:13pm revealed it was the facility's policy to have resident's who fall and hit their head be sent out for evaluation.

c. Review of Resident #5's medication orders signed by the Nurse Practitioner (NP) dated 11/13/20 revealed:
-There was an order for amlodipine (used to treat high blood pressure) 5mg daily.
-There was an order for aspirin (used to prevent blood clots) 81mg daily.
-There was an order for bumetanide (diuretic used to treat heart failure) 0.5mg daily.
-There was an order for metoprolol ER (used to treat high blood pressure) 25mg daily hold for heart rate less than 60 beats per minute.
-There was an order for potassium chloride ER (used to supplement potassium levels) 10mEq daily.

Review of Resident #5's NP order dated 01/04/21 revealed doxycycline (used to treat COVID-19

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associated pneumonia) 100mg 1 capsule every 12 hours for 7 days.

Review of Resident #5's hospital discharge summary dated 01/05/21 revealed:
-The resident's arrival date was 01/02/21.
-The resident was COVID-19 positive.
-The discharge diagnoses included fall, closed head injury, pneumonia, and urinary tract infection.
-There was an order for amlodipine (used to treat high blood pressure) 5mg daily.
-There was an order for aspirin (used to prevent blood clots) 81mg daily.
-There was an order for bumetanide (diuretic used to treat heart failure) 0.5mg daily.
-There was an order for metoprolol ER (used to treat high blood pressure) 25mg daily hold for heart rate less than 60 beats per minute.
-There was an order for potassium chloride (used to supplement potassium levels) ER 10mEq daily.

Review of Resident #5's December 2020 electronic Medication Administration Record (eMAR) revealed:
-Amlodipine was documented as not administered from 12/21/20 to 12/25/20 due to "refused."
-Aspirin was documented as not administered from 12/21/20 to 12/25/20 due to "refused."
-Bumetanide was documented as not administered from 12/21/20 to 12/25/20 due to "refused."
-Metoprolol ER was documented as not administered from 12/21/20 to 12/25/20 due to "refused."
-Potassium chloride ER was documented as not administered from 12/21/20 to 12/25/20 due to "refused", on 12/26/20 due to "medication has been ordered", and on 12/28/20 due to "should be

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getting picked up today".

Review of Resident #5's January 2020 eMAR from 01/01/21 to 01/14/21 revealed:
-Amlodipine was documented as not administered on 01/01/20, 01/02/21, and 01/03/21 due to "refused."
-Aspirin was documented as not administered 01/01/21 due to "refused."
-Bumetanide was documented as not administered on 01/01/21, 01/02/21, and 01/07/21 due to "refused."
-Doxycycline was documented as not administered on 01/06/21 at 10:23am, 01/07/21 at 9:05am, 01/10/21 at 8:40pm, 01/11/21 at 7:40pm, and 01/13/21 at 8:12pm due to "refused."
-Metoprolol ER was documented as not administered on 01/01/21, 01/02/21, and 01/07/21 due to "refused."
-Potassium chloride ER was documented as not administered on 01/01/21, 01/02/21, and 01/07/21 due to "refused."

Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:48am revealed:
-Residents had a right to refuse their medications.
-She did not know if Resident #5's Nurse Practitioner (NP) was notified of Resident #5's medication refusals.
-"Usually" staff let the PCP know when a resident refused their medications "immediately" after the refusal.

Telephone interview with a medication aide (MA) on 01/13/21 at 1:05pm revealed:
-Resident #5 was "known" to refuse her medications in December 2020.

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-Resident #5 had been taking her medications "lately."
-Staff tried their best to get Resident #5 to take her medications.
-If a resident refused to take their medication the first time, she would try to go back and ask a couple times.
-If the resident continued to refuse to take their medication, she reported it to the MA on the oncoming shift and to the Administrator.

Telephone interview with the Administrator on 01/13/21 at 2:13pm revealed:
-The facility policy on medication refusals required the MA to notify the PCP when a resident refused a medication three times.
-Notification of primary care providers about any resident medication refusals should be documented in the resident's progress notes.

Telephone interview with Resident #5's Nurse Practitioner (NP) on 01/14/21 at 2:58pm revealed:
-She had just been notified today (01/14/21) Resident #5 was not taking her doxycycline.
-"I told them to put her doxycycline in applesauce and try that."
-The risk associated with the resident not taking doxycycline as it was ordered could cause worsening pneumonia or worsening infections.
-With COVID-19 associated pneumonia (which what the doxycycline was ordered to treat) it "could be deadly" because Resident #5 was "old and vulnerable."
-Resident #5 stopping metoprolol "abruptly can shoot the blood pressure up to dangerously high levels and cause a stroke."
-"I think they should notify me when people are not taking their meds."

Review of the facility's medication management

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policy dated 07/20/20 revealed:
-The Medication Refusal form was required documentation each time medication was refused by a resident.
-Communities were required to contact the physician when a resident had refused any prescribed medication three consecutive times.
-The PCP notification should be sent via fax and documented in the resident chart.

d. Review of Resident #5's entries on the facility's weight variance report dated 11/01/20 to 01/13/21 revealed:
-On 11/08/20, the resident weight was 122lbs.
-On 12/14/20, the resident weight was 119lbs.
-On 01/11/21, the resident weight was 121lbs.
-On 01/13/21, the resident weight was 101.5lbs.

Review of Resident #5's Emergency Department (ED) discharge summary dated 12/09/20 revealed the resident weighed 127lbs.

Review of Resident #5's ED discharge summary dated 01/05/21 revealed the resident weighed 112lbs.

Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:48am revealed the NP always asked for the residents weights and vitals during the resident telehealth visits.

Telephone interview with a medication aide (MA) on 01/13/21 at 1:05pm revealed:
-Personal care aides (PCA) would know if a resident was losing weight.
-The PCA was supposed to let us know of decreased resident weights.
-It was the MAs responsibility to inform the SCC of decreased resident weights.

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D 273	Continued From page 15 Telephone interview with Resident #5's NP on 01/14/21 at 2:58pm revealed she had not been notified by facility staff about Resident #5 losing weight. Telephone interview with the Administrator on 01/15/21 at 11:46am revealed: -The facility staff were going to reweigh all the residents in the building. -They were going to ensure the scales were calibrated "right". -When staff had been weighing residents they may not have weighed Geri-chairs and wheelchairs accurately. -It was the SCC's responsibility to pull a monthly weight variance report and notify the PCP of any significant weight changes. -The SCC was new and they were trying to get the SCC trained. -The SCC had started in the position "3 to 4 weeks ago." -The last weight variance report had been pulled in October 2020. -She was not sure if a weight variance report had been pulled in November 2020. -She "should have" pulled the weight variance reports for November and December 2020 since she did not have an SCC. 2. Review of Resident #13's current FL2 dated 09/14/20 revealed: -Diagnoses included dementia, cognitive impairment, hypertension, macular degeneration, hearing loss, and osteopenia. -The resident was constantly disoriented and non-ambulatory. -The resident was incontinent of bladder and bowel.	D 273		

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Review of Resident #13's Care Plan dated 10/10/20 revealed:
-The resident required limited assistance with eating.
-The resident required extensive assistance with toileting, ambulation, grooming, and transfers.
-The resident was totally dependent on staff for bathing and dressing.

a. Review of Resident #13's Nurse Practitioner's (NP) order dated 12/10/20 revealed fall mat for bedside due to diagnoses of generalized muscle weakness, fall risk, and history of falls.

Review of Resident #13's NP order dated 12/31/20 revealed Eliquis (used to prevent blood clots) 2.5mg two times a day for 10 days.

Review of Resident #13's Event Report dated 01/07/21 revealed:
-Resident #13 was found on the floor by her bed on 01/07/21 at 5pm.
-She had a skin tear on her left elbow.
-A bandage was applied for first aid to the left elbow skin tear.
-There was no documentation a fall mat was used.
-The resident was not sent out to the hospital for evaluation.

Telephone interview with a personal care aide (PCA) on 01/20/21 at 4:05pm revealed:
-The medication aides (MAs) were responsible for checking residents after a fall.
-If the MA thought the resident was "okay" then the PCAs were responsible for assisting the resident back to bed.
-She had assisted Resident #13 back into bed after the resident rolled out of bed on 01/07/21.
-She noticed bruising on Resident #13 the week

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after she fell.
-She was not in Resident #13's room when she fell so she was not sure she had hit her hip during the incident on 01/07/21.

Review of Resident #13's Progress Note dated 01/07/21 at 10:54pm revealed:
-Resident #13 was biting her finger hard enough to puncture a hole on the side of the left index finger.
-Resident #13 was sent to the hospital for evaluation.

Review of Resident #13's Emergency Department (ED) discharge instructions dated 01/08/21 revealed the reason for the visit was for a contusion of the left hand, COVID-19, and open bite of left index finger without damage to nail.

Telephone interviews with an MA on 01/19/21 at 9:00am and 1:46pm revealed:
-Resident #13 was non-ambulatory and needed assistance to transfer.
-She noticed bruising on the inner thigh of Resident #13 two to three days before she was sent to the hospital to have her hip evaluated (01/14/21).
-She thought Resident #13 sustained bruising when she was being provided incontinent care and staff did not report the bruising.
-She and another MA had assisted the resident from the bed to the chair the morning before she was sent to the hospital and did not notice any swelling around her hip.
-Another MA had assisted Resident #13 back to the bed sometime between breakfast and lunch and noticed the swelling in the hip.

Telephone interview with a second MA on 01/21/21 at 6:00am revealed:

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-On 01/11/21, the MA went into Resident #13's room to assist her roommate.
-While assisting the roommate, the MA noticed Resident #13 was lying in bed uncovered.
-After assisting the roommate, the MA went over to Resident #13 to cover her up and noticed "a lot of bruising on the backs of her legs."
-The MA covered Resident #13 back up and left the room.
-The MA did not assess the resident because the resident had been asleep.
-No one had reported any bruises on Resident #13 when she received report on 01/11/21.
-She had reported the bruises on Resident #13 to the third shift Supervisor when she saw them on 01/11/21.

Telephone interview with a PCA on 01/19/21 at 12:58pm revealed:
-During third shift on 01/12/21, she had noticed bruising on Resident #13's left thigh as she and another PCA were providing incontinent care to the resident.
-On 01/13/21 at 5:30am, she had reported the bruising on Resident #13's inner thigh to both MAs who were on duty at the time.

Telephone interview with a second PCA on 01/20/21 at 6:03am revealed:
-She had noticed the bruising on Resident #13's legs on the night of 01/11/21.
-She and another PCA had been working together to provide incontinence care for Resident #13 when she saw the bruises.
-She had seen "purple bluish" bruising on Resident #13's right and left inner thighs.
-The right inner thigh bruise was "fairly large" and "darker than the left."
-The left inner thigh bruise was "lighter and not as big as the bruise on the right" inner thigh.

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D 273	Continued From page 19 Telephone interview with a third MA on 01/20/21 at 5:58am revealed: -She became aware of the bruising on Resident #13 on 01/11/21 or 01/12/21. -She did not know how Resident #13 had sustained the bruises. Telephone interview with a fourth MA on 01/19/21 at 10:15am revealed: -The MA had transferred Resident #13 from the bed to the wheel chair to assist her with lunch. -She had transferred Resident #13 by herself. -She and another MA observed Resident #13's left leg was swollen while she was sitting in her wheelchair. -She and the other MA had transferred Resident #13 back to the bed to assess her and noticed her left leg was "rotated out." -She and the other MA took a picture of Resident #13's leg and sent it to the Administrator and Nurse Practitioner (NP). -"We were afraid it was dislocated and might not be getting blood supply." -She had been "very" concerned as the leg had not been swollen or bruised "like that" at 7:30am when she and another MA had provided incontinent care then transferred the resident to her wheelchair for breakfast. -She had noticed a "fresh" blue bruise about the size of 4 finger widths on Resident #13's left inner thigh when she and the other MA had provided incontinent care at 7:30am. -That was the first time she had seen the bruise. -She and the MA then transferred Resident #13 into the wheelchair for breakfast. -It was difficult to tell if Resident #13 had experienced any pain during either transfer because the resident "always yells" to communicate with the staff.	D 273		

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D 273	Continued From page 20 -The MA who assisted her reported the bruise to the Administrator. Telephone interview with a fifth MA on 01/19/21 at 1:19pm revealed: -The MA had been walking by Resident #13's room and observed a PCA having difficulty getting Resident #13 to swallow. -She had felt Resident #13's legs and the left leg felt more raised than the other. -She and the other staff then "very carefully" transferred Resident #13 back to the bed to assess her. -"I saw bruising on the inner left thigh and her hip did not look right." -The hip was "dislocated or something." -She let the Administrator know and then she notified the NP. -The NP ordered the resident sent out to the hospital for evaluation. Review of Resident #13's Progress Note dated 01/14/21 at 12:15pm revealed: -The resident's left hip "seemed more raised than the other" while she was sitting up in her wheelchair for lunch. -An MA and PCA transferred the resident to bed to check the resident after she was done eating lunch. -The MA and PCA "noticed" that Resident 13's left hip was "definitely injured" and she had bruising on the inner part of her thigh. -Resident #13's NP was immediately notified. -Resident #13 was sent out for evaluation. Review of Resident #13's Triage Note dated 01/14/21 revealed: -Staff reported Resident #13 "was crying out" and "saying her hip hurt." -The resident "has had no recent falls."	D 273		

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-Staff had noticed bruises on her hip and inner thigh.
-Resident was sent to the Emergency Department (ED) for hip evaluation.

Review of Resident #13's Event Report dated 01/15/21 revealed:
-There was an un-witnessed incident with injury on 01/14/21 at 12:15pm in the resident's bedroom.
-The resident's left hip was raised and swollen and "looked out of place."
-There was a bruise on the resident's left inner thigh.
-The resident was taken to the ED for evaluation on 01/14/21 at 12:45pm.

Review of Resident #13's ED report dated 01/14/21 revealed:
-The chief complaint was left hip pain and swelling.
-The resident was non-verbal and gave no history.
-There was no history of a fall.
-There was some swelling at the left hip with some bruising near the groin.
-There was pain with any passive movement of the left hip.
-The resident was diagnosed with a fracture of the left hip.

Review of Resident #13's Triage Note dated 01/15/21 revealed:
-Resident #13 had a left hip fracture.
-The hospital had determined Resident #13 did not need surgery.
-There was an order to monitor Resident #13 for pain as the resident was "unable" to ask for pain medication.
-There was an order for oxycodone 5/325mg

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(used to treat pain) 1 tab every 4 hours as needed for pain for 3 days.

Telephone interview with the Special Care Coordinator (SCC) on 01/20/21 at 9:38am revealed:
-She had completed the Event Report on Resident #13 on 01/07/21.
-The resident had "rolled out of her bed" and had a skin tear on her left elbow.
-The resident did not have to be sent to the hospital for evaluation when she rolled out of bed because the resident "was not around anything, no knots on her head or anything" when she had assessed her.
-The residents range of motion had been "good".
-After she assessed Resident #13, a PCA helped to get the resident back into bed.
-The bruising found on Resident #13 had been reported to her on 01/14/21 by an MA who had noticed the bruising on the morning of 01/14/21 while providing incontinent care.
-Staff had not reported any bruising found on Resident #13 before 01/14/21.
-The staff had not left any notes under her office door concerning the bruises on Resident #13.
-She would have notified the NP had she known about the bruises.

Telephone interview with Resident #13's NP on 01/21/21 at 2:00pm revealed:
-She had not been notified about the incident on 01/07/21 when the resident rolled out of bed and sustained a skin tear on her left elbow.
-She was told about the bruising and injury to Resident #13's hip on 01/14/21.
-It had "surprised" her Resident #13 had gotten a broken bone without having a fall.
-The broken hip was not going to make a "huge" difference in her quality of life, as the resident

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was already been bed bound and non-ambulatory.
-The resident had limited verbal ability and could "only say a few words."
-The resident would have been unable to tell staff if her hip had hurt.

Telephone interview with Resident #13's family member on 01/20/21 at 8:15am revealed:
-Resident #13 had "gone down hill considerably" since admission to the facility.
-The family member did not understand why Resident #13 fell so much as the resident "can't stand up on her own."

Telephone interview with the Administrator on 01/21/21 at 3:36pm revealed:
-Resident #13 rolled out of bed "a lot" and had a wedge to use to help keep the resident from rolling out of bed.
-Her staff had reported to her when they went to pickup Resident #13 from the hospital on 01/08/21, the nurses at the hospital picked the resident up under her arms and under her legs to transfer the resident.
-She became aware of the injury to Resident #13 hip on 01/14/21 at 12:24pm.
-She immediately sent a picture of the injury to Resident #13's NP.
-The staff did not tell the SCC until 12:24pm on 01/14/21, because they were both in the Administrator's office when the MA told them.
-When staff noticed bruising on a resident, they were supposed to report it to management.
-She had interviews "now" from two staff who "admitted" they knew about the bruising on 01/12/21 and 01/13/21, but they "never told us" before 01/14/21.
-Staff were not supposed to leave notes under the door to notify management about resident

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injuries.
-Staff were supposed to use the communication log for shift to shift reporting.

b. Review of Resident #13's Palliative Care visit note dated 11/05/20 revealed Resident #13's last documented weight on 10/07/20 was 90lbs.

Review of Resident #13's Emergency Department (ED) discharge instructions dated 11/28/20 revealed the resident weighed 84lbs.

Review of Resident #13's Nurse Practitioner's (NP) order dated 12/10/20 revealed monthly weights due to history of weight loss.

Review of Resident #13's entries on the facility's weight variance report dated 11/01/20 to 01/13/21 revealed:
-On 12/14/20, the resident weight was 101lbs.
-On 01/01/21, the resident weight was 101lbs.
-On 01/07/21, the resident weight was 81lbs.

Review of Resident #13's ED discharge instructions dated 01/08/21 revealed the resident weighed 81lbs.

Review of Resident #13's ED discharge instructions dated 01/14/21 revealed the resident weighed 85lbs.

Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:48am revealed the NP "always" asked for the residents weights and vitals during the resident telehealth visits.

Telephone interview with a medication aide (MA) on 01/13/21 at 1:05pm revealed:
-Personal care aides (PCA) would know if a

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resident was losing weight.
-The PCA was supposed to let the MAs know of decreased resident weights.
-It was the MAs responsibility to inform the SCC of decreased resident weights.

Telephone interview with Resident #13's NP on 01/14/21 at 2:58pm revealed she had not been notified by facility staff about Resident #13 losing weight.

Telephone interview with the Administrator on 01/15/21 at 11:46am revealed:
-When staff had been weighing residents they may not have weighed Geri-chairs and wheelchairs accurately.
-It was the SCC's responsibility to pull a monthly weight variance report and notify the PCP of any significant weight changes.
-The last weight variance report had been reviewed in October 2020.
-She did not know if a weight variance report had been reviewed in November 2020.
-She "should have" reviewed the weight variance reports for November and December 2020 since she did not have an SCC.

3. Review of Resident #4's current FL2 dated 11/01/20 revealed:
-Diagnoses included severe stage Alzheimer's disease, weight loss, vision loss, history of syncope, blood pressure instability, and bipolar disorder.
-The resident was ambulatory and constantly disoriented.

Review of Resident #4's Resident Register revealed an admission date of 11/20/20.

Review of Resident #4's Care Plan dated

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11/24/20 revealed:
-The resident required limited assistance with toileting, bathing, dressing, and grooming.
-The resident was totally dependent on staff for eating.

a. Review of Resident #4's Nurse Practitioner's (NP) order dated 01/01/21 revealed Eliquis (used to prevent blood clots) 2.5mg 1 tablet twice a day for 10 days with meals.

Review of Resident #4's Event Report dated 01/05/21 revealed:
-The had a fall and hit head while getting out of bed.
-The fall was witnessed.
-There was no injury noted.
-The resident was not taken to the hospital for evaluation.

Telephone interview with laundry staff on 01/11/21 at 1:55pm revealed:
-She had been in Resident #4's room putting clean clothes in the resident's closet and heard the resident fall.
-Resident #4 hit the side of her head on the wall heating unit.
-Resident #4 had gotten up and stumbled due to the blanket in her lap getting tangled around the resident's feet causing her to fall.
-She immediately let the medication aide (MA) know Resident #4 had fallen and hit the side of her head.
-When the MA arrived to check on Resident #4, the laundry staff went back to the laundry room.

Observation of Resident #4 on 01/06/21 at 9:50am revealed:
-The resident was lying in bed.
-There was a dark purple and green colored

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bruise approximately 2 inches wide by 2 inches long on the back of Resident #4's right hand.

Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:48am revealed:
-Resident #4 had fallen and hit her head on 01/05/21.
-The SCC had not worked on 01/05/21.
-Staff did not send Resident #4 out to the hospital for evaluation of the fall with head injury until 01/06/21.
-She had notified the Nurse Practitioner (NP) on 01/06/21 of Resident #4's fall with head injury.
-Staff had not made her aware of the bruising Resident #4's right hand on 01/05/21.
-Resident #4 was taking Eliquis which put the resident at an increased risk for bleeding.
-It was the facility's policy to send out resident's who hit there head.
-Resident #4 could have had an internal bleed "that we didn't know about."

Observation of Resident #4 on 01/06/21 at 1:21pm revealed:
-Resident #4 refused to get up to the chair.
-Resident #4 refused to allow the MA to assist with helping her to put on a pair of pants.

Interview with the MA assigned to care for Resident #4 on 01/06/21 at 2:30pm revealed EMS was taking Resident #4 to be evaluated for hip pain.

Review of Resident #4's discharge instructions dated 01/06/21 revealed:
-The resident was evaluated for a fall.
-No acute abnormalities were found in completed imaging studies of Resident #4's spine, pelvis or lower extremities.

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D 273	Continued From page 28 Telephone interview with the MA who completed Resident #4's Event Report dated 01/05/21 revealed: -She had known Resident #4 had hit her head when she fell on 01/05/21. -She was unaware Resident #4 had been taking Eliquis since 01/02/21. -They had not sent Resident #4 out for evaluation because the resident was still "really responsive and with us." -She was training that day on the medication cart with another MA. -She had asked the MA she was training with if she needed to send Resident #4 out to the hospital and she said no the resident "seemed ok." -She documented the Event Report including documenting contacting the Administrator. -She had thought the other MA was going to contact the Administrator. Telephone interview with the Administrator on 01/13/21 at 2:13pm revealed: -It was the facility's policy to have resident's who fall and hit their head be sent out for evaluation. -The MA who was training the MA who was responsible for Resident #4's care on 01/05/21 should have sent her out for evaluation immediately after the fall. -It was policy that staff call the Administrator after a fall with head injury and she would have instructed them to send the resident out to the hospital, however staff had not called her. -She did not know if staff had notified Resident #4's NP about the fall on 01/05/21. -The MA who was training the MA who was responsible for Resident #4's care on 01/05/21 was responsible for notifying Resident #4's NP about the fall on 01/05/21.	D 273		

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D 273	Continued From page 29 Telephone interview with Resident #4's NP on 01/14/21 at 2:58pm revealed: -She did not remember facility staff contacting her about Resident #4's fall on 01/05/21. -Resident #4 was at risk of a having a "brain bleed or bleed anywhere" after a fall while taking Eliquis. -Resident #4 should have been evaluated at the hospital for a head injury after the fall on 01/05/21. b. Review of Resident #4's FL2 dated 11/01/20 revealed: -There was an order for a regular diet with cut-up foods with prompted meals. -There was an order for supplement shakes twice daily. Review of Resident #4's Nurse Practitioner's (NP) order dated 12/18/20 revealed: -There was an order for weights two times a month. -Notify provider of a weight loss of 3 lbs. or greater from previous weight. -Begin high protein shakes three times a day. Review of Resident #4's entries on the facility's weight variance report dated 11/01/20 to 01/13/21 revealed: -On 11/12/20, the resident weight was 160lbs. -On 12/14/20, the resident weight was 145lbs. -On 01/07/21, the resident weight was 131.5lbs. Review of Resident #4's Emergency Department (ED) discharge instructions dated 01/06/21 revealed the resident weighed 128.7lbs. Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:48am	D 273		

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revealed the NP always asked for the residents weights and vitals during the resident telehealth visits.

Telephone interview with a medication aide (MA) on 01/13/21 at 1:05pm revealed:
-Personal care aides (PCA) would know if a resident was losing weight.
-The PCA was supposed to let us know of decreased resident weights.
-It was the MAs responsibility to inform the SCC of decreased resident weights.

Telephone interview with Resident #4's NP on 01/14/21 at 2:58pm revealed:
-She had not been notified that Resident #4 had lost 13.5lbs in 24 days.
-She had written an order to be notified of any weight loss greater than 3lbs.

Telephone interview with the Administrator on 01/15/21 at 11:46am revealed:
-The facility staff were going to reweigh all the residents in the building.
-They were going to ensure the scales were calibrated "right".
-When staff had been weighing residents they may not have weighed Geri-chairs and wheelchairs accurately.
-It was the SCC's responsibility to pull a monthly weight variance report and notify the primary care provider (PCP) of any significant weight changes.
-The SCC was new and they were trying to get the SCC trained.
-The SCC had started in the position "3 to 4 weeks ago."
-The last weight variance report had been pulled in October 2020.
-She was not sure if a weight variance report had been pulled in November 2020.

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-She "should have" pulled the weight variance reports for November and December 2020 since she did not have an SCC.

4. Review of Resident #2's current FL-2 dated 12/29/20 revealed diagnoses included Alzheimer's Disease, COVID-19 pneumonia, migraines, osteoporosis, and primary progressive aphasia.

Review of Resident #2's entries on the facility's weight variance report dated 11/01/20 to 01/13/21 revealed:
-On 11/08/20, the resident weight was 117lbs.
-On 12/14/20, the resident weight was 120lbs.
-On 01/13/21, the resident weight was 105.5lbs

Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:48am revealed the Nurse Practitioner (NP) always asked for the residents weights and vitals during the resident telehealth visits.

Telephone interview with a medication aide (MA) on 01/13/21 at 1:05pm revealed:
-Personal care aides (PCA) would know if a resident was losing weight.
-The PCA was supposed to let us know of decreased resident weights.
-It was the MAs responsibility to inform the SCC of decreased resident weights.

Telephone interview with a consultant nurse from a local home health agency on 01/11/21 at 12:45pm revealed:
-She had visited Resident #2 to complete an initial assessment on 01/05/21 around 1:30pm.
-Resident #2 was very quiet and was a poor "historian."

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-Resident #2's breakfast and lunch plates were still on the bedside table.
-It appeared that Resident #2 had only eaten a bite or two off each plate.
-She was very concerned that Resident #2 was not getting enough food to eat and was losing weight.
-She reported her concern related to Resident #2 not eating and losing weight to the staff.

Telephone interview with Resident #2's NP on 01/14/21 at 2:58pm revealed:
-She had not been notified by facility staff about any of the residents losing a significant amount of weight.
-The facility staff were responsible for prompting the residents to eat.

Telephone interview with the Administrator on 01/15/21 at 11:46am revealed:
-The facility staff were going to reweigh all the residents in the building.
-They were going to ensure the scales were calibrated "right".
-When staff had been weighing residents they may not have weighed Geri-chairs and wheelchairs accurately.
-It was the SCC's responsibility to pull a monthly weight variance report and notify the PCP of any significant weight changes.
-The SCC was new and they were trying to get the SCC trained.
-The SCC had started in the position "3 to 4 weeks ago."
-The last weight variance report had been pulled in October 2020.
-She was not sure if a weight variance report had been pulled in November 2020.
-She "should have" pulled the weight variance reports for November and December 2020 since

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D 273	Continued From page 33 she did not have an SCC. _____ The facility failed related to bruising of a resident's thighs discovered three days before sending the resident (#13) for hospital evaluation and diagnosed with a hip fracture resulted in serious and substantial risk of serious injury to Resident #13 and constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/19/21 for this violation.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the	D 276		

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D 276	Continued From page 34 facility failed to implement physician's orders for 1 of 6 sampled residents related to checking oxygen saturation levels for a resident (Resident #11) who had tested positive for COVID-19 and was showing signs of declining health. The findings are: Review of Resident #11's current FL-2 dated 12/15/20 revealed there were no diagnoses included on the FL-2. Review of the facility's list of COVID-19 positive residents revealed Resident #11 received a positive COVID-19 test result on 12/30/20. Review of Resident #11's triage note dated 01/07/21 revealed a physician's order to check oxygen saturation every hour for four hours. Review of Resident #11's January 2020 electronic Medication Administration Record (eMAR) revealed: -There was no computer-generated entry dated 01/07/21 to check oxygen saturation every hour for 4 hours. -There was a computer-generated entry to check vital signs, including oxygen saturation, every shift if resident started displaying respiratory symptoms, fever greater than 99.6, or difficulty breathing. -There was documentation that Resident #11 had vital signs checked for 14 of 20 shifts from 01/01/21 to second shift on 01/07/21. -From 01/01/21 to 01/07/21, Resident #11's oxygen saturation ranged from 91% to 98%. -The last documented oxygen saturation for Resident #11 was recorded on first shift on 01/07/21 with a reading of 93% with no other readings documented for that day.	D 276		

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D 276	Continued From page 35 Review of Resident #11's January 2020 Treatment Administration Record (TAR) revealed: -There was no computer-generated entry to check Resident #11's oxygen saturation every hour for four hours on 01/07/21. -There was no documentation that Resident #11's oxygen saturation was checked every hour for four hours on 01/07/21. Telephone interview with a personal care aide (PCA) on 01/19/21 at 11:57pm revealed: -She worked on second shift on 01/07/21 when Resident #11 was sent to the hospital. -She could tell Resident #11 was "not feeling good" and his "oxygen level was down." -The PCAs had started helping check vital signs because the medication aides (MA) were busy. -She did not remember checking an oxygen saturation on Resident #11 on 01/07/21. -She did not "usually" check the oxygen saturation for the residents unless the MAs needed help. Telephone interview with a second PCA on 01/20/21 at 4:15pm revealed: -She worked on second shift on 01/07/21 when Resident #11 was sent to the hospital. -She did not remember checking an oxygen saturation on Resident #11 on 01/07/21. Telephone interview with a MA on 01/19/21 at 9:00am revealed: -Resident #11 had a slow decline before he was sent to the hospital on 01/07/21. -The MAs were responsible for checking vital signs according to the eMAR. -The MAs would not know to check the vital signs unless there was an order on the eMAR.	D 276		

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Telephone interview with the Special Care Coordinator (SCC) on 01/15/21 at 11:29am revealed:
-She was working in the facility on 01/07/21 when Resident #11 was sent to the hospital.
-He was walking around earlier in the day.
-He was sent to the hospital because they could not get an oxygen saturation reading during the second shifts rounds.
-Each resident had their vital signs checked at the beginning of each shift.
-She did not know Resident #11 had an order to have oxygen saturation levels checked every hour for 4 hours.
-The order to check the oxygen saturation needed to be processed and verified by her or the Administrator before the MAs would know to check the oxygen saturation more frequently than once each shift.
-She did not know why the order was not processed.
-She or the Administrator were responsible for verifying all orders for the eMAR.
-She or the Administrator were responsible for auditing the orders when the order was verified to ensure accuracy of the eMAR.
-If the oxygen saturations were checked according to the order for Resident #11 then the results would have been on the eMAR.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm and 01/15/21 at 1:55pm revealed:
-She had two telemedicine visits with Resident #11 while he was in the facility.
-She completed her telemedicine visits in the afternoon on 01/07/21 around 3:00pm because she worked with the SCC and she worked second shift on 01/07/21.
-The facility had sent vital signs for Resident #11

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to her during the day and Resident #11's oxygen saturation was 92%.
-She gave the facility an order to check Resident #11's oxygen saturation every hour for 4 hours.
-She expected the facility to implement the order immediately.
-The last vital sign documented on the eMAR was recorded on 01/07/21 at 11:19am.
-The facility contacted her on 01/07/21 at 6:15pm and informed her that they could not get an oxygen saturation reading for Resident #11 and his blood pressure was 84/40.
-She told the facility to send Resident #11 out to the hospital immediately.
-Resident #11 would have died if the facility did not send him to the hospital.

Review of facility's communication log with the facility's Nurses Practitioner (NP) on 01/07/21 revealed the Administrator contacted the NP at 6:17pm that Resident #11 had a blood pressure of 84/40 and his oxygen saturation was not reading.

Telephone interview with a paramedic from the local emergency medical services (EMS) on 01/11/21 at 3:13pm revealed:
-EMS transported Resident #11 to the hospital on 01/07/21 around 6:30pm.
-Resident #11 was having a hard time breathing.
-Resident #11 "appeared" septic by the time he arrived at the local emergency room.
-She was not sure how long he had laid in his bed without someone checking on him.
-She believed it would have taken several hours for Resident #11 to become "septic."

Review of the EMS report for Resident #11 on 01/07/21 revealed:
-The facility called EMS at 6:19pm on 01/07/21.

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-Resident #11 was unresponsive and in acute respiratory distress.
-The staff reported that Resident #11 was only in respiratory distress approximately "five minutes" prior to placing the call to EMS.
-Resident #11 was shaking, groaning, and moaning with his eyes shut when EMS arrived.
-Resident #11 had shallow respirations with oxygen saturation in the mid-high 80s.
-Resident #11 continued to decline during transport with blood pressure and oxygen saturation decreasing with increased difficulty breathing.

Review of Resident #11's hospital admission records dated 01/08/21 revealed:
-Resident #11 had a past medical history that included dementia, dyslipidemia, hypothyroidism, and a transient ischemic attack.
-He was admitted to the hospital on 01/07/21 and diagnosed with COVID-19 pneumonia with acute on chronic hypoxemic respiratory failure and a small peripheral pulmonary embolism.

Telephone interview with the Administrator on 01/15/21 at 1:55pm and 01/19/21 at 3:30pm revealed:
-The telemedicine visits with the NP were scheduled on 01/07/21 starting during second shift around 3:30pm.
-The SCC worked with the NP during the telemedicine visits.
-All orders had to go through the order processing procedure including the order to check oxygen saturations for Resident #11.
-The SCC could take a verbal order to make the process faster.
-She or the SCC were responsible for entering and verifying the orders to appear on the eMAR.
-The MAs were responsible for checking vital

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 39 signs if a resident had an order to check more than once per shift. -She did know why the order to check the oxygen saturation every hour for four hours was not on the eMAR -She administered medications on 01/07/21 and had the PCA check vital signs. -The vital signs were checked for each resident at the beginning of each shift. -The PCA told her at 5:40pm on 01/07/21 that she could not get an oxygen saturation reading on Resident #11. -This was the first time she had heard that Resident #11 was having trouble breathing. -She sent the NP a message and then called EMS to come pick up Resident #11. _____ The facility failed to ensure physician orders were implemented for Resident #11 who had an order to measure oxygen saturation levels every hour for 4 hours because Resident #11 was having difficulty breathing and had tested positive for COVID-19. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/19/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 8, 2021.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes:	D 310		

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D 310	Continued From page 40 (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews, and record reviews, the facility failed to ensure nutritional supplements were served as ordered by the physician to 2 of 4 sampled residents (#1 and #4). The findings are: 1. Review of Resident #4's current FL2 dated 11/01/20 revealed: -Diagnoses included severe stage Alzheimer's disease, weight loss, vision loss, history of syncope, blood pressure instability, and bipolar disorder. -The resident was constantly disoriented. -There was an order for supplement shakes twice daily. Review of Resident #4's Resident Register revealed an admission date of 11/20/20. Review of Resident #4's Care Plan dated 11/24/20 revealed the resident was totally dependent on staff for eating. Review of Resident #4's Nurse Practitioner's (NP) order dated 12/18/20 revealed begin high protein shakes three times a day.	D 310		

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Observation of Resident #4 during the initial tour on 01/06/21 at 9:54am revealed:
-The resident was lying in bed.
-There was an uneaten plate of scrambled eggs, 1 piece of bacon, and a piece of toast with an unopened pack of jelly and butter on the wall heating/cooling unit beside the head of the resident's bed.
-There was a half cup of clear amber tinged liquid in a 10 oz. sized cup on the windowsill to the left of the head of Resident #4's bed.
-The plate of food and beverage cup were out of reach of Resident #4.
-There was not a supplement shake in the room.

Observation of the food and beverage carts sent out from the kitchen for lunch meal service delivery on 01/06/21 at 12:20pm revealed there were no supplement shakes on either cart.

Observation of Resident #4 on 01/06/21 at 12:46pm revealed:
-The resident was lying in bed in her room.
-Staff delivered Resident #4 a disposable plate with food wrapped in plastic wrap.
-A supplement shake was not delivered to the resident.

Review of Resident #4's December 2020 electronic Treatment Administration Record (eTAR) revealed:
-There was an entry for supplemental shakes three times a day scheduled at 7:00am, 11:30am, and 5:00pm.
-There was documentation Resident #4 received supplement shakes from 12/27/20 to 12/31/20 three times a day.

Review of Resident #4's January 2021 eTAR dated 01/01/21 to 01/13/21 revealed:

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-There was an entry for supplemental shakes three times a day scheduled at 7:00am, 11:30am, and 5:00pm.
-There was documentation Resident #4 received supplement shakes from 01/01/21 to 01/12/21 three times a day.

Review of Resident #4's entries on the facility's weight variance report dated 11/01/20 to 01/13/21 revealed:
-On 11/12/20, the resident weight was 160lbs.
-On 12/14/20, the resident weight was 145lbs.
-On 01/07/21, the resident weight was 131.5lbs.
-According to the facility's weights, Resident #4 lost 13.5lbs in 24 days.

Review of Resident #4's Emergency Department (ED) discharge instructions dated 01/06/21 revealed the resident weighed 128.7lbs.

Telephone interview with a medication aide (MA) on 01/11/21 at 11:10am revealed she did not know for sure if Resident #4 had been getting supplement shakes.

Telephone interview with a personal care aide (PCA) on 01/11/21 at 2:11pm revealed:
-Resident #4 only received food and beverages at meals.
-Resident #4 never got supplement shakes.

Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:48am revealed Resident #4 was supposed to get supplement shakes three times a day.

Telephone interview with an MA on 01/13/21 at 1:05pm revealed:
-She was not sure why Resident #4 had not received a supplement shake on 01/06/21 at

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breakfast and lunch.
-On 01/06/21, we were "so short staffed" and which may have been the reason why Resident #4 did not get a supplement shake.

Based on interviews and record review it was determined Resident #4 was not interviewable.

Refer to the telephone interview with the Dietary Manager on 01/11/21 at 10:57am, on 01/13/21 at 10:12am, and 01/15/21 at 9:24am.

Refer to the review of the facility's list of residents who were ordered supplement shakes.

Refer to the review of the facility's supplement shake invoices dated 08/13/20 to 01/07/21.

Refer to the review of the U.S. National Library of Medicine National Institutes of Health article entitled "An approach to the management of unintentional weight loss in elderly people" dated 03/15/05.

Refer to the telephone interview with a medication aide (MA) on 01/11/21 at 11:08am.

Refer to the telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:50am.

Refer to the telephone interview with a MA on 01/13/21 at 1:07pm.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

2. Review of Resident #1's current FL2 dated 07/23/20 revealed:
-Diagnosis included Alzheimer's, Diabetes, and hypertension.

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D 310	Continued From page 44 -There was a physician's order for a supplement shake (nutritional supplement) 4 oz two times daily with meals. Observation during the initial tour on 01/06/21 at 9:38am revealed: -Resident #1 was sitting in a recliner in her room with her eyes closed. -There was an uneaten plate of eggs, sausage, and bread on a table in front of Resident #1. -There was a cup of water on the bedside table. -There was not a supplemental shake in the room. Review of Resident #1's December 2020 electronic Treatment Administration Record (eTAR) revealed: -There was an entry for supplement shakes 4oz two times daily with meals with administration times of 8:00am and 5:30pm. -There was documentation the shakes were administered two times daily on 12/01/20 - 12/13/20, and 12/17/20 - 12/31/20 at 8:00am and 5:30pm. -There was documentation the shakes were administered one time on 12/14/20 at 8:00am, not administered on 12/14/20 at 5:30pm and not administered 12/15/21 - 12/16/21 due to "waiting on order" "has been ordered". Review of Resident #1's January electronic Treatement Administration Record (eTAR) dated 01/01/21 to 01/13/21 revealed there was an entry for supplement shakes 4 oz two times daily with meals with administration times of 8:00am and 5:30pm and documentation the shakes were administered correctly. Review of the facility's Weight Variance Report for 11/10/20 to 01/13/21 revealed Resident #1	D 310		

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weighed 149.0 lbs. on 11/08/20 and 140.0 lbs. on 01/07/21 for a loss of 9 lbs.

Telephone interview with the Hospice Nurse for Resident #1 on 01/15/21 at 9:30am revealed:
-The supplement shakes were standard protocol for the facility.
-The Medication Aides should be administering the shakes as ordered.

Based on interviews and record review it was determined Resident #1 was not interviewable.

Refer to the telephone interview with the Dietary Manager on 01/11/21 at 10:57am, on 01/13/21 at 10:12am, and 01/15/21 at 9:24am.

Refer to the review of the facility's list of residents who were ordered supplement shakes.

Refer to the review of the facility's supplement shake invoices dated 08/13/20 to 01/07/21.

Refer to the review of the U.S. National Library of Medicine National Institutes of Health article entitled "An approach to the management of unintentional weight loss in elderly people" dated 03/15/05.

Refer to the telephone interview with a medication aide (MA) on 01/11/21 at 11:08am.

Refer to the telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:50am.

Refer to the telephone interview with a MA on 01/13/21 at 1:07pm.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

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Telephone interview with the Dietary Manager on 01/11/21 at 10:57am, on 01/13/21 at 10:12am, and 01/15/21 at 9:24am revealed:
-She was responsible for keeping the supplement shakes in stock.
-The supplement shakes were stored in the facility kitchen.
-She ordered 2-3 cases a week of supplement shakes.
-There were 75 shakes in a case.
-She could only reorder shakes if her inventory got down to a certain point.
-"If I have so many in stock, I can't order more."
-"I don't know why I have left overs but I do."
-The medication aides (MA) were responsible for passing out supplement shakes to residents who had orders for supplement shakes.
-The supplement shakes were scheduled to be given out at mealtimes.
-"I don't know if they are being given out."
-She usually asked for an updated list of residents who were supposed to receive supplement shakes "every couple of months."

Review of the facility's list of residents who were ordered supplement shakes revealed:
-There were twelve residents on the list who had orders for supplement shakes.
-Ten residents out of 12 residents was ordered supplement shakes 3 times a day.
-One resident out of 12 residents was ordered supplement shakes 2 times a day.
-One resident out of 12 residents was ordered 1 supplement shake a day.
-If all 12 residents received their shakes as ordered 231 shakes would be needed for a 7 day supply.

Review of the facility's supplement shake invoices

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dated 08/13/20 to 01/07/21 revealed:
-There were a total of 300 supplement shakes ordered for the month of August 2020.
-There was a total of 150 supplement shakes ordered for the month of September 2020.
-There was a total of 225 supplement shakes ordered for the month of October 2020.
-There was a total of 150 supplement shakes ordered for the month of November 2020.
-There was a total of 225 supplement shakes ordered for the month of December 2020.
-There were no supplement shakes ordered on the facility's 01/07/21 order.

Telephone interview with a medication aide (MA) on 01/11/21 at 11:08am revealed:
-The MAs were responsible for making sure residents received their supplement shakes.
-The supplement shakes were kept in the kitchen.
-The supplement list in the kitchen was not accurate.
-She had to pull a list from the computer to have an accurate list.
-The supplements would come up as a treatment and "pop" with the resident's medications.
-Supplements were not being put out on the food carts by dietary staff.
-When the dining room was open, supplement shakes had been given out.
-She went to the kitchen to get supplements for the resident's that were supposed to have them on her assigned hall.

Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:50am revealed:
-The MAs were responsible for letting the kitchen know which residents had orders for the shakes.
-A list of residents with orders for supplement shakes was displayed in the kitchen.

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-She had updated the supplement list in the kitchen "a couple days ago."
-The dietary staff placed the shakes on the dietary trays with the meals.
-The facility pharmacy placed orders for supplement shakes on the eTARs.

Telephone interview with a MA on 01/13/21 at 1:07pm revealed:
-A list of residents receiving supplement shakes was posted in the kitchen.
-The kitchen would place the shakes on the beverage cart.
-On 01/06/21 the facility had been "very" short staffed and that's why the shakes were not given out to the residents.
-Normally if the MA did not see the shakes on the beverage cart she would go to the kitchen and get them.

Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed:
-The MAs were responsible for going to the kitchen and getting the shakes and delivering them to the residents.
-The MAs should be watching the residents drink the supplemental shakes before documenting the administration.

Review of the U.S. National Library of Medicine National Institutes of Health article entitled "An approach to the management of unintentional weight loss in elderly people" dated 03/15/05 revealed:
-Weight loss in elderly people can have a deleterious effect on the ability to function and on quality of life and is associated with an increase in mortality over a 12-month period.
-Weight loss of 4%-5% or more of body weight within 1 year, or 10% or more over 5-10 years or

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D 310	Continued From page 49 longer, is associated with increased mortality or morbidity or both. -Voluntary weight loss among elderly patients is also associated with increased risk of death and of hip fracture, which highlights the importance of maintaining weight with age. _____ The failure of the facility to serve supplement shakes as ordered for two residents (#1 and #4) resulted in a 13.5lb weight loss in 24 days (#4) and a 9lb weight loss (#1) and this amount of weight loss in the elderly is associated with increased mortality and morbidity and was detrimental to the health, safety, and welfare of Residents #1 and #4 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/14/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 8, 2021.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the rights of all residents in a Special Care Unit (SCU) rights	D 338		

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were maintained and residents were free from neglect related to not receiving appropriate assistance during the meal service during in-room dining, after stopping communal dining, resulting weight loss for 31 of 48 residents.

The findings are:

Observation during the initial tour of the 100 hall on 01/06/21 from 9:38am to 10:20am revealed:
-At 9:38am there was a resident sitting in a recliner with her eyes closed in room #100.
-There was a plate of uneaten scrambled eggs, sausage, and bread on a bedside table.
-There was no staff in the room.
-At 9:45am there was a resident sitting in a recliner in room #108.
-There was a paper plate with uneaten eggs, sausage, and bread on a tray in front of her.
-The resident was awake but did not respond when spoken to.
-There was no staff in the room.
-At 9:50am there was a resident lying in bed with their eyes closed in room #112.
-There was an uneaten plate of eggs, sausage, and bread with an unopened pack of jelly and butter on the windowsill.
-There was no staff in the room.
-At 9:51am there was a resident lying in bed with their eyes closed in room #108.
-There was an uneaten plate of scrambled eggs, 1 piece of bacon, and a piece of toast with an unopened pack of jelly and butter on the wall heating unit beside the head of the resident's bed.
-There was no staff in the room.
-At 9:54am there was a resident sitting in a chair with their eyes closed in room #108.
-There was an uneaten plate of scrambled eggs, 1 piece of bacon, and 3/4 piece of toast with an unopened pack of jelly and butter on the seat of

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the rollator walker pulled up in front of the resident's chair.
-There was no staff in the room.
-At 10:14am there was a resident lying in bed with their eyes closed in room #109.
-There was a plate of uneaten eggs, sausage, and bread on a chair bedside the bed.
-There was no staff in the room.

Review of the facility's Weight Variance Report for 11/01/20 - 01/13/21 revealed:
-There was documentation for monthly weights for 48 residents.
-There was documentation that 31 residents had weight loss ranging from 3 lbs. - 28.5 lbs.
-There was documentation that one resident weighed 199.0 lbs. on 12/14/20 and 193.0 lbs. on 01/13/21 for a loss of 6 lbs.
-There was documentation that a second resident weighed 123.0 lbs. on 11/08/20 and 113.50 lbs. on 01/07/21 for a loss of 9.5 lbs.
-There was documentation that a third resident weighed 125.0 lbs. on 12/14/20 and 114.50 lbs. on 01/07/21 for a loss of 10.5 lbs.
-There was documentation that a fourth resident weighed 189.0 lbs. on 12/14/20 and 174.5 lbs. on 01/07/21 for a loss of 14.5 lbs.
-There was documentation that a fifth resident weighed 125.0 lbs. on 11/08/20 and 102.0 lbs. on 01/13/21 for a loss of 23.0 lbs.
-There was documentation that a sixth resident weighed 160.0 lbs. on 11/12/20 and 131.50 lbs. on 01/07/21 for a loss of 28.5 lbs.

Telephone interview with a resident's family member on 01/07/21 at 9:52am revealed:
-He had a window visit with a resident on 01/03/21 at 1:30pm.
-The resident was in a recliner in her room and her uneaten lunch was on the bedside table.

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KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

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-He knew lunch was served between 11:30am and 12:30pm.
-He waited at the window for 45 minutes looking through the window and staff never attempted to assist her with her meal, warm up her plate of food or bring her other items to eat.
-He thought that not being assisted with meals had happened before.
-He thought the resident looked like she had lost weight since he had seen the resident last.
-The resident looked "thin".

Telephone interview with a Medication Aide (MA) on 01/08/21 at 12:44pm and 1:10pm revealed:
-The food delivered to the residents rooms was "not being touched" even by residents who could feed themselves.
-She had told the Administrator the residents were not eating their meals.
-They did not have enough staff to feed everybody.
-Personal Care Aides (PCA) should be going back into the residents' rooms to continue to assist them with their meals.
-She did not know if the PCAs were doing that as the facility was "severely short staffed".

Telephone interview with a Personal Care Aide (PCA) on 01/08/21 at 2:15pm revealed:
-The PCA had found uneaten plates of food from all three meals in most of the residents' rooms.
-The facility had a lot of staff resign and the facility had been extremely short staffed.

Telephone interview with a second MA on 01/11/21 at 11:08am revealed:
-"It was upsetting" to see the amounts of food being left on the plates being uneaten.
-When the residents began eating in their rooms, there was more food being left on the plates.

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D 338	Continued From page 53 Telephone interview with a third MA on 01/13/21 at 1:05pm revealed: -The residents required more assistance due to eating their meals in their rooms instead of the dining room. -Assisting the residents with their meals was slower when the facility was short staffed. Telephone interview with a consultant nurse from a local home health agency on 01/11/21 at 12:45pm revealed: -She had visited with a resident to complete an initial assessment on 01/05/21 around 1:30pm. -The resident's breakfast and lunch plates were still on the bedside table. -It appeared that the resident had only eaten a bite or two off each plate. -She was very concerned that the resident was not getting enough food and was losing weight. -She reported her concern related to the resident needing feeding assistance to the staff. Telephone interview with a paramedic from the local emergency medical services (EMS) on 1/11/21 at 3:13pm revealed: -EMS entered the facility on 12/27/20 a little after 3:00pm to transport a resident to the hospital. -The breakfast plate from the morning was still on the resident's bedside table untouched. Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:50am revealed: -She thought the residents had lost their appetite and taste due to being ill with COVID-19. -She had not watched the PCA's assisting residents with meals. -If a resident would not eat the PCA would inform the MA and then they would attempt to "get soup	D 338		

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down".
-She was not aware there had been food left on plates.
-The facility Nurse Practitioner had been informed about all the weights as they provided that information to her when she was in the facility.

Telephone interview with the SCC on 01/15/21 at 11:30am revealed:
-She had not known about the weight "discrepancies" until 01/13/21.
-The MAs look at the weight variance report and would then inform the SCC.
-She did not think the staff was clearing the scale before weighing a resident thus giving an inaccurate weight.

Telephone interview with the Administrator on 01/14/21 at 2:15pm revealed:
-Floor staff could not be in every room to assist with all meals so management was also assisting.
-Loss of taste happened with the COVID-19 virus and they might have been why the residents were not eating well.
-Staff would continuously offer drinks and snacks to residents.
-The facility had 9 staff members resign and 20 staff members tested positive for COVID-19.
-The facility's corporate office would not allow agency staff or staff from sister facilities to work in the facility.

Telephone interview with the Administrator on 01/15/21 at 11:46am revealed:
-She thought the discrepancies on the weight variance report were due to staff confusion regarding the weight of a wheelchair vs a geriatric chair.
-The SCC was responsible for reviewing the

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report monthly, but she was newly hired and in training.
-She "assumed" the previous SCC reviewed the report in October 2020 and placed it in the doctor's file.
-She should have reviewed the report in November 2020 as there had not been a SCC.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed:
-She was not aware of the wide spread weight loss in the facility.
-She knew the facility had been short staffed.
-Residents with a diagnosis of dementia would require more assistance than usual due to eating in their rooms versus eating in the dining room with supervision.
-When she monitored the residents' laboratory results "everyone" seemed to be low in protein and calcium.

_____

The facility failed to ensure rights were maintained and all residents in a Special Care Unit were free from neglect related to not receiving appropriate assistance during the meal service during in room dining when stopping communal dining which resulted in weight loss for 31 of 48 residents. This failure was detrimental to all the residents and constitutes a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S.131D-34 on 01/08/21 for this violation.

CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 8, 2021.

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D 344	10A NCAC 13F .1002(a) Medication Orders	D 344		

10A NCAC 13F .1002 Medication Orders
(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to clarify orders with the prescribing practitioner for 1 of 8 sampled residents (#11) related to an order for mirtazapine (used to treat depression and anxiety) from the resident's admission orders.

The findings are:

Review of Resident #11's current FL-2 dated 12/15/20 revealed:
-There were no diagnoses included on the FL-2.
-There was an order for mirtazapine soltab 15mg take half tablet daily at bedtime.

Review of Resident #11's Resident Register revealed an admission date of 12/21/20.

Review of Resident #11's December 2020 and January 2021 electronic Medication Administration Record (eMAR) revealed there

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was no computer-generated entry for mirtazapine.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/15/21 at 12:50pm revealed:
-The pharmacy received an order for mirtazapine soltabs on an FL-2 faxed to the pharmacy when Resident #11 was admitted to the facility.
-The medication order was written for 15mg tablets, but the directions were to administer a half tablet to resident.
-The order was written for dissolvable tablets that could not be cut in half.
-The pharmacy was waiting on the facility to clarify the order before they would dispense the medication.

Telephone interview with a medication aide (MA) on 01/19/21 at 9:00am revealed:
-It was common for a new admission to be without medications for several days before the admission FL-2 was processed.
-The MAs were not responsible for processing physician orders.
-The Special Care Coordinator (SCC) and the Administrator were responsible for processing new physician orders.

Telephone interview withe SCC on 01/12/21 at 10:48am revealed:
-She or the Administrator was responsible for processing and verifying orders for the eMAR, including admission orders.
-She or the Administrator was responsible for getting an order clarified if needed.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/15/21 at 2:36pm revealed:
-She did not remember receiving information to

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D 344	Continued From page 58 clarify the medication order for mirtazapine for Resident #11. -Resident #11's serotonin levels may crash from stopping the mirtazapine without a taper. -The resident could experience worsening depression, having no energy, and feeling like they were "knocked out." Review of Resident #11's hospital admission record dated 01/07/21 revealed the resident reported to the emergency room with decreased baseline mental status and increased confusion along with a diagnosis of acute on chronic hypoxemic respiratory failure. Telephone interview with the Administrator on 01/15/21 at 1:55pm revealed: -She did not remember needing to get a clarification on the mirtazapine order before the pharmacy would deliver the medication. -Resident #11's admission FL-2 was faxed to the pharmacy on 12/23/20. -She or the SCC was responsible for processing admission orders for new residents. -The SCC had processed the admission orders for Resident #11 and was responsible for getting the clarification order.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358		

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and procedures.

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

Based on these findings, the previous Type A2 Violation was not abated.

Based on interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 8 of 14 sampled residents (Residents #2, #6, #7, #9, #11, #13, #14, #15) related to medications for prevention of blood clots (#6, #7, #9, #13), infection (#13, #14), medications for shortness of breath (#2, #15) and inflammation (#2), pain relief (#15), anxiety and depression (#11), and admission medications (#11).

The findings are:

1. Review of Resident #6's current FL2 dated 09/26/20 revealed diagnosis included vascular dementia, hypertension, and seizures.

Review of Resident #6's Resident Register revealed an admission date of 09/29/20.

Review of physicians' orders for Resident #6 revealed there was an order dated 12/31/20 to start Eliquis (blood thinner) 2.5mg, take one tablet twice daily for 10 days then discontinue.

Review of Resident #6's electronic Medication Administration Record (eMAR) for 01/01/21 - 01/11/21 revealed:
-There was an entry for Eliquis 2.5mg take one tablet by mouth twice daily for 10 days with administration times of 9:00am, 1:00pm, and

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9:00pm.
-There was documentation the Eliquis had been administered on 01/01/21 at 9:00pm.
-There was documentation the Eliquis had been administered three times daily on 01/02/21 and 01/04/21 - 01/08/21 at 9:00am, 1:00pm, and 9:00pm.
-There was documentation the Eliquis had been administered two times daily on 01/03/21 at 9:00am and 9:00pm.
-There was documentation the Eliquis had been administered one time daily on 01/09/21 and 01/10/21 at 9:00pm.
-There was documentation on 01/11/21 at 8:40am the medication was not administered due to the resident received the medication three times daily and is now out.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/12/21 at 8:26am revealed:
-The pharmacy had received an electronically signed physician's order for Resident #6 for Eliquis 2.5mg two times daily for 10 days on 01/01/21 and the medication had been dispensed to the facility on 01/01/21.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed:
-Eliquis was an anticoagulant and part of their COVID-19 protocol.
-The facility had notified her that only one resident had received too much Eliquis.
-Residents that received more than the prescribed dose of Eliquis were at risk for a brain bleed, gastrointestinal bleeding, or major bleeding if they had a fall.
-She expected the Medication Aides (MA) to administer the medications as ordered.

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Based on interviews and record review it was determined that Resident #6 was not interviewable.

Refer to the telephone interview with a Medication Aide (MA) on 01/13/21 at 1:05pm.

Refer to the telephone interview with a second MA on 01/13/21 at 2:00pm.

Refer to the telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:50am.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

Refer to the review of the facility's Medication Administration Policy and Procedure.

2. Review of Resident #7's current FL2 dated 09/30/20 revealed diagnosis included dementia, diabetes, and hypertension.

Review of Resident #7's Resident Register revealed an admission date of 10/01/20.

Review of physician's orders for Resident #7 revealed an order dated 12/31/20 to start Eliquis 2.5mg two times daily for 10 days then discontinue.

Review of Resident #7's electronic Medication Administration Record (eMAR) for 01/01/21 - 01/11/21 revealed:
-There was an entry for Eliquis 2.5mg take 1 tablet twice a day for 10 days then discontinue with administration times of 9:00am, 1:00pm, and 9:00pm.
-There was documentation the Eliquis had been administered on 01/01/21 at 9:00pm.

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-There was documentation the Eliquis had been administered three times daily 01/02/21 - 01/08/21 at 9:00am, 1:00pm, and 9:00pm.
-There was documentation the Eliquis had been administered two times daily 01/09/21 - 01/10/21.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/12/21 at 8:26am revealed the pharmacy had received an electronically signed physician's order for Resident #7 for Eliquis 2.5mg two times daily for 10 days on 01/01/21 and the medication had been dispensed to the facility on 01/01/21.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed:
-Eliquis was an anticoagulant and part of their COVID-19 protocol.
-The facility had notified her that only one resident had received too much Eliquis.
-Residents that received more than the prescribed dose of Eliquis were at risk for a brain bleed, gastrointestinal bleeding, or major bleeding if they had a fall.
-She expected the Medication Aides (MA) to administer the medications as ordered.

Based on interviews and record review it was determined that Resident #7 was not interviewable.

Refer to the telephone interview with a Medication Aide (MA) on 01/13/21 at 1:05pm.

Refer to the telephone interview with a second MA on 01/13/21 at 2:00pm.

Refer to the telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:50am.

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Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

Refer to the review of the facility's Medication Administration Policy and Procedure.

3. Review of Resident #13's current FL2 dated 09/14/20 revealed diagnosis included dementia, hypertension and osteopenia.

Review of the Resident Register for Resident #13 revealed an admission date of 09/22/20.

a. Review of physicians' orders for Resident #13 revealed there was an electronically signed order dated 12/31/20 for Eliquis 2.5mg twice daily for 10 days then discontinue.

Review of Resident #13's electronic Medication Administration Record (eMAR) for 01/01/21 - 01/18/21 revealed:
-There was an entry for Eliquis 2.5mg tablet take 1 tablet twice daily for 10 days then discontinue with administration times of 9:00am, 1:00pm, and 9:00pm.
-There was documentation the Eliquis had been administered one time on 01/01/21 at 9:00pm, and three times daily 01/02/21 - 01/08/21 at 9:00am, 1:00pm, and 9:00pm.
-There was documentation the Eliquis had not been administered on 01/09/21 - 01/10/21 with documentation of "completed" and "doesn't have".

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/21 at 8:00am revealed the pharmacy had received an electronically signed physician's order for Eliquis 2.5mg twice daily for 10 days then discontinue on 01/01/21 and had dispensed

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the medication on 01/01/21.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed:
-Eliquis was an anticoagulant and part of their COVID-19 protocol.
-The facility had notified her that only one resident had received too much Eliquis.
-Residents that received more than the prescribed dose of Eliquis were at risk for a brain bleed, gastrointestinal bleeding, or major bleeding if they had a fall.
-She expected the Medication Aides (MA) to administer the medications as ordered.

Telephone interview with the facility's Nurse Practitioner on 01/20/21 at 2:15pm revealed receiving too much Eliquis could have lead to extensive bruising around the hip as Resident #13 had a hip fracture.

Based on interviews and record review it was determined Resident #13 was not interviewable.

Refer to the telephone interview with a Medication Aide (MA) on 01/13/21 at 1:05pm.

Refer to the telephone interview with a second MA on 01/13/21 at 2:00pm.

Refer to the telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:50am.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

Refer to the review of the facility's Medication Administration Policy and Procedure.

b. Review of physicians' orders for Resident #13

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revealed there was a signed physician's order dated 01/08/21 for clindamycin 150mg capsules, take 2 capsules every 6 hours for 7 days with a start date of 01/08/21 and end date of 01/15/21.

Review of Resident #13's electronic Medication Administration Record (eMAR) for 01/01/21 - 01/18/21 revealed:
-There was an entry for clindamycin (treats infection) 150mg capsules, take 2 capsules every 6 hours for 7 days with administration times of 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was an entry to start the clindamycin on 01/08/21 and end on 01/11/21 for a total of 3 days.
-There was documentation the clindamycin had been administered every 6 hours on 01/09/21 - 01/10/21 at 12:00am, 6:00am, 12:00pm, and 6:00pm, and three times on 01/11/21 at 12:00am, 6:00am, and at 12:00pm.
-There was documentation the clindamycin had not been administered on 01/11/21 at 6:00pm due to resident being "done with medicine".

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/21 at 8:00am revealed:
-The pharmacy had received a signed faxed prescription from the facility for clindamycin 150mg capsules, give 2 capsules every 6 hours for 7 days on 01/08/21.
-The pharmacy had dispensed 56 150mg capsules of clindamycin on 01/08/21.
-The pharmacy had entered into the eMAR system the start date of 01/08/21 and end date of 01/11/21 for the clindamycin.
-The facility had the ability to edit start and end dates for medications in the eMAR system.

Telephone interview with the Special Care

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Coordinator (SCC) on 01/20/21 at 9:40am revealed:
-Resident #13 was prescribed the clindamycin because she had bitten her left index finger and punctured a pin sized hole in it.
-The pharmacy entered the start and end dates for the medications in the eMAR system but the facility was able to edit those dates.
-She had edited the start and end dates for the Clindamycin but did not know why she had.

Telephone interview with the facility's Nurse Practitioner on 01/21/21 at 2:15pm revealed:
-Resident #13 had been prescribed clindamycin after biting her left index finger to prevent osteomyelitis (infection of the bone).
-The resident not receiving the full 7 day course of clindamycin put the Resident at risk of osteomyelitis and could also contribute to a mutation and the antibiotic not working as well in the future if she required it.

Telephone interview with the Administrator on 01/21/21 at 3:38pm revealed:
-The Administrator did not know why the SCC discontinued the clindamycin order.
-She and the SCC were able to edit start and stop dates of medications in the eMAR system.
-The MAs were responsible for doing medication cart audits for 6 residents each every week and they had missed it as well.

Refer to the review of the facility's Medication Administration Policy and Procedure.

Based on interviews and record review it was determined that Resident #13 was not interviewable.

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

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D 358	Continued From page 67 12/29/20 revealed diagnoses included Alzheimer's Disease, COVID-19 pneumonia, migraines, osteoporosis, and primary progressive aphasia. Review of Resident #2's Resident Register revealed an admission date of 04/17/19. Review of facility's COVID-19 positive residents revealed Resident #2 tested positive on 12/25/20. a. Review of Resident #2's triage note dated 12/30/20 revealed a physician's order for albuterol HFA 90mcg inhale 2 puffs every 4 hours as needed for shortness of breath (used to treat lung disease and improve breathing). Review of Resident #2's December 2020 and January 2021 electronic Medication Administration Records (eMAR) revealed there was no computer-generated entry for albuterol HFA. Observation of medication on hand for Resident #2 on 01/06/21 at 1:12pm revealed there was no albuterol HFA available for administration. Review of a physician's order sheet for Resident #2 dated 10/29/20 to 01/06/21 revealed: -The physician's order sheet was not signed by the provider. -There was a computer-generated entry for albuterol HFA inhale 2 puffs every 4 hours as needed for shortness of breath with an order date of 12/31/20. -Below the entry for albuterol HFA was a note that the order was "awaiting verification." Telephone interview with a pharmacy technician from the facility's contracted pharmacy on	D 358		

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01/11/21 at 11:58am revealed:
-The pharmacy had received an electronically signed physician's order for albuterol HFA inhale 2 puff every 4 hours as needed for shortness of breathing on 12/31/20.
-The physician's order for albuterol HFA was dispensed and delivered to the facility on 12/31/20.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed:
-She did not know Resident #2 did not have an albuterol HFA inhaler available for administration.
-She had ordered the inhaler for Resident #2 because she had tested positive for COVID-19.
-The albuterol HFA was important because the medication would open the airways quickly and improve Resident #2's breathing if she had an emergency and was having trouble breathing.
-"It would be disastrous if the resident needed the inhaler and it was not available."

Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed:
-She or the Special Care Coordinator (SCC) was responsible for approving medication orders daily.
-She did not know why the physician's order sheet had a note that the order for the albuterol HFA was "awaiting verification."
-She and the SCC waited until the medication was available in the facility to approve the order.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am.

Refer to the telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm.

Refer to the telephone interview with the SCC on

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D 358	Continued From page 69 01/12/21 at 10:50am. Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm. b. Review of Resident #2's discharge summary from local hospital dated 01/01/21 revealed a physician's order for dexamethasone 2mg take 2 tablets daily for 3 days then 1 tablet daily for 3 days then a half tablet daily for 3 days then stop. Review of Resident #2's January 2021 electronic Medication Administration Record (eMAR) revealed there was no computer-generated entry for dexamethasone 2mg. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am revealed: -The pharmacy had received a faxed physician's order for dexamethasone from the facility on 01/01/21. -The order was for dexamethasone 2mg take 2 tablets daily for 3 days then 1 tablet daily for 3 days then a half tablet daily for 3 days then stop. -The order was profiled in the pharmacy computer system but was never sent to the facility. -She did not know why the order for dexamethasone was profiled. -The order was discontinued on 01/04/21 and there was no explanation why it was not sent to the facility. -She did not have documentation that the facility had called about the dexamethasone order. Telephone interview with a medication aide (MA) on 01/13/21 at 1:05pm revealed: -The MAs were not responsible for processing or approving physician orders.	D 358		

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-She only administered medications that were listed on a resident's eMAR.
-She would not know if an order was written for dexamethasone unless it showed up on the eMAR or was delivered by the pharmacy.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed:
-She did not know that Resident #2 did not receive the dexamethasone after she returned to the facility from the hospital.
-The dexamethasone was started while Resident #2 was in the hospital with COVID-19 pneumonia.
-The dexamethasone was important to decrease inflammation and irritation in the lungs.
-The dexamethasone would make it easier for Resident #2 to breath.

Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed:
-She did not know why the dexamethasone order was not processed and available to be administered to Resident #2.
-She or the Special Care Coordinator (SCC) was responsible for faxing physician orders to the pharmacy.

Refer to the telephone interview with a pharamacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am.

Refer to the telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm.

Refer to the telephone interview with the SCC on 01/12/21 at 10:50am.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

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D 358	Continued From page 71 5. Review of Resident #9's current FL-2 dated 07/23/20 revealed diagnoses included dementia, hypertension, anxiety, and hypothyroidism. Review of Resident #9's triage note dated 01/05/21 revealed a physician's order for Eliquis (blood thinner) 2.5mg take 1 tablet twice daily for 10 days and then discontinue. Review of Resident #9's January 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Eliquis 2.5mg take 1 tablet twice daily for 10 days with administration times of 9:00am, 1:00pm, and 9:00pm. -Eliquis was documented as administered from 9:00pm on 01/07/21 to 9:00am on 01/11/21 daily at 9:00am, 1:00pm, and 9:00pm. -There was documentation that Eliquis was not administered at 1:00pm on 01/07/21 because the medication was supposed to be administered twice daily only. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am revealed: -The pharmacy delivered twenty tablets of Eliquis to the facility on 01/05/21 with the directions to take 1 tablet twice daily for 10 days. -The administration times for Eliquis was 8am and 8pm. -The pharmacy was not able to see changes the facility made to the administration times. -If the administration times were different then the facility had changed the administration times. Telephone interview with a medication aide (MA) on 01/11/21 at 1:16pm revealed: -The facility's Nurse Practitioner (NP) was starting	D 358		

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Eliquis 2.5mg twice daily for ten days on all the residents that tested positive for COVID-19.
-The Administrator entered the administration times for the Eliquis as 9:00am, 1:00pm and 9:00pm instead of twice daily.
-She noticed the incorrect administration times one day while she was adminstering medications.
-The Administrator or the Special Care Coordinator (SCC) were responsible for auditing the medication cart weekly before the multi-dose packaged medication were delivered.
-She and the other MAs were responsible for auditing a few residents weekly, but they had not completed audits in awhile because they did not have time.

Telephone interview with a second MA on 01/13/21 at 1:05pm revealed:
-She did not know the Eliquis was administered to Resident #9 three times daily.
-She usually worked first shift and could not see the administration times for medications administered during second or third shift.
-She thought the Eliquis was administered at 9:00am and 1:00pm only.

Telephone interview with a third MA on 01/19/21 at 1:46pm revealed:
-She and other MAs did not notice the Eliquis was given incorrectly until the medication was running out before the order was finished.
-She was responsible for administering the medications that were due during first shift and did not know when the medications were due on another shift.

Telephone interview with the SCC on 01/12/21 at 10:50am revealed:
-A MA had told her the administration times for Eliquis were wrong on the eMAR and it needed to

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be corrected.
-She had not corrected the incorrect administration times because it had been "busy" at the facility.
-The physician order for Eliquis was sent to the pharmacy electronically by the provider and sometimes electronic prescriptions would "pop" on the eMAR before the order could be approved.
-The pharmacy was responsible for putting in the administration times.
-She should have corrected it when the MA called it out to her.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed:
-Eliquis was an anticoagulant and part of their COVID-19 protocol.
-The facility had not notified her that Resident #9 had recieved Eliquis incorrectly.
-Residents that received more than the prescribed dose of Eliquis were at risk for a brain bleed, gastrointestinal bleeding, or major bleeding if they had a fall.
-She expected the MAs to administer the medications as ordered.

Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed:
-The Eliquis had been entered into the eMAR system to be administered at 9:00am, 1:00pm, and 9:00pm by the pharmacy.
-She or the SCC were responsible for changing the administration times in the eMAR but failed to do so.
-The MAs were responsible for checking the directions on the packaging for each medication and comparing it to the eMAR before administration.

Refer to the telephone interview with a pharmacy

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technician from the facility's contracted pharmacy on 01/11/21 at 11:58am.

Refer to the telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm.

Refer to the telephone interview with the SCC on 01/12/21 at 10:50am.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

6. Review of Resident #11's current FL-2 dated 12/15/20 revealed:
-There were no diagnoses included on the FL-2 from the local hospital when the resident was admitted to the facility.
-There was an order for lorazepam (used to treat anxiety) 0.5mg take 1 tablet twice daily.
-There was an order for atorvastatin (used to treat high cholesterol) 20mg take 1 tablet daily.
-There was an order for budesonide-formoterol (used to reduce inflammation in the lungs) 160/4.5mcg inhaler inhale 2 puffs twice daily.
-There was an order for donepezil (used to treat dementia) 5mg take 1 tablet daily at bedtime.
-There was an order for famotidine (used to treat acid indigestion) 40mg take 1 tablet at bedtime.
-There was an order for levothyroxine (used to treat decreased thyroid function) 50mcg take 1 tablet daily.
-There was an order for mirtazapine soltab (used to treat anxiety, depression, and increase appetite) 15mg take half tablet daily at bedtime.
-There was an order for pantoprazole (used to treat acid reflux) 40mg take 1 tablet daily.
-There was an order for risperidone (used to treat mood disorders) 1mg take 1 tablet twice daily.
-There was an order for tamsulosin (used to treat enlarged prostate) 0.4mg take 1 capsule twice

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daily.

Review of Resident #11's Resident Register revealed an admission date of 12/21/20.

a. Review of Resident #11's December 2020 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for atorvastatin 20mg take 1 tablet daily, budesonide-formoterol 160/4.5mcg inhaler inhale 2 puffs twice daily, donepezil 5mg take 1 tablet daily at bedtime, famotidine 20mg take 2 tablets at bedtime, levothyroxine 50mcg take 1 tablet daily, pantoprazole 40mg take 1 tablet daily, risperidone 1mg take 1 tablet twice daily and tamsulosin 0.4mg take 1 capsule twice daily.
-The start date for each medication was 12/23/20.
-The first day each medication was documented as administered to Resident #11 was 12/23/20.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/15/21 at 12:50pm revealed the facility did not fax the admission FL-2 to the pharmacy to be processed until 12/23/20.

Telephone interview with a medication aide (MA) on 01/19/21 at 9:00am revealed:
-It was common for it to take a "few days" to get the medications for a new admission in the facility.
-The residents would go wihout their medications until the pharmacy delievered the resident's medications.
-Resident #11's family member brought in budesonide-formoterol and donepezil for the resident after the pharmacy notified the facility the medications could not be refilled.

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Telephone interview with the facility's Nurse Practitioner (NP) on 01/15/21 at 2:36pm revealed:
-The facility should fax the admission orders for a newly admitted resident to the pharmacy the same day the resident arrives at the facility.
-It was important for all maintenance medications to start immediately when a resident was admitted to the facility.
-Resident #11 was at an increased risk for trouble breathing associated with the missed inhaler.
-He is at an increased risk for depression, anxiety, or behaviors if he missed his mental health medications.

Telephone interview with the Administrator on 01/15/21 at 1:55pm revealed:
-Resident #11 was admitted to the facility on 12/21/20 from a local hospital.
-She or the Special Care Coordinator (SCC) was responsible for processing all new admissions to the facility.
-The SCC faxed Resident #11's FL-2 to the pharmacy on 12/23/20.
-She did not know why the FL-2 was not sent to the pharmacy on the day Resident #11 was admitted to the facility.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am.

Refer to the telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm.

Refer to the telephone interview with the SCC on 01/12/21 at 10:50am.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

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D 358	Continued From page 77 b. Review of Resident #11's December 2020 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for lorazepam 0.5mg take 1 tablet twice daily scheduled to be administered daily at 8:00am and 8:00pm with a start date of 12/23/20. -There was documentation that the medication was "on hold" beginning 12/23/20. -Lorazepam was not documented as administered from 12/23/20 to 12/31/20. Review of Resident #11's January 2021 eMAR revealed: -There was a computer-generated entry for lorazepam 0.5mg take 1 tablet twice daily scheduled to be administered daily at 8:00am and 8:00pm with a start date of 12/23/20. -There was documentation that the medication was "on hold" beginning 12/23/20. -Lorazepam was not documented as administered from 01/01/21 to 01/07/20. -There was documentation that Resident #11 was out of the facility at the hospital beginning on 01/07/21. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/15/21 at 12:50pm revealed the pharmacy never received a hard copy of the prescription from the facility to fill lorazepam for Resident #11. Telephone interview with a medication aide (MA) on 01/19/21 at 9:00am revealed: -It was common for a new admission to be without medications for several days before the admission FL-2 was processed. -She did not know why the facility never recieved the lorazepam. -The Administrator placed the medicattion order	D 358		

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on hold.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/15/21 at 2:36pm revealed:
-Resident #11 was at an increased risk for anxiety without the lorazepam.
-Resident #11 was at an increased risk of experiencing withdrawal symptoms from stopping medication abruptly including having no energy and increased depression.
-She did not remember the facility requesting a hard copy prescription for the lorazepam for Resident #11.

Telephone interview with the Administrator on 01/15/21 at 1:55pm revealed:
-She did not remember needing to get a hard copy prescription for lorazepam so the pharmacy could send the medication to the facility for Resident #11.
-The Special Care Coordinator (SCC) had processed the admission orders for Resident #11.
-The SCC was responsible for contacting the NP to get the appropriate orders for Resident #11 when he was admitted to the facility.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am.

Refer to the telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm.

Refer to the telephone interview with the SCC on 01/12/21 at 10:50am.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

c. Review of Resident #11's December 2020 and

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January 2021 electronic Medication Administration Record (eMAR) revealed there was no computer-generated entry for mirtazapine.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/15/21 at 12:50pm revealed:
-The pharmacy received an order for mirtazapine soltabs on an FL-2 faxed to the pharmacy when Resident #11 was admitted to the facility.
-The medication order was written for 15mg tablets, but the directions were to administer a half tablet.
-The order was written for dissolvable tablets that could not be cut in half.
-The pharmacy was waiting on the facility to clarify the order before they would dispense the medication.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/15/21 at 2:36pm revealed:
-She did not remember receiving information to clarify the medication order for mirtazapine for Resident #11.
-Resident #11's serotonin levels may crash from stopping the mirtazapine without a taper.
-The resident could experience worsening depression, having no energy, and feeling like they were "knocked out."

Telephone interview with the Administrator on 01/15/21 at 1:55pm revealed:
-She did not remember needing to get a clarification on the mirtazapine order before the pharmacy would deliver the medication.
-The Special Care Coordinator (SCC) had processed the admission orders for Resident #11.
-The SCC was responsible for contacting the NP to clarify the orders for Resident #11 when he

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D 358	Continued From page 80 was admitted to the facility. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am. Refer to the telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm. Refer to the telephone interview with the SCC on 01/12/21 at 10:50am. Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm. 7. Review of Resident #14's current FL-2 dated 08/21/2020 revealed diagnoses included advanced dementia with behavioral disorder, atrial fibrillation, coronary artery disease, diabetes, and Chronic Obstructive Pulmonary Disease (COPD) Review of Resident #14's Resident Register revealed and admission date of 10/24/19. Review of Resident #14's physician order dated 01/14/21 revealed a physician's order for azithromycin (an antibiotic used to treat infections) 250mg take 1 tablet by mouth daily for 4 days. Review of Resident #14's January 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for azithromycin 250mg take 1 tablet daily for four days scheduled to be administered daily at 9:00am from 01/15/21 to 01/18/21. -There was documentation that the azithromycin 250mg was not administered on 01/15/21.	D 358		

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-There was documentation that the azithromycin 250mg was not administered on 01/16/21 because it was the "wrong shift."
-There was documentation that the order for azithromycin 250mg was placed on hold and not administered on 01/17/21 and 01/18/21.
-There was a computer-generated entry for azithromycin 250mg take 2 tablets today then take 1 tablet daily for 4 days scheduled to be administered daily at 11:00am with a start date of 11/19/21.
-Azithromycin 250mg was documented as administered on 01/19/21 at 11:00am.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/20/21 at 2:14pm revealed:
-The pharmacy dispensed 4 tablets of azithromycin 250mg to the facility on 01/15/21 for Resident #14.
-The physician order was written on 01/15/21 for azithromycin 250mg take 1 tablet daily for 4 days.
-The pharmacy cannot put an order "on hold."
-If a medication order was put on hold then the facility would have to make the change on the eMAR.

Telephone interview with a medication aide (MA) on 01/21/21 at 11:22am revealed:
-Resident #15 was supposed to start azithromycin 250mg when she returned from the hospital on 01/14/21.
-She had tried to administer the azithromycin 250mg on 01/17/21 but did not find the medication available in the medication cart.
-She called the pharmacy and was told the medication was delivered to the facility.
-She told the Special Care Coordinator (SCC) and the Administrator that the medication was not available, and she could not find the medication

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in the facility.
-The SCC and the Administrator were responsible to make sure the medications were available to administer.

Telephone interview with a pharmacy technician from the facility's contracted back-up pharmacy on 01/22/21 at 1:21pm revealed a physician order for azithromycin 250mg take 2 tablets today then 1 tablet daily for 4 days was filled on 01/18/21 and picked up by the facility on 01/19/21.

Telephone interview with the SCC on 01/21/21 at 3:13pm revealed:
-Resident #14 was not COVID-19 positive but was diagnosed with pneumonia recently at the local emergency room.
-She remembered signing the delivery ticket from the pharmacy for the azithromycin, but she did not see the medication in the bag.
-She called the facility's Nurse Practitioner (NP) to call in a new order at the facility's back-up pharmacy

Telephone interview with the facility's NP on 01/21/21 at 2:01pm revealed:
-Resident #14 has COPD.
-Resident #14 was at an increased risk of worsening pneumonia and having difficulty breathing if he did not receive his antibiotic.

Telephone interview with the Administrator on 01/21/21 at 3:44pm revealed:
-The facility's contracted pharmacy said the azithromycin for Resident #14 was delivered to the facility on 1/15/21 but the medication was not in the facility.
-The SCC had signed the pharmacy delivery ticket to receive the azithromycin when the medication was delivered.

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-The facility's NP was notified to send in a new physician order for the azithromycin at the facility's back-up pharmacy.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am.

Refer to the telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm.

Refer to the telephone interview with the SCC on 01/12/21 at 10:50am.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

8. Review of Resident #15's current FL-2 dated 09/18/20 revealed diagnoses included dementia, schizophrenia, hemochromatosis, and hypertension.

Review of facility's COVID-19 positive list dated 01/06/21 revealed Resident #15 had tested positive for COVID-19 on 01/05/21.

a. Review of Resident #15's triage note dated 01/10/21 revealed a signed physician order for albuterol HFA (used to open lungs and allow for easier breathing) inhale 2 puffs every 4 hours as needed for shortness of breath.

Review of Resident #15's January 2021 electronic Medication Administration Record (eMAR) revealed there was no computer-generated entry for albuterol HFA.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/21/21 at 2:14pm revealed there was no

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physician order on file at the pharmacy for Resident #15's albuterol HFA inhaler.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed:
-She did not know Resident #15 did not have an albuterol HFA inhaler available for administration.
-She had ordered the inhaler for Resident #15 because she had tested positive for COVID-19.
-The albuterol HFA was important because the medication would open the airways quickly and improve Resident #15's breathing if they had an emergency and was having trouble breathing.
-"It would be disastrous if the resident needed the inhaler and it was not available."

Telephone interview with the Administrator on 01/21/21 at 3:44pm revealed:
-She did not know Resident #15 had a physician order for albuterol HFA.
-She or the Spcial Care Coordinator (SCC) should have called the facility's NP to obtain an order for the albuterol HFA to make sure the medication was available for the resident.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am.

Refer to the telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm.

Refer to the telephone interview with the SCC on 01/12/21 at 10:50am.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

b. Review of Resident #15's physician orders dated 11/29/20 revealed an order for tramadol (a

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controlled substance used to treat pain) 50mg take 1 tablet twice daily.

Review of Resident #15's progress note dated 12/18/20 revealed a physician order to discontinue tramadol 50mg take 1 tablet twice daily and start tramadol 50mg take 1 tablet three times daily.

Review of Resident #15's December 2020 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for tramadol 50mg take 1 tablet twice daily scheduled to be administered at 8:00am and 8:00pm.
-There was documentation that tramadol 50mg was administered twice daily at 8:00am and 8:00pm from 12/01/20 to 12/26/20.
-There was a computer-generated entry for tramadol 50mg take 1 tablet daily at 8:00am, 2:00pm, and 8:00pm with a start date of 12/18/20 scheduled to be administered at 9:00am only.
-There was documentation that tramadol 50mg was not administered on 12/19/20 at 9:00am because the new order needed approval.
-There was documentation that tramadol 50mg was administered on 12/20/20 at 9:00am.
-There was a computer-generated entry for tramadol 50mg take 1 tablet three times daily at 8:00am, 2:00pm, and 8:00pm.
-Tramadol was documented as administered at 8:00am, 2:00pm, and 8:00pm from 12/27/20 to 12/31/20.

Review of Resident #15's January 2021 eMAR revealed:
-There was a computer-generated entry for tramadol 50mg take 1 tablet three times daily at 8:00am, 2:00pm, and 8:00pm scheduled to be

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administered at 8:00am, 2:00pm, and 8:00pm.
-Tramadol was administered three times daily at 8:00am, 2:00pm, and 8:00pm from 01/01/21 to 01/08/21 at 2:00pm.
-There was documentation that tramadol was not administered from 01/08/21 at 9:00pm to 01/17/21 at 8:00am because the facility was waiting on the pharmacy to receive a new physician order for tramadol.
-There was documentation that tramadol was administered on 01/17/21 at 2:00pm and 8:00pm and on 01/18/21 at 8:00am, 2:00pm, and 8:00pm.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/21/21 at 9:09am revealed:
-The pharmacy dispensed 46 tablets to the facility for Resident #15 from a physician order for tramadol 50mg take 1 tablet twice daily on 12/05/20.
-The pharmacy received an order for tramadol 50mg take 1 tablet three times daily for Resident #15 dated 12/18/20 and delivered 90 tablets to the facility on 12/19/20.
-The pharmacy delivered 9 tablets of tramadol 50mg to the facility on 01/16/21 for Resident #15.

Telephone interview with a medication aide (MA) on 01/19/21 at 1:46pm revealed:
-Resident #15's tramadol was increased to three times daily.
-Resident #15 was out of tramadol and her order could not be refilled because the refill was too soon to refill.
-Resident #15 had been out of medication for "weeks" and was having obvious signs of pain.
-The Administrator told her that she was trying to get a new hard copy for the tramadol.

Telephone interview with the Special Care

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Coordinator (SCC) on 01/21/21 at 10:56am revealed:
-Resident #15 has pain in her feet and the tramadol was ordered to treat the pain.
-She remembered signing for the 90 tablets of tramadol 50mg delivered to Resident #15 on 12/19/20 from the pharmacy.
-She put the medication in a drawer in her office because Resident #15 already had tramadol 50mg on the medication cart.
-The extra controlled substances were not locked in her office unless the office door was locked.
-The medication aides (MA) did not bring it to her attention that the medication was not available to Resident #15.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/21/21 at 2:01pm revealed:
-Resident #15 was being treated with tramadol for pain in her back.
-In December, Resident #15 rated her pain level at 10 out of 10.
-She had increased the dose of Resident #15's tramadol to 1 tablet three times daily.
-She did not know Resident #15 did not start receiving tramadol 50mg 1 tablet three times daily until 12/27/20.
-She did not know Resident #15 was not administered her tramadol from 01/08/21 to 01/09/21.
-The Administrator had called to get the order for tramadol filled two weeks early.
-Resident #15 was at an increased risk for pain and being uncomfortable if she did not receive her pain medications.
-She was worried about Resident #15 having withdrawal symptoms from stopping the medication suddenly.
-Symptoms from withdrawal included nausea, vomiting, severe pain, headache, abdominal

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D 358	Continued From page 88 cramping, and sweating. Telephone interview with the Administrator on 01/22/21 at 10:58am revealed: -She did not know Resident #15 was out of tramadol until a MA brought it to her attention on 01/08/21. -She thought the medication had ran out because the provider had increased the dose in December. -She tried to have the medication refilled but it was too early to be filled. -The NP told her the resident should have plenty of tramadol tablets remaining. -Resident #11 was out of medication until the order could be refilled. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am. Refer to the telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm. Refer to the telephone interview with the SCC on 01/12/21 at 10:50am. Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm. _____ Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am revealed: -The pharmacy entered the medication orders into the computer for the facility to verify. -The facility must verify the order before it would appear on the eMAR. -The pharmacy was responsible for entering administration times for each medication based on agreed upon times by the facility.	D 358		

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D 358	Continued From page 89 -A medication written for twice daily dosing would have an administration time of 8am and 8pm unless noted on the medication order. -The facility was responsible for adjusting medication administration times that were different than the standard times. Telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm revealed: -The provider or the facility would send a new medication order to the pharmacy to be processed. -The pharmacy entered the medication order into the computer. -The Administrator or the Special Care Coordinator (SCC) must verified the order in the computer before the medication would appear on electronic Medication Administration Record (eMAR). -The MAs were not responsible for processing or verifying medications orders for the eMAR. -The Administrator and the SCC were responsible for processing deliveries from the pharmacy because they did not verify the orders to appear on the eMAR until the medication was in the facility. -If the Administrator and the SCC were not in the facility when a medication needed to be put on the medication cart then the MA was supposed to call the Administrator or SCC to verify the medication order. -Each MA was responsible for auditing the medication cart for 4 to 5 residents weekly to make sure the resident had all medications available for administration. Telephone interview with the SCC on 01/12/21 at 10:50am revealed: -The pharmacy entered the physician orders. -She or the Administrator was responsible for	D 358		

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verifying the orders for the eMAR.
-The MAs were responsible for auditing the medication carts weekly.
-She or the Administrator was responsible for auditing the medication carts weekly.
-The pharmacy was responsible for entering the administration times on the eMAR.
-The pharmacy had entered the administration times into the eMAR system for three times daily.
-The SCC was responsible for ensuring the orders entered by the pharmacy matched the physician orders and the eMAR.
-It had been very busy at the facility and the facility had been short staffed.

Telephone interview with a second MA on 01/13/21 at 1:05pm revealed:
-She had administered Eliquis to residents.
-The MAs were only able view the administration times that were to be administered on their shift.
-The SCC and the Administrator were responsible for auditing new physician orders, the eMAR, and the medications in the medication cart.

Telephone interview with a third MA on 01/13/21 at 2:00pm revealed:
-She had administered Eliquis to residents.
-She had only been able to view the administration times during her shift when the medication "popped up" for her to administer.
-The SCC and the Administrator were responsible for new physician orders and compared the new orders with the eMAR.
-The pharmacy entered the administration times into the eMAR system and management was able to adjust the times.

Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed:
-The Eliquis had been entered into the eMAR

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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
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system to be administered at 9:00am, 1:00pm, and 9:00pm by the pharmacy.
-She or the SCC were responsible for changing the administration times in the eMAR but failed to do so.
-The MAs had been trained to read the labels on the medication bubble packs but had not done so.
-She or the SCC were responsible for looking at new orders on the eMAR to edit and approve.
-The pharmacy was responsible for entering the physician order into the computer.
-She or the SCC was responsible for approving the physician orders on the eMAR.
-Physician orders were approved daily.
-If something was wrong with the physician order then she or the SCC was responsible for manually correcting the order on the eMAR.

Review of the facility's Medication Administration Policy and Procedure dated 07/2020 revealed review all medications ordered for specific times to ensure actual administration times are compliant with physician orders and ensure all medication orders are processed and implemented based on physician orders.

_____

The facility failed to ensure medications were administered as ordered including a blood thinner to prevent blood clots to Resident #6, #7, #9, and #13, an antibiotic to Resident #13 to prevent an infection of the bone, a steroid to Resident #2 to help reduce inflammation in the lungs following a diagnosis for COVID-19 associated pneumonia , Resident #11 was not administered medications for two days following admission and never administered medications for anxiety and depression, delaying the administration of an antibiotic to Resident #14 to treat pneumonia, not providing an inhaler to improve breathing in the case of an emergency after being diagnosed with

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D 358	Continued From page 92 COVID-19 for Resident #2 and #15. The facility's failure placed the residents at substantial risk of physical harm and constitutes an unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/11/21 for this violation.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by 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: Based on interviews and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt and administration of controlled substances for 1 of 6 sampled residents (#15) who received a medication for mild to moderate pain. The findings are: Review of the facility's Medication Diversion Policy revealed: -The facility will assure that all Federal and State regulations relevant to the control of narcotic medications are followed. -Each narcotic medication must have a control count sheet for every medication card, and it must be maintained in the eMAR software system.	D 392		

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D 392	Continued From page 93 -A new narcotic sheet must be started for all new orders. -Oncoming staff should count the narcotic medication and the off-going staff should read the count on the narcotic page at the end of each shift. Review of Resident #15's current FL-2 dated 09/18/20 revealed diagnoses included dementia, schizophrenia, hemochromatosis, and hypertension. Review of Resident #15's physician orders dated 11/29/20 revealed an order for tramadol (a controlled substance used to treat mild to moderate pain) 50mg take 1 tablet twice daily. Review of Resident #15's progress note dated 12/18/20 revealed a physician order to discontinue tramadol 50mg take 1 tablet twice daily and start tramadol 50mg take 1 tablet three times daily. Review of Resident #15's December 2020 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for tramadol 50mg take 1 tablet twice daily scheduled to be administered at 8:00am and 8:00pm. -There was documentation that tramadol 50mg was administered twice daily at 8:00am and 8:00pm from 12/01/20 to 12/26/20. -There was a computer-generated entry for tramadol 50mg take 1 tablet daily at 8:00am, 2:00pm, and 8:00pm with a start date of 12/18/20 scheduled to be administered at 9:00am only. -There was documentation that tramadol 50mg was not administered on 12/19/20 at 9:00am because the new order needed approval.	D 392		

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D 392	Continued From page 94 -There was documentation that tramadol 50mg was administered on 12/20/20 at 9:00am. -There was a computer-generated entry for tramadol 50mg take 1 tablet three times daily at 8:00am, 2:00pm, and 8:00pm. -Tramadol was documented as administered at 8:00am, 2:00pm, and 8:00pm from 12/27/20 to 12/31/20. -A total of 68 tramadol 50mg tablets were documented as administered to Resident #15 from 12/01/21 to 12/31/21. Review of Resident #15's January 2021 eMAR revealed: -There was a computer-generated entry for tramadol 50mg take 1 tablet three times daily at 8:00am, 2:00pm, and 8:00pm scheduled to be administered at 8:00am, 2:00pm, and 8:00pm. -Tramadol was administered three times daily at 8:00am, 2:00pm, and 8:00pm from 01/01/21 to 01/08/21 at 2:00pm. -There was documentation that tramadol was not administered from 01/08/21 at 9:00pm to 01/17/21 at 8:00am because the facility was waiting on the pharmacy to receive a new physician order for tramadol. -There was documentation that tramadol was administered on 01/17/21 at 2:00pm and 8:00pm and on 01/18/21 at 8:00am, 2:00pm, and 8:00pm. -A total of 28 tramadol 50mg tablets were documented as administered to Resident #15 from 01/01/21 to 01/07/21. Review of Resident #15's Controlled Substance Count Sheet (CSCS) dated 12/08/20 revealed: -The quantity dispensed was 14 tablets of tramadol 50mg for Resident #15. -The quantity received was written in as 14 tablets and then correct to 15 tablets of tramadol 50mg.	D 392		

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-There was documentation that 16 tablets of tramadol 50mg was administered to Resident #15 from 12/08/21 at 8:00am to 12/15/20 at 8:00pm.

Review of Resident #15's Controlled Substance Count Sheet (CSCS) dated 12/05/20 revealed:
-The quantity dispensed was 30 tablets of tramadol 50mg for Resident #15.
-The quantity received was written in as 30 tablets of tramadol 50mg.
-There were 28 of 30 tablets documented as administered from 12/16/21 at 7:33am to 12/29/20 at 2:00pm but there was a balance of zero documented as the amount remaining.

Review of Resident #15's Controlled Substance Count Sheet (CSCS) dated 12/29/20 revealed:
-The quantity dispensed was 30 tablets of tramadol 50mg for Resident #15.
-The quantity received was written in as 30 tablets of tramadol 50mg.
-There were 29 of 30 tablets documented as administered from 12/29/21 at 7:20am to 01/08/21 at 2:00pm but there was a balance of zero documented as the amount remaining

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/21/21 at 9:09am revealed:
-The pharmacy dispensed 46 tablets of tramadol 50mg to the facility for Resident #15 on 12/05/20
-The pharmacy received an order for tramadol 50mg take 1 tablet three times daily for Resident #15 dated 12/18/20 and delivered 90 tablets to the facility on 12/19/20.
-The pharmacy delivered 9 tablets of tramadol 50mg to the facility on 01/16/21 for Resident #15.
-The pharmacy dispensed a total of 145 tablets of tramadol 50mg to the facility for Resident #15 from 12/05/20 to 01/16/21.

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D 392	Continued From page 96 Review of the pharmacy delivery records revealed: -The pharmacy dispensed 46 tablets of tramadol 50mg to the facility for Resident #15 on 12/05/20 and the medication was delivered to the facility and signed for by a MA on 12/06/20 at 12:20am. -The pharmacy dispensed 90 tablets of tramadol 50mg to the facility for Resident #15 on 12/18/19 and the medication was delivered to the facility and signed for by the Special Care Coordinator (SCC) on 12/19/20 at 2:38pm. -The pharmacy dispensed 9 tablets of tramadol 50mg to the facility for Resident #15 on 01/16/21 and the medication was delivered to the facility and signed for by a MA on 01/16/21 at 11:39pm Telephone interview with the facility's Nurse Practitioner (NP) on 01/21/21 at 2:01pm revealed: -Resident #15 was being treated with tramadol for pain in her feet. -In December, Resident #15 rated her pain level at 10 out of 10. -She had increased the dose of Resident #15's tramadol 50mg to 1 tablet three times daily. -She did not know Resident #15 was not administered her tramadol from 01/08/21 to 01/17/21. -The facility did call and try to get the order for tramadol filled two weeks early. Telephone interview with the SCC on 01/21/21 at 10:56am revealed: -Resident #15 had pain in her feet and the tramadol was ordered to treat the pain. -She remembered signing for the 90 tablets of tramadol 50mg delivered to Resident #15 on 12/19/20 from the pharmacy. -She put the medication in a drawer in her office because Resident #15 already had tramadol	D 392		

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50mg on the medication cart.
-The extra controlled substances were not locked in her office unless the office door was locked.
-She was out for several days beginning on 12/22/20 and was told her office was left opened while she was out of the facility.
-All the extra controlled substances were moved to the medication cart after it was discovered the tramadol for Resident #15 was missing.
-The MAs were responsible for counting the controlled substances and documenting the count on the CSCS.

Interview with the Administrator on 01/22/21 at 10:58am revealed:
-All controlled substances that were delivered by the pharmacy had to be checked in by a MA.
-The extra controlled substances were stored in the SCC's office in a locked filing cabinet along with a corresponding CSCS.
-She thought the 90 tablets of tramadol delivered on 12/19/20 was locked on the medication cart after the pharmacy delivered the medication.
-There should be a CSCS available on the medication cart for each package of controlled substances in the medication cart and the count was documented on the computer.
-The MAs were responsible for notifying management if the count for a controlled substance was entered in the computer three times incorrectly.
-The facility was responsible for filling out the CSCS.
-The date written on the CSCS was the date the medication was placed in the medication cart and not when the medication was dispensed by the pharmacy.
-When a controlled substance is moved from the overflow to the medication cart, the entire quantity filled by the pharmacy should be moved to the

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D 392	Continued From page 98 cart.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report suspected drug diversion of controlled substance to the pharmacy, local law enforcement, and the Health Care Personnel Registry for 1 of 1 sampled resident (#15) who was prescribed tramadol (used to treat mild to moderate pain). The findings are: Review of the facility's Medication Diversion Policy revealed: -The facility will assure that all Federal and State regulations relevant to the control of narcotic medications are followed. -If the narcotic count is incorrect, both the supervisor and the administrator must be notified immediately and every should stay in the facility until allowed to leave by the administrator.	D 399		

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-If the medication is not found or accounted for, either the Care Manager or the Administrator will report the situation to local law enforcement, Health Care Personnel Registry, the local Department of Social Services, the dispensing pharmacy, and the resident's physician.
-The Administrator will be responsible for completion of any necessary Health Care Registry twenty-four hour and five-day report.
-Staff implicated in diversion will be suspended until completion of an investigation.

Review of Resident #15's current FL-2 dated 09/18/20 revealed diagnoses included dementia, schizophrenia, hemochromatosis, and hypertension.

Review of Resident #15's physician orders dated 11/29/20 revealed an order for tramadol (a controlled substance used to treat pain) 50mg take 1 tablet twice daily.

Review of Resident #15's progress note dated 12/18/20 revealed a physician order to discontinue tramadol 50mg take 1 tablet twice daily and start tramadol 50mg take 1 tablet three times daily.

Review of Resident #15's December 2020 electronic Medication Administration Record (eMAR) revealed:
-There was a total of 68 tramadol tablets documented on the eMAR as administered to Resident #15 from 12/01/21 to 12/31/21.
-There was a computer-generated entry for tramadol 50mg take 1 tablet twice daily scheduled to be administered at 8:00am and 8:00pm.
-There was documentation that tramadol 50mg was administered twice daily at 8:00am and

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D 399	Continued From page 100 8:00pm from 12/01/20 to 12/26/20. -There was a computer-generated entry for tramadol 50mg take 1 tablet daily at 8:00am, 2:00pm, and 8:00pm with a start date of 12/18/20 scheduled to be administered at 9:00am only. -There was documentation that tramadol 50mg was not administered on 12/19/20 at 9:00am because the new order needed approval. -There was documentation that tramadol 50mg was administered on 12/20/20 at 9:00am. -There was a computer-generated entry for tramadol 50mg take 1 tablet three times daily at 8:00am, 2:00pm, and 8:00pm. -Tramadol was documented as administered at 8:00am, 2:00pm, and 8:00pm from 12/27/20 to 12/31/20. Review of Resident #15's January 2021 eMAR revealed: -There was documentation that a total of 28 tramadol 50mg tablets were administered to Resident #15 from 01/01/21 to 01/07/21. -There was a computer-generated entry for tramadol 50mg take 1 tablet three times daily at 8:00am, 2:00pm, and 8:00pm scheduled to be administered at 8:00am, 2:00pm, and 8:00pm. -Tramadol was administered three times daily at 8:00am, 2:00pm, and 8:00pm from 01/01/21 to 01/08/21 at 2:00pm. -There was documentation that tramadol was not administered from 01/08/21 at 9:00pm to 01/17/21 at 8:00am because the facility was waiting on the pharmacy to receive a new physician order for tramadol. -There was documentation that tramadol was administered on 01/17/21 at 2:00pm and 8:00pm and on 01/18/21 at 8:00am, 2:00pm, and 8:00pm. Review of Resident #15's Controlled Substance County Sheet (CSCS) for December 2020 and	D 399		

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D 399	Continued From page 101 January 2021 revealed: -There was a total of 72 tablets of tramadol 50mg documented as administered to Resident #15 from 12/08/20 to 01/08/21 on the CSCS. -There were three CSCS available that documented administration of tramadol 50mg to Resident #15 in December 2020 and January 2021. -There was a CSCS dated 12/08/20 that documented the administration of 16 tablets of tramadol 50mg from 12/08/20 to 12/15/20. -There was a CSCS dated 12/05/20 that documented the administration of 27 tablets of tramadol 50mg from 12/16/20 to 12/29/20. -There was a CSCS dated 12/29/20 that documented the administration of 7 tablets of tramadol 50mg from 12/29/20 to 12/31/20 and 22 tablets from 01/01/21 to 01/08/21. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/21/21 at 9:09am revealed: -The pharmacy dispensed 46 tablets to the facility for Resident #15 from a physician order for tramadol 50mg take 1 tablet twice daily on 12/05/20. -The pharmacy received an order for tramadol 50mg take 1 tablet three times daily for Resident #15 dated 12/18/20 and delivered 90 tablets to the facility on 12/19/20. -The pharmacy delivered 9 tablets of tramadol 50mg to the facility on 01/16/21 for Resident #15. -The pharmacy dispensed a total of 145 tablets of tramadol 50mg to the facility for Resident #15 from 12/05/20 to 01/16/21. -The facility had not notified the pharmacy that they were missing some of the tramadol tablets. Telephone interview with a medication aide (MA) on 01/19/21 at 1:46pm revealed:	D 399		

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-Resident #15's tramadol was increased to three times daily.
-Resident #15 was out of tramadol around the middle of January.
-The order could not be refilled because the refill was too soon.
-Resident #15 had been out of medication for "weeks" and was having obvious signs of pain.
-The Administrator told her that she was trying to get a new hard copy for the tramadol.
-She was not sure why the facility was out of tramadol for Resident #15.

Telephone interview with the Special Care Coordinator (SCC) on 01/21/21 at 10:56am revealed:
-She signed for the 90 tablets of tramadol 50mg delivered to Resident #15 on 12/19/20 from the pharmacy.
-She put the medication in a drawer in her office because Resident #15 already had tramadol 50mg on the medication cart.
-Her office was supposed to be kept locked unless she was in the office.
-The extra controlled substances were not locked in her office unless the office door was locked.

Telephone interview with the facility's Nurse Practitioner (NP) on 01/21/21 at 2:01pm revealed:
-Resident #15 was being treated with tramadol for pain in her back.
-In December, Resident #15 rated her pain level at 10 out of 10.
-She had increased the dose of Resident #15's tramadol to 1 tablet three times daily.
-She did not know Resident #15 was not administered her tramadol from 01/08/21 to 01/17/21.
-The facility did call and try to get the order for tramadol filled two weeks early.

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D 399	Continued From page 103 -She told the facility the tramadol prescription could not be filled until 01/18/21. Interview with the Administrator on 01/22/21 at 10:58am revealed: -The extra controlled substances were stored in the SCC's office in a locked filing cabinet. -Each MA leaving the medication cart must sign off on the count with the MA coming on for the next shift. -If the controlled substance count was entered incorrectly three times then the MA must notify management. -She knew she needed to call the local law enforcement and complete an investigation once she was notified the medication was missing. -She did not know Resident #15 was out of tramadol until a MA brought it to her attention on 01/08/21. -She did not complete a twenty-four hour or five-day report for the Health Care Personnel Registry. -She did not call local law enforcement or the pharmacy. -She thought the medication had ran out because Resident #15's order changed in December.	D 399		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete a Health Care	D 438		

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Personnel Registry (HCPR) initial allegation report within 24 hours of knowledge of injury for 1 of 1 sampled resident (Resident #13) who had an injury of unknown origin in the form of bruising on the inner thighs and left hip fracture.

The findings are:

Review of Resident #13's current FL2 dated 09/14/20 revealed:
-Diagnoses included dementia, cognitive impairment, hypertension, macular degeneration, hearing loss, and osteopenia.
-The resident was constantly disoriented and non-ambulatory.
-The resident was incontinent of bladder and bowel.

Review of Resident #13's Care Plan dated 10/10/20 revealed:
-The resident required limited assistance with eating.
-The resident required extensive assistance with toileting, ambulation, grooming, and transfers.
-The resident was totally dependent on staff for bathing and dressing.

Review of Resident #13's NP order dated 12/31/20 revealed Eliquis (used to prevent blood clots) 2.5mg two times a day for 10 days.

Telephone interview with a medication aide (MA) on 01/19/21 at 9:00am and 1:46pm revealed:
-Resident #13 was non-ambulatory and needed assistance to transfer.
-She noticed bruising on the inner thigh of Resident #13 two to three days before she was sent to the hospital to have her hip evaluated (01/14/21).
-She thought Resident #13 was bruised when she

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was provided incontinence care and did not report the bruising.
-She and another MA had assisted the resident up from the bed and moved her to the chair the morning before she was sent to the hospital and did not notice any swelling around her hip.

Telephone interview with an MA on 01/21/21 at 6:00am revealed:
-On 01/11/21, she went into Resident #13's room to assist her roommate.
-While assisting the roommate, the MA noticed Resident #13 was lying in bed uncovered.
-After assisting the roommate, she went over to Resident #13 to cover her up and noticed "a lot of bruising on the backs of her legs."
-She covered Resident #13 back up and left the room.
-She did not assess the resident because the resident had been asleep.
-No one had reported any bruises on Resident #13 when she received report on 01/11/21.
-She had reported the bruises on Resident #13 to the third shift Supervisor when she saw them on 01/11/21.

Telephone interview with a PCA on 01/19/21 at 12:58pm revealed:
-During third shift on 01/12/21, she had noticed bruising on Resident #13's left thigh as she and another PCA were providing incontinent care to the resident.
-On 01/13/21 at 5:30am, she had reported the bruising on Resident #13's inner thigh to both MAs who were on duty at the time.

Telephone interview with a second PCA on 01/20/21 at 6:03am revealed:
-She had noticed the bruising on Resident #13's legs on the night of 01/11/21.

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-She and another PCA had been working together to provide incontinence care to Resident #13 when she saw the bruises.
-She had seen "purple bluish" bruising on Resident #13's right and left inner thighs.
-The right inner thigh bruise was "fairly large" and "darker than the left."
-The left inner thigh bruise was "lighter and not as big as the bruise on the right" inner thigh.

Telephone interview with a second MA on 01/20/21 at 5:58am revealed:
-She became aware of the bruising on Resident #13 on 01/11/21 or 01/12/21.
-She did not know how Resident #13 had sustained the bruises.

Telephone interview with a third MA on 01/19/21 at 10:15am revealed:
-On 01/14/21, the MA had transferred Resident #13 to the wheel chair to assist her with lunch.
-She had transferred Resident #13 by herself.
-She and another MA observed Resident #13's left leg was swollen while she was sitting in her wheelchair.
-She and the other MA had transferred Resident #13 back to bed to assess her and noticed her left leg was "rotated out."
-She and the other MA took a picture of Resident #13's leg and sent it to the Administrator and Nurse Practitioner (NP).
-"We were afraid it was dislocated and might not be getting blood supply."
-She had been "very" concerned as the leg had not been swollen or bruised "like that" at 7:30am when she and another MA had provided incontinent care then transferred the resident to her wheelchair for breakfast.
-She had noticed a "fresh" blue bruise about the size of 4 finger widths on Resident #13's left inner

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thigh when she and the other MA had provided incontinent care at 7:30am.
-That was the first time she had seen the bruise.
-She and the MA then transferred Resident #13 into the wheelchair for breakfast.
-It was difficult to tell if Resident #13 had experienced any pain during either transfer because the resident "always yells" to communicate with the staff.

Telephone interview with a fourth MA on 01/19/21 at 1:19pm revealed:
-The MA had walked by Resident #13's room and floor staff was having difficulty getting Resident #13 to swallow.
-She had felt Resident #13's legs and one leg felt more raised than the other.
-She and the other staff then "very carefully" transferred Resident #13 back to the bed to look at the leg.
-"I saw bruising on the inner left thigh and her hip did not look right."
-The hip was "dislocated or something."
-She had let the Administrator know and then she notified the NP.
-The NP ordered the resident sent out to the hospital for evaluation.

Review of Resident #13's Progress Note dated 01/14/21 at 12:15pm revealed:
-The resident's left hip "seemed more raised than the other" while she was sitting up in her wheelchair for lunch.
-A MA and PCA assisted the resident back to bed to check the resident after the resident was done eating lunch.
-The MA and PCA "noticed" that her left hip was "definitely injured" and she had bruising on the inner part of her thigh.
-Resident #13's NP was immediately notified.

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D 438	Continued From page 108 -Resident #13 was sent out for evaluation. Review of Resident #13's PCP triage note dated 01/14/21 revealed: -Staff reported Resident #13 "was crying out" and "saying her hip hurt." -The resident "has had no recent falls." -Staff had noticed bruises on her hip and inner thigh. -Resident was sent to the Emergency Department (ED) for hip evaluation. Review of Resident #13's Event Report dated 01/15/21 revealed: -There was an un-witnessed incident with injury on 01/14/21 at 12:15pm in the resident's bedroom. -The resident's left hip was raised and swollen and "looked out of place." -There was a bruise on the resident's left inner thigh. -The resident was taken to the Emergency Department (ED) for evaluation on 01/14/21 at 12:45pm. Review of Resident #13's ED report dated 01/14/21 revealed: -The chief complaint was left hip pain and swelling. -The resident was non-verbal and gave no history. -There was no history of a fall. -There were do not resuscitate documents indicating that there were to be comfort measures only, with no IV fluids or other interventions besides pain control. -There was some swelling at the left hip with some bruising near the groin. -There was pain with any passive movement of the left hip.	D 438		

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D 438	Continued From page 109 -The resident was diagnosed with a fracture of the left hip. Review of Resident #13's PCP triage note dated 01/15/21 revealed Resident #13 had a left hip fracture. Telephone interview with the Special Care Coordinator (SCC) on 01/20/21 at 9:38am revealed: -The bruising found on Resident #13 had been reported to her on 01/14/21 by an MA who had noticed the bruising on the morning of 01/14/21 while providing incontinent care. -Staff had not reported any bruising found on Resident #13 before 01/14/21. -The staff had not left any notes under her office door concerning the bruises on Resident #13. -She would have notified the NP had she known about the bruises. Telephone interview with Resident #13's NP on 01/21/21 at 2:00pm revealed: -She was told about the bruising and injury to Resident #13's hip on 01/14/21. -It had "surprised" her Resident #13 had gotten a broken bone without having a fall. Telephone interview with Resident #13's family member on 01/20/21 at 8:15am revealed: -Resident #13 had "gone down hill considerably" since admission to the facility. -The family member did not understand why Resident #13 fell so much as the resident "can't stand up on her own." Telephone interview with the Administrator on 01/19/21 at 8:57am revealed she had sent the initial allegation report into the HCPR on 01/15/21 which was within the 24 hour timeframe of	D 438		

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discovery of Resident #13's injury of unknown origin.

Review of the Initial Allegation Report dated 01/15/21 revealed:
-The allegation /incident type was injury of known source.
-The incident date was 01/14/21.
-The date the facility became aware of the incident was 01/14/21.
-Details of physical or mental injury/harm was "bruising on inside of left leg and hip looks out of place."
-The incident was not reported to law enforcement.
-The form was completed by the Administrator and signed 01/15/21.

Review of the facility's Accident/Falls/Emergency and Fire Safety Policy revealed:
-In the event of physical, verbal abuse, fraud or exploitation of the resident or resident property, or allegations of physical, verbal abuse, fraud or exploitation of the resident or facility property by facility staff, the facility will complete the 24 hour report and send to the Health Care Personnel Registry as indicated in 10A NCAC 13F .1205.

Telephone interview with the Administrator on 01/21/21 at 3:36pm revealed:
-Her staff had reported to her when they went to pickup Resident #13 from the hospital on 01/08/21, the nurses at the hospital picked the resident up under her arms and under her legs to transfer the resident.
-She became aware of the injury to Resident #13 hip on 01/14/21 at 12:24pm.
-She immediately sent a picture of the injury to Resident #13's NP.
-The staff did not tell the SCC until 12:24pm on

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D 438	Continued From page 111 01/14/21, because they were both in the Administrator's office when the MA told them. -When staff noticed bruising on a resident, they were supposed to report it to management. -She had interviews now from two staff who admitted they knew about the bruising on 01/12/21 and 01/13/21, but they "never told us" before 01/14/21.	D 438		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.	D 454		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to notify the responsible persons for 2 of 2 sampled residents (#4, #5) within 24 hours for injury that required emergency medical evaluations and hospitalization.

The findings are:

1. Review of Resident #4's current FL2 dated 11/01/20 revealed:
-Diagnoses included severe stage Alzheimer's disease, bipolar disorder, vision loss, weight loss, history of syncope, vertigo, and blood pressure instability.
-The resident was ambulatory.

Review of Resident #4's Care Plan dated 01/07/21 revealed:
-The resident was forgetful and needed reminders.
-The resident needed assistance with eating, toileting, bathing, dressing, and grooming/personal hygiene.

Review of Resident #4's Event Report dated 01/05/21 at 1:50pm revealed:
-The resident fell getting out of bed and hit head.
-The fall was witnessed.
-There was no injury noted.
-The resident was not sent out for evaluation.
-The resident representative was documented as having been notified of the incident on 01/05/21 at 1:50pm.

Review of Resident #4's Emergency Department (ED) discharge instructions dated 01/06/21 revealed:
-The reason for visit was to evaluate after a fall.
-Resident #4's imaging studies at the ED showed

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no acute abnormalities.

Telephone interview with Resident #4's responsible person on 01/07/21 at 11:46am revealed:
-A nurse from the ED had notified him on 01/06/21 at 3:07pm Resident #4 had been brought in for evaluation for a fall which had occurred on 01/06/21 due to an incident of syncope.
-He was unaware the fall had occurred on 01/05/21 and that Resident #4 was not sent out for hospital evaluation until 01/06/21.

Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:48am revealed:
-She had not worked on 01/05/21 when Resident #4's fall had occurred.
-Staff did not send Resident #4 to the hospital for evaluation after the fall on 01/05/21 even though the resident had hit her head.
-She did not know the medication aide (MA) who had completed the Event Report had failed to notify Resident #4's responsible person about the incident.
-The MA who had called Emergency Medical Services (EMS) was responsible for notifying the resident's responsible person about the incident.

Telephone interview with the Administrator on 01/13/21 at 2:13pm revealed:
-The MA who completed the Event Report on 01/05/21 for Resident #4's fall was responsible for contacting the responsible person on 01/05/21.
-The MA who sent Resident #4 out to the hospital on 01/06/21 should have notified the responsible person on 01/06/21 about the resident being sent out to the hospital.

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D 454	Continued From page 114 Refer to the facility's Accident/Falls/Emergency and Fire Safety policy. 2. Review of Resident #5's current FL2 dated 01/05/21 revealed: -Diagnoses included vascular dementia, sepsis secondary to cellulitis, heart failure with preserved ejection fraction, stage II chronic kidney disease, and left lower cellulitis with deep ulcer. -The resident was ambulatory. Review of Resident #5's Care Plan dated 10/10/20 revealed: -The resident was sometimes disoriented. -The resident was forgetful and needed reminders. -The resident needed assistance with eating toileting, bathing, dressing, grooming/personal hygiene, and transferring. -The resident used a walker. Review of Resident #5's Event Report dated 01/02/21 revealed: -The resident had an unwitnessed fall. -The resident was found face down in the floor. -There was a bump and swelling on the left side of the resident's forehead above the eye. -The resident was sent to the hospital for evaluation. -The resident representative was documented as having been notified of the incident on 01/02/21 at 3:39pm. Review of Resident #5's hospital discharge summary dated 01/05/21 revealed: -Resident #5 was admitted to the hospital on 01/02/21 and discharged from the hospital on 01/05/21. -The diagnoses were fall, closed head injury,	D 454		

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D 454	Continued From page 115 pneumonia, and urinary tract infection. Telephone interview with Resident #5's Guardian on 01/07/21 at 12:55pm revealed: -The hospital had contacted the Guardian on "01/02/21 or 01/03/21" to inform her Resident #5 had been hospitalized for a "concussion and kidney infection." -The facility had failed to notify her of Resident #5's fall and hospitalization. Telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:48am revealed: -Resident #5 was sent to the hospital for evaluation for a head injury on 01/02/21. -The medication aide who had called Emergency Medical Services (EMS) was responsible for notifying the resident's Guardian of the incident. Telephone interview with the Administrator on 01/13/21 at 2:13pm revealed the medication aide who completed the Event Report on 01/05/21 was responsible for contacting Resident #5's Guardian. Refer to the facility's Accident/Falls/Emergency and Fire Safety policy. _____ Review of the facility's Accident/Falls/Emergency and Fire Safety policy revealed staff were responsible for notifying the resident's responsible party when a resident required emergency medical evaluation.	D 454		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION	D 612		

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D 612	Continued From page 116 PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding screening of staff for signs and symptoms of COVID-19, staff who had tested positive for COVID-19 providing care for residents who were not COVID-19 positive, and staffing shortages resulting in an inability to meet the needs of the residents. The findings are: Review of the CDC Return to Work Criteria for Healthcare Personnel dated 08/10/20 revealed healthcare personnel who are asymptomatic	D 612		

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throughout their infection may return to work when at least ten days have passed since the date of their first positive viral diagnostic test.

Review of the CDC Infection Control guidance updated 12/14/20 revealed screen everyone entering a healthcare facility for signs and symptoms of COVID-19.

Review of the CDC Contingency Capacity Strategies to Mitigate Staffing Shortages updated 12/14/20 revealed mitigate staffing shortages by communicating with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional healthcare personnel when needed.

Review of the NCDHHS guidance dated 09/04/20 revealed:
-Consult with the LHD and CDC guidance on management of COVID-19 positive staff.
-Staff who test positive for COVID-19 must remain in isolation until they meet the criteria for discontinuation of isolation.
-In the event of a staffing shortage facilities should contact temporary staffing agencies, sister facilities, the local emergency manager and other local partners for temporary staffing support.

Review of a COVID-19 resident testing spreadsheet for the facility from the LHD revealed:
-Thirty-nine residents tested positive for COVID-19 from 12/22/20 - 01/05/21.
-Eighteen staff tested positive for COVID-19 from 12/16/20 - 01/04/21.

Telephone interview with the Administrator on 01/15/21 at 11:46am revealed:

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D 612	Continued From page 118 -Forty-four residents tested positive for COVID-19 from 12/22/20-01/15/21. -Nineteen staff tested positive for COVID-19 from 12/16/20-01/15/21. -There had been four resident deaths due to COVID-19 as of 01/15/21. 1. Screening of Staff Review of the facility COVID-19 staff screening log for 12/22/20 to 12/31/20 and direct care staff time records for 12/22/20 to 12/31/20 revealed: -For 12/22/20, 25 direct care staff clocked hours, 14 direct care staff had entries on the COVID-19 staff screening log. -For 12/23/20, 19 direct care staff clocked hours, 13 direct care staff had entries on the COVID-19 staff screening log. -For 12/24/20, 25 direct care staff clocked hours, 10 direct care staff had entries on the COVID-19 staff screening log. -For 12/25/20, 22 direct care staff clocked hours, 5 direct care staff had entries on the COVID-19 staff screening log. -For 12/26/20, 14 direct care staff clocked hours, 7 direct care staff had entries on the COVID-19 staff screening log. -For 12/27/20, 16 direct care staff clocked hours, 2 direct care staff had entries on the COVID-19 staff screening log. -For 12/28/20, 22 direct care staff clocked hours, 7 direct care staff had entries on the COVID-19 staff screening log. -For 12/29/20, 27 direct care staff clocked hours, 8 direct care staff had entries on the COVID-19 staff screening log. Review of the facility's infection control coronavirus policy dated 10/02/20 revealed: -Staff members are in-serviced on the importance	D 612		

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D 612	Continued From page 119 of self-assessing and reporting Coronavirus symptoms before they come to work. -Ensure all visitors are screened upon entry into the community for signs and symptoms of COVID-19 (e.g., temperature checks and symptom questions). -Any visitor exhibiting signs or symptoms should be denied entry. -Signs and symptoms of Coronavirus that develop in any caregiver shall be reported by the caregiver to their immediate supervisor as soon as possible. -Caregivers should be tracked for his/her symptoms or lack thereof, follow-up, test results, and disposition. -The caregiver's supervisor requested the caregiver to go home and then reports the event to the Executive Director. -All staff at the Community will be advised that a caregiver with Coronavirus symptoms has been identified, and they are asked to report any Coronavirus signs and symptoms that they might develop to their immediate supervisor as soon as possible and not to come to work until the symptoms resolve. -Advise caregivers of the sick leave standards which shall be flexible and consistent with public health guidance. a. Review of the staff time records for 12/23/20 revealed a Personal Care Aide (PCA) clocked in to work at 10:56pm on 12/23/20 and out at 11:00am on 12/24/20. Review of the facility COVID-19 staff screening log 12/23/20 revealed there was no screening information for the PCA on 12/23/20. Telephone interview with the PCA on 01/11/21 at 2:11pm revealed:	D 612		

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D 612	Continued From page 120 -Staff were supposed to screen for signs and symptoms of COVID-19 at the start of their shift, however "we don't get screened at all." -The information entered for the screening of symptoms was "fake." -Staff temperatures were not being checked. -Staff were just entering their temperatures as 97 degrees. Telephone interview with a Nurse from the local Health Department (LHD) on 01/13/21 at 8:45am revealed the guidance given to the facility included staff and all essential visitors should be screened when going into the facility with temperature checks and signs and symptoms of COVID-19. Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed: -Staff had been trained to have a manager or a MA screen them for COVID-19 when arriving to work. -Staff should not be screening themselves. Telephone interview with the facility's Nurse Practitioner on 01/14/21 at 3:00pm revealed all staff should be screened for COVID-19. b. Review of the staff time records for 12/29/20 revealed a Personal Care Aide (PCA) clocked in to work at 2:40pm and out at 11:00pm. Review of the facility COVID-19 staff screening log revealed there was no screening information for the PCA on 12/29/20. Telephone interview with the PCA on 01/19/21 at 11:58am revealed: -She was required to screen for signs and symptoms of COVID-19 at the start of her shift.	D 612		

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D 612	Continued From page 121 -She would self screen with a temperature check and oxygen saturation level and enter the results on a computerized tablet inside the front door. -She had been trained to self screen before every shift but did not remember who had trained her. -There was no record of her screening on 12/29/20 when she worked in the facility because sometimes she forgot to screen. Telephone interview with a Nurse from the local Health Department (LHD) on 01/13/21 at 8:45am revealed the guidance given to the facility included staff and all essential visitors should be screened when going into the facility with temperature checks and signs and symptoms of COVID-19. Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed: -Staff had been trained to have a manager or a MA screen them for COVID-19 when arriving to work. -Staff should not be screening themselves. Telephone interview with the facility's Nurse Practitioner on 01/14/21 at 3:00pm revealed all staff should be screened for COVID-19. c. Review of the staff time records for 12/27/20 revealed the Special Care Coordinator (SCC) clocked in to work at 9:00pm and clocked out at 7:00am on 12/28/20. Review of the facility COVID-19 staff screening log revealed there was no screening information for the SCC on 12/27/20. Telephone interview with the SCC on 01/20/21 at 3:15pm revealed: -The SCC had been trained that staff screening	D 612		

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for COVID-19 included temperature checks, oxygen saturation levels and a list of "COVID-19 questions".
-The results of the screenings were entered into a computerized tablet.
-Staff from the corporate office had trained her.
-The SCC did not remember if she had or had not screened for symptoms of COVID-19 on 12/27/20.
-Sometimes the computerized tablet would not "capture" the results entered.

Telephone interview with a Nurse from the local Health Department (LHD) on 01/13/21 at 8:45am revealed the guidance given to the facility included staff and all essential visitors should be screened when going into the facility with temperature checks and signs and symptoms of COVID-19.

Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.

Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed:
-Staff had been trained to have a manager or a MA screen them for COVID-19 when arriving to work.
-Staff should not be screening themselves.

Telephone interview with the facility's Nurse Practitioner on 01/14/21 at 3:00pm revealed all staff should be screened for COVID-19.

2. Staff positive with COVID-19 working in the facility

Review of a COVID-19 staff testing spreadsheet for the facility revealed the SCC had tested positive on 12/22/20.

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D 612	Continued From page 123 Review of the facility's time records revealed the SCC worked in the facility on 12/27/20 from 9:00pm to 7:00am on 12/28/20. Telephone interview with a Medication Aide (MA) on 01/08/21 at 1:10pm revealed: -The SCC had tested positive for COVID-19 (12/22/20). -The SCC came back to work on second shift on the fifth day (12/27/20) after testing positive and worked as a MA. -The Administrator told "everyone" that the SCC was only going to work in her office. Telephone interview with a Personal Care Aide (PCA) on 01/08/21 at 2:15pm revealed: -The SCC had been in the facility administering medications to residents on third shift before her ten day isolation was completed (01/02/21). -The SCC was putting medications in the medication cart. -The SCC was going in and out of rooms of residents that were negative and positive for COVID-19. -The SCC was only wearing a mask and gloves when she entered the rooms. -The facility had been short staffed that night. Telephone interview with a second MA on 01/08/21 at 4:38pm revealed the SCC tested positive and was "out a few days" and "then she was back" to work. Review of electronic Medication Administration Records (eMAR) for December 2020 revealed there was documentation the SCC had administered medications on 12/29/20 at 8:00pm and 9:00pm, and 01/01/21 at 9:00pm to a resident who tested positive for COVID-19 on	D 612		

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D 612	Continued From page 124 12/30/20. Telephone interview with the SCC on 01/12/21 at 10:50am revealed: -She had been in the SCC role for about three months. -The SCC had tested positive for COVID-19 on 12/22/20 and was asymptomatic. -The SCC came back to work on 12/28/20 before her ten day isolation period was completed to "do some paperwork" in her office. -The SCC administered medications on second shift on 12/29/20 to residents that were positive for COVID-19 because she was asymptomatic. -A nurse from the local Health Department (LHD) and the facility's corporate office had informed her she could administer medications to residents that were positive for COVID-19 if she was asymptomatic. Telephone interview with a third MA on 01/11/21 at 1:16pm revealed: -She was tested positive for COVID-19 on 12/16/21 but her symptoms started on 12/15/21. -The local health department (LHD) told her to stay out of work for 10 days starting from the first day of symptoms. -She was supposed to stay out of work until 12/25/20. -She was in the facility on 12/23/20 to pick up her check and the Administrator asked her if she wanted to work the next day. -She was not going to refuse any hours because she needed to get paid. -She was fever free and symptom free on 12/23/20 when she entered the facility. Telephone interview with a Nurse from the local Health Department (LHD) on 01/13/21 at 8:45am revealed:	D 612		

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-The guidance given to the facility was staff that tested positive for COVID-19 should remain at home on isolation for 10 days and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms.
-The LHD had informed the Administrator of the guidance upon notification of the first staff positive for COVID-19.
-She had not informed the Administrator or the SCC that the SCC could return to work before her ten day isolation at home was completed.
-The SCC should not have been in the facility positive for COVID-19 during her ten day isolation period.

Telephone interview with the nurse from the LHD on 01/13/21 at 11:15am revealed:
-The facility had been reporting to her the positive COVID-19 results.
-The information was then entered into a computer and assigned a number.
-A contact tracer would then contact the staff member and notify them of the date to return to work.

Telephone interview with a second nurse from the LHD on 01/11/21 at 1:20pm revealed:
-She had telephoned the facility on 12/28/21 and she thought the staff person that assisted her on the phone was a staff that had tested positive for COVID-19 and should be still out of work on 10 days of isolation.
-She did not ask the staff why they were in the facility working because she was not sure if there were more than one staff with the same name.
-She informed another LHD nurse on 12/29/21 of the staff person working in the facility because that nurse worked closely with the Administrator.
-The Administrator had been informed after the

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first staff tested positive for COVID-19 that a ten day isolation was required.
-A contact tracer within the state notified COVID-19 positive staff of their return to work dates.

Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed:
-Nine staff had resigned and twenty staff had tested positive for COVID-19.
-The staff that tested positive for COVID-19 and were symptomatic were sent home for a ten day isolation.
-The SCC was the only staff that tested positive for COVID-19 and was asymptomatic.
-A nurse from the LHD had informed the Administrator that staff that tested positive with COVID-19 and were asymptomatic could care for residents that tested positive for COVID-19 before their ten day isolation period was completed.

Telephone interview with the facility's Nurse Practitioner on 01/14/21 at 3:00pm revealed:
-The NP thought that staff that had tested positive for COVID-19 were sent home and not allowed to work.
-She was very concerned about staff working in the facility positive for COVID-19 as that could spread the virus.

Review of the facility's infection control coronavirus policy dated 10/02/20 revealed:
-Exclude staff with Coronavirus-like illness from work until at least 24 hours after they are no longer symptomatic and no longer have a fever (off fever reducing medications).
-If the staff member had direct resident contact of any type, those residents are identified quickly and to the extent possible and appraised over a

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D 612	Continued From page 127 14-day period for the development of Coronavirus signs and symptoms. -Droplet precautions (surgical masks, eye shields and or goggles, gloves, gowns, hand hygiene) should be implemented for suspected or confirmed Coronavirus for no less than 7 days after illness onset. -Once an outbreak has been identified, outbreak prevention and control measures should be implemented immediately. -During an outbreak, once a single laboratory-confirmed case of Coronavirus has been identified, it is likely there are other cases among exposed persons. -Coronavirus is thought to be primarily spread from person-to-person by large droplets of respiratory secretions from an infected person. -As is practical, avoid rotating staff between areas/units until no new cases have been identified for at least one week. -To help control transmission, separate residents who are ill from residents who are asymptomatic to prevent transmission by staff or other who are ill to people who are asymptomatic. -The following processes will be used for the isolation of caregivers who come to work and are suspected of being infected: the symptomatic caregiver will be given a surgical mask to help to prevent exposure to others, the care giver will be isolated in a room with a door that closes, the caregiver will be asked to identify any other contacts he/she had while in the Community that day, the caregiver will be asked to contact his/her healthcare provider and leave the Community, areas this person was in during his/her time at the Community will be decontaminated immediately. 3. Review of the facility's current license effective 01/01/20 revealed the facility was licensed as a special care unit (SCU) with a capacity of 60	D 612		

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D 612	Continued From page 128 beds. Review of the facility's resident census report revealed: -From 12/22/20 to 12/25/20, the census in the facility was 56 residents. -On 12/26/20, the census in the facility was 54 residents. -From 12/27/20 to 12/28/20, the census in the facility was 53 residents. -From 12/29/20-12/30/20, the census in the facility was 52 residents. -From 12/31/20-01/01/21, the census in the facility was 51 residents. -On 01/02/21, the census in the facility was 52 residents. -From 01/03/21 to 01/05/21, the census in the facility was 50 residents. Review of the individual employee time cards dated 12/22/20 to 01/05/21 revealed: -There were 13 of 42 shifts reviewed that did not meet staffing hour requirements. -On 12/24/20, there was a total of 35.25 staff hours provided on third shift with a shortage of 9.55 hours. -On 12/24/20, there was a total of 42.25 staff hours provided on second shift with a shortage of 13.75 hours. -On 12/26/20, there was a total of 42.5 staff hours provided on second shift with a shortage of 13.5 hours. -On 12/27/20, there was a total of 33.5 staff hours provided on third shift with a shortage of 9.5 hours. -On 12/27/20, there was a total of 49 staff hours provided on second shift with a shortage of 4 hours. -On 12/31/20, there was a total of 32.5 staff hours provided on third shift with a shortage of 8.3	D 612		

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hours.
-On 01/01/21, there was a total of 34.75 staff hours provided on second shift with a shortage of 6.05 hours.
-On 01/02/21, there was a total of 25.25 staff hours provided on third shift with a shortage of 16.75 hours.
-On 01/03/21, there was a total of 25.75 staff hours provided on third shift with a shortage of 14.25 hours.
-On 01/03/21, there was a total of 47 staff hours provided on first shift with a shortage of 3 hours.
-On 01/03/21, there was a total of 44 staff hours provided on second shift with a shortage of 6 hours.
-On 01/04/21, there was a total of 32.75 staff hours provided on third shift with a shortage of 7.25 hours.
-On 01/05/21, there was a total of 32.5 staff hours provided on third shift with a shortage of 7.5 hours.

Interview with a medication aide (MA) pm 01/08/21 at 12:44pm revealed:
-She had found residents that needed to be provided incontinent care during her medication passes.
-A supervisor was supposed to be assigned to each hallway to make sure all tasks for each resident was completed.
-There was probably not someone available to supervise because the facility did not have enough staff.

Telephone interview with a personal care aide (PCA) on 01/08/21 at 2:15pm revealed staff members had been quitting and it was creating some staffing issues.

Telephone interview with a second PCA on

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D 612	Continued From page 130 01/12/21 at 1:02pm revealed: -The facility had been "ridiculously" short staffed over the past several weeks. -It was hard to care for all the residents with only two PCAs working during second shift. -They have had several staff quit including two on third shift. -Management was helping pass meds but they do not help provide personal care to the residents. Telephone interview with a second MA on 01/13/21 at 1:05pm revealed: -Their process has been slower because the facility has been short staffed. -It was taking longer to administer medications and for the PCAs to give showers to all the residents. Telephone interview with a third shift Supervisor on 01/14/21 at 9:42am revealed: -She was responsible for preparing the third shift schedule. -She had a surplus of staff to cover the third shift. -She was out on quarantine starting on 01/01/21 and was not sure what happened while she was out. -She tried to schedule six to eight staff per night. -The Special Care Coordinator (SCC) and the Administrator was working some third shifts to help cover for the staff that had tested positive for COVID-19. Telephone interview with a paramedic from the local emergency medical services (EMS) on 01/11/21 at 3:13pm revealed: -EMS had transported several residents from the facility recently to the local emergency room. -It was hard to get the attention of a staff member to let her in the facility when EMS arrived to transport a resident.	D 612		

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D 612	Continued From page 131	D 612		

-Sometimes the staff did not know which resident was being transported.
-On 12/27/20, EMS staff entered the facility to transfer a resident and found the resident covered in feces and smelling of urine, feces, and body odor with greasy upkept hair.
-The resident's room was cluttered and had food wrappers on the floor.
-She did not think they had enough staff to take care of all the residents.

Telephone interview with a consultant nurse from a local home health agency on 01/11/21 at 12:45pm and 01/14/21 at 9:34am revealed:
-She had visited Resident #2 to complete an initial assessment on 01/05/21 around 1:30pm.
-Resident #2 needed incontinence care when she assessed the resident.
-Resident #2's breakfast and lunch plate was on the bedside table and was barely touched.
-She was concerned that Resident #2 was not eating because she needed assistance.

Telephone interview with the Administrator on 01/13/21 at 2:14pm revealed:
-She was responsible for making the staff schedule for first and second shift.
-There were 20 COVID-19 positive staff and 9 staff had quit as of 01/13/21, including 2 staff that walked out in the middle of a shift.
-Corporate would not allow her to bring workers in from an outside agency.
-Corporate did not call other workers in from "sister facilities."
-She was out for five days over Christmas and was not sure about the staffing during this time.

Review of the facility's infection control coronavirus policy dated 10/02/20 revealed:
-The Executive Director or designee will contact

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D 612	Continued From page 132 licensing if deviation from current regulations relative to staffing standards must occur. -Make proactive contact with companies that supply temporary workers. -Appropriate staff is cross trained to perform essential duties. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. _____ The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) for infection prevention and transmission during the COVID-19 pandemic related to staff not screening for COVID-19 signs and symptoms, staff positive with COVID-19 working in the facility, and staffing shortages. The facility's failure to follow the guidance related to infection prevention for COVID-19 increased the risk for the virus to spread in the facility, resulting 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 01/11/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 21, 2021.	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are	D912		

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D912	Continued From page 133 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to nutrition and food service. The findings are: 1. Based on observation, interviews, and record reviews, the facility failed to ensure nutritional supplements were served as ordered by the physician to 2 of 4 sampled residents (#1 and #4). [Refer to tag D310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free from mental and physical abuse, neglect, and exploitation as related to health care, medication administration, resident rights, and infection prevention and control program. The findings are:	D914		

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D914	Continued From page 134 1. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 4 of 8 sampled residents (#2, #4, #5, and #13) as related to delay in responding to a low heart rate and oxygen saturation (#5), bruising on resident thighs discovered three days before sending the resident (#13) for hospital evaluation and diagnosed with a hip fracture, a resident who fell and had a head injury while taking Eliquis (#4) and was not sent out for evaluation, a resident taking aspirin with a fall and impact to the left eye causing bruising and swelling (#5) not being sent out for evaluation, and significant weight loss not being reported to the PCP for residents (#2, #4, #5, and #13). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type Unabated A2 Violation)]. 2. Based on interviews and record reviews, the facility failed to implement physician's orders for 1 of 6 sampled residents related to checking oxygen saturation levels for a resident (Resident #11) who had tested positive for COVID-19 and was showing signs of declining health. [Refer to Tag D276, 10A NCAC 13F .0902(c3-4) Health Care (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure the rights of all residents in a Special Care Unit (SCU) rights were maintained and residents were free from neglect related to not receiving appropriate assistance during the meal service during in-room dining, after stopping communal dining, resulting weight loss for 31 of 48 residents.[Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 4. Based on interviews and record reviews, the facility failed to administer medications as	D914		

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D914	Continued From page 135 ordered by a licensed prescribing practitioner for 8 of 14 sampled residents (Residents #2, #6, #7, #9, #11, #13, #14, #15) related to medications for prevention of blood clots (#6, #7, #9, #13), infection (#13, #14), medications for shortness of breath (#2, #15) and inflammation (#2), pain relief (#15), anxiety and depression (#11), and admission medications (#11). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type Unabated A2 Violation)]. 5. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding screening of staff for signs and symptoms of COVID-19, staff who had tested positive for COVID-19 providing care for residents who were not COVID-19 positive, and staffing shortages resulting in an inability to meet the needs of the residents. [Refer to Tag D611, 10A NCAC 13F .1801 Infection Prevention and Control Program (Type A2 Violation)].	D914		