STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092144	A. BUILDING: _____ B. WING _____	C 03/19/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a complaint investigation with onsite visit on 03/16/21 through 03/18/21. A desk review survey was conducted 03/19/21 with a telephone exit on 03/19/21.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled staff (Staff C) was tested upon hire for Tuberculosis (TB) disease in compliance with the TB control measures adopted by the Commission for Health Services. The findings are: Review of Staff C's personnel record revealed: -She was hired 10/20/20. -The first TB skin test was administered on 01/21/20 and read as negative on 01/23/20. -There was no documentation a second tuberculosis skin test was administered and read.	D 131		

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D 131	Continued From page 1 Interview with the Administrator on 03/18/21 at 3:43pm revealed: -She was responsible to ensure staff obtained the TB skin test upon hire. -She was responsible to ensure the second TB skin test was administered. -She was aware Staff C needed a second TB skin test.	D 131		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure 2 of 5 resident's (#2, #4) sampled received personal care assistance with toileting. The findings are: 1. Review of Resident #2's current FL-2 dated 05/01/20 revealed: -Diagnoses included Alzheimer's disease, hypertension, gastroesophageal reflux disorder with esophagitis, and heart murmur. -The resident was constantly disoriented, ambulated with a walker, and incontinent of bladder.	D 269		

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D 269	Continued From page 2 -The resident needed staff assistance with bathing and dressing. Review of Resident #2's current Special Care Unit (SCU) quarterly care plan dated 01/14/21 revealed the resident was disoriented and had memory loss, needed staff assistance with activities of daily living (ADLs), and was incontinent of bowel and bladder. Review of Resident #2's care plan dated 05/18/20 revealed: -The resident was sometimes forgetful and needed reminders. -The resident had daily incontinence of bowel and bladder. -The resident required extensive staff assistance with ambulation, toileting, bathing, and grooming. -The resident required staff assistance to clean, change, and adjust garments because of incontinence. -The resident required extensive hands on staff assistance with dressing and undressing. -The resident required extensive hands on staff assistance with transfers due to unsteady gait. Review of the third shift personal care aide (PCA) assignment sheet for east hall dated 03/16/21 revealed: -There was documentation of 15-minute rounds for high risk falls. -Resident #2 was listed on the assignment sheet. -There was an "R" documented under each 15-minute round beside Resident #2's name from 11:00pm - 6:45am . -There was a ledger at the bottom of the 15-minute rounding sheet: R = room. sheet. Review of Resident #2's activity of daily living	D 269		

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D 269	Continued From page 3 (ADL) log for third shift dated 03/16/21 revealed the resident received limited staff assistance with toileting on 6 different occasions; times were not documented. Observation of Resident #2's room on 03/17/21 at 5:45am revealed: -The resident was shaking, moaning, and calling for help. -The resident's pants were wet. -"Oh, somebody help me. I'm cold. I'm wet. Somebody poured ice cold water on me." -Under the resident were 2 disposable incontinent pads; the bottom pad was plastic side down; the top pad was plastic side up and contacted the resident. -Under the 2 disposable incontinent pads was a flat sheet, and a fitted sheet; there was a pillow under the resident's head. -Both incontinent pads, the flat sheet, fitted sheet, and pillowcase were saturated with urine. -The flat and bottom sheets were saturated with urine from under the pillow to the resident's feet; there was a definitive margin of wetness on the sheets that extended to the right edge of the bed. -Urine was on the floor, beside the middle of the bed towards the head, between the bed and the nightstand. -There was a PCA in the room attending to Resident #2's roommate. -The PCA walked over to Resident #2 as the resident was calling for help. -Resident #2 told the PCA she was wet and cold. -The PCA pulled the bedspread up over Resident #2 and told the resident she would be back. -The PCA exited the room without changing Resident #2 or performing incontinent care. Interview with the PCA on 03/17/21 at 5:54am revealed:	D 269		

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D 269	Continued From page 4 -Resident #2 was confused, and thought she was wet. -Resident #2 was not really wet. Observation of Resident #2's room on 03/17/21 from 5:54am - 6:12am revealed: -Resident #2 was still lying in her bed shaking, complaining of being wet, cold, and that someone had poured ice water on her. -The PCA entered the room at 5:54am. -At 6:00am the PCA removed Resident #2's clothes from the closet, approached the resident, and asked Resident #2 if she wanted to put on the clothes chosen. -The PCA assisted the resident to sit on the bedside as the resident, in urine soiled clothing, continued to shake and complain of being wet and cold. -The PCA exit the room and returned with a dry towel; the resident remained sitting on the bedside in urine saturated clothing. -There was a strong urine smell in the room. -The PCA removed Resident #2's shirt; the resident's pants were not removed. -The PCA began wiping Resident #2's back and right shoulder with the dry towel. -The PCA proceeded to put a clean shirt on Resident #2 while still wearing urine saturated pants. -The PCA continued to put a clean shirt on Resident #2. -The PCA was prompted to perform personal hygiene and incontinent care to Resident #2 prior to changing into clean clothing by surveyor. A second interview with the PCA on 03/16/21 at 6:10am revealed: -When asked by surveyor if Resident #2 was wet, the PCA responded yes, she was wet with urine. -Resident #2 was independent with all ADL's.	D 269		

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-She was drying the urine from Resident #2's back and right shoulder with the towel before she changed the resident into a clean shirt.
-She put a clean shirt on Resident #2 prior to performing personal hygiene because the resident was cold.
-Resident #2's sheets were wet with urine from under the pillow to the foot of the bed.
-She usually made incontinent rounds every 15 - 30 minutes.
-She last made an incontinent check on Resident #2 at 2:00am.
-She did not make an incontinent check on Resident #2 after 2:00am 03/16/21 because normally the resident would ambulate with her walker to the bathroom independently to use the bathroom and change her incontinent brief.
-When she last checked on Resident #2 around 2:00am the resident's pants and her incontinent pad was a "little wet" with urine.
-She changed Resident #2's incontinent pad but not the resident's pants or incontinent brief because she thought the resident had already changed her own incontinent brief.
-She was going to remove Resident #2's urine saturated clothing into clean, dry clothing prior to personal hygiene then wheel her to the community bathroom for incontinent care and a shower.

Observation of the community shower room on 03/17/21 at 6:20am revealed:
-Resident #2 was assisted to stand from the wheelchair by the PCA; the resident was shaking, unstable, and leaned backwards into the PCA's arms when standing.
-The incontinent pad in Resident #2's wheelchair was saturated with urine.
-Resident #2's incontinent brief was sagging to the resident's upper thighs.

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D 269	Continued From page 6 -Resident #2 was given a shower by the PCA. Interview with the medication aide/supervisor (MA/S) on 03/17/21 at 7:15am revealed: -He worked 3rd shift on 03/16/21. -It was his responsibility as the MA/S to make rounds behind the PCAs to ensure they were performing incontinent checks and changing the residents. -He did not say how often he was to round behind the PCAs. -He had not yet checked on Resident #2 to ensure incontinent care had been performed by the PCA. -When he did attempt to check on Resident #2 this morning, 03/17/21, to ensure incontinent care had been performed the resident was in the shower with the PCA. Interview with the Administrator on 03/17/21 at 8:36am revealed: -She did not know Resident #2 was saturated in urine. -She did not know the PCA had not rounded on Resident #2 since 2:00am. -Any resident that was listed on the every 15 - 30-minute rounding sheet was expected to be rounded on by the PCAs every 15 - 30 minutes to included incontinent checks. -The PCAs on every shift were expected to perform incontinent checks every 2 hours or as needed. -The PCA was expected to wash and change a resident when soiled with urine or bowel. -The PCA was expected to change resident's linens when soiled with urine or bowel. -The PCA should not dress a resident in clean clothes before performing incontinent care when the resident was wet with urine. -The PCAs documented incontinent rounds on	D 269		

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the personal care logs.
-The MA/Ss were responsible to ensure the PCAs performed personal and incontinent care on the residents by rounding between incontinent checks.
-The Resident Care Coordinator (RCC) was responsible to ensure resident's received incontinent care by random rounds on all shifts.
-The Administrator had not made random rounds on third shift to ensure incontinent care had been performed.
-It was the responsibility of the RCC to ensure the MAs and the PCAs were doing what they were supposed to do.
-There was no other system in place to ensure incontinent care was being performed.

Telephone interview with a second PCA on 03/19/21 at 1:25pm revealed:
-She would round on residents every 15 - 20 minutes throughout the day to make sure they were in their room and there were no trip hazards; she would not look or check for anything else.
-She would check residents' 3 times a day before breakfast, lunch, and dinner to see if the residents' needed to use the bathroom; she would not perform incontinent checks any other times.
-Sometimes Resident #2 was saturated in urine; she would assist the resident in changing her incontinent brief.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

2. Review of Resident #4's current FL-2 dated 02/03/21 revealed diagnoses of dementia, type 2 diabetes mellitus, hypertension, and frontal

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meningioma.

Review of Resident #4's care plan dated 02/03/21 revealed:
-Resident #4 was sometimes disoriented and had significant memory loss that required redirection.
-Resident #4 was incontinent of bowel and bladder.
-Resident #4 had a limited range of motion to his right hand due to a previous stroke.
-Resident #4 required extensive assistance with toileting, bathing, dressing, grooming, and transferring.
-Resident #4 required facility staff to clean, change, and adjust garments due to incontinent bowel and bladder.

Review of Resident #4's personal care log for March 2021 revealed Resident #4 required extensive assistance with incontinent care on the third shift.

Observation of Resident #4 on 03/17/21 at 6:26am revealed:
-Resident #4 was standing beside his bed with his clothing and brief removed.
-Resident #4 had urinated and defecated on his clothing and brief that was located directly under his feet.
-Resident #4's white blanket of his bed had a large, yellow-stained wet spot.
-It was not known how long Resident #4 had been in this condition.
-There was no staff in the hallway.

Interview with a personal care aide (PCA) on 03/17/21 at 6:45am revealed:
-Residents are checked every two hours for incontinent care that included changing soiled or wet briefs.

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-PCA's also checked residents every 30 minutes to make sure they were dry and they were still breathing.
-PCA's documented 30 minutes checks on the third shift certified nursing assistant (CNA) assignment sheet.
-She last performed incontinent care on Resident #4 at 3:30am.

Interview with the Administrator on 03/17/21 at 8:36am revealed:
-PCA's were supposed to check residents every two hours and as needed for incontinent care.
-Incontinent care consisted of cleaning and changing resident's briefs, remove soiled garments, apply clean clothes, and bathe residents as needed.
-The medication aide/supervisor (MA/S) was responsible to make sure the PCA's performed incontinent care every two hours.
-The Resident Care Coordinator (RCC) was responsible to make sure the MA/S checked that the PCA's performed incontinent care.
-She was not aware that Resident #4 had urinated and defecated on his clothing and brief.
-She expected the PCA to check Resident #4 every two hours for incontinent care.

Attempted interview with Resident #4 on 03/17/20 at 7:30am was unsuccessful.

_____

The facility failed to provide incontinent care to a resident (#2) who had a diagnosis of dementia; the resident had two disposable incontinent pads under her buttocks, was saturated in urine from her head to her lower legs, the sheets were saturated, urine was pooled on the floor between the bed and night stand, and had not received incontinent care in 3 hours and 54 minutes; the resident was shaking and cold. A resident (#4)

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D 269	Continued From page 10 who had a diagnosis of dementia that had urinated and defecated on the floor in his room because he had not received incontinent care in three hours. The facility's failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on March 17, 2021, for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 7, 2021.	D 269		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure an immediate response and intervention by staff and in accordance with the facility's policies and procedures during an incident in which 1 of 5 sampled residents (#1) experienced a change in	D 271		

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level of consciousness.

The findings are:

Review of Resident #1's current FL-2 dated 07/27/21 revealed:
-Diagnoses included Alzheimer's, dementia, hyperlipidemia, gastroesophageal reflux, glaucoma, dysphagia, mild cognitive impairment, muscle weakness and lack of coordination.
-The resident required assistance with bathing and dressing.
-The resident was ambulatory with a walker.

Review of Resident #1's current assessment and care plan dated 11/27/20 revealed:
-The resident wandered, had significant memory loss, and required redirection.
-She had occasional incontinence of bladder and bowel.
-She used a walker for mobility but had unsteady gait.
-She needed extensive assistance with all activities of daily living (ADL).

Review of Resident #1's Emergency Department Provider Note dated 02/07/21 revealed:
-She had a history of diabetes (high blood sugar).
-She was sent to the Emergency Department via emergency management services (EMS) by the facility after being found with an altered mental status and unconscious on the floor.
-She was treated for hypoglycemia (low blood sugar) at the Emergency Department then released back to the facility on 02/07/21.
-Discharge instructions included calling 911 immediately for any signs of sudden confusion, trouble speaking, or understanding.

Review of Resident #1's Emergency Department

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Provider Note and Hospitalization records dated 02/08/21-02/09/21 revealed:
-She was sent to the Emergency Department via EMS by the facility after obtaining a low blood sugar on 02/08/21.
-She was hospitalized for symptoms related to hypoglycemia from 02/08/21-02/09/21.
-Her diabetes medications, that included oral medications and insulin, were discontinued upon her discharge from the hospital on 02/09/21 due to her continued risk of hypoglycemia.
-The facility was to contact Resident #1's primary care provider (PCP) immediately for any symptoms of difficulty concentrating or decreased alertness.

Observation of Resident #1 on 03/17/21 from 6:01am to 6:37am revealed:
-She had been asleep and was awoken by a personal care aide (PCA).
-She was difficult to rouse and lethargic, did not open her eyes, did not speak or respond to questions from the PCA, and kept trying to lay back down in bed.
-She was assisted to the wheelchair by the PCA with extensive assistance.
-She was slumped over in the wheelchair and went back to sleep after the transfer.

Observation of PCA on 03/17/21 from 6:01am to 6:37am revealed:
-She spoke to Resident #1 in a calm manner and explained her plan of care for the resident regarding personal care and getting out of bed.
-She tried repeatedly to arouse Resident #1, but the resident only followed commands and did not speak or open her eyes.
-The PCA asked another PCA to get the supervisor for help regarding the resident's behavior, because she was concerned that the

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resident was not as "peppy" as usually, not talking, and very tired.

Observation of another MA/supervisor on 03/17/21 at 6:32am revealed:
-He assisted Resident #1 to be more upright in the wheelchair upon entering the room.
-He attempted to arouse Resident #1, but she did not respond.
-He spoke to Resident #1 to get her to respond but she remained quiet and never opened her eyes.
-He told the PCA that Resident #1 was "okay" and "just tired".

Interview with PCA on 03/17/21 from 6:01am to 6:37am revealed:
-The facility staff usually began waking up residents around 5:40am to provide personal care and get the residents ready to eat breakfast.
-Resident #1 usually had slow mornings to wake up, but she normally talked and was more alert.

Observation of Resident #1 on 03/17/21 at 12:21pm revealed:
-The resident was sitting in a wheelchair slumped over and asleep.
-The PCA and speech therapist were at the resident's side trying to wake her up to eat lunch.
-The resident was unresponsive to verbal commands and would not wake up.
-The speech therapist advised the PCA not to feed Resident #1 due to her being unresponsive.
-The PCA left the room to report Resident #1's behavior to the mediation aide (MA) and the speech therapist stayed with the resident when the PCA left the resident's room.

Observations on 03/17/21 from 12:27pm to 1:01pm (34 minutes) revealed:

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-At 12:27pm, The PCA to report her concerns to the MA regarding Resident #1's.
-At 12:28pm, the MA arrived at Resident #1's side and stated she had taken the residents blood sugar earlier and it was in the 200's.
-The MA attempted to arouse Resident #1 but was unable to do so.
-At 12:31pm, the MA left the room to report the incident to the RCC.
-At 12:34pm, the Resident Care Coordinator (RCC) instructed the MA to obtain a blood sugar and a set of vital signs on Resident #1.
-At 12:44pm, the MA did not have the supplies she needed to take a manual blood pressure and left the room to obtain the supplies leaving Resident #1 unattended or supervised.
-At 12:46pm, the MA returned to Resident #1's room.
-At 12:47pm, the MA obtained vital signs on Resident #1(blood sugar 212, blood pressure 120/60, and a temperature of 97.1 Fahrenheit) and reported them to the RCC; Resident #1 remained unresponsive.
-At 12:49pm, the RCC advised the MA to report Resident #1's "sluggishness", change in mental status, vital signs, and blood sugar to the Primary Care Provider (PCP) for further orders and guidance.
-The MA left Resident #1's room.
-At 12:51pm, the Administrator came out of her office and instructed the MA to call 911 and have Resident #1 sent to the hospital, then call the PCP to update her on the resident's status.
-The Administrator went to Resident #1's room to be with Resident #1.
-At 12:56pm, the MA was gathering paperwork from Resident #1's chart and electronic medical record (EMR) and had not called 911 even after being prompted by the Administrator.
-At 12:58, the RCC instructed the MA to call 911

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immediately.
-At 1:01pm, the MA called 911.
-At 1:07pm, EMS arrived to transport Resident #1 to the hospital due to her inability to wake up and respond.

Observation of MA/supervisor from 1:13pm to 1:21pm revealed that she called Resident #1's guardian and left a message for Resident #1's PCP to let them know that the resident had been sent to the emergency department due to being unresponsive.

Interview with the PCA 03/17/21 at 12:21pm revealed that Resident #1 normally slept a lot, but her behavior today, 03/17/21, seemed to be a change from the resident's normal behavior and she "wasn't herself today".

Interview with the MA on 03/17/21 at 12:34pm and 1:12pm revealed:
-Resident #1 had been "different" all morning and was usually very interactive.
-She worked yesterday (03/16/21) and Resident #1 was "very normal" trying to get up several times independently and requiring redirection.
-The process for emergent situations was to see what was wrong with a resident, obtain vital signs, gather the paperwork, and then call 911.
-She would gather paperwork to send a resident out of the facility prior to calling 911, depending on how emergent a situation was, because EMS did not like to wait for the paperwork.
-If the resident had been bleeding, she would have called 911 first, before gathering paperwork.

Review of Resident #1's Emergency Department notes dated 03/17/21 revealed:
-The resident appeared in the Emergency Department as very lethargic and chronically ill

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and was treated for weakness and lack of energy.
-She was administered intravenous fluids and released after she received a CT scan and lab work to rule out differential diagnoses of a cardiovascular accident, urinary tract infection, electrolyte disturbance, anemia, and elevated valproic acid.

Review of facility's Incident/Accident or Injury Policy on 03/17/21 revealed:
-If a supervisor had any question concerning a resident's need for medical attention, they must call the resident's PCP.
-If there was a life-threatening emergency, the facility supervisor must call 911.
-Once resident care has been provided, the facility supervisor should notify the resident's family or responsible party, the resident's PCP, and the resident care coordinator (RCC).

Interview with the RCC on 03/17/21 at 12:58pm and 5:33pm revealed:
-The expected process for emergent situations included assessing the situation, ensuring a resident was stable and provide the resident any care needed, call 911, have a staff member stay with the resident until EMS personnel arrived, another staff member should to gather the transfer paperwork, and the supervisor should then report the situation to the EMS team, and then subsequently call the resident's guardian and PCP to update them.
-Staff had not reported Resident #1's change in status to her that morning.

Interview with the facility Administrator on 03/17/21 at 12:32pm and 6:05pm revealed:
-She expected to be notified of a resident change in status immediately, but she had not been notified of Resident #1's change in status that

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morning, 03/17/21.
-She expected staff to contact the resident's PCP for a change in resident status or condition.
-If a resident had a change in status or became unresponsive, she expected the resident to be sent out to the hospital.
-She would "never" expect staff to delay calling 911 because staff were unlicensed personnel who could not assess residents.
-The MA or the facility supervisor should have called 911 immediately when they noticed Resident #1's change in mental status.

Telephone interview with Resident #1's PCP on 03/17/21 at 3:24pm and 03/22/21 at 11:56am revealed:
-She had been notified on the afternoon of 03/17/21 that Resident #1 had been sent out to the hospital for being overly tired, but she had not been notified of Resident #1's change in status that began in the early morning of that same day, 03/17/21, nor was there any documentation of the resident's status change in the resident's record.
-She would have expected to be notified of any resident change in status and she would have expected for the resident to be sent to the hospital for further evaluation.
-The facility staff were not trained to assess residents as unlicensed personnel, so it was never wrong to send a resident out to the hospital for a better assessment or further evaluation.
-She expected the facility staff to call 911 prior to gathering transfer paperwork for the EMS team.

The facility failed to respond immediately when Resident #1 experienced a change in level of consciousness with inablity to respond to commands. The resident was not sent to the emergency department for evaluation until six

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D 271	Continued From page 18 and one half hours later. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/17/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 7, 2021.	D 271		
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: Based on observations, interviews, and record reviews the facility failed to ensure referral and follow up to meet the acute healthcare needs for 1 of 7 residents (#2) sampled who had swelling and redness to both lower legs. The findings are: Review of Resident #2's current FL-2 dated 05/01/20 revealed: -Diagnoses included Alzheimer's Disease, hypertension, gastroesophageal reflux disorder with esophagitis, and heart murmur. -The resident was constantly disoriented, ambulated with a walker, and incontinent of bladder. -The resident needed staff assistance with bathing and dressing. -The resident's skin was documented as normal.	D 273		

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D 273	Continued From page 19 Review of Resident #2's current Special Care Unit (SCU) quarterly care plan dated 01/14/21 revealed the resident was disoriented and had memory loss, needed staff assistance with activities of daily living (ADLs), and was incontinent of bowel and bladder. Review of Resident #2's care plan dated 05/18/20 revealed: -The resident was sometimes forgetful and needed reminders. -The resident had daily incontinence of bowel and bladder. -The resident required extensive staff assistance with ambulation, toileting, bathing, and grooming. -The resident required staff assistance to clean, change, and adjust garments because of incontinence. -The resident required extensive hands on staff assistance with dressing and undressing. -The resident required extensive hands on staff assistance with transfers due to unsteady gait. -The resident's skin was documented as normal. Review of Resident #2's local hospital's emergency department visit note dated 01/22/21 revealed the resident had a history of bilateral lower leg edema and venous stasis dermatitis of the right lower extremity. Observation of Resident #2 on 03/17/21 at 6:34am revealed: -The resident was sitting in a wheelchair of the community shower room. -Resident #2's legs were swollen from the feet to the knees; the left was more swollen than the right. -Resident #2 had redness to both lower 1/4th of her legs.	D 273		

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D 273	Continued From page 20 -Resident #2' skin on both lower legs were shiny and taught. -Resident #2 was complaining of pain to the right leg that increased when touched or moved by the personal care aide (PCA). Interview with the PCA on 03/17/21 at 6:35am revealed: -She did not know if Resident #2's legs were normally swollen, red, and painful. -She did not think she had to report to anyone Resident #2's legs were red, swollen, and painful. Interview with the medication aide/supervisor (MA/S) on 03/17/21 at 7:15am revealed; -He did not know what Resident #2's legs normally looked like. -The PCA had not informed him Resident #2's legs were swollen, red, and painful. -He would have informed Resident #2's PCP if he had been told by the PCA Resident #2's legs were red, swollen, and painful. Interview with Resident #2's family member on 03/17/19 at 2:00pm revealed the resident normally had swelling to both feet. Telephone interview with Resident #2's PCP on 03/17/21 at 4:00pm revealed: -Staff did not inform her the resident's legs were swollen, red, and painful. -She had received an electronic note from the Resident Care Coordinator (RCC) within the past few days the resident had dry skin but no other reports. -She expected the facility to have informed her the resident's lower legs were swollen, red, and painful when discovered so she could have evaluated the resident.	D 273		

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Interview with the RCC on 03/18/21 at 2:39pm revealed:
-Resident #2 normally had swelling from her feet to her upper legs.
-She did not know Resident #2 had redness to both lower legs.
-The previous PCP knew Resident #2 had leg swelling and staff were to encourage the resident to elevate her legs throughout the day to aide in decreased swelling.
-Resident #2 did not like to elevate her legs.
-She called Resident #2's current PCP on 03/15/21 and informed her the resident's legs were swollen.
-Resident #2's PCP examined the resident's legs on 03/16/21.

Telephone interview with the receptionist of Resident #2's PCP office on 03/18/21 at 3:00pm revealed:
-There were no visits documented for the resident after 02/03/21 by the previous PCP.
-There no visits documented for the resident by the current PCP.

Telephone interview with a MA/S on 03/19/21 at 1:00pm revealed:
-She saw both of Resident #2's legs on Tuesday, (03/16/21).
-Resident #2 had swelling to both legs but no redness.
-Resident #2 did not complain of pain to her legs at that time.
-Resident #2 would complain of leg pain at times but could not remember when.
-The PCA was expected to report the redness on Resident #2's legs to the MA when discovered so the PCP could evaluate the resident.
-The MA would inform the MA/S and the MA/S would inform the PCP "right away" and then

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inform the RCC.
-The report of redness to Resident #2's legs and notification of the PCP would be documented in the 24-hour shift report book.

Telephone interview with the Administrator on 03/19/21 at 3:00pm revealed:
-She had not been told by staff Resident #2 had redness to her lower legs.
-She expected Resident #2's PCP to have been informed so the PCP could examine the resident.
-The RCC told Resident #2's PCP this week the resident had dry skin to her legs.
- Resident #2's PCP had ordered a cream for the resident's legs 2 days ago.

A second telephone interview with Resident #2's current PCP on 03/19/21 at 3:38pm revealed:
-She had not been informed by the facility Resident #2's lower legs were red when she was at the facility on 03/16/21.
-She expected to have been told the resident's lower legs were red so she could have examined the resident on 03/16/21.
-She did not examine Resident #2 at the facility on 03/16/21 or anytime this week because she did not know the resident needed to be seen.
-On 03/16/21 she asked the RCC if the resident needed to be seen and was told no by the RCC.
-Resident #2 had venous stasis per hospital records which would cause skin changes and made the resident more prone to infection and cellulitis which could lead to sepsis and death.
-The leg swelling, redness, and pain in Resident #2's lower legs could signify a deep vein thrombosis (DVT) which could cause a blood clot to migrate to the lungs and could result in death.

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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 record reviews and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 5 (#1) sampled residents regarding implementation of order for weekly blood pressure monitoring and to notify a resident's physician of weights and blood pressure results that were outside parameters which were supposed to be reported to the residents primary care physician (PCP). The findings are: Review of Resident #1's current FL-2 dated 07/27/21 revealed: -Diagnoses included Alzheimer's, dementia, hyperlipidemia (high cholesterol), gastroesophageal reflux, glaucoma, dysphagia,	D 276		

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mild cognitive impairment, muscle weakness and lack of coordination.
-The resident required assistance with bathing and dressing.
-The resident was ambulatory with a walker.
-The resident was incontinent of both bladder and bowel.

Review of Resident #1's primary care provider (PCP) notes dated 02/3/21 revealed diagnoses of hypertension, type 2 diabetes, and chronic kidney disease.

Review of Resident #1's hospital discharge summary dated 02/08/21 revealed diagnoses of transient ischemic attach (TIA - mini stroke) and stroke (damage to the brain when blood supply is interrupted or reduced preventing the tissues from access to oxygen and nutrients).

Review of Resident #1's current assessment and care plan dated 11/27/20 revealed:
-She wandered, had significant memory loss, and required redirection.
-She had occasional incontinence of bladder and bowel.
-She used a walker for mobility but had unsteady gait.
-She needed extensive assistance with all activities of daily living (ADL).

Review of the facility's medication and parameter policies revealed:
-The facility should assure medications, prescription and non-prescription treatments would be administered in accordance with the prescribing PCP's orders.
-Individual specified parameters were expected to be followed per the PCP's orders.

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a. Review of Resident #1's facility record on 02/19/21 revealed:
-The resident had a history of hypertension (high blood pressure).
-She had an order for Norvasc 5mg (a medication that treats high blood pressure) twice daily.
-She had an order for Coreg 25mg (a medication that treats high blood pressure) twice daily.
-There was an order from the primary care provider (PCP) to check blood pressure (BP) weekly and record on the MAR, notify provider of systolic blood pressure (SPB) greater than 180 or diastolic blood pressure (DBP) greater than 110.

Review of Resident #1's electronic medication administration (eMAR) record for February 2021 revealed:
-There was no entry on the eMAR for weekly blood pressure checks with parameters to begin on 02/19/21.
-Resident #1's blood pressure was not checked weekly with parameters and documented on the MAR per PCP order in February 2021 for 9 out of 9 days.

Review of Resident #1's eMAR for March 2021 revealed:
-There was no entry for weekly blood pressure monitoring with parameters.
-Resident #1's blood pressure was not checked weekly with parameters and documented on the MAR per PCP order in March 2021 for 16 out of 16 reviewed days.

Review of Resident #1's facility record revealed there was no documentation that the weekly blood pressure monitoring order with parameters had been discontinued.

Telephone interview with the Resident Care

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D 276	Continued From page 26 Coordinator on 03/19/21 at 2:55pm revealed: -She was responsible to process PCP orders either on the date it was written or the next day. -She would read the order then fax it to the pharmacy. -She would call the pharmacy to ensure they received the faxed order. -She sometimes entered blood pressure orders onto the eMAR herself. -She was unsure why Resident #1's weekly blood pressure order did not appear on the eMAR, therefor Resident #1's blood pressure had not been checked against parameters per the PCP order. Telephone interview with the Administrator on 03/19/21 at 1:42pm revealed: -It was the RCC's responsibility to review and initiate orders on the day the order was received. -The RCC was responsible for reviewing orders to made sure they were correct and matched the resident's record. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 03/18/21 at 3:21pm revealed they had not received a weekly blood pressure check order from the facility dated 02/19/21. Telephone interview with Resident #1's PCP on 03/22/21 at 11:56am revealed: -The order dated 02/19/21 to monitor Resident #1's blood pressure weekly with parameters should have been an active order on the resident's eMAR. -If the resident had blood pressures outside of the parameters ordered she would be concerned about hypertensive urgency which could result in end organ damage, stroke, heart attack, and acute kidney injury.	D 276		

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WAKE ASSISTED LIVING	2800 KIDD ROAD RALEIGH, NC 27610

(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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-She would want to be notified if Resident #1 had blood pressures outside of parameters per the order.

b.Review of Resident #1's facility record revealed an order to weight Resident #1 daily and to report a greater than 2-pound weight gain in one day, or a greater than 5-pound weight gain in one week, to the primary care provider (PCP).

Review of Resident #1's electronic medication administration records (eMAR) for March 2021 revealed:
-There was an entry for the resident to be weighed daily and to report a greater than 2-pound weight gain in one day, or a greater than 5-pound weight gain in one week, to the primary care provider (PCP).
-There was documentation that the resident was weighed every day.
-On 03/03/21 Resident #1 was documented at a weight of 98.4 pounds, then documented at 103 pounds the next day, 03/04/21, indicating a 4.6-pound weight gain.
-On 03/07/21 Resident #1 was documented at a weight of 103 pounds, then documented at 108 pounds the next day, 03/08/21, indicating a 5-pound weight gain.
-There was no documentation in the notes on the eMAR that the weight gain outside of parameters was reported to the PCP.

Review of Resident #1's record revealed there was no documentation in the resident record that weights were reported to Resident #1's PCP.

Telephone interview with a medication aide (MA) on 03/19/21 at 9:35am revealed results outside ordered parameters should be reported to the PCP as ordered and Resident Care Coordinator

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D 276	Continued From page 28 (RCC) to get further orders. Telephone interview with the RCC on 03/19/21 at 2:55pm revealed: -She was unaware that Resident #1 had a 4.6-pound weight gain on 03/04/21 and 5-pound weight gain on 03/08/21. -Resident #1's weight gain outside of ordered parameters should have been reported to her and reported to Resident #1's PCP to ensure resident care was administered as ordered. -She was concerned because the weights were not reported, and resident may be retaining fluid. Telephone interview with the Administrator on 03/19/21 at 1:42pm revealed: -It was the MA's responsibility to follow PCP orders and parameter instructions on the eMAR. -She expected the MA to report results outside of ordered parameters to the PCP and documented on an outside parameter documentation form that should then be faxed to the PCP. -Daily resident weights were "resident specific ordered care" that usually monitored a resident for retained fluid or nutritional status. -She was not aware that Resident #1 had a more than 2-pound weight gain overnight on 03/04/21 and 03/08/21 and did not know why it was not reported. -The weight gains should have been reported. Telephone interview with Resident #1's PCP on 03/22/21 at 11:56am revealed: -She was not notified of Resident #1's 4.6-pound weight gain on 03/04/21 and 5-pound weight gain on 03/08/21. -She would have expected to be notified of Resident #1's weight gains per orders. -She would be concerned about Resident #1 retaining fluid which could contribute to fluid	D 276		

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overload and could lead to congestive heart failure, which could then lead to acute failure issues such as difficulty breathing and decreased blood circulation.

c. Review of Resident #1's electronic medication administration records (eMAR) for February 2021 revealed:
-There was an entry to check blood pressure daily for one week beginning 02/11/21 and ending on 02/19/21, notify provider of systolic blood pressure (SBP) great than 180 or diastolic blood pressure (DBP) greater than 110.
-The resident had a blood pressure documented with an SBP greater than 180 on 02/12/21 of 192/98.
-The resident had a blood pressure documented with an SBP greater than 180 on 02/15/21 of 182/108.
-There was no documentation that the provider was notified of SBPs greater than 180 outside of parameter.

Telephone interview with a medication aide (MA) on 03/19/21 at 9:35am revealed she would report blood pressures outside of ordered parameters to the PCP and Resident Care Coordinator (RCC) right away.

Telephone interview with the RCC on 03/19/21 at 2:55pm revealed:
-Staff were expected to follow PCP orders and notify the PCP of any blood pressures outside of parameters.
-Staff were expected to document results outside of parameters on paperwork that was given to the PCP.

Telephone interview with the Administrator on 03/19/21 at 1:42pm revealed she expected staff

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D 276	Continued From page 30 to report blood pressures outside of parameters to the PCP immediately. Telephone interview with Resident #1's PCP on 03/22/21 at 11:56am revealed: -Resident #1 had a history of hypertension (high blood pressure). -Her blood pressures were to be monitored more closely due to hypertension experienced during a recent hospitalization. -She was not notified that Resident #1 had an SBP greater than 180 on 02/12/21 and 02/15/21. -She expected facility staff to notify her of SBPs outside of parameters as ordered. -She would be concerned about the resident having hypertensive urgency which could cause end organ damage, stroke, heart attack, and acute kidney injury. The facility failed to implement orders for weekly blood pressure checks with parameters and reporting blood pressures outside of those ordered parameters related to medication administration for Resident #1 which could have resulted in hypertensive urgency, end organ damage, stroke, heart attack, and acute kidney injury. The facility also failed to report results outside of parameters related to weights for Resident #1 that could have resulted in fluid overload, congestive heart failure, difficulty breathing, and decreased blood circulation. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/12/21 for	D 276		

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D 276	Continued From page 31 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 7, 2021.	D 276		
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 assure the rights of residents were guaranteed as evidence by failing to provide privacy to 2 of 5 sampled residents by exposing the residents during incontinent care and personal hygeine (#1, #2); failing to communicate with 2 of 2 sampled residents who spoke Vietnamese (#3) and Spanish (#6); and failing to provide tray tables to residents. The findings are: 1. Review of Resident #2's current FL-2 dated 05/01/20 revealed: -Diagnoses included Alzheimer's disease, hypertension, gastroesophageal reflux disorder with esophagitis, and heart murmur. -The resident was constantly disoriented, ambulated with a walker, and incontinent of bladder. -The resident needed staff assistance with bathing and dressing.	D 338		

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D 338	Continued From page 32 Review of Resident #2's current Special Care Unit (SCU) quarterly care plan dated 01/14/21 revealed the resident was disoriented and had memory loss, needed staff assistance with activities of daily living (ADLs), and was incontinent of bowel and bladder. Review of Resident #2's care plan dated 05/18/20 revealed: -The resident was sometimes forgetful and needed reminders. -The resident had daily incontinence of bowel and bladder. -The resident required extensive staff assistance with ambulation, toileting, bathing, and grooming. -The resident required staff assistance to clean, change, and adjust garments because of incontinence. -The resident required extensive hands on staff assistance with dressing and undressing. -The resident required extensive hands on staff assistance with transfers due to unsteady gait. Observation of Resident #2's room on 03/17/21 from 6:00am - 6:12am revealed: -There was a female resident awake and laying in bed. -Resident #2 was sitting on the edge of another bed. -The personal care aide (PCA) removed the shirt of Resident #2 and exposed the resident's breast to the first resident. -The PCA assisted Resident #2 to transfer to a wheelchair with her breast exposed. -The PCA proceeded to push Resident #2 in a wheelchair out of the room into the east hallway without covering the resident's breast. -The PCA was prompted by the surveyor to cover Resident #2's breast before exiting the threshold of Resident #2's room door.	D 338		

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D 338	Continued From page 33 Interview with the PCA on 03/17/21 at 6:12am revealed: -She removed Resident #2's shirt because it was saturated with urine. -She did not think of covering Resident #2 with a towel until prompted by the surveyor. -She was going to push Resident #2 in the wheelchair to the community bathroom for a shower with the resident's breast exposed. Interview with the Administrator on 03/17/21 at 8:36am revealed: -It was unacceptable to expose Resident #2's breast during personal care. -It was unacceptable to transport Resident #2 through the hallway and to the community bathroom with her breast exposed because it "violates" the resident's rights for dignity and respect. -The PCA should have covered the Resident #2's breast. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. 2. Review of Resident #1 current FL-2 dated 07/27/20 revealed: -Diagnoses included Alzheimer's, dementia, mild cognitive impairment, muscle weakness and lack of coordination. -She needed assistance with bathing and dressing. -She was incontinent of bladder and bowel. Review of Resident #1's current care plan dated 11/27/20 revealed she required extensive assistance with all activities of daily living (ADLs).	D 338		

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D 338	Continued From page 34 Observation of a personal care aide (PCA) on 03/17/21 at 6:01am revealed: -She was providing Resident #1 with incontinence care, a bed bath, and a clothing change. -The door to Resident #1's room was open about 1 ½ feet. -After being prompted she agreed to close the door leaving only a 1-inch opening. Interview with the personal care aide on 03/17/21 at 6:01am revealed: -She left the door cracked so she could hear and listen out for the other residents regardless of Resident #1's privacy. -She closed the door to 1 inch width after discussion with surveyor. Based on observation, interviews, and record review it was determined that Resident #1 was not interviewable. 3. Review of Resident #3's current FL-2 dated 02/03/21 revealed: -Diagnoses included Alzheimer's disease, Parkinson's disease, and major depressive disorder. -Resident #3 only spoke Vietnamese. -Resident #3 was semi-ambulatory with a wheelchair. Review of Resident #3's care plan dated 02/03/21 revealed: -Resident #3 was sometimes disoriented and forgetful. -Her speech was Vietnamese. Interview with a PCA on 03/16/21 at 3:49pm revealed: -Resident #3 only spoke "Chinese". -Resident #3 had a communication book that had	D 338		

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three statements in it that were in Chinese and translated into English.
-The communication book was supposed to be kept on Resident #3's nightstand next to her bed.
-She found the communication book in the dresser of Resident #3's roommates' nightstand.
-She had not used the communication book to communicate with Resident #3.
-The facility did not provide her with a translator tool to communicate with Resident #3.
-She determined what Resident #3 needed by the body language.

Observation of Resident #3's communication book on 03/17/21 at 3:53pm revealed:
-The communication book was a red folder that contained three laminated sheets of paper.
-The first laminated sheet of paper had the statement "I'm wet of urine" in English and beneath it, the statement was translated in Vietnamese "toi uot dam nuoc tieu".
-The second laminated sheet of paper had the statement "I'm hungry" in English and beneath it, the statement was translated in Vietnamese "toi doi".
-The third laminated sheet of paper had the statement "I want to lay in bed" in English and beneath it, the statement was translated in Vietnamese "Tam on nam tren giuong".

Observation of Resident #3 on 03/17/21 at 7:21am revealed:
-The PCA was providing incontinent care to Resident #3.
-The PCA spoke with Resident #3 in English.
-Resident #3 did not respond to the PCA in English or Vietnamese.

Interview with Resident #3's Primary Care Provider (PCP) on 03/17/21 at 3:07pm revealed:

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-Resident #3 was only under her care for the past month.
-She had last seen Resident #3 once on 03/09/21.
-She believed that Resident #3 was fluent in English at some point in the past.
-She used a translator on her cellphone to communicate with Resident #3.
-Resident #3 did not respond to the translator.
-She did not know how staff communicated with Resident #3.

Interview with the Administrator on 03/17/21 at 8:36am revealed:
-Resident #3 spoke Vietnamese.
-Resident #3 had a communication book of keywords that Resident #3's family member and the facility staff put together when she first arrived at the facility.
-She did not have a translator system in the facility to communicate with Resident #3 in Vietnamese.
-She expected her staff to observe Resident #3's body language and visual cueing to determine what the resident needed.
-Facility staff were trained on visual cueing last month.
-She also expected staff to use a translator system on their phone to communicate with Resident #3.
-She expected staff to call Resident #3's family member if they were unable to communicate with her and needed to.

Interview with the facility's contracted Occupational Therapist (OT) on 03/17/21 at 11:07am revealed:
-He did a cognitive assessment on Resident #3 who had language barriers of speaking Vietnamese.

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-Resident #3 was cognitively able to express her needs and or wants.
-He made a translation book for Resident #3 in her native language that included basic needs.
-The translation book was placed in Resident #3's room on top of her dresser.
-Care staff on the hall where Resident #3 resided was educated on how to use the translation books to communicate basic needs with the resident.
-Staff were told when educated, to let him know if the translation book was not beneficial.
-Staff had not informed him the translation book did not help.

A second interview with the facility's contracted OT on 03/18/21 at 8:50am revealed:
-The translator book for Resident #3 was made about 8 weeks ago.
-He emailed the RCC and the Administrator to inform them of the books the day each translator book was made.

Interview with Resident #3's family member on 03/19/21 at 10:14am revealed:
-Resident #3 spoke Vietnamese.
-Resident was able to understand a little amount of English.
-Staff had not called her to translate for Resident #3.
-She did not know facility staff communicated with Resident #3.
-She did not know if any of the facility staff spoke Vietnamese.
-Resident #3 would not talk unless she was spoken to in Vietnamese.
-She did not have any concerns with the communication between Resident #3 and facility staff.

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D 338	Continued From page 38 Attempted interview with Resident #3 on 03/17/21 at 7:45am was unsuccessful. 4. Review of Resident #6's FL-2 dated 11/03/20 revealed: -Diagnoses included dementia and acute cystitis. -She was nonverbal and semi-ambulatory with a wheelchair. Review of Resident #6's care plan dated 10/16/2 revealed she was always disoriented. Review of Resident #6's hospice noted dated 02/03/21, 01/06/21, 12/10/20, 11/25/20 and 10/29/20 revealed resident was Spanish speaking only and nonverbal. Interview with a personal care aide (PCA) on 03/17/21 at 6:50am revealed: -She started at the facility 3 to 4 months ago and Resident #6 had not spoken to her since. -She communicated with Resident #6 verbally by speaking English. -She was not certain Spanish was Resident #6's primary language because Resident #6 had never spoke to staff or responded to staff when Spanish was used. -She used visual aides to communicate with Resident #6. -She had not expressed a concern regarding the communication barrier with Resident #6 to anyone. Observation of Resident #6 on 03/17/21 at 7:31am revealed: -Staff communicated with Resident #6 verbally using English. -Resident #6 did not communicate verbally or nonverbally with staff. -Resident #6 resisted care from staff.	D 338		

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D 338	Continued From page 39 Interview with the facility's contracted Occupational Therapist (OT) on 03/17/21 at 11:07am revealed: -He did a cognitive assessment on Resident #6 who had language barriers of speaking Spanish. -Resident #6 was cognitively able to express her needs and or wants. -He made a translation book for Resident #6 in her native language that included basic needs. -The translation book was placed in Resident #6's room on top of her dresser. -Care staff on the hall where Resident #6 resided was educated on how to use the translation books to communicate basic needs with the resident. -Staff were told when educated, to let him know if the translation book was not beneficial. -Staff had not informed him the translation book did not help. A second interview with the facility's contracted OT on 03/18/21 at 8:50am revealed: -The translator book for Resident #6 was made about 2 weeks ago. -He emailed the RCC and the Administrator to inform them of the books the day each translator book was made. Interview with another PCA on 03/17/21 at 1:20pm revealed: -Resident #6 had not communicated with her since she started at the facility January 2021. -She used visual aides to communicate with Resident #6. Interview with a medication aide (MA) on 03/17/21 at 1:24pm revealed: -Resident #6 was verbal and spoke Spanish when she was admitted to the facility.	D 338		

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D 338	Continued From page 40 -Staff did not understand Resident #6 when she was verbal due to the language barrier. -Resident #6 did not communicate with residents or staff. Interview with the Resident Care Coordinator on 03/17/21 at 6:00pm revealed: -She had been working at the facility for 2 years. -Resident #6 spoke Spanish when she was admitted to the facility. -Resident #6 had declined since COVID-19 and stopped attempting to communicate verbally. -She expected staff to communicate with Resident #6 using nonverbal cues. -She expected staff to use electronic devices to translate for Resident #6. -She expected staff to monitor Resident #6 to determine her needs. Interview with the Administrator on 03/19/21 at 12:16pm revealed: -Resident #6 had declined in the past few months and did not show any signs of communication. -She expected staff to use visual aides to communicate with Resident #6. Attempted telephone interview with Resident #6's guardian on 03/19/21 at 12:15pm was unsuccessful. 5. Observation of a resident in room #101 who resided on the east hall on 03/17/21 at 12:14pm revealed: -The resident was eating lunch using her night stand as a table. -The resident was confused. -There was no tray table located in the room. -There was no staff in the room. Interview with a resident on 03/17/21 at 7:46am	D 338		

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D 338	Continued From page 41 revealed: -She would like to place her food on a table. -She was told she would be able to hold her plate in her hands. -Resident said it was uncomfortable to eat while holding her plate in her hands. Interview with a second resident on 03/17/21 at 7:57am revealed: -She would prefer to have a table to eat her food. -She was not able to hold her plate in her hands because she had tremors; therefore, staff had to assist her with her meals. Interview with a personal care aide on 03/17/21 at 7:45am revealed there were no trays available to place residents' food. Interview with the Administrator on 03/17/21 at 8:36am revealed: -The facility did not have enough tray tables for all residents. -The residents who could feed themselves were given tray tables. -The lower functioning residents would use their night stands to eat off; staff would feed those residents. _____ The facility failed to treat residents with respect, privacy and dignity by leaving the door open while providing personal care to Resident #1 and Resident #2, exposed Resident #2's (who was confused and diagnosed with Alzheimers) breast to another resident and attempted to wheel the resident into the east hallway exposing her breast; failed to ensure staff communicated with 2 of 2 sampled residents (#3, #6) who spoke Vietnamese and Spanish resulting in a language barrier between staff and residents; and failing to provide tray tables for residents. The facility's	D 338		

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D 338	Continued From page 42 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 03/17/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 7, 2021.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 7 residents (#7, #8, #9, #10, #11) observed during the medication passes including errors with inhalers for breathing problems (#7), a nasal spray for allergies (#8), and oral medications ordered with meals (#9, #10, #11); and for 2 of 5 residents sampled (#1, #2) whose antihypertensive medication was not held as ordered (#1) and whose anticoagulant was held without an order (#2).	D 358		

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D 358	Continued From page 43 Review of the facility's medication administration policy revealed medications, prescription and nonprescription, and treatments would be administered in accordance with the prescribing Primary Care Provider's (PCP) orders. The findings are: 1. The medication error rate was 22% as evidenced by the observation of 6 errors out of 27 opportunities during the 12:00pm medication passes on 03/16/21 and 8:00am medication passes on 03/17/21. a. Review of Resident #10's current FL-2 dated 06/08/20 revealed diagnoses included Alzheimer's disease, dementia, hypertension. Review of Resident #10's electronic physician's order with a print date of 09/14/20 revealed: -There was an order for Carbidopa/Levodopa 25-100 milligrams (mg) 3 times daily with meals. [A combination medication used to treat symptoms of Parkinson's disease or Parkinson-like symptoms (such as shakiness, stiffness, difficulty moving)]. -The order was not dated. -The order was signed by the previous Primary Care Provider (PCP). Review of Resident #10's March 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Carbidopa/Levodopa 25-100mg 3 times daily with meals. -Carbidopa/Levodopa was to be administered at 8:00am, 12:00pm, and 4:00pm. -Carbidopa/Levodopa was administered three times daily from 03/01/21 - 03/15/21.	D 358		

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-Carbidopa/Levodopa was administered at 8:00am and 12:00pm on 03/16/21.

Review of Resident #10's Carbidopa/Levodopa pharmacy label revealed there was documentation to take 3 times daily with meals.

Observation of the 12:00pm medication pass on 03/16/21 revealed:
-The medication aide/supervisor (MA/S) compared the Carbidopa/Levodopa pill pack to the eMAR.
-The MA/S administered Carbidopa/Levodopa to Resident #10 at 11:16am.
-The MA/S did not ask Resident #10 if he had eaten.
-The MA/S did not offer Resident #10 food.
-The MA/S returned to the medication cart and documented administration of Carbidopa/Levodopa on the eMAR.
-The MA/S continued with the medication pass.

Interview with Resident #10 on 03/16/21 at 11:15am revealed:
-He had chocolate pudding as a snack at 10:00am.
-He had not eaten lunch.

Interview with the MA/S on 03/16/2 at 11:16am revealed lunch would be served to the residents at 12:00pm.

A second interview with the MA/S on 03/16/21 at 2:51pm revealed:
-He compared the Carbidopa/Levodopa orders on the pill pack to the orders on the eMAR.
-He "overlooked" the instructions to take with meals.
-The medications populated on the eMAR 1 hour before due and he was in a hurry to pass

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medications.
-There was no alert on the eMAR to flag medications that were ordered to be administered with meals.
-He should have administered the Carbidopa/Levodopa to Resident #10 about 5 minutes before lunch.
-He had never administered Carbidopa/Levodopa to Resident #10 with meals.

Telephone interview with Resident #10's current PCP on 03/17/21 at 4:00pm revealed:
-She expected the MAs to administer medications as ordered.
-She became the facility PCP about one month ago.
-Carbidopa/Levodopa was used to treat behaviors or Parkinson's Disease.
-She did not know the reason Resident #10 was prescribed Carbidopa/Levodopa because it was ordered by the previous PCP.
-Carbidopa/Levodopa was to be administered with meals to aide in absorption.
-Carbidopa/Levodopa could cause indigestion or diarrhea if not administered with meals.

Refer to interview with the Resident Care Coordinator on 03/16/21 at 3:30pm.

Refer to interview with the Administrator on 03/17/21 at 4:30pm.

b. Review of Resident #11's current FL-2 dated 01/20/21 revealed:
-Diagnoses included multi-infarct dementia, anemia, gastroesophageal reflux disease, and chronic subdural hematoma.
-There was an order for antacid chewable 1000 milligrams (mg) three times daily with meals. (Antacid is a medication used to decrease

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D 358	Continued From page 46 stomach acid.) Review of Resident #11's March 2021 electronic medication administration record (eMAR) revealed: -There was an entry for antacid chewable 1000mg three times daily with meals. -Antacid was scheduled to be administered at 8:00am, 12:00pm, and 5:00pm. -Antacid was administered at 8:00am, 12:00pm, and 5:00pm from 03/01/21 - 03/03/21, 03/06/21, and 03/08/21 - 03/15/21. -Antacid was administered at 8:00am and 12:00pm on 03/04/21, 03/05/21, 03/07/21, and 03/16/21. Review of Resident #10's antacid pharmacy label revealed there was documentation to take antacid three times daily with meals. Observation of the 12:00pm medication pass on 03/16/21 revealed: -The medication aide/supervisor (MA/S) compared the Antacid container label to the eMAR. -The MA/S administered Antacid to Resident #11 at 11:22am. -The MA/S did not ask Resident #11 if he had eaten. -The MA/S did not offer Resident #11 food. -The MA/S returned to the medication cart and documented administration of Antacid on the eMAR. -The MA/S continued with the medication pass. Interview with the MA/S on 03/16/21 at 11:16am revealed lunch would be served to the residents at 12:00pm. A second interview with the MA/S on 03/16/21 at	D 358		

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2:51pm revealed:
-He compared the Antacid orders on the bottle to the orders on the eMAR.
-He did not realize there were orders to administer Resident #11 the antacid with meals until today (03/16/21).
-The medications populated on the eMAR 1 hour before due and he was in a hurry to pass medications.
-There was no alert on the eMAR to flag medications that were ordered to be administered with meals.
-He should have administered the antacid to Resident #11 about 5 minutes before lunch.
-He had never administered antacid to Resident #11 with meals.

Telephone interview with Resident #11's Primary Care Provider (PCP) on 03/17/21 at 4:00pm revealed:
-She expected the MAs to administer medications as ordered.
-Antacid was ordered to take with food to improve absorption and decrease gastric acid build up in the stomach.
-Antacid not administered with food could cause gastrointestinal upset.

Refer to interview with the Resident Care Coordinator on 03/16/21 at 3:30pm.

Refer to interview with the Administrator on 03/17/21 at 4:30pm.

Based on observations, interviews, and record reviews it was determined Resident #11 was not interviewable.

c. Review of Resident #9's current FL-2 dated 01/20/21 revealed:

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D 358	Continued From page 48 -Diagnoses included dementia, hypertension, gastroesophageal reflux disorder, and chronic kidney disease. -There was an order for Sodium Chloride 1 gram (g) three times daily with meals. (Sodium Chloride is a medication used to treat or prevent sodium loss). Review of Resident #9's March 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Sodium Chloride 1g three times daily with meals. -Sodium Chloride was scheduled to be administered at 7:30am, 12:15pm, and 5:15pm. -Sodium Chloride was documented as administered at 7:30am, 12:15pm, and 5:15pm from 03/01/21 - 03/15/21. -Sodium Chloride was documented as administered at 7:30am and 12:15pm on 03/16/21. Observation of the 12:00pm medication pass on 03/16/21 revealed: -The medication aide/supervisor (MA/S) compared the Sodium Chloride label to the eMAR. -The MA/S administered Sodium Chloride to Resident #9 at 11:22am. -The MA/S did not ask Resident #9 if she had eaten. -The MA/S did not offer Resident #9 food. -The MA/S returned to the medication cart and documented administration of Sodium Chloride on the eMAR. -The MA/S continued with the medication pass. Interview with the MA/S on 03/16/21 at 11:16am revealed lunch would be served to the residents at 12:00pm.	D 358		

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D 358	Continued From page 49 A second interview with the MA/S on 03/16/21 at 2:56pm revealed: -He compared the Sodium Chloride label on the pill pack to the orders on the eMAR to be sure the resident and medication names matched. -He did not read the complete order that contained the order to administer Sodium Chloride with meals. -He did not realize there were orders to administer Resident #9 Sodium Chloride with meals until today 03/16/21). -The medications populated on the eMAR 1 hour before due and he was in a hurry to pass medications. -There was no alert on the eMAR to flag medications that were ordered to be administered with meals. -He should have read the complete order and administered Sodium Chloride to Resident #9 with her meal. -He had never administered Sodium Chloride to Resident #9 with meals. Telephone interview with Resident #9's Primary Care Provider (PCP) on 03/17/21 at 4:00pm revealed: -Resident #9 was prescribed Sodium Chloride to treat Syndrome of Inappropriate Antidiuretic Hormone Secretion [(SIADH) a condition where the body makes too much antidiuretic hormone causing the body to retain to much water.] which placed the resident at risk for hyponatremia (abnormally low sodium levels in the blood). -She expected the MAs to administer Resident #9's Sodium Chloride with meals as ordered. -Administering Sodium Chloride with meals would help prevent hyponatremia because more fluid was consumed with meals which could cause hyponatremia.	D 358		

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-Hyponatremia could cause nausea, vomiting, headache, confusion, and weakness.

Refer to interview with the Resident Care Coordinator on 03/16/21 at 3:30pm.

Refer to interview with the Administrator on 03/17/21 at 4:30pm.

Based on observations, interviews, and record reviews it was determined Resident #9 was not interviewable.

d. Review of Resident #7's current FL-2 dated 01/26/21 revealed diagnoses included Alzheimer disease, vascular dementia, chronic obstructive pulmonary disease (COPD), and diabetes myelitis.

Review of Resident #7's physician's order dated 03/16/21 revealed:
-There was an order for Symbicort Aerosol 160-4.5 inhale 2 puffs by mouth twice daily. [Symbicort is a bronchodilator inhaler used to treat COPD. The mouth should be rinsed with water after use to lessen the chance of getting thrush (a fungal) infection].
-Rinse after use.

Review of Resident #7's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort aerosol 160-4.5 inhale 2 puffs by mouth twice daily. Rinse mouth after use.
-Symbicort was scheduled to be administered at 8:00am and 8:00pm.
-Symbicort was documented as administered twice daily from 03/01/21 - 03/15/21.
-Symbicort was documented as administered on

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D 358	Continued From page 51 03/16/21 at 8:00am. -The MA administered Symbicort to Resident #7 for 13 out of 17 days. Observation of the 8:00am medication pass on 03/17/21 revealed: -The medication aid (MA) prepared and administered 1 puff of the Symbicort at 7:38am. -The MA administered a 2nd puff of the Symbicort at 7:38am. -The MA placed the Symbicort back in a clear plastic zip bag. -The MA continued to administer medications to Resident #7. -The MA did not prompt Resident #7 to rinse her mouth after inhaling the Symbicort. Interview with the MA on 03/17/21 at 1:30pm revealed: -She compared the Symbicort orders that were on the clear plastic zip closure bag to the order on the eMAR for any additional instructions. -The only instructions on the eMAR for Symbicort were to shake prior to administering. -She did not see instructions on the eMAR and the medication label to rinse the mouth after inhaling Symbicort. -She had never had Resident #7 rinse her mouth after inhaling Symbicort. -She was not trained to have residents rinse their mouth after administering inhalants. Telephone interview with Resident #7's Primary Care Provider (PCP) on 03/17/21 at 4:00pm revealed: -Staff were expected to have Resident #7 rinse her mouth with water after inhaling Symbicort to prevent thrush. -Thrush was a yeast infection that could cause mouth pain and/or ulcers.	D 358		

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-She expected the MAs to administer medications as ordered.

Refer to interview with the Resident Care Coordinator on 03/16/21 at 3:30pm.

Refer to interview with the Administrator on 03/17/21 at 4:30pm.

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

e. Review of Resident #7's current FL-2 dated 01/26/21 revealed diagnoses included Alzheimer disease, vascular dementia, chronic obstructive pulmonary disease (COPD), and diabetes myelitis.

Review of Resident #7's physician's order dated 03/16/21 revealed:
-There was an order for Incruse Ellipta inhaler 62.5 micrograms (mcg) 1 cap per inhalation daily. [Incruse Ellipta is an inhaler used to treat chronic obstructive pulmonary disease. The mouth should be rinsed with water after use to lessen the chance of getting thrush (a fungal) infection.]
-Rinse mouth after use.

Review of Resident #7's March 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Incruse Ellipta, inhale 1 cap per inhalation daily. Rinse mouth after use.
-Incruse Ellipta was scheduled to be administered at 8:00am.
-Incruse Ellipta was documented as administered daily from 03/01/21 - 03/17/21.

Observation of the 8:00am medication pass on

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D 358	Continued From page 53 03/17/21 revealed: -The medication aide (MA) prepared and administered 1 puff of Incruse Ellipta at 7:41am. -The MA placed the Incruse Ellipta back in the clear plastic zip bag. -The MA continued to administer Resident #7 medications. -The MA put the Incruse Ellipta inhaler back in the medication cart and continued the medication pass. -The MA did not prompt Resident #7 to rinse her mouth after inhaling the Incruse Ellipta. Interview with the MA on 03/16/21 at 1:30pm revealed: -She compared the Incruse Ellipta inhalant orders that were on the clear plastic zip closure bag to the order on the eMAR for any additional instructions. -The only instructions on the eMAR for Incruse Ellipta inhalant were to shake prior to administering. -She did not see instructions on the eMAR or the medication label to rinse the mouth after inhaling Incruse Ellipta. -She had never had Resident #7 rinse her mouth after inhaling Incruse Ellipta. -She was not trained to have residents rinse their mouth after administering inhalants. Telephone interview with Resident #7's Primary Care Provider (PCP) on 03/17/21 at 4:00pm revealed: -Staff were expected to have Resident #7 rinse her mouth with water after inhaling Incruse Ellipta to prevent thrush. -Thrush was a yeast infection that could cause mouth pain and/or ulcers. -She expected the MAs to administer medications as ordered.	D 358		

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D 358	Continued From page 54 Refer to interview with the Resident Care Coordinator on 03/16/21 at 3:30pm. Refer to interview with the Administrator on 03/17/21 at 4:30pm. Based on observations, interviews, and record reviews Resident #7 was not interviewable. 2. Review of Resident #2's current FL-2 dated 05/01/20 revealed: -Diagnoses included Alzheimer's disease, hypertension, gastroesophageal reflux disorder with esophagitis, and heart murmur. -There was an order for Eliquis 2.5 milligram (mg) twice daily (Eliquis is a blood thinner medication used to treat and prevent blood clots and may take longer for bleeding to stop). Review of Resident #2's physician's order with a print date of 09/14/20 revealed: -There was an order for Eliquis 2.5mg twice daily. -The order was not dated. -The order was signed by the resident's Primary Care Provider (PCP). Review of Resident #2's oral surgeons "request for risk assessment" dated 01/20/21 revealed: -There was documentation the resident was scheduled for surgical teeth extraction under general and local anesthesia. -There was documentation the resident was prescribed Eliquis. -There was an order to hold Eliquis 24 - 48 hours prior to surgery and to resume the day following surgery. -The risk assessment was signed by Resident #2's PCP on 01/20/21.	D 358		

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Review of Resident #2's incident/accident report dated 01/21/21 at 9:30pm revealed:
-There was documentation the resident had a "procedure", was continuing to bleed, and was transferred to the local hospital by emergency medical services (EMS).
-There was documentation the resident returned with no additional medications and staff was to monitor.
-It was signed by the medication aide/supervisor (MA/S) on 01/21/21.
-It was signed by the Administrator on 01/22/21.

Review of Resident #2's local hospital emergency department (ED) visit note dated 01/21/21 revealed:
-The resident had 6 teeth removed on 01/21/21.
-The resident was administered Eliquis 01/21/21 after surgery.
-There was heavy bleeding with large clots removed from the resident's mouth per EMS.
-A large clot was removed from the resident's mouth in the ED with continued oozing from dental extraction sites.
-The resident required an intravenous access and labs to assess prothrombin times (a blood test that measures how long it takes for the blood to clot. Normal is 9.9 - 12.7 seconds), hemoglobin (a blood test that measures the amount of red blood cells. Normal is 11.4 - 15.0), and hematocrit (a blood test that measures the volume of percentage of red blood cells in the blood. Normal is 31 - 42).
-The resident's laboratory results were hemoglobin 8.1, hematocrit 24%, and prothrombin time 16.6.
-The resident required 2 Lidocaine and 2 epinephrine injections into the resident's gumline. (Lidocaine and epinephrine are medications used to control bleeding.)

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-The resident required a gauze soaked with Tranexamic Acid (a medication used to control bleeding) applied to the bleeding gum line for 30 minutes.
-The resident was diagnosed with postprocedural hemorrhage of skin and subcutaneous tissue.
-The resident was discharged at 2:58am with instructions to hold the 8:00am dose of Eliquis on 01/22/21.
-The visit note was electronically signed by the ED provider.

Review of an email from Resident #2's oral surgeon dated 01/21/21 at 11:15pm revealed:
-There was documentation to hold the resident's Eliquis for the next 24 - 48 hours to stop acute bleeding from extractions.
-There was documentation the oral surgeon had written communication with the facility to hold the Eliquis for the next 24 - 48 hours prior to extraction surgery on 01/21/21.
-He had been verbally informed the Eliquis was held for 24 hours prior to surgical extraction on 01/21/21.
-There was no documentation who informed the oral surgeon the resident's Eliquis was held for 24 hours prior to surgical extraction on 01/21/21.
-He was informed the night of 01/21/21 the resident's Eliquis was administered the morning of 01/21/21 prior to the surgical extraction.
-There was no electronic signature.

Review of Resident #2's January 2021 electronic administration medication record (eMAR) revealed:
-There was an entry for Eliquis 2.5mg twice daily.
-There was documentation Eliquis was administered at 8:00am and 8:00pm from 01/20/21 - 01/21/21 and 01/24/21 - 01/31/21.
-There was documentation Eliquis was not due

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from 01/22/21 - 01/23/21.
-Eliquis was not administered at 8:00am and 8:00pm from 01/22/21 - 01/23/21.

Interview with the MA/S on 03/18/21 at 7:30am revealed:
-Resident #2 had dental surgery in January 2021.
-Resident #2 did not have an order to hold Eliquis prior to, or the day of her 01/21/21 dental surgery.
-She administered Resident #2 Eliquis at 8:00pm on 01/21/21.
-She called EMS for Resident #2 on the night of 01/21/21 because she was bleeding "heavy" from her mouth.
-Resident #2 had a hospital discharge order to hold Eliquis for 2 days after hospital discharge.

Interview with the Administrator on 03/18/21 at 7:54am revealed:
-Resident #2 was sent to the hospital in January 2021 for bleeding.
-The transporter or the Resident Care Coordinator (RCC) called Resident #2's oral surgeon on 01/12/21 and was told to stop the Eliquis.
-She had not seen Resident #2's surgery risk assessment order form dated 01/20/21.
-The risk assessment form was a physician's order because it was signed by the PCP.
-The RCC should have implemented the hold Eliquis order dated 01/20/21.

Telephone interview with the dental assistant for Resident #2's oral surgeon on 03/18/21 at 8:44am revealed:
-Resident #2 had 7 teeth surgically extracted on 01/21/21.
-The risk assessment form was a recommendation from the oral surgeon for the resident's PCP to hold the Eliquis to decrease

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post-operative bleeding.
-The risk assessment form would become an order once signed by the PCP.

Interview with the RCC on 03/18/21 at 2:39pm revealed:
-Resident #2 was evaluated by an oral surgeon on 01/20/21.
-The oral surgeon sent Resident #2's request for risk assessment form back to the facility with the transporter.
-The RCC, without reviewing, placed Resident #2's risk assessment form in a folder for the PCP to review and sign on 01/20/21.
-Resident #2's PCP reviewed and signed the form on 01/20/21 and placed it in a folder on the RCC's desk.
-The risk assessment form became an order once signed by Resident #2's PCP.
-The RCC did not have time to review Resident #2's risk assessment form order before the resident's surgical appointment on 01/21/21.
-The RCC, without reviewing, obtained Resident #2's risk assessment order from the folder on 01/21/21 and gave to the transporter for the oral surgeon.
-The RCC did not review Resident #2's order because she was "swamped" with tasks.
-Resident #2 had oral extractions on 01/21/21 and was returned the facility the same day.
-The night of 01/21/21, Resident #2 was bleeding from her mouth and blood was on her clothing; EMS was called to transport to the hospital.
-She tried to review orders immediately when received, if not immediate, she would review within 2 - 3 hours of receipt.
-Resident #2's PCP did not tell her to stop the resident's Eliquis or discuss/review the order with her.
-The process to ensure orders were not missed

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was to write a reminder on a sticky note; she did not write on a sticky note to review Resident #2's hold Eliquis order on 01/20/21.
-She thought it was the responsibility of Resident #2's PCP to have told her the surgical risk assessment dated 01/20/21 was an order and needed to be processed.
-If she had read Resident #2's order dated 01/20/21 she would have placed a hold on the Eliquis.

Telephone interview with the Administrator on 03/19/21 at 3:00pm revealed she expected the RCC to review and initiate all orders the same day received to ensure safe resident care.

Telephone interview with the RCC on 03/19/21 at 3:30pm revealed:
-There was not a signed order to hold Resident #9's Eliquis for 8:00pm dose on 01/22/21 and the 8:00am and 8:00pm doses on 01/23/21.
-She did not obtain a verbal order to hold Resident #2's Eliquis for 8:00pm dose on 01/22/21 and the 8:00am and 8:00pm doses on 01/23/21.
-There was an email dated 01/21/21 sent to the transporter from Resident #2's oral surgeon that stated to hold the Eliquis for the next 24 - 48 hours.
-Resident #2's oral surgeon told the transporter during a phone call on the night of 01/21/21 to hold the resident's Eliquis for 2 days after the 01/21/21 ED visit discharge.
-The transporter told the RCC that Resident #2's oral surgeon wanted to hold the resident's Eliquis for 2 days after the 01/21/21 ED visit discharge.
-The RCC did not speak with Resident #2's oral surgeon to take a verbal order to hold the Eliquis.
-The transporter was relaying messages between the oral surgeon and the RCC because the RCC

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was busy helping prepare the resident for transport.
-The RCC did call the oral surgeon back on the night of 01/21/21 for a verbal order but there was no answer.
-The RCC did not attempt to call the oral surgeon back after that attempt.
-The RCC did not call Resident 2's PCP for an order to hold the Eliquis.

Telephone interview with Resident #2's PCP on 03/19/21 at 3:38pm reveled:
-She expected the facility to have reviewed the request for risk assessment form from the resident's oral surgeon when received signed by the resident's previous PCP to ensure the Eliquis was held prior to surgery.
-She expected Resident #2's Eliquis to have been held prior to surgical extraction of the teeth because Eliquis was a blood thinner; it would have been difficult to stop a bleeding episode during surgery which could have led to hypovolemia (low blood volume) and hypovolemic shock.
-She expected the facility to have contacted the on-call provider for the resident's Eliquis orders after speaking with the oral surgeon and the resident was discharged from the hospital.
-Holding Eliquis placed the resident at risk for blood clots.
-The longer the Eliquis was held increased the resident's risk for developing blood clots.
-The resident was prescribed Eliquis for a heart murmur, which placed the resident at risk for blood clots from blood regurgitation.
-A blood clot to the resident's lungs could be fatal.

Attempted interview with the transporter on 03/17/21 at 12:20pm was unsuccessful.

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Attempted telephone interview with Resident #2's oral surgeon on 03/18/21 at 8:44am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

3. Review of the facility's medication and parameter policies revealed:
-The facility should assure medications, prescription and non-prescription treatments would be administered in accordance with the prescribing PCP's orders.
-Individual specified parameters were expected to be followed per the PCP's orders.

Review of Resident #1's current FL-2 dated 07/27/20 revealed diagnoses that included Alzheimer's, dementia, hyperlipidemia (high cholesterol), gastroesophageal reflux, glaucoma, dysphagia, mild cognitive impairment, muscle weakness and lack of coordination.

Review of Resident #1's primary care provider (PCP) notes dated 02/3/21 revealed diagnoses of hypertension, type 2 Diabetes Mellitus, and chronic kidney disease.

Review of Resident #1's hospital discharge summary dated 02/08/21 revealed diagnoses of transient ischemic attack (TIA - mini stroke) and stroke (damage to the brain when blood supply is interrupted or reduced preventing the tissues from access to oxygen and nutrients).

a. Review of Resident #1's current FL-2 dated 07/27/20 revealed an order for Carvedilol 25mg (used to treat high blood pressure) take one tab twice daily, hold if systolic blood pressure (SBP)

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D 358	Continued From page 62 less than 100. Review of Resident #1's electronic medication administration records (eMAR) for March 2021 revealed: -There was an entry for Carvedilol 25mg to be administered twice daily at 8:00am and 8:00pm, hold if SBP less than 100. -There was documentation that Resident #1 was administered the medication on 03/08/21 at 8:00pm when it should have been held, because the residents SBP was 97 which was less than 100. Telephone interview with a medication aide on 03/19/21 at 9:35am revealed: -Blood pressure medications were to be administered as ordered and held if a resident's BP was outside of parameters. -She would also document this on the 'daily shift report' that the facility used for handoff communications between shifts. Telephone interview with the RCC on 03/19/21 at 2:55pm revealed: -Blood pressure medications should have been held for Resident #1 with an SBP outside of parameter per orders on 03/08/21 to ensure the resident stayed stable. -Holding the medication should have been documented on the eMAR. Telephone interview with the Administrator on 03/19/21 at 1:42pm revealed: -Medications with parameters were to be administered as ordered and held if outside parameters. -Results outside parameters were to be reported to the PCP and documented on the parameter form.	D 358		

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-She had concerns regarding the safety of Resident #1 if this process was not followed.
-Not holding Resident #1's BP medication could have lowered her blood pressure even more.
-She did not know why Resident #1's BP medication was not held and reported to the PCP.

Telephone interview with Resident #1's PCP on 03/22/21 at 11:56am revealed:
-She expected facility staff to hold the resident's blood pressure medication per ordered parameters.
-Administering the resident's blood pressure medication with an SBP less than 100 could lower the resident's blood pressure even more causing hypotension (low blood pressure), dehydration, dizziness, or falls.

Refer to interview with the RCC on 03/16/21 at 3:30pm.

Refer to interview with the Administrator on 03/17/21 at 4:30pm.

b. Review of Resident #1's current FL-2 dated 07/27/20 revealed and order for diabetic accucheck testing (blood sugar testing) twice daily.

Review of Resident #1's facility record revealed the finger stick blood sugar (FSBS) testing was scheduled to occur at 8:00am and 8:00pm every day.

Review of Resident #1's emergency department discharge instructions dated 02/07/21 revealed the resident had been treated for hypoglycemia (low blood sugar).

Review of Resident #1's emergency deparment

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and hospitilization notes dated 02/08/21-02/09/21 revealed:
-The resident had been admitted and treated for hypoglycemia.
-All of her diabetes medications to include oral pills and injectable insulin had been discontinued to prevent future hypoglycemia.

Review of Resident #1's electronic medication record (eMAR) for February 2021 and March 2021 revealed:
-There was an entry to check blood sugar twice daily; if finder stick blood sugar (FSBS) less than 40 call EMS, give 8oz. of juice, and notify the provider; if FSBS 40-60 give 8oz. of juice; if FSBS 61-80, give 4oz. of juice.
-There was documentation of a FSBS on 02/21/21 of 75.
-There was documentation of a FSBS on 03/12/21 of 80.
-There was no documentation that juice was provided to the resident on 02/21/21 or 03/12/21.
-There was no documentation that Resident #1's blood sugar was rechecked to ensure it came up on 02/21/21 or 03/12/21.

Telephone interview with a medication aide (MA) on 03/19/21 at 9:35am revealed:
-She would follow blood sugar parameter orders and provide a resident juice for low blood sugars as ordered.
-After administering juice for low blood sugars, she would recheck the resident's blood sugar.
-If the resident's blood sugar was still low after receiving juice, she would notify the resident's primary care provider (PCP) and the Resident Care Coordinator (RCC) for further orders.
-She would document this on daily shift report.

Review of the daily shift reports and Resident

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D 358	Continued From page 65 #1's facility record revealed there was no documentation that juice was offered to Resident #1, or that her blood sugar was rechecked to ensure it came up on 02/21/21 and 03/12/21. Telephone interview with the RCC on 03/19/21 at 2:55pm revealed: -She was unaware that Resident #1 required low blood sugar interventions on 02/21/21 and 03/12/21 per the parameter orders. -She expected staff to follow the parameter orders and document this on the medication technician communication form. -The staff should have rechecked Resident #1's blood sugar to make sure it came up. Telephone interview with the Administrator on 03/19/21 at 1:42pm revealed: -She expected staff to follow physician parameter orders and notify the primary care provider of any results outside of parameters. -She expected results outside of parameter to be documented on the MAR or parameter documentation sheet and faxed to the PCP. Telephone interview with Resident #1's PCP on 03/22/21 at 11:56am revealed: -She would expect the facility staff to document interventions per parameter orders to treat low blood sugars. -She would have reviewed the documentation at her next visit and adjusted medication as needed. -It was concerning that Resident #1 was having low blood sugars. -She would want to know if the resident had any other symptoms when having low blood sugar. -Resident #1 may have had low blood sugars due to not eating enough. -If Resident #1 continued to have low blood sugars it could lead to coma.	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 66 Refer to interview with the RCC on 03/16/21 at 3:30pm. Refer to interview with the Administrator on 03/17/21 at 4:30pm. _____ Interview with the Resident Care Coordinator (RCC) on 03/16/21 at 3:30pm revealed: -She expected the MAs to compare the orders on the eMAR to the orders on the medication label for a total of 3 times to ensure appropriate administration. -It was the responsibility of the RCC to ensure medications were administered as ordered by random observations of the medication passes. Interview with the Administrator on 03/17/21 at 4:30pm revealed: -She expected medications to be administered as ordered. -She expected the MAs to have compared the orders on the medication label to the orders in the eMAR to ensure the medication was administered as ordered. _____ The facility failed to administer medications as ordered for 5 of 7 residents observed during the medication passes resulting in a 22% medication error rate with 6 errors out of 27 opportunities including Resident #7 who was diagnosed with diabetes and chronic obstructive pulmonary disease and placed at risk for mouth pain and oral lesions by not rinsing the resident's mouth after administering inhalants; and Resident #2 who was prescribed a blood thinner and had an order to hold the blood thinner on 01/20/21 and 01/21/21 to prevent post operative bleeding from surgical dental extractions on 01/21/21, who was administered the blood thinner twice daily on	D 358		

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D 358	Continued From page 67 01/20/21 and 01/21/21, had uncontrolled bleeding of the gums, required emergency transport to the local hospital, required 4 injections of medications used to stop bleeding in the gumline and pressure for 30 minutes with a gauze soaked in medication to stop bleeding placing the resident at risk for acute blood loss and shock; held the blood thinner for 3 doses without an order placing the resident at risk for blood clots that if migrated to the lungs could have been fatal. The failure of the facility to administer medications as ordered resulted in substantial risk of serious physical harm or death and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/17/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 16, 2021.	D 358		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION 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	D 612		

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D 612	Continued From page 68	D 612		

local health
department, the specific guidance or directives shall be implemented by the facility.

This Rule is not met as evidenced by:
Based on observations 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 (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to staff not wearing personal protective equipment (PPE), a mask while on duty in the facility, staff were not self-screened, staff were not prompting visitors to screen.

The findings are:

Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the Coronavirus Disease in long-term care (LTC) facilities dated 11/20/20 revealed:
-Healthcare personnel should always wear a facemask while they are in the facility.
-Residents should wear a facemask (if tolerated) whenever they leave their room.

Review of the Centers for Disease Control (CDC) infection control guidance dated 02/23/21 revealed:
-Facilities should have established a process to ensure everyone (residents, healthcare personnel, and visitors) that entered the facility is assessed for symptoms of COVID-19, or exposure to others with suspected or confirmed COVID-19.

Review of the CDC's Considerations for Memory

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Care Units in Long-term Care Facilities dated 05/12/20 revealed facilities should limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area.

Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of coronavirus in LTC facilities dated 12/22/20 revealed:
-Screening of all individuals who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions, or observations about signs or symptoms).
-Facility must conduct daily screening for the presence of symptoms and known exposure to COVID-19 and temperature check of all residents and staff, and social distancing at least six feet between persons.
-Appropriate staff use of personal protective equipment (PPE).
-Staff must be present to allow for help with the screening of visitors.

Review of the facility's infection prevention and control policy revealed:
-The policy was to prevent and stop the spread of infection within the facility.
-All visitors will be screened for the presence of fever and symptoms consistent with COVID-19.
-Visitors with signs and symptoms consistent with COVID-19 would not be allowed to enter the building.
-Facemask were supposed to be worn and fit snug to the face and below the chin.

Interview with a Communicable Disease nurse at the local health department on 03/15/21 at 1:44pm revealed:
-He spoke with the Administrator on 02/22/21.

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D 612	Continued From page 70 -The Administrator called him to notify that she had one staff member positive with COVID-19. -The facility was not in outbreak status. -He had advised her to call him back if she any residents or staff members tested positive for COVID-19. -He sent out information on COVID-19 at the onset of an outbreak. -Facility staff were supposed to wear a mask at all times while in the facility. -Facility staff were supposed to have a mask on before they entered the facility. 1. Observation of the activity room on 03/16/21 at 10:10am revealed: -There was a personal care aide (PCA) standing in front of a seated resident; the PCA was feeding the resident. -The PCAs facemask was below her chin while she was feeding the resident. -The PCA repositioned her facemask over her nose and under her chin at 10:12am. Interview with the PCA on 03/16/21 at 10:12am revealed: -She would pull down her facemask for about 1 or 2 minutes 3 times a day to breath better. -She should wear her facemask over the nose and under the chin to prevent the spread of germs. -It was common sense to wear the facemask over the nose and under the chin. Observation with the laundry staff on 03/16/21 at 10:17am revealed: -She was in the laundry room alone folding resident clothes. -She was not wearing a facemask. -Her facemask was laying on the laundry table.	D 612		

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D 612	Continued From page 71 Interview with the laundry staff on 03/16/21 at 10:18am revealed: -She was trained by the Administrator 1 week ago to always wear her face mask to cover the nose and chin. -She did not wear her facemask when in the laundry room because she was in the laundry room alone. -If staff or residents walked in the laundry room, she would put on her facemask to cover the nose and chin. -She should wear a facemask to cover the nose and chin to prevent transmission of COVID-19. Observation of the first medication aide/supervisor (MA/S) on 03/16/21 at 10:30am revealed: -The MA/S was standing in the room with a resident. -The MA/S was wearing the facemask below his nose. -The MA/S repositioned his face mask when approached by surveyor. Interview with the first MA/S on 03/16/21 at 10:40am revealed: -He had to wear his facemask over his mouth and nose his entire shift. -The Administrator told him that residents did not have to wear facemask in the facility. -Resident only had to wear a facemask when they left the facility for an appointment. Observation of a housekeeper on 03/16/21 at 11:02 revealed she wore her mask below her nose. Interview with the Administrator on 03/16/21 at 11:30am revealed: -Staff on all shifts were expected to always wear	D 612		

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their facemasks to cover the nose and chin while working to decrease the spread of COVID-19.
-Everyday she would see staff not wearing their facemasks to cover their nose or chin.
-Everyday she would educate those staff to reposition their facemasks to cover their nose and chin.
-The last formal education on the appropriate way to wear a facemask was in December 2020 by a contracted company.
-She had to prompt the first MA/S today (03/16/21) to reposition his facemask to cover his nose and chin; the first MA/S's facemask was up over his chin.
-Staff were expected to wear their facemask to cover the chin and nose even when in a room alone other than when in the breakroom alone.
-Staff were expected to wear their facemasks over the nose and under the chin prior to entering the facility.

Interview with a PCA on 03/17/21 at 7:05am revealed:
-All facility staff were supposed to wear a mask properly.

Interview with an MA/supervisor on 03/17/21 at 7:10am revealed:
-All staff wore a mask due to the COVID-19 pandemic.
-Staff were expected to screen for COVID-19 before every shift by taking their temperature and filling out a symptom questionnaire sheet.
-Staff were not supposed to enter the building and would leave if they had or developed symptoms of COVID-19.
-Staff were expected to self-report symptoms of COVID-19 because there wasn't always someone at the facility to review or supervise staff screening.

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D 612	Continued From page 73 -The RCC and the facility Administrator were responsible for reviewing the COVID-19 symptom questionnaire sheets filled out by staff. A second observation of the first MA/S on 03/17/21 at 8:36am revealed he was wearing his facemask below his bottom lip. Observation of a second MA/S on 03/17/21 from 10:43am - 10:46am revealed: -The MA/S was standing at the entrance way into the east hall with her facemask below her nose. -The MA/S entered the east hall with her facemask below her nose. -The MA/S repositioned her facemask over the nose and under the chin on surveyors' approach. -The MA/S pulled her facemask below her mouth 3 times during the interview. Interview with the second MA/S on 03/17/21 at 10:45am revealed: -She would pull down her facemask below her nose to get some air. -The Administrator had previously told her she could pull the facemask below her nose for "air" when she was off the resident hallway; she could not remember when. Observation of the west hall on 03/17/21 at 12:07pm revealed: -The medication aide (MA) was standing at the medication care wearing her facemask below her nose. -A resident was sitting beside the medication cart. -The Resident Care Coordinator (RCC) was talking to the MA. -The RCC did not prompt the MA to reposition the facemask above the nose and under the chin. -The RCC was prompted to prompt the MA to reposition her facemask.	D 612		

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D 612	Continued From page 74 Interview with the RCC on 03/17/21 at 12:10pm revealed she did not see the MA wearing the facemask below her nose because her vision was blurred. A second observation of the second MA on 03/17/21 at 12:14pm revealed: -She was wearing her facemask below her nose. -She required prompting to reposition her facemask to cover her nose and chin. Observations on 03/17/21 at 5:30am revealed the MA/S walked down the hall with no facemask that covered his mouth and nose. 2. Observations of the inside of the main facility entrance on 03/16/21 at 10:00am revealed: -There was a table against the left side of the wall when entering the facility. -On the table were blank forms titled "COVID-19 Visitor/Staff Screening", a thermometer, and completed forms placed face down. Interview with the laundry staff on 03/16/21 at 10:18am revealed: -Staff were to self-screen when entering the facility for signs and/or symptoms of COVID-19 and temperature checks. -There was no one to observe or make sure staff performed self-screening because they were all adults. Interview with an MA/supervisor on 03/17/21 at 7:10am revealed: -All staff wore a mask due to the COVID-19 pandemic. -Staff were expected to screen for COVID-19 before every shift by taking their temperature and filling out a symptom questionnaire sheet.	D 612		

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D 612	Continued From page 75 -Staff were not supposed to enter the building and would leave if they had or developed symptoms of COVID-19. -Staff were expected to self-report symptoms of COVID-19 because there wasn't always someone at the facility to review or supervise staff screening. -The RCC and the facility Administrator were responsible for reviewing the COVID-19 symptom questionnaire sheets filled out by staff. Interview with the Administrator on 03/16/21 at 11:30am revealed: -Staff were expected to self-screen on entrance to the facility. -There was a thermometer and a self-screening COVID-19 signs/symptoms form staff were to complete on entrance to the facility located at the front door. -The Administrator, Resident Care Coordinator (RCC), and the Business Office Manager (BOM) reviewed the self-screening forms daily to ensure staff had self-screened. Observation on 03/17/21 at 6:21am revealed: -Staff entered the facility without self-screening for COVID-19. -Staff was prompted by the MA/S to self-screen. Observation on 03/17/21 at 6:23am revealed: -Staff entered the facility without self-screening for COVID-19. -Staff was prompted by the MA/S to self-screen. Interview with the MA/S on 03/17/21 at 6:23am revealed staff knew they were to self-screen for COVID-19 when entering the facility. 3. Observation of the facility on 03/17/21 at 5:40am revealed:	D 612		

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D 612	Continued From page 76 -The personal care aide (PCA) opened the front facility door to allow surveyor to enter facility. -The PCA walked away without screening or prompting the surveyor to self-screen temperature and COVID-19 screening questions. -The surveyor prompted the PCA of any steps to be taken prior to entering the facility. -The PCA informed the surveyor of the need to assess temperature and complete the screening questionnaire. Interview with the PCA on 03/17/21 at 5:42am revealed: -She should have instructed the surveyor to self-screen with temperature and completing the COVID-19 screening questions. -She should have stayed to observe the surveyor perform self-screening to ensure it was done. -There was no reason she walked away without prompting the surveyor to self-screen. -There was no reason she did not stay to observe surveyor self-screen. -She would not have known if a visitor was symptomatic for COVID-19 if visitors did not report signs or symptoms. Interview with the Administrator on 03/16/21 at 11:30am revealed staff were to prompt and observe visitors to self-screen with a temperature assessment and complete the COVID-19 screening questionnaire.	D 612		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.	D911		

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D911	Continued From page 77 This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to ensure residents were treated with respect and dignity. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure the rights of residents were guaranteed as evidence by failing to provide privacy to 2 of 5 sampled residents by exposing the residents during incontinent care and personal hygeine (#1, #2); failing to communicate with 2 of 2 sampled residents who spoke Vietnamese (#3) and Spanish (#6); and failing to provide tray tables to residents.[Refer to Tag 338, NCAC 13F .0909 Resident Rights (Type B Violation)].	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews, observations and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to health care, personal care and medication administration. The findings are:	D912		

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D912	Continued From page 78 1. Based on observations, interviews, and record reviews the facility failed to ensure 2 of 5 resident's (#2, #4) sampled received personal care assistance with toileting. [Refer to Tag 269, NCAC 13F .0901(a) (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 7 residents (#7, #8, #9, #10, #11) observed during the medication passes including errors with inhalers for breathing problems (#7), a nasal spray for allergies (#8), and oral medications ordered with meals (#9, #10, #11); and for 2 of 5 residents sampled (#1, #2) whose antihypertensive medication was not held as ordered (#1) and whose anticoagulant was held without an order (#2). [Refer to Tag 358, NCAC 13F .1004(a) (Type A2 Violation)]. 3. Based on record reviews and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 5 (#1) sampled residents regarding implementation of order for weekly blood pressure monitoring and to notify a resident's physician of weights and blood pressure results that were outside parameters which were supposed to be reported to the residents primary care physician (PCP).[Refer to Tag 276, NCAC 13F .0902(c) (Type B Violation)]. 4. Based on observations, interviews, and record reviews the facility failed to ensure an immediate response and intervention by staff and in accordance with the facility's policies and procedures during an incident in which 1 of 5 sampled residents (#1) experienced a change in level of consciousness. [Refer to Tag 271, NCAC 13F .0901(c) (Type B Violation)].	D912		