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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted an annual, follow up, and a complaint investigation with on site visits on 03/10/21 and 03/11/21 and a desk review survey on 03/12/21, and 03/15/21-03/18/21 with a telephone exit on 03/18/21.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs for 2 of 6 sampled residents (#2, #4), residing on an Alzheimer's Special Care Unit, who sustained multiple falls with injuries including Resident #2 who required treatment at the emergency room for 8 of 9 falls with multiple head injuries requiring sutures, staples, and wound adhesion and a displaced fracture of the C2 vertebra; and Resident #4 who sustained head injuries and facial fractures and was found eating non-food materials such as feces. The findings are: Review of the facility's fall management program revealed:	D 270		

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D 270	Continued From page 1 -A "Fall Risk Assessment Tool" was completed for all residents admitted to determine factors that may contribute to possible falls. -The staff completed an "Incident Report" in it's entirely for any fall. Staff were to contact the family/responsible party and the physician. -The staff completed a 72 hour follow up on the residents' fall to investigate possible circumstances contributing to the fall and document observations after the fall of the resident for 72 hours. -If a resident had 2 falls within a 4-week period, the physician was to be contacted to request an order for a physical therapy (PT) evaluation or other treatment/interventions as applicable. Telephone interview with the Administrator on 03/18/21 at 1:30pm revealed: -She initiated a new fall intervention on Friday, 03/12/21, which was the "Angel Program." -The Angel Program designated a staff member (Activities Director) to be assigned to the residents who were identified by the Angel Program. -The Activities Director was responsible for monitoring and providing supervision to the identified residents in a designated area. -The Activities Director was responsible for creating resident specific activities within the designated area to engage the residents' attention. 1. Review of Resident #2's current FL-2 dated 03/10/21 revealed: -Diagnoses included Alzheimer's dementia, schizophrenia, brief psychotic disorder/psychoses, anxiety disorder, and paranoia. -The resident was constantly disoriented. -The resident was ambulatory and required	D 270		

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assistance with bathing and dressing.
-The resident was incontinent of bowel and bladder.

Review of Resident #2's special care unit (SCU) resident profile and care plan dated 02/25/21 revealed:
-The resident's behavior patterns were documented as afraid, anxious, and cooperative.
-The resident's behaviors were triggered by other residents wandering into her room.
-Interventions were to reassure the resident that she was okay.
-The resident was independent with toileting and ambulation without devices.
-The resident required limited assistance from staff with bathing and dressing.
-The resident required supervision from staff with transferring with standby assistance.
-There was documentation to leave the bathroom light on and door cracked.
-The resident required extensive assistance from staff with grooming and hygiene.

Review of Resident #2's current assessment and care plan dated 03/04/21 revealed:
-The resident ambulated with no problems and no assistive devices.
-The resident had no problems with her upper extremities.
-The resident had occasional incontinence of the bladder but was continent of bowel.
-The resident was sometimes disoriented, forgetful, and needed reminders.
-The resident could hear loud sounds/voices.
-The resident was independent with toileting, ambulation, and transferring.
-The resident required supervision with dressing.
-The resident required limited assistance by staff with bathing and grooming.

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D 270	Continued From page 3 -There was no documentation related to the resident's falls or interventions for falls. Review of Resident #2's accident/incident (A/I) reports, resident progress notes, provider communication and visit notes, and hospital visit notes revealed: -Resident #2 had 9 falls with injuries from 11/09/20 - 03/12/21. -The resident required evaluation by emergency medical services (EMS) and transport to the emergency room (ER) for 8 of the 9 falls. -The resident's injuries included: abrasions and skin tears under the right arm; laceration above the right eyebrow requiring 3 sutures and closed, displaced fracture of the C2 vertebra; right scalp hematoma (pocket of blood under the skin); laceration above the left eyebrow requiring wound adhesive (skin glue); swelling and laceration to the back of the head requiring 5 staples; closed head injury with laceration above the left eye; bruises to the face, forehead, and knees; bruising and laceration over the right eyebrow; and a large hematoma on the left side of the forehead. Observation of Resident #2 on 03/10/21 at 11:55am revealed: -The resident was sitting up on her bed and had a black scab and bruise above her right eyebrow and was wearing a hospital bracelet. -The resident did not respond verbally when spoken to. Review of Resident #2's resident progress notes dated 11/09/20 at 10:03am revealed: -The resident stated she fell in her room last night. -The resident had a long scrape and small skin tears on the underside of her right arm. -The wounds were cleaned and bandaged.	D 270		

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-The Resident Care Coordinator (RCC), the primary care provider (PCP), and the power of attorney (POA) were notified.

Review of Resident #2's provider notification notes dated 11/09/20 revealed:
-Staff notified the PCP that the resident fell on the night of 11/08/20.
-The resident had a scrape on her right arm but no other bumps or bruises.
-The resident's arm had been bandaged.
-The PCP's signature was on the form with a date of 11/11/20 and the PCP documented to continue to monitor the resident.

Review of Resident #2's A/I report dated 11/09/20 at 10:05am revealed:
-The resident had an unwitnessed fall in the resident's room.
-The resident had a scrape, redness, and small skin tears on her right arm.
-The area was cleaned, treated, and bandaged.
-The resident was not sent to the ER.
-The resident's PCP and POA were notified.
-The Falls Prevention Program was initiated and the resident was to be monitored every shift for 72 hours for vital signs, bruising, changes in mental status/condition, pain, or other injuries related to fall.
-The resident was to receive standing order for Neosporin and dry gauze daily and as needed until skin tears were healed.
-The evaluation section of the report noted the resident would be monitored closely for the next 72 hours.
-The resident's care plan was marked as not updated in the evaluation section of the form.

Review of Resident #2's resident progress notes dated 01/22/21 at 6:30am revealed:

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-The resident was coming out of the bathroom and slipped and fell.
-The resident hit her head on the floor, EMS was called, and the resident went to the ER.

Review of Resident #2's A/I report dated 01/22/21 at 6:30am revealed:
-The resident had a witnessed fall in the resident's room.
-The resident was running out of the bathroom, slipped, and hit her head on the floor.
-The resident had a laceration above her right eyebrow.
-The resident had pain and was taken to the ER.
-The resident's PCP and POA were notified.
-The resident had a scan of the spine and head at the hospital.
-The Falls Prevention Program was initiated and the resident was to be monitored every shift for 72 hours (01/22/21 - 01/25/21) for vital signs, bruising, changes in mental status/condition, pain, or other injuries related to fall.
-The resident was to receive standing order for Neosporin and dry gauze daily and as needed until skin tears were healed.
-The evaluation section of the report noted to make sure the resident had proper fitting shoes and non-skid socks on in the morning.

Telephone interview on 03/17/21 at 1:34pm with the personal care aide (PCA) who discovered Resident #2's accident on 01/22/21 revealed:
-On 01/22/21 at 6:30am, she was in the room across the hall from Resident #2's room.
-As she turned around, she saw Resident #2 come running out of the bathroom and the resident hit the floor.
-The resident hit her head on the floor and was bleeding from a wound above her eyebrow.
-The resident had only one shoe on at the time of

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the fall.
-The resident was sent to the ER.

Review of Resident #2's after visit summary and hospital encounter notes dated 01/22/21 at 7:33am revealed:
-The resident was seen for fall and head injury without loss of consciousness.
-It was reported the resident was getting up to go to the bathroom early this morning and fell, striking her head on the floor.
-The resident had a laceration over her right eyebrow.
-The resident was diagnosed with fall, facial laceration repaired with 3 sutures, head injury, and closed displaced fracture of the second cervical vertebra.

Review of Resident #2's resident progress notes dated 01/22/21 at 5:40pm revealed:
-The resident returned from the ER and was still off balance.
-The resident continued to fall backwards every time she got up.
-The resident was sent back to the ER.
-The resident's PCP and POA were notified.

Review of Resident #2's A/I report dated 01/22/21 at 5:44pm revealed:
-The resident had an unwitnessed fall in the hallway.
-The resident was lying on the floor on her back.
-There was no injury noted.
-The resident was taken to the ER and the PCP and POA were notified.
-The resident had x-rays of chest and pelvis and head scan at the hospital.
-The Falls Prevention Program was initiated and the resident was to be monitored every shift for 72 hours (01/23/21 - 01/26/21) for vital signs,

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bruising, changes in mental status/condition, pain, or other injuries related to fall.
-The evaluation section of the report noted the resident's care plan was not updated.

Review of Resident #2's provider notification form dated 01/22/21 revealed:
-The resident was completely off balance and fell in the hallway.
-While waiting on the ambulance, the resident got up out of the chair and fell again.
-The PCP signed the notification form and it was dated 01/23/21.
-The PCP instructed facility staff to continue to monitor the resident.
-The PCP ordered physical therapy/occupation therapy (PT/OT) to evaluate and assist.

Review of Resident #2's provider visit notes revealed no documentation the resident had received PT/OT as ordered on 01/23/21 by the PCP.

Review of Resident #2's second after visit summary and hospital encounter notes dated 01/22/21 at 6:13pm revealed:
-Per EMS, the resident had an unwitnessed fall at the facility.
-The resident denied complaints and was seen at the hospital earlier today for a fall and reportedly had a chronic cervical fracture.
-The resident had bruising to the right eye from the previous fall.
-X-rays of the chest and pelvis were completed along with a head scan.
-The resident had a right scalp hematoma.

Review of Resident #2's resident progress notes dated 01/23/21 at 5:50am revealed:
-The resident came back from the ER last night.

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D 270	Continued From page 8 -An hour after arriving, the resident got up and "ran the halls". Review of Resident #2's lab report revealed the resident tested positive for COVID-19 on 01/25/21. Review of Resident #2's PCP visit notes dated 01/27/21 revealed: -The resident was being evaluated for a contusion and dementia. -The resident was status post two head injuries on 01/22/21 for which she was evaluated in the ER. -The resident's scalp bruising was unchanged. -The resident had a tendency to become "unpredictable" at times starting to run in the hallway without forewarning. -The resident injured her cervical spine in the distant past as she was thought to be running and fell, hitting her head against the wall. -The resident had dementia and paranoia. -The resident required frequent redirection and reorientation. Review of Resident #2's January 2021 electronic medication administration record (eMAR) revealed: -There were entries to initiate fall prevention program to check vital signs for 3 days every shift and to document any changes or no changes scheduled to be done first shift (6:00am - 2:00pm), second shift (2:00pm - 10:00pm), and third shift (10:00pm - 6:00am). -The falls prevention program was documented from 01/22/21 - 01/26/21, with vital signs documented as refused on 8 shifts during this time period. Review of Resident #2's resident progress notes	D 270		

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dated 02/06/21 at 9:14am revealed:
-The resident fell at 6:36am this morning.
-EMS was called and the resident was taken to the ER.

Review of Resident #2's A/I report dated 02/06/21 at 6:36am revealed:
-The resident had an unwitnessed fall in the resident's room.
-The resident was sitting on the bed with a laceration above her left eyebrow.
-Staff documented the resident would arouse when her name was called.
-The resident was taken to the ER and the PCP and POA were notified.
-The resident's laceration above the eyebrow was repaired with wound adhesive (skin glue) at the hospital.
-The Falls Prevention Program was initiated and the resident was to be monitored every shift for 72 hours (02/06//21 - 02/09/21) for vital signs, bruising, changes in mental status/condition, pain, or other injuries related to fall.
-The evaluation section of the report noted the resident's PCP was contacted to let the PCP know the resident was "off balanced" when getting up.

Telephone interview on 03/17/21 at 2:00pm with the PCA/Activity Director who discovered Resident #2's accident on 02/06/21 revealed:
-She worked on the COVID-19 unit on 02/06/21.
-She clocked in at 6:00am, changed her clothes and went to the COVID-19 unit.
-When she got to the unit, there was no staff in the COVID-19 unit with the residents.
-There were about 5 to 6 residents in the unit at that time.
-She had noticed some third shift staff (could not recall who) standing at the nurses' station on her

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way to the unit but no one reported anything to her.
-She went to check on the residents and about 6:10am -6:15am and she found Resident #2 on the mattress on the floor in her room.
-The resident was on her knees with her "butt in the air" and her head on the mattress.
-When she sat the resident up, the resident's whole head was bloody but it was completely dried.
-It looked like 2 big gashes toward the crown at the back of the resident's head and the resident complained that her head was hurting.
-There was a trail of dried blood from the bathroom floor back to the resident's bed and some dried blood on the door frame of the closet door near the bathroom.
-The resident was not able to say what happened.
-She unzipped the COVID-19 barrier curtain and called out to the medication aide (MA) for help.
-The resident was sent out to the ER.
-Staff was supposed to be on the COVID-19 unit at all times so the residents would not be left alone without staff present.
-Staff were supposed to wait until the next shift arrived in the unit before leaving the unit.
-There had been a couple of other times when she went to the unit to work and no staff was present but she could not recall the dates.
-She told the Administrator that Resident #2 had fallen and there was no staff in the unit on 02/06/21.
-The resident was currently on 15-minute checks but she was not sure how long the resident had been on 15-minute checks.
-The resident was now on the Angel Program for falls so if the resident left her room, staff was supposed to take the resident to the activity room.
-The problem with that was if the resident jumped up to leave the activity room the PCA/Activity

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Director could not leave the room because other residents were in the room in the Angel Program.
-So far, she had been able to find a staff person to get the resident if the resident left the activity room.
-The resident was also wearing a helmet now but the resident took it off when it started irritating her.

Telephone interview with the PCA/Transporter on 03/18/21 at 11:52am revealed:
-Resident #2 was "off balance" and she liked to run up and down the halls.
-It threw the resident off balance and she had falls.
-She thought the resident was on 15-minute checks but she was not sure.
-When the resident was in the COVID-19 unit, they put her mattress on the floor because she was so weak and would fall.
-On one occasion when she was assigned to the COVID-19 unit, she and another PCA came into work.
-The other PCA went to the unit to start the cleaning process while she gathered clothes and sheets to take to the unit.
-As she entered the COVID-19 unit, the other PCA told her she thought Resident #2 had fallen and the other PCA had been cleaning up blood.
-Resident #2 had dried blood all down the side of her face and there was a trail of dried blood on the floor from the bed to the bathroom.
-The other PCA said when she got to the unit that morning, there was no other staff in the unit.
-She did not know which staff was supposed to be in the unit from third shift.
-The other PCA notified the first shift MA and the resident was sent out to the hospital.
-When EMS came, they made the comment that it looked like the blood had been "dried for a

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while".
-She always waited for the next shift staff to get to the unit before she left from her shift.
-There were several times when she got to the COVID-19 unit that there were no staff in the unit.
-It was reported to the Administrator and the Administrator addressed it in a stand-up meeting.

Telephone interview with a third shift MA on 03/17/21 at 11:45pm revealed:
-Resident #2's "stability is off" and the resident liked to run.
-Staff usually tried to get in front of the resident and slow her down.
-One time before the resident had COVID-19 (prior to 01/25/21), one of the PCAs came and got her because the resident was on the floor.
-The resident had tried to go to the bathroom and fell and had a "goose egg" on her head.
-The resident was sent to the ER.
-Residents were usually on 15-minute checks for 72 hours after a fall.
-Resident #2 was currently on 15-minute checks and she could never get off the checks because of frequent falls.
-She did not know how long the resident had been on 15-minute checks.
-She did not know anything about Resident #2 falling when she worked on third shift on 02/06/21.

Telephone interview with the Memory Care Manager (MCM) on 03/18/21 at 12:43pm revealed:
-She came into work around 10:00am on 02/06/21.
-Staff reported Resident #2 had a fall and was sent to the hospital.
-She was not aware of the dried blood and no one reported to her that there was no staff in the

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COVID-19 unit when first shift arrived.
-Staff were supposed to stay in the COVID-19 unit until the next shift arrived to relieve them.
-The residents in the COVID-19 unit should have never been left alone without staff supervision.
-If staff came in and found a resident had fallen and had dried blood, staff should notify her immediately.
-Third shift staff should have checked on the residents right before the end of their shift and they should have noticed the blood on the floor and the resident.
-Each shift should do rounds together before they changed out staff at shift change.

Telephone interview with the Administrator on 03/18/21 at 1:35pm revealed:
-On 02/06/21, she remembered staff telling her that Resident #2 had fallen and first shift staff reported no staff was in the COVID-19 unit when they arrived to work.
-She had a stand-up meeting with staff about staff being late for their shift and staff leaving early from their shifts.
-She was concerned there were no staff in the unit that morning on 02/06/21 and the resident had dried blood on her because that could indicate it was there for "a while".
-Staff were supposed to get to the facility early enough for their shift so they could do a walk through with the shift going off duty to check on the residents.

Review of Resident #2's after visit summary and hospital encounter notes dated 02/06/21 at 7:45am revealed:
-The resident was seen for an unwitnessed fall "sometime through the night".
-The resident was found this morning with a wound to her right forehead and dried blood.

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-The resident had a laceration above the right eye with swelling and bruising.
-The resident had swelling and bruising to the left wrist.
-The resident was confused and nonverbal.
-The resident was diagnosed with closed head injury and laceration of the forehead which was repaired with wound adhesive (skin glue).

Review of Resident #2's A/I report dated 02/08/21 at 5:00pm revealed:
-The resident had a witnessed fall in the resident's room.
-The resident was laying on the floor and had swelling and a laceration on the back of her head.
-The resident complained of pain and pressure was applied to the wound.
-The resident was taken to the ER and the PCP and POA were notified.
-The resident had a negative scan and staples to the laceration at the hospital.
-The Falls Prevention Program was initiated and the resident was to be monitored every shift for 72 hours (02/09/21 - 02/12/21) for vital signs, bruising, changes in mental status/condition, pain, or other injuries related to fall.
-The evaluation section of the report noted the resident's POA was talked to about reaching out to hospice.
-The evaluation section noted the facility staff talked with a hospice provider to schedule an appointment for evaluation.

Telephone interview on 03/17/21 at 2:48pm with the PCA who discovered Resident #2's accident on 02/08/21 revealed:
-When she worked night shift, Resident #2 was constantly getting up, running everywhere, tripping over herself and falling.
-On 02/08/21, she was working in the COVID-19

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unit and had bathed the resident.
-She helped the resident get back in bed.
-Afterwards, the resident tried to get up and slipped and fell backwards and hit her head on the headboard of the bed.
-The resident was bleeding from the back of her head.
-She got the MA and the MCM and they stayed with the resident until EMS came and took the resident to the ER.
-About 2 to 3 weeks ago, the resident was moved up the hall closer to the nurses' station.
-She thought the resident had been on 15-minute checks since she was in the COVID-19 unit.
-The 15-minute checks would be documented on the paper logs if they were done.
-The resident just got a helmet "a couple of days ago".

Review of Resident #2's after visit summary and hospital encounter notes dated 02/08/21 at 6:41pm revealed:
-The resident slipped out of bed tonight and hit her head on the side of the bed and the bleeding was mostly controlled currently.
-The resident was diagnosed with a head injury and laceration of the posterior scalp which was repaired with staples.

Review of Resident #2's resident progress notes dated 02/16/21 at 10:39am revealed:
-The resident had an unwitnessed fall.
-EMS was called and the resident was taken to the ER.
-The resident's PCP was notified.

Review of Resident #2's A/I report dated 02/16/21 at 10:33am revealed:
-The resident had an unwitnessed fall in the hallway.

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-The resident was found on the floor with a laceration to the left eye.
-Pressure was applied to stop the bleeding.
-The resident was taken to the ER and the PCP and POA were notified.
-The resident had a negative head scan at the hospital.
-The Falls Prevention Program was initiated and the resident was to be monitored every shift for 72 hours (02/17/21 - 02/20/21) for vital signs, bruising, changes in mental status/condition, pain, or other injuries related to fall.
-The evaluation section of the report noted the resident would be evaluated for physical therapy on 02/18/21.

Review of Resident #2's provider visit notes revealed no documentation the resident was evaluated for PT as indicated on the A/I report dated 02/16/21.

Telephone interview on 03/17/21 at 3:33pm with the MA who discovered Resident #2's accident on 02/16/21 revealed:
-She could not recall all details about Resident #2's fall on 02/16/21 but she remembered the resident's eye being "busted".
-It started bleeding and she called EMS and the resident went to the hospital.
-She thought Resident #2 was on 15-minute checks but she was not sure how long she had been on the checks.
-The PCAs did the 15-minutes checks and the MAs checked over the logs.

Review of Resident #2's hospital encounter notes dated 02/16/21 at 12:18pm revealed:
-The resident was seen for an unwitnessed fall and laceration above the left eye.
-The resident was diagnosed with a closed head

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D 270	Continued From page 17 injury. Review of Resident #2's PCP visit notes dated 02/17/21 revealed: -The resident was being evaluated for a contusion and dementia. -The resident had sustained "yet another fall", requiring evaluation by the ER. -The resident had a laceration to the occipital area (back of the head) which required staples. -It was difficult to assess the resident's symptoms as her level of dementia had progressed. -All 4 extremities had declined in her ambulatory capability. -She had sustained several falls in the recent past, having been observed by staff on the floor. -The resident was currently back in her room from the COVID-19 isolation unit and "being observed every 15 minutes by staff for a short duration". -The resident had several bruises to her face, forehead and knees from previous falls. -The resident would continue to be monitored. Review of Resident #2's PCP visit notes dated 02/24/21 revealed: -The resident was being evaluated for a contusion and dementia. -The resident was status post most recent ER visit on 02/16/21 having sustained a fall with consequent closed head injury. -The resident remained lethargic and unpredictable. -Staff reported the resident may be in bed and suddenly she would wake up and start running down the hall. -The resident had a poor gait as well as poor balance and remained at very high risk for falls with injury. -The PCP had discussed with staff the need for	D 270		

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progressing the resident to a "higher level of care" for self-protection as she was unpredictable and spontaneous and remained at very high risk for falls with injury.
-Staples from the resident's scalp would be removed during the next visit to the facility.
-The resident was to follow-up with orthopedics for a cervical fracture.

Review of Resident #2's mental health provider (MHP) visit note dated 02/24/21 revealed:
-On 01/23/21, staff reported the resident had fallen 2 times in one day.
-She was walking so fast/running through the halls of the facility and fell resulting in a laceration on the right eyebrow.
-The second fall, she fell backwards and was sent to the ER with no injuries.
-On 02/08/21, staff reported another fall but it was not due to sedation.
-The resident was frequently falling due to impulsively jumping from her seat and "running" through the halls of the facility.
-The resident continued to have confusion, delusional thought content, and visual hallucinations.
-Instructions were to continue current medications and continue to monitor.

Review of Resident #2's A/I report dated 02/27/21 at 6:42am revealed:
-The resident had an unwitnessed fall in the resident's room.
-The resident was sitting on the floor by her bed.
-The resident had bruising and a laceration over her right eyebrow.
-The resident was taken to the ER and the PCP and POA were notified.
-The resident had a negative scan of the head and spine at the hospital.

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-The Falls Prevention Program was initiated and the resident was to be monitored every shift for 72 hours (02/27/21 - 03/02/21) for bruising, changes in mental status/condition, pain, or other injuries related to fall.
-The evaluation section of the report noted the resident's furniture had been rearranged to create a safe walking path.
-The evaluation section also noted referral to PT/OT for balance.

Review of Resident #2's provider visit notes revealed no documentation the resident was referred to PT/OT as indicated on the A/I report dated 02/27/21.

Telephone interview on 03/17/21 at 1:34pm with the PCA who discovered Resident #2's accident on 02/27/21 revealed:
-She did not recall the specific details of Resident #2's fall on 02/27/21.
-After Resident #2 got COVID-19, the resident started declining and staff had to provide more assistance with personal care for the resident.
-The resident went "downhill quick" and now the resident ran and had falls.
-Staff started doing 15-minute checks on Resident #2 when the resident moved out of the COVID-19 unit (could not recall date).
-Staff had been doing the 15-minute checks "on and off"; every time the resident fell, they did the 15-minute checks for about 2 weeks.
-She thought they had just started back doing the 15-minute checks after last Friday, 03/12/21.
-At some point (could not recall when), furniture was moved around in the resident's room.
-The resident just started wearing a helmet recently (no date provided).
-She was not aware of any other interventions for the resident's falls.

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D 270	Continued From page 20 Review of Resident #2's after visit summary and hospital encounter notes dated 02/27/21 at 7:34am revealed: -The resident was seen for an unwitnessed fall at the facility. -The resident had a right brow wound with some oozing of blood, history of frequent falls, and a recent ER visit for suturing of the right brow. -It appeared per review of hospital chart, the resident had the right forehead repaired on 02/06/21, a posterior scalp laceration stapled on 02/08/21, and the left brow sutured on last visit on 02/16/21. -The resident was diagnosed with a contusion of the brow. Review of Resident #2's February 2021 eMAR revealed: -There were entries to initiate fall prevention program to check vital signs for 3 days every shift and to document any changes or no changes scheduled to be done first shift (6:00am - 2:00pm), second shift (2:00pm - 10:00pm), and third shift (10:00pm - 6:00am). -The falls prevention program was documented from 02/06/21 - 02/12/21, with vital signs documented as refused on 7 shifts during this time period. -The falls prevention program was documented from 02/17/21 - 02/20/21, with vital signs documented as refused on 8 shifts during this time period. -The falls prevention program was documented from 02/27/21 - 02/28/21, with vital signs documented as refused on 4 shifts during this time period. Review of Resident #2's PCP visit notes dated 03/03/21 revealed:	D 270		

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-The resident was being evaluated for a contusion and dementia.
-The resident was status post most recent ER visit on 02/27/21 having sustained a fall with consequent head laceration.
-The laceration to the scalp was healed and 5 staples were removed without complications.
-The resident had sustained several falls in the recent past as she was observed spontaneously getting up and starting to run throughout the facility, losing her footage and falling.
-Most recent paperwork from the ER indicated the resident was diagnosed with a dens (upward extension) fracture of the cervical spine.
-The resident would follow-up with orthopedics to determine the instability of the fracture and plan of care going forward.

Review of Resident #2's provider notification form dated 03/04/21 revealed:
-Staff noted the resident's FL-2 dated 02/24/21 did not indicate the recommended level of care was special care unit.
-Staff asked the PCP to indicate if he agreed with SCU placement.
-The PCP documented to please progress the resident to a higher level of care and it was dated 03/10/21 .

Review of Resident #2's orthopedic visit notes dated 03/05/21 revealed:
-The resident was referred by her PCP for evaluation of her cervical spine secondary to recent falls.
-The resident was unable to provide information due to secondary advanced dementia.
-A scan on 02/27/21 showed no acute fracture but a chronic ununited C2 dens fracture (upward extension of the C2 vertebra) described on prior exams.

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-This appeared unchanged on today's x-ray when compared to scans in February 2021.
-Options for treatment were discussed with facility staff accompanying the resident but would not be pursued at this time as orthopedist did not feel the resident would be able to cooperate.
-The orthopedist recommended treatment as needed with over-the-counter medications should be resident have complaints of pain.

Review of Resident #2's PCP visit notes dated 03/10/21 revealed:
-The PCP discussed with facility administration and staff the need for increased supervision for the resident as she remained at high risk for falls with injury.
-Staff were to provide the resident with a bicycle helmet for protection against further head injuries and the resident was to be observed every 15 minutes around the clock.
-The PCP discussed with facility administration the need for advancing the resident to a higher level of care.
-The Administration had discussed this issue with the resident's POA and the POA had provided names of nursing homes she had chosen.
-The resident would continue to be monitored while awaiting final disposition for advancing to a higher level of care.

Review of Resident #2's resident progress notes dated 03/12/21 at 2:00pm revealed:
-The resident was found on the floor by staff after running up the hall.
-The resident had a knot on the left side of her forehead.
-The resident was sent to the ER via EMS.

Review of Resident #2's A/I report dated 03/12/21 at 11:50am revealed:

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-The resident had an unwitnessed fall in the hallway.
-The resident was lying in the middle of the hallway on her left side.
-The resident had a bump on the left side of her head.
-The resident was taken to the ER and the PCP and POA were notified.
-The Falls Prevention Program was initiated and the resident was to be monitored every shift for 72 hours (03/12/21 - 03/15/21) for bruising, changes in mental status/condition, pain, or other injuries related to fall.
-The evaluation section of the report noted the resident was in the Angel Program and had a helmet to protect her head.
-The resident's care plan was marked as not updated in the evaluation section of the form.

Review of Resident #2's after visit summary and hospital encounter notes dated 03/12/21 revealed:
-The resident was seen at the ER secondary to a fall.
-The resident was running down the hall and had a witnessed fall.
-The resident had a large hematoma on the left side of her forehead.
-The resident was diagnosed with a forehead hematoma.

Review of Resident #2's resident progress notes dated 03/14/21 at 11:16am revealed:
-The resident was talked to about wearing her helmet (bike helmet).
-Staff explained the resident needed to wear the helmet while she was walking around the facility.

Review of Resident #2's March 2021 eMAR revealed:

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D 270	Continued From page 24 -There were entries to initiate fall prevention program to check vital signs for 3 days every shift and to document any changes or no changes scheduled to be done first shift (6:00am - 2:00pm), second shift (2:00pm - 10:00pm), and third shift (10:00pm - 6:00am). -The falls prevention program was documented from 03/01/21 - 03/03/21, with vital signs documented as refused on 6 shifts during this time period. -The falls prevention program was documented from 03/12/21 - 03/15/21, with vital signs documented as refused on 6 shifts during this time period. Review of Resident #2's 15-minute checklist for increased supervision and accountability for January 2021 - March 2021 revealed: -There were no 15-minute checklists dated January 2021, so there were no documented checks for the resident's falls on 01/22/21. -There were 15-minute checks documented from 02/01/21 - 02/09/21 and 02/12/21. -There were no other 15-minute checks documented for February 2021 including no checks for the resident's falls on 02/16/21 and 02/27/21. -There were no 15-minute checklists dated March 2021, including the fall on 03/12/21. Telephone interview with the Director of Clinical Instruction (DCI) on 03/17/21 at 4:30pm revealed the were unable to locate any other documentation of 15-minute checks for Resident #2. Interview with a MA on 03/10/21 at 11:56am revealed: -Resident #2 was a fall risk and they tried to "keep eyes" on the resident at all times.	D 270		

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-Staff tried to keep the resident close to them in common areas.

Interview with a second MA on 03/10/21 at 4:28pm revealed:
-Resident #2 had falls and she recently fell and had to get staples in her head.
-The resident would get up at night and run up and down the halls and lose her balance when running.
-Staff tried to redirect the resident.
-The resident had also fallen out of bed before (could not recall date).
-Residents who were frequent fallers got checked on every 15 minutes and staff documented the checks on paper logs.
-She could not recall if Resident #2 was on 15-minute checks.

Interview with a PCA on 03/11/21 at 1:05pm revealed:
-Resident #2 needed assistance with bathing and dressing.
-The resident could transfer and ambulate independently.
-When Resident #2 contracted COVID-19 (could not recall date), the resident was unsteady and had a couple of falls.
-She thought Resident #2 was on 15-minutes checks at one time and it would have been documented on the logs if the checks were done.
-She did not think the resident was currently on 15-minute checks.
-The MAs sometimes just tried to keep the residents with falls close to them.

Telephone interview with a second PCA on 03/17/21 at 10:54pm revealed:
-When Resident #2 got up, she "takes off", ran or walked real fast, and she would fall.

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-When the resident got up, someone needed to be with her.
-Some residents were on 15-minute checks so she usually checked all residents every 15 minutes, including Resident #2.
-Resident #2 was not included on their 15-minute logs sheets so she did not document the resident's 15-minute checks.
-If the resident fell and was sent to the ER, they should be on the log sheets for 15-minute checks.
-She did not know why there were no log sheets for Resident #2.
-She was not aware of any other interventions implemented for Resident #2's falls.

Interview with Resident #2's PCP on 03/10/21 at 5:40pm revealed:
-The resident was spontaneous and unpredictable and had a habit of lying down on the bed and then she would be up and running.
-The resident had multiple falls with injuries, including head injuries.
-When the resident was in the COVID-19 unit, staff put her top mattress on the floor so the resident would be closer to the floor to help prevent falls.
-The resident was currently back in her own room but she was still having falls.
-He was not sure of the facility's fall policy but staff could check on the resident every 15 minutes but she still may fall because she would jump up and run.
-The resident may need a geri-chair or one-on-one supervision for her safety.

A second telephone interview with Resident #2's PCP on 03/16/21 at 9:33am revealed:
-The resident had deterioration in cognition and was at very high risk for falls.

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-The resident had a "tendency to be paranoid" and would run because she thought people were coming after her.
-The resident could be lying in bed, jump up and start running.
-He thought 15-minute checks was something all facilities had but he did not know how long 15-minute checks were kept in place for residents.
-At this point, the resident was wearing a bicycle helmet that just started after her last fall on 03/12/21.
-He had observed two staff walking with the resident at times but he did not know if that was a daily occurrence.
-The resident was spontaneous and unpredictable and he did not know of any other interventions except one-on-one supervision.
-The resident needed more supervision and more safety so she needed a higher level care.
-He had spoken with facility staff (could not recall who) about a higher level of care for the resident.
-He usually discussed concerns with the MCM or the Administrator and sometimes with the MAs.
-It sometimes took a while for another facility to accept a resident for admission so he was not sure where the facility was in the process of looking for a higher level of care for the resident.

Telephone interviews with the Administrator on 03/16/21 at 11:15am and 03/18/21 at 1:35pm revealed:
-Resident #2 had falls; a couple of the falls occurred when the resident was in the COVID-19 unit.
-The resident jumped up and ran "out of nowhere".
-The facility did 72-hour monitoring after each fall, they checked the resident's shoes and socks to see if something was making her fall.

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-They made sure she had non-skid socks and properly fitting shoes.
-Around 01/23/21, she emailed the MHP to have them to look at the resident's medications and she thought they evaluated the medications.
-On 02/06/21, they contacted the PCP to let him know the resident was off balance.
-Resident #2 could be asleep and then suddenly jump up and take off running and you could not stop that behavior unless you had eyes on her or were close to her.
-It was easier to do one-on-one supervision when the resident was in the COVID-19 unit.
-Once the resident returned to her own room, they rearranged the furniture.
-They also moved the resident to a room closer to the nurses' station.
-They rearranged her furniture again and moved her bed against the wall.
-If a resident was on 15-minute, 30-minute, or 1 hour checks, it would be documented on the logs.
-She was "sure" Resident #2 was on 15-minutes checks and had been on them for a while.
-For residents on 15-minute checks, these residents need to be in eyesight of staff very frequently because "you never know".
-She could not explain why staff had not been documenting 15-minute checks for Resident #2.
-The facilty just started an "Angel Program" for falls on 03/12/12 and Resident #2 started that program after her last fall on 03/12/21.
-The facility purchased a helmet for the resident after her last fall on 03/12/21.
-The PCP spoke with her about a higher level of care for Resident #2 (no date provided).
-She spoke with the resident's POA and they just recently started looking for placement for the resident.

Telephone interview with the Area Director of

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D 270	Continued From page 29 Operations (ADO) on 03/16/21 at 11:15am revealed: -The facility just started the Angel Program for falls on Friday, 03/12/21. -The facility provided increased supervision for up to 8 residents in a one-on-one program during activities and increased monitoring. -Resident #2 started the Angel Program after her last fall on Friday, 03/12/21. -The facility also got the resident a bicycle helmet that the resident wore when out of bed. -Fall risk assessments were to be completed by the MCM and the MCM was responsible for implementing the facility's Falls Management Policy. Review of Resident #2's assessments and progress notes revealed no falls assessments were documented for Resident #2. Telephone interview with the MCM on 03/16/21 at 2:12pm revealed: -The facility management determined if a resident needed to be on 15-minute checks in fall assessment meetings. -Resident #2 would always be on 15-minute checks because she was off balance and you had to keep your eyes on her. -The 15-minute checks were done by the PCAs and the MAs checked behind the PCAs to make sure they were done. -They were currently doing 15-minute checks on the resident and had been doing that for "about a month". -The PCP had ordered a helmet after the resident's last fall on Friday, 03/12/21. -She had completed a new FL-2 for a higher level of care for Resident #2 and she would have the PCP sign it tomorrow, 03/17/21. -The Administrator had been in contact with the	D 270		

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resident's POA and calling other facilities for placement.

Attempted telephone interview with Resident #2's POA on 03/17/21 at 5:41pm was unsuccessful.

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

Refer to telephone interview with the facility's MCM on 03/16/21 at 2:03pm.

Refer to telephone interview with facility's contracted PCP on 03/16/21 at 9:33pm.

2. Review of Resident #4's current FL-2 dated 11/27/20 revealed:
-Diagnoses included Alzheimer's dementia, Down's Syndrome, hypothyroidism, and hypertension.
-The resident was ambulatory and was disoriented intermittently.
-The resident resided in a special care unit (SCU).

Review of Resident #4's SCU resident profile and care plan dated 02/25/21 revealed:
-The resident's behavior was uncooperative due to "sundowning" behaviors.
-The resident was incontinent and required extensive assistance with toileting and hygiene.
-The resident ambulated without assistive devices but required extensive assistance of staff with ambulation.
-The resident transferred with supervision.

a. Review of incident/accident reports and emergency room (ER) encounter reports revealed Resident #4 sustained 5 falls with

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head/facial injuries from 01/09/21 through 03/02/21 of which 3 falls were unwitnessed.

Review of an incident/accident report dated 01/09/21 at 02:00pm revealed:
-Resident #4 was found with a blue bruising area and a small scratch around his right eye.
-The incident was not witnessed, and no first aide was administered.

Review of an incident/accident report dated 02/17/21 at 3:30pm revealed:
- Resident #4 was found in his bathroom with a "knot" on the top of his head.
-The resident was transported to the local emergency room (ER) via emergency medical service (EMS) where a CAT scan of the resident's head and spine was performed and was negative.
-The resident's supervision was increased for 72 hours.

Record review revealed no documentation of 15-minute checks/increased supervision for 72 hours from 02/17/21 - 02/02/2-/21 for Resident #4.

Review of an ER encounter report dated 02/17/21 revealed:
-Resident #4 was seen at the ER for an unwitnessed fall and noted to have a hematoma on the back of his head
-The impression of a CAT scan of the resident's head and spine was no acute intracranial abnormality detected or traumatic injury.
-The final diagnoses were closed head injury/scalp hematoma

Review of an incident/accident report dated 02/25/21 at 7:45am revealed:
-Resident #4 was found in his room, sitting on the

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floor with a laceration on top of his head.
-The resident was transported to the local ER via EMS and the laceration was treated and closed with 2 staples.
-The furniture was rearranged in the resident's room so that obstacles were out of his walking space.

Record review revealed no documentation of 15-minute checks/increased supervision for 72 hours for Resident #4 from 02/25/21 - 02/228/21.

Review of an ER encounter report dated 02/25/21 revealed:
-The reason for Resident #4's visit was for a head injury related to an unwitnessed fall.
-The resident was diagnosed with laceration of the scalp which was cleaned and closed with one staple.

Review of an incident/accident report dated 02/26/21 at 5:29pm revealed:
-Resident #4 was in the hallway and hit the right side of his head on the wall and fell to the floor and injured the right side of his head.
-The resident was transported to the local ER via EMS where a CAT scan of his head and spine was performed and results were negative.

Record review revealed no documentation of 15-minute checks/increased supervision for 72 hours for Resident #4 from 02/26/21 - 02/229/21.

Review of an ER encounter report dated 02/26/21 revealed:
-The reason for Resident #4's visit was for a head injury from a fall witnessed by staff at the facility.
-The EMS staff stated the resident fell from a standing position onto the back of his head without loss of consciousness.

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D 270	Continued From page 33 -A CT scan (a 2 or 3 dimensional computerized x-ray scan of the body or parts of the body) to the resident's head showed no evidence of intracranial abnormalities. -The resident complained of pain to head and was seen yesterday (02/25/21) for a fall and received staples to a scalp wound. -Resident #4 had been seen at the ER multiple times in the recent past for falls and currently had staples to the back of his scalp. -There was a previous head injury several days ago causing a hematoma to the back of Resident #4's scalp. Review of an incident/accident report dated 03/02/21 at 10:10am revealed: -Resident #4 was observed standing against the wall in the hallway and leaned over and fell. -The resident complained of pain and sustained a cut on his right eyebrow and his right eye was swollen and bruised. -The resident was transported to the local ER and was diagnosed with a closed fracture of the right arch/orbital wall. -The resident was monitored for 72 hours for bruising, change in mental status, pain or other injuries related to fall. Review of an ER after visit summary dated 03/02/21 revealed: -The reason for Resident #4's visit was after an accidental fall. -CT scan done of the resident's maxillofacial area confirmed diagnoses of closed fracture of the right zygomatic arch (the bone extending from the temporal bone at the side of the head around to the jawbone) and closed fracture of the orbital wall (bones near the eye). -The resident was administered lidocaine for pain and Ativan.	D 270		

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D 270	Continued From page 34 Observation made on 03/11/21 at 07:35am revealed: -Resident #4 ambulated/ran into the dining room without assistance. -The resident was unsteady and stumbling. -A personal care aide who was in the dining room assisted the resident to his table and chair. Interview with a personal care aide (PCA) on 03/11/21 at 12:30pm revealed: -Some of the residents were placed on 15-minute checks because of falls. -The PCA did not know how many residents were on 15-minute checks because there had been so many falls recently. -Resident #4 last fall occurred about 1 and ½ weeks ago and he injured/fractured his facial bones. -He had 3-4 falls before the last fall (she did not remember the dates). -The resident was sent to the ER when he fell because he always hit his head, or he ate feces or material from his brief. -After the incidents, the resident was placed on 15-minute checks for 72 hours, but the staff tried to keep an eye on him at times by keeping him in their site as much as possible. Interview with Resident #4's family member on 03/12/21 at 9:45am revealed: -She was Resident #4's power of attorney but had not been inside of the facility for about 1 year, before the COVID-19 outbreak. -The facility called her if Resident #4 had to be sent to the ER. -The resident had been falling "a lot" and was sent to the ER for evaluation. -She did not know what was going on because Resident #4 had fallen 5 times and sustained	D 270		

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head or facial injuries since January 2021.
-She always met the resident at the ER because he had dementia and Down's Syndrome and did not understand what was going on.
-About 3 weeks ago, the resident fell on something pointy and sustained a gash on top of his head that required 2 staples.
-On Friday of the same week, the resident fell in the hallway and hit the back of his head and sustained 2 hematomas.
-On Tuesday of the next week the facility called and reported the resident had fallen and he was injured. He was transported to the hospital and had fractured "quiet a few bones" in his face.
-After the 5th fall, the Administrator informed the family member that she was going to talk to the staff about keeping an "extra eye" on Resident #4, did not tell her what that meant.
-The resident was referred to maxillofacial surgeon after the last fall and she was informed by the surgeon that if Resident #4 fell again and hit his face/head, it could be "bad' and he may not survive.

Interview with Resident #4's personal care provider (PCP) on 03/16/21 at 9:33pm revealed:
-He was aware Resident #4 had several falls since January 2021.
-He had known Resident #4 for quite a while, and until a few months ago, he walked independently and would not sit for long periods.
-The resident's level of cognition and mental status was childlike and he always wanted to do what he wanted.
-Because of the resident's increased dementia, falls and behaviors were unpredictable.
-One on one supervision would be helpful but difficult for the facility, but the facility should be checking the resident as often as possible at all times to keep him safe and prevent more injuries.

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D 270	Continued From page 36 Interview with the facility's Administrator on 03/16/21 at 11:16am revealed: -She was aware of the multiple fall sustained by Resident #4. -She was aware of the multiple head injuries including the resident's head laceration, multiple head hematomas and facial fractures. -Resident #4 was placed on 15-minute checks for 72 hours after each fall and the staff should have kept him close by within eye site as frequently as possible. -There was no other fall prevention interventions put in place for Resident #4. -She did not know if the resident had a recent fall assessment. -The MCM was responsible for completing fall assessments on residents after a fall. Telephone interview with the facility's memory care manager (MCM) on 03/16/21 at 2:03pm revealed: -She was aware of Resident #4's multiple falls and injuries. -Resident #4 was placed on 15-minute checks for 72 hours after falls. -A fall mat was placed at the resident's bed (she did not know the date), but she did not know if the resident sustained any falls out of bed. -At times the MCM "walked the hall" to check on residents. -Resident #4 "scared her" because of his behaviors such as falling asleep while standing, repeated falls with head injuries and eating non-food items such as feces and parts of briefs. -The resident was placed on the facility's Angel Program which was started on 03/10/21 and his supervision will increase. Review of Resident #4's assessments and	D 270		

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progress notes revealed no falls assessments were documented for Resident #4.

Review of Resident #4's PCP notes/orders revealed no PT evaluations/treatments were ordered for Resident #4.

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

Refer to telephone interview with the facility's MCM on 03/16/21 at 2:03pm.

Refer to telephone interview with facility's contracted PCP on 03/16/21 at 9:33pm.

b. Review of accident reports and progress notes revealed Resident #4 was found eating non-food substances on 3 occasions between 9/26/2020 - 12/10/2020.

Review of an emergency room (ER) encounter report dated 09/26/2020 revealed:
-Per emergency medical service (EMS) report, Resident #4 was exposed to hepatitis C.
-The resident was found eating his roommate's stool this morning and the roommate had a history of hepatitis C.

Review of an incident/accident report dated 11/08/20 at 4:55pm revealed:
-Resident #4 was found in his room with "a mouth full of an adult brief" and staff made him spit it into their hand.
-After spitting it out, the staff noticed the resident holding his throat like something was stuck in his throat.

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D 270	Continued From page 38 -The resident complained of pain of his throat and was transported to the local ER via EMS. -The resident was to be monitored for 72 hours (15 minutes checks) and chart in progress notes. Review of an ER encounter report dated 11/08/2020 revealed: -Resident #4 was transported to the ER via EMS for ingesting an adult brief, and he had no complaints and his airway was patent. -The resident was discharged back to the facility. Review of resident progress notes for Resident #4 dated 11/08/2020 revealed the resident was sent to the ER for possible ingestion of a foreign object. The resident returned to the facility with no new orders and was put on 15-minute checks. Review of an incident/accident report dated 12/10/2020 07:45am revealed: -Resident #4 ate his own feces and his primary care provider (PCP) and family member was informed. -The resident was placed on increased supervisor (hourly checks) from 12/10/2020 - 12/13/2020. Review of a resident progress note for Resident #4 dated 12/10/2020 revealed the resident was in his room and ate his own feces this morning. The resident was washed, and his teeth were brushed. The PCP and family were notified. Record review revealed no documentation of 15-minute checks/increased supervision for 72 hours. Interview with a personal care aide (PCA) on 03/11/21 at 12:30pm revealed: -The resident was sent to the ER when he ate feces or material from his brief.	D 270		

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-After the incidents, the resident was placed on 15-minute checks for 72 hours, but the staff tried to keep an eye on him at times.

Interview with Resident #4's family member on 03/12/21 at 9:45am revealed:
-She was Resident #4's power of attorney but has not been inside of the facility for about 1 year, before the COVID-19 outbreak.
-The facility called her if the resident had to be sent to the ER.
-The resident was sent to the ER last year due to eating feces and eating material from his brief.
-After the 5th fall, the Administrator informed the family member that she was going to talk to the staff about keeping an "extra eye" on Resident #4.

Interview with Resident #4's PCP on 03/16/21 at 9:33pm revealed:
-He had known Resident #4 for quite a while.
-The resident's level of cognition and mental status was childlike and he always wanted to do what he wanted.
-Because of the resident increased dementia, his behaviors were unpredictable.
-One on one supervision would be helpful but difficult for the facility, but the facility should be checking the resident as often as possible at all times to prevent him from eating feces and material from his brief and to keep him safe (exposure to hepatitis C).

Interview with the Administrator on 03/16/21 at 11:16am revealed:
-She was aware Resident #4 consumed non-food material (brief material and feces)
-Resident #4 was placed on 15-minute checks for 72 hours and the staff should have kept him close by within eye site as frequently as possible.

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D 270	Continued From page 40 Interview with the facility's memory care manager (MCM) on 03/16/21 at 2:03pm revealed: -At times the MCM "walked the hall" to check on residents. -Resident #4 "scared her" because of his behaviors such as eating non-food items such as feces and parts of briefs. -The resident was placed on the facility's Angel Program which was started on 03/10/21 and his supervision would increase. Telephone interview with the Administrator on 03/18/21 at 1:30pm revealed: -She had concerns Resident #4 needed a higher level of care than what the facility could provide him. -Her concerns were related to Resident #4 being combative, resistant to care, and it was hard for Resident #4 to communicate his needs. -She "tried" to assign staff members to work with Resident #4 who he had a "rapport" with him. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to telephone interview with the facility's MCM on 03/16/21 at 2:03pm. Refer to telephone interview with facility's contracted PCP on 03/16/21 at 9:33pm. _____ Telephone interview with the facility's Memory Care Manager (MCM) on 03/16/21 at 2:03pm revealed: -When incident reports were entered into the computer, it triggered a 72-hour fall assessment in the electronic system and residents were placed on 15-minute checks for 72 hours.	D 270		

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D 270	Continued From page 41 -The MCM verbally informed the PCAs, the MAs and the Administrator of the 15-minute checks and a 15-minute check form was completed every shift each day for each resident on 15-minute checks. Telephone interview with facility's contracted primary care provider (PCP) on 03/16/21 at 9:33am revealed: -He talked to the Administrator and the MCM about the increased number of falls/injuries the residents were sustaining the weekend of 02/26/21 - 02/28/21, but they did not have any answers and stated, "things happen". -The PCP expected the facility to have supervision measures in place to protect the residents from falls/injuries. _____ The facility failed to provide supervision to 2 of 6 sampled residents (#2, #4), residing in an Alzheimers Special Care Unit, based on their assessed needs which resulted in Resident #2 sustaining 9 falls with injuries from 11/09/20 through 03/12/21 with required evaluation by emergency medical services and transport to the emergency room for 8 of the 9 falls; Resident #2's injuries included a displaced fracture of the C2 vertebra, a closed head injury, abrasions to her right arm, skin tears to her right arm, lacerations above her right and left eyebrows and to the back of her head, swelling to the back of her head, bruising to her face, forehead, and knees, hematomas (pocket of blood under the skin) to left side of her forehead and to her right scalp, which required the following medical interventions sutures, wound adhesive (skin glue), and staples; and Resident #4 sustained 5 falls from 01/09/21 through 03/02/21 with head and multiple facial fractures and ate a resident's feces who had a history of Hepatitis C. The facility's failure resulted	D 270		

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D 270	Continued From page 42 in serious physical harm and serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/16/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 17, 2021.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for acute and routine health care needs for 3 of 6 sampled residents (#2, #4, #6) including follow up with the primary care provider (PCP) for missed doses of an antibiotic and a choking episode (#4); tracking bowel movement patterns and notifying the PCP of a change in condition (#6); notifying the PCP of a skin rash and itching, refusals of multiple medications, obtaining physical therapy/occupational therapy (PT/OT) as ordered for multiple falls with injuries, and a delay in reporting and seeking care for change in condition including not eating or drinking, lethargy, and weakness (#2). The findings are:	D 273		

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1. Review of Resident #4's current FL-2 dated 11/27/20 revealed:
-Diagnoses included Alzheimer's dementia, Down's Syndrome, hypothyroidism, and hypertension.
-The resident was ambulatory and was disoriented intermittently.
-The resident resided in a special care unit (SCU).

a. Review of an incident/accident report for Resident #4 dated 10/19/20 at 12:00pm revealed:
-Resident #4 complained of a headache, was off balanced and his blood pressure was low.
-The resident was transported to the local emergency room (ER) via emergency medical services (EMS).
-The resident returned from the ER with a diagnosis of a urinary tract infection (UTI).

Review of an ER summary visit report for Resident #4 dated 10/19/20 revealed:
-The reason the ER visit was due to weakness and the resident sustained a fall.
-A urinalysis was completed, and the resident was diagnosed with bacteria in his urine and a abrasion on his head.
-The resident's urine showed an unexpectedly high amount of bacteria and he was treated for a UTI.
-The resident was ordered Ciprofloxacin 500mg tablet (an antibiotic used to treat bacterial infections), take 1 tablet by mouth every 12 hours for 10 days.

Review of an ER visit summary revealed on 10/22/20, Resident #4 was transported to the ER for evaluation after a fall and again diagnosed with bacteria in his urine.

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Telephone interview with the facility's pharmacist on 03/16/21 at 11:00am, revealed Ciprofloxacin 500mg, 20 tablets were delivered for Resident #4 to the facility on 10/19/20 and no tablets were returned.

Review of Resident #4's electronic medication administration record (eMAR) dated October 2020 revealed the resident was administered 13 of the 20 ordered doses of the ordered Ciprofloxacin:
- On 10/19/20, the Ciprofloxacin was not administered at 9:00am and 9:00pm because the facility was waiting for the pharmacy to deliver the medication.
-On 10/22/20, the Ciprofloxacin was not administered at 9:00pm because the resident was not available.
-On 10/24/20 (at 9:00pm) 10/25/20 (at 9:00am and 9:00pm), and 10/26/20 (at 9:00am), the Ciprofloxacin was not administered at 9:00pm because the resident refused the Ciprofloxacin.
-On 10/29/20 (the 10th day), there was no documentation that the resident was administered the Ciprofloxacin or the reason the medication was not administered.
-There was no documentation on the eMAR that Resident #4's primary care provider (PCP) was notified of the missed doses of ciprofloxacin

Review of Resident #4's progress notes dated October 2020 revealed there was documentation the PCP was notified of the missed doses of ciprofloxacin.

Review of a resident progress notes for Resident #4 dated 11/15/20 revealed Resident #4 complained of abdominal pain and was shaking. The resident was transported to the local ER with a temperature of 105.6 degrees Fahrenheit (F).

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D 273	Continued From page 45 for evaluation. Review of hospital admission/discharge records dated 11/15/20 - 11/26/20 for Resident #4 revealed: -The resident was admitted with diagnoses including sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs); septic shock (a potentially fatal medical condition that occurs with sepsis, which causes organ injury in response to infection); secondary to E. coli bacteremia infection (UTI); and pyelonephritis (inflammation of the kidney due to bacterial infection, acute kidney failure); hypotension and a temperature of 105.9 degrees F. -Resident #4 was treated in the critical care unit with intravenous (IV) antibiotics, vasopressors (antihypertensive medications used to stabilize blood pressure) and IV fluids Telephone interview with Resident #4's PCP on 03/16/21 at 9:33am revealed: -Resident #4 had repeated UTIs and was placed on antibiotics to treat the infections. -The resident was diagnosed with a UTI on 10/19/20 at the local ER and was ordered an antibiotic to treat the infection. -He expected the facility to complete the entire regimen of antibiotic as ordered to successfully treat the UTI. -The PCP expected the facility to inform him if the resident refused the medication or if the regimen was not completed as ordered. -If the antibiotics were not completed or if there was a gap in administration of the medication, bacteria in the resident's bladder would grow and take over again, infecting other organs and the blood stream, causing sepsis or septic shock, which would be life threatening to the resident.	D 273		

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-The facility did not notify him the resident did not complete his ordered antibiotic regimen.
-If the facility had notified him in October 2020 that the antibiotic regimen not completed, he would have ordered another regimen of antibiotics to prevent sepsis and septic shock.

Telephone interview with Resident #4's family member on 03/12/21 at 9:45am revealed:
-The resident was hospitalized for almost 2 weeks in November 2020 because the resident became septic from a UTI.
-About 3 weeks before the hospitalization (October 2020), Resident #4 was treated with antibiotics for a UTI, but the hospital medical providers questioned whether the first UTI was completely gone.
-The resident was treated in the hospital with IV antibiotics to assure the resident's infection was clear.

Telephone interview with the Administrator on 03/16/21 at 11:16am revealed:
-She was not aware Resident #4 missed multiple doses of ciprofloxacin which was ordered on 10/19/20.
-The Administrator did not know if the MAs had reported the missed doses to the MCM or the PCP.
-The medication aides (MA) should have informed the Memory Care Manager (MCM) of the missed doses and the PCP should have been notified by the MCM or the MAs.
-She was aware Resident #4 was hospitalized on 11/15/20 for treatment of septic shock and hypotension.

Telephone interview with the MCM on 03/16/21 at 2:05pm revealed:
-Resident #4 was transported to the ER on

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D 273	Continued From page 47 10/19/20 and was ordered antibiotics to treat a UTI. The resident had been treated for UTIs multiple times. -She was not aware Resident #4 did not receive the full ciprofloxacin regimen ordered on 10/19/20 until 3/12/21. -If the resident refused a dose of an antibiotic, or if doses of antibiotics were not administered for any reason, the PCP should have been notified immediately of the refusals. -The MAs were responsible for notifying the PCP of medication refusals or medications not administered for any reason and for notifying the MCM. Telephone interview with a personal care aide/medication aide (PCA/MA) on 03/17/21 at 2:00pm revealed: -She was working as a MA in October 2020 and remembered Resident #4 being transported to the ER and diagnosed with a UTI on 10/19/20. -The resident was ordered Ciprofloxacin every 12 hours. -She did not remember why the resident refused the medication or why the resident did not recieve the ciprofloxacin on the 10th day, but the medication refusals where documented on resident's MAR. -The medication refusals should have been reported to the PCP and documented in the electronic progress notes. -When Resident #4 refused his antibiotic, she attempted a second and third time before documenting the refusal but did not remember if she reported the refusals to the resident's PCP. -She remembered the resident was hospitalized in November 2020 after complaining of stomach pain and having a fever over 105 degrees F. The resident was treated for septic shock.	D 273		

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D 273	Continued From page 48 Refer to telephone interview with the Administrator on 03/18/21 at 1:30pm. b.Review of a speech therapist (ST) diet recommendation for Resident #4 dated 01/27/2021 revealed the ST recommended a diet upgrade which was signed by the primary care provider (PCP) to mechanical soft textures with thin liquids, distant supervision with meals to encourage slow rate, small bites, sips, and intermittent liquid wash. Telephone interview the Resident #4's family member on 03/12/21 at 9:45am revealed: -In February 2021 (did not remember the date), she received a call from the facility, but did not remember if the call was from the Administrator or the memory care manager (MCM), and was informed the resident had choked on a hot dog in the dining room during meal time. -The resident was served a hot dog the wasn't chopped or pureed. -She did not know if the resident was transported to the hospital for evaluation because she was informed the resident had coughed the hot dog up. Telephone interview with the MCM on 03/16/21 at 2:05pm revealed: -She was informed by the Administrator around the end of February 2021, Resident #4 had choked on a hot dog in the dining room while eating his lunch meal. -The resident eventually coughed the hot dog up and the Administrator reported the incident to the resident's family member. -The MCM was not sure if the incident was reported to the resident's PCP, but should have been reported by the medication aide or the Administrator.	D 273		

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A second telephone interview with the MCM on 03/17/21 at 1:15pm revealed:
-The choking incident should have been reported to Resident #4's PCP by the MA or the Administrator.
-The resident's PCP was not informed of the resident's choking incident that occurred in February 2021.

Telephone interview Resident #4's PCP on 03/16/21 at 9:35pm revealed:
-He was not informed by the facility that Resident #4 had a choking incident anytime in February 2021.
-If the resident choked on food, whether he was sent to the ER or not, he expected the facility to report the incident to him or to the on-call medical provider because the resident could have aspirated (breathing in a foreign object into the airway) some of the food.

Telephone interview with the Administrator on 03/16/21 at 11:16pm revealed:
-She did not remember Resident #4 choking on a hot dog in February 2021 in the dining room.
-There was no documentation of a choking incident in February 2021.

A second telephone interview with the Administrator on 03/18/21 at 1:30pm revealed:
-She was not aware of Resident #4 choking on a hot dog within the facility in February 2021.
-She was aware of a "choking" situation that was brought to her attention by Resident #4's family member.
-Resident #4's family member had taken him out of the facility for a meal and he had a "choking" episode outside of the facility.
-The "choking" episode did not happen at the

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facility and was not reported to the resident's PCP.
-She could not recall if Resident #4 had "choked" on a hot dog at the facility.
-If this had occurred Resident #4 would have been sent out to the hospital and the MA would have completed an accident/incident report.
-She knew Resident #4 had trouble swallowing and his diet orders changed from a pureed diet to mechanical soft diet, and back to a pureed diet.
-She had observed and heard Resident #4 coughing at meal times (no additional details given).

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

Refer to telephone interview with the Administrator on 03/18/21 at 1:30pm.

2. Review of Resident #2's current FL-2 dated 03/10/21 revealed:
-Diagnoses included Alzheimer's dementia, schizophrenia, brief psychotic disorder/psychoses, anxiety disorder, and paranoia.
-The resident was constantly disoriented.
-The resident was ambulatory and required assistance with bathing and dressing.
-The resident was incontinent of bowel and bladder.

Review of Resident #2's special care unit (SCU) resident profile and care plan dated 02/25/21 revealed:
-The resident was independent with toileting and ambulation without devices.
-The resident required limited assistance from staff with bathing and dressing.

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D 273	Continued From page 51 -The resident required supervision with transferring with standby assistance. -The resident required extensive assistance from staff with grooming and hygiene. Review of Resident #2's current assessment and care plan dated 03/04/21 revealed: -The resident ambulated with no problems and no devices. -The resident had occasional incontinence of the bladder but was continent of bowel. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident was independent with toileting, ambulation, and transferring. -The resident required supervision with dressing. -The resident required limited assistance from staff with bathing and grooming. a. Review of Resident #2's accident/incident (A/I) reports, resident progress notes, provider communication and visit notes, and hospital visit notes revealed: -Resident #2 had 9 falls with injuries from 11/09/20 - 03/12/21. -The resident required evaluation by emergency medical services (EMS) and transport to the emergency room (ER) for 8 of the 9 falls. -The resident's injuries included: abrasions and skin tears under the right arm; laceration above the right eyebrow requiring 3 sutures and closed, displaced fracture of the C2 vertebra; right scalp hematoma (pocket of blood under the skin); laceration above the left eyebrow requiring wound adhesive (skin glue); swelling and laceration to the back of the head requiring 5 staples; closed head injury with laceration above the left eye; bruises to the face, forehead, and knees; bruising and laceration over the right eyebrow; and a large hematoma on the left side of the forehead.	D 273		

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Observation of Resident #2 on 03/10/21 at 11:55am revealed:
-The resident was sitting up on her bed and had a black scab and bruise above her right eyebrow and was wearing a hospital bracelet.
-The resident did not respond verbally when spoken to.

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

Review of Resident #2's provider notification form dated 01/22/21 revealed:
-The resident was completely off balance and fell in the hallway.
-While waiting on ambulance, the resident got up out of the chair and fell again.
-The primary care provider (PCP) signed the notification form on 01/23/21.
-The PCP instructed facility staff to continue to monitor the resident.
-The PCP ordered physical therapy/occupation therapy (PT/OT) to evaluate and assist.

Review of Resident #2's provider visit notes revealed there was no documentation the resident had received PT/OT as ordered on 01/23/21 by the PCP.

Review of Resident #2's lab report revealed the resident tested positive for COVID-19 on 01/25/21.

Telephone interviews with the Memory Care Manager (MCM) on 03/16/21 at 2:12pm and on 03/18/21 at 12:43pm revealed:
-When she received Resident #2's referral order for PT/OT in January 2021, the resident got

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COVID-19 and was put in the COVID-19 unit.
-The resident tested positive for COVID-19 on 01/25/21 and was moved to the facility's COVID-19 unit that same day (14th day of quarantine would have been 02/07/21).
-The resident was in the COVID-19 unit longer than the 14 days quarantine because she was very weak, getting up and stumbling, temperature was up and down, and the resident would only eat "a little" at some meals.
-The resident stayed longer because she was very weak and there was closer supervision in the unit.
-The resident was moved back to her own room in February 2021 but she could not recall the date.
-She did not contact Resident #2's home health provider about the PT/OT order.

Review of Resident #2's PCP visit notes dated 02/17/21 revealed the resident was currently back in her room from the COVID-19 isolation unit.

Review of Resident #2's A/I reports, resident progress notes, provider communication and visit notes, and hospital visit notes revealed:
-The resident had 4 falls (1 on 11/09/20 and 3 on 01/22/21) prior to the PCP ordering PT/OT on 01/23/21.
-The resident had 3 additional falls on 02/06/21; 02/08/21; and 02/16/21 after PT/OT was ordered on 01/23/21 and not implemented.
-All 3 of those falls required treatment at the hospital including head injuries repaired with suturing, staples, and/or wound adhesive (skin glue).

Review of Resident #2's A/I report dated 02/16/21 at 10:33am revealed:
-The resident had an unwitnessed fall in the

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hallway.
-The resident was found on the floor with a laceration to the left eye.
-Pressure was applied to stop the bleeding.
-The resident was taken to the ER and the PCP and power of attorney (POA) were notified.
-The evaluation section of the report noted the resident would be evaluated for PT on 02/18/21.

Review of Resident #2's provider visit notes revealed there was no documentation the resident was evaluated for PT as indicated on the A/I report dated 02/16/21.

Review of Resident #2's A/I reports, resident progress notes, provider communication and visit notes, and hospital visit notes revealed:
-The resident had a fall on 02/27/21 after the resident failed to be evaluated by PT on 02/18/21 as indicated on the A/I report dated 02/16/21.
-The resident was sent to the ER for bruising and laceration over the right eyebrow.

Review of Resident #2's A/I report dated 02/27/21 at 6:42am revealed:
-The resident had an unwitnessed fall in the resident's room.
-The resident was sitting on the floor by her bed.
-The resident had bruising and a laceration over her right eyebrow.
-The resident was taken to the ER and the PCP and POA were notified.
-The evaluation section also noted referral to PT/OT for balance.

Review of Resident #2's provider visit notes revealed there was no documentation the resident was referred to PT/OT as indicated on the A/I report dated 02/27/21.

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Review of Resident #2's A/I reports, resident progress notes, provider communication and visit notes, and hospital visit notes revealed:
-The resident had a fall on 03/12/21 after the resident failed to be referred to PT/OT for balance as indicated on the A/I report dated 02/27/21.
-The resident was sent to the ER and diagnosed with a large hematoma on the left forehead.

Telephone interview with Resident #2's PCP on 03/16/21 at 9:33am revealed:
-He was aware of the resident's falls.
-The resident had deterioration in cognition and was at high risk for falls.
-The resident could be lying in bed and jump up and start running.
-He frequently wrote orders for PT/OT if a resident had more than one fall.
-He expected the facility to follow through with a referral for PT/OT when it was ordered.
-He did not know if Resident #2's PT/OT referral had been implemented or completed.
-PT/OT could work with the resident's cognition, space, balance, and strengthening.
-PT/OT (ordered on 01/23/21) could have potentially helped with the resident's falls.

Telephone interview with the Administrator on 03/16/21 at 11:15am revealed:
-Resident #2 had falls and a couple of the falls occurred when the resident was in the COVID-19 unit.
-The resident jumped up and ran "out of nowhere".
-She was not sure if the resident received PT/OT services because the MCM would be responsible for coordinating that.

Telephone interview with the Area Director of

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D 273	Continued From page 56 Operations (ADO) on 03/16/21 at 11:15am revealed: -Resident #2 had not received PT/OT services. -The facility's in-house therapy provider could not do PT/OT services for Resident #2 because the resident was already contracted with an outside home health provider for antipsychotic injections. -Then, the resident was in the COVID-19 unit and did not receive PT/OT while in the unit. -The facility should have obtained an order to hold PT/OT services while she was in the COVID-19 unit. -The MCM was responsible for notifying the PCP of a delay in implementing the PT/OT referral. -They were currently in the process of setting up PT/OT for the resident. Telephone interview with the Clinical Manager at Resident #2's home health provider on 03/17/21 at 4:15pm revealed: -It looked like from their records an order for PT/OT was filed in their system in February 2021 but the order was "missed"; she was not sure what that meant. -She was not sure why the order was not received into their system until February 2021. -They were in the process of getting a new order since the previous order was "missed". -The resident may not have received PT/OT initially because they did not work with COVID-19 positive residents until starting 03/01/21. -She did not know why the resident did not start receiving the PT/OT services as of 03/01/21 since the resident was not COVID-19 positive at that time. -There was no documentation in their records of any correspondence from the facility to set up or implement the PT/OT order. A second telephone interview with the	D 273		

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Administrator on 03/18/21 at 1:35pm revealed:
-She contacted the facility's in-house therapy provider sometime around 02/18/21 and asked them to evaluate the resident for PT/OT due to continued falls
-She did not document the conversation with the therapist on 02/18/21 and she did not recall what the plan was during the conversation.
-She had called the in-house therapy provider after she had spoken with the resident's POA and the POA asked if PT would help the resident since the resident was off balance.
-She had not contacted the facility's in-house therapy provider since 02/18/21.
-She thought she had talked to the MCM about the PT/OT referral order dated 01/23/21.
-The MCM was responsible for carrying out the order and she would have expected the ordered to be carried out.

Telephone interviews with the MCM on 03/16/21 at 2:12pm and 03/18/21 at 12:43pm revealed:
-She found out on Friday, 03/12/21, that the home health provider had called the facility and left a message for her (not sure when) but she never received the message
-She thought the PCP was aware the resident did not receive PT/OT services.
-The PCP had now decided not to continue with the plan for PT/OT now due to the resident's current cognitive decline.

Review of Resident #2's provider notification form dated 03/12/21 revealed:
-Facility staff documented the resident was not receiving PT/OT and may they have an order to discontinue it.
-The PCP signed the form on 03/13/21 and noted no PT/OT due to the resident's decline in level of mentation after the PT/OT evaluation order was

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written.

Refer to telephone interview with the Administrator on 03/18/21 at 1:30pm.

b. Review of Resident #2's lab report revealed the resident tested positive for COVID-19 on 01/25/21.

Review of Resident #2's resident progress notes dated 01/29/21 at 8:44pm revealed:
-The resident was sleeping a lot and did not eat any of her dinner.
-The resident was now sleeping again.

Review of Resident #2's resident progress notes dated 02/01/21 at 8:25pm revealed the resident ate about 50% of her dinner.

Review of Resident #2's resident progress notes dated 02/02/21 at 3:02pm revealed the resident ate about 65% of her food.

Review of Resident #2's resident progress notes dated 02/02/21 at 8:49pm revealed:
-The resident did not eat much supper tonight and stayed in bed most of the shift.
-The medication aide (MA) would continue to monitor.

Review of Resident #2's resident progress notes dated 02/03/21 at 3:24pm revealed:
-The resident was not eating or drinking and had a temperature of 99.5 degrees Fahrenheit (F).
-The primary care provider (PCP) examined the resident and she was sent to the hospital.

Review of Resident #2's PCP visit notes dated 02/03/21 revealed:
-On examination, the resident was lethargic and

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not responding appropriately to simple questions.
-The resident followed commands with considerable delay.
-The resident had a small laceration to the bridge of her nose as well as bilateral periorbital ecchymosis from a fall in the very recent past.
-The PCP was unable to determine the resident's discomfort over her spine due to her level of lethargy.
-The resident was non-ambulatory at this time.
-Staff indicated for the last 24 to 36 hours, the resident had not eaten and had drank small amounts only.
-On evaluation today, the resident was quite pale, having lost weight.
-The resident's skin integrity was poor with dried flaky skin and poor skin turgor with tenting (decreased skin turgor and tenting is a late sign of dehydration).
-The resident had a low-grade temperature.
-The facility's most recent testing of entire facility determined the resident was positive for COVID-19.
-Therefore, the resident was isolated in the COVID-19 unit.
-The PCP requested the resident be sent to the emergency room (ER) for hypoxia (low oxygen levels), increased lethargy, and gross malnutrition and dehydration.

Telephone interview with Resident #2's PCP on 03/16/21 at 9:33am revealed:
-For Resident #2's visit note dated 02/03/21 when the resident was in the COVID-19 unit and had not eaten or drank very little in 24 - 36 hours, he expected to be notified within the first day of the resident not eating or drinking.
-He needed to know that information because Resident #2 usually ate 100% of her meals so it was not normal for her to not eat or drink.

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-When he saw the resident on 02/03/21, he was concerned about her condition and had her sent to the ER.

Telephone interview with a personal care aide (PCA) on 03/17/21 at 1:34pm revealed:
-She worked in the COVID-19 unit when Resident #2 declined "badly" and would not eat or drink.
-The resident was not taking her medications for at least a couple of days and she had diarrhea.
-She reported it to the Resident Care Coordinator (RCC) and she was not sure if the RCC reported it to the PCP.
-The PCP came to the facility that day, 02/03/21, saw the resident and sent the resident to the hospital.
-Two to 3 days prior to the PCP's visit on 02/03/21, the resident was just laying around and would not eat or drink.
-If working, she would report the symptoms to the MA on duty.
-The PCAs reported changes of condition to the MAs and the MAs would let the PCP know.

Attempted interviews with the RCC on 03/17/21 at 3:30pm and 3:53pm were unsuccessful.

Telephone interview with a second PCA on 0./17/21 at 2:48pm revealed:
-Around the first week Resident #2 was in the COVID-19 unit (placed in COVID-19 unit on 01/25/21), the resident was very lethargic and weak and did not eat or drink.
-She did not know if these symptoms were reported to the PCP.
-She would have reported it to the PCA who delivered/picked up the food trays or the MA on duty.

Telephone interview with a third PCA on 03/17/21

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D 273	Continued From page 61 at 10:54pm revealed: -When Resident #2 was in the COVID-19 unit (placed in COVID-19 unit on 01/25/21), the resident slept a lot and did not have an appetite. -The resident was weak and she reported it to the MAs because the PCAs did not contact the PCP. -She did not recall the exact date or time she reported the resident's symptoms to the MA. Telephone interview with a fourth PCA on 03/18/21 at 11:52am revealed: -Resident #2 was very weak and very pale while in the COVID-19 unit (placed in COVID-19 unit on 01/25/21). -The resident was so weak, she had to sit up the resident and hold her up to feed her or give her drink. -The resident did not eat much so she gave her applesauce and fluids. -She reported the resident's symptoms to the MAs and the MAs were supposed to report it to the PCP. -She could not recall the dates she reported the symptoms to the MAs. Telephone interview with a MA on 03/17/21 at 11:45pm revealed: -When she worked on the COVID-19 unit, Resident #2 was very weak and did not get up at all. -The resident just laid there and staff tried to "push fluids" but the resident was barely eating. -The PCP usually came to the facility once a week and staff usually reported any concerns to him during the weekly visits. -She did not recall reporting the symptoms to the PCP but she was "sure" someone would have reported it to the PCP. -The PCP sent the resident to the ER during one visit when the resident was in the COVID-19 unit.	D 273		

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D 273	Continued From page 62 Telephone interview with the Memory Care Manager (MCM) on 03/16/21 at 2:12pm revealed: -Resident #2 tested positive for COVID-19 on 01/25/21 and was moved to the facility's COVID-19 unit that same day. -The resident was in the COVID-19 unit longer than the 14 days quarantine because she was "really doing bad". -The resident stayed longer in the designated COVID-19 unit because she was weak and there was closer supervision in the unit. -The resident was really weak and her temperature was up and down while she was in the COVID-19 unit. -They could only get the resident to eat a little and some meals she would not eat anything. -She was not aware Resident #2 not eating and drinking was not reported to the PCP for 24 - 36 hours. -The MAs should have notified the PCP the first day the resident was not eating. Telephone interviews with the Administrator on 03/16/21 at 11:15am 03/18/21 at 1:35pm revealed: -The resident slept a lot when she was in the COVID-19 unit and she fell getting up going to the bathroom. -The PCP saw the resident on one occasion when she was in the COVID-19 units and the PCP was really concerned about the way the resident looked. -The MAs had access to contact the PCP anytime about a resident's condition. -She expected staff to contact Resident #2's PCP immediately when the resident was sick and had stop eating while in the COVID-19 unit. Based on observations, interviews, and record	D 273		

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reviews, it was determined Resident #2 was not interviewable.

Refer to telephone interview with the Administrator on 03/18/21 at 1:30pm.

c. Observation of Resident #2 on 03/10/21 at 11:55am revealed:
-The resident was sitting up on her bed.
-The resident was pulling up her shirt and scratching her stomach, trunk, and breast area vigorously.
-There were small red circular dots on the resident's stomach and multiple scratch marks and scabbed areas on her stomach, trunk, and breasts.
-The resident did not respond verbally when spoken to.

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

Interview with a medication aide (MA) on 03/10/21 at 11:56am revealed:
-She just saw the rash on Resident #2's stomach that morning, 03/10/21.
-She thought the resident had the rash a while because she had seen her scratch "on and off" for 2 weeks,
-She borrowed some cream from another resident and applied it to Resident #2's rash on 3 occasions over the last 2 weeks.
-The cream did not seem to help the rash or itching.
-She had not notified the resident's primary care provider (PCP) about the rash or scratching because she planned to tell the PCP when he came to the facility today, 03/10/21, for his weekly visit.

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D 273	Continued From page 64 A second interview with the same MA on 03/11/21 at 1:42pm revealed she did not report Resident #2's rash to the PCP yesterday, 03/10/21, because the PCP was coming into the facility as she was leaving to go home. Review of Resident #2's Body Evaluation and Observation Bath Sheet dated 02/15/21 revealed: -The resident was given a "whole body shower" and her hair was washed. -The resident had scratch marks on 80% of her body where the resident had been scratching. -A personal care aide (PCA) signed and dated the bath sheet on 02/15/21, first shift. -The Resident Care Coordinator (RCC) also signed the form but did not date when she signed it. Telephone interview on 03/18/21 at 11:52am with the PCA who signed Resident #2's bath sheet dated 02/15/21 revealed: -She had documented on Resident #2's bath sheet dated 02/15/21. -The resident was scratching a lot so she washed the resident and put lotion on her. -She was not sure how long the scratches had been on the resident. -She gave the bath sheet to the RCC and she did not know if anyone notified the PCP. Telephone interview with the Administrator on 03/16/21 at 11:15am revealed: -Sometimes staff would give the completed bath sheets to her or the Memory Care Manager (MCM). -She was not sure what the procedure was for reviewing bath sheets. -She was notaware of Resident #2's bath sheet dated 02/15/21 with documentation of scratch	D 273		

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marks on 80% of the resident's body.

Telephone interview with the MCM on 03/16/21 at 2:12pm revealed:
-The RCC was responsible for reviewing and following up on resident bath sheets.
-If anything was noted on the bath sheets like a rash or skin breakdown, the RCC should notify the PCP and the MCM.
-She was not aware of Resident #2's bath sheet dated 02/15/21 noting the resident had scratch marks on 80% of her body.
-The RCC should have notified her and notified the resident's PCP.

Review of Resident #2's skilled nursing visit note dated 03/08/21 revealed:
-The resident was being seen for recertification for monthly antipsychotic injections.
-The registered nurse (RN) noted the resident was scratching both ankles, lower legs, and arms and was complaining of itching.
-No rash or bumps were noted.
-The resident had scratch marks on her arms, legs and ankles.
-The RN told the MA and the MA stated the resident did that "when she doesn't take her shower".

Review of Resident #2's after visit summary and hospital encounter notes dated 03/08/21 at 7:08pm revealed:
-The resident was seen for complaints of abdominal pain.
-The resident was diagnosed with acute cystitis (bladder infection) and skin rash.
-The resident was scratching her abdomen.
-The resident had a generalized erythematous (redness) rash on her abdomen with excoriation (abrasions) and scabbed over components

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secondary to scratching.
-The resident had "some significant skin rash" and excoriated tissue on her abdomen that she was scratching at.
-This may be causing some discomfort and problem.
-The resident was given Benadryl (an antihistamine used to treat itching).

Interview with a second MA on 03/10/21 at 4:28pm revealed:
-Resident #2's current rash started on the skin under her bra.
-She had noticed the current rash for "maybe a couple of days" but the resident had been scratching at least since a couple of weeks ago.
-The resident always scratched her rashes and sometimes the rashes were on her back, legs, and arms.
-The resident's rash never completely went away.
-She had not reported the resident's rash or scratching to anyone (no reason given).
-She was not sure if any other staff had reported it to the MCM or the PCP.

Interview with a PCA on 03/10/21 at 5:15pm revealed:
-Resident #2 had the skin rash for more than 6 months and she used to scratch it "real bad".
-She usually had red dots on her stomach and she had some red bumps on her feet in the past.
-The resident still scratched the rash on her stomach.
-She last gave the resident a shower the day before yesterday (03/08/21) and got some cream (did not know what kind) from the MA to put on the rash.
-She did not document the resident' shower or rash on a bath sheet because it was not the resident's regular bath time.

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-She did not know if the MA reported the rash to the PCP.

Telephone interview with a second PCA on 03/17/21 at 2:00pm revealed:
-Resident #2 "itched a lot" and scratched her back, stomach, and side.
-The resident had "little red bumps" on her skin and she had reported it to the RCC and a MA when the resident was on the COVID-19 unit.
-She did not know if the RCC or MA reported it to the PCP.
-The resident was still scratching her left side today, 03/17/21.

Telephone interview with a third PCA on 03/17/21 at 10:54pm revealed:
-She last saw Resident #2's skin the night before last (03/15/21) and there were some welts on her skin where she was scratching, mostly on her back and breast area.
-Resident #2 would always come up and say she was itching and she had scabs and scratch marks.
-She notified the MA that the resident was itching and the MA would always instruct her to give the resident a shower.

Interview with the MCM on 03/10/21 at 5:03pm revealed:
-Resident #2's rash "comes and goes" and it was usually around her stomach area.
-She saw the resident scratching the day before yesterday (03/08/21) so the resident was given a shower and staff put moisturizing lotion on her and she stopped scratching.
-There was a "light rash" on her skin at that time on 03/08/21.
-She did not notify the resident's PCP on 03/08/21 because she thought a MA had faxed a note to

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D 273	Continued From page 68 the PCP. Interview with the Administrator on 03/10/21 at 5:53pm revealed: -About 2 days ago when Resident #2 went out to the ER for stomach pain, she saw the resident's stomach when emergency medical services (EMS) pulled up the resident's shirt. -The resident had scabbed scratch marks on her stomach at that time. -The facility staff were expected to report any rashes, itching, or change in a resident's condition when observed to the MCM. -The MCM would notify the resident's PCP. Interview with Resident #2's PCP on 03/10/21 at 5:40pm revealed: -He was at the facility to see residents but he had not seen any residents yet today, including Resident #2. -A MA told him this afternoon when he arrived to the facility about Resident #2 having a skin rash and scratching. -He was not notified prior to today, 03/10/21, but he would have expected the facility staff to notify him as soon as they saw the rash or saw the resident itching and scratching. -He would evaluate the resident's skin today, 03/10/21, and determine proper treatment. Review of Resident #2's PCP visit notes dated 03/10/21 revealed: -The resident was being evaluated for pain and rash. -The PCP noted the resident had an abdominal rash with dried, flaky skin and poor skin turgor as she was chronically dehydrated. -The resident had multiple self-induced scratch marks to her abdomen and flanks bilaterally. -The resident had been observed scratching,	D 273		

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most likely pruritis associated with chronic dehydration and dried skin.
-The PCP ordered Hydrocortisone Cream 1% to be applied to the rash 3 times a day for 7 days.
-If the condition deteriorated, the PCP would order moisturizing cream and re-evaluate and follow-up with dermatology if indicated.

Telephone interview with Resident #2's PCP on 03/16/21 at 9:33am revealed:
-He saw the resident on 03/10/21 and the skin rash was mostly on her abdomen and was mostly dried skin.
-He ordered Hydrocortisone Cream as a first line of defense.
-If staff had let him know about the resident's rash, he would have treated it sooner.
-He would have tried to determine if the rash and scratching could have been related to the resident's nerves/anxiety or if it was a skin condition.
-The facility staff had access to call him or fax him 24 hours a day 7 days a week.

Attempted interviews with the RCC on 03/17/21 at 3:30pm and 3:53pm were unsuccessful.

Refer to telephone interview with the Administrator on 03/18/21 at 1:30pm.

d. Review of the facility's Medication Refusal Policy revealed:
-The medication refusal form was required documentation each time a medication was refused by a resident.
-The facility was to contact the primary care provider (PCP) when a resident had refused any prescribed medication 3 consecutive times.
-The PCP notification should be sent via fax and documented in the resident's record.

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-Immediate notification to the provider of a missed dose of medication for a specific medication was required for medications listed on the chart including antibiotics, thyroid medications, anticoagulants, insulin, anticonvulsants, oral anti-diabetics, cardiovascular, psychotropics, dialysis medications, and chemotherapy agents.

Review of Resident #2's physician's orders sheet dated 11/07/20 revealed:
-There was an order for Depakote DR Sprinkle 125mg, take 1 capsule every evening for mood, may open capsule and sprinkle on food. (Depakote may be used to treat mood disorders.)
-There was an order for Levothyroxine 25mcg take 1 ½ tablets (37.5mcg) every morning. (Levothyroxine is used to treat hypothyroidism, underactive thyroid disease.)

Review of Resident #2's previous FL-2 dated 02/24/21 revealed:
-There was an order for Depakote DR Sprinkle 125mg, take 1 capsule every evening.
-There was an order for Levothyroxine 25mcg take 1 ½ tablets (37.5mcg) every morning.
-There was an order for Seroquel 50mg 1 tablet at bedtime. (Seroquel is an antipsychotic used to treat schizophrenia and psychosis.)
-There was an order for Lorazepam 0.5mg 1 tablet 3 times a day. (Lorazepam is used to treat anxiety and agitation.)

Review of Resident #2's current FL-2 dated 03/10/21 revealed:
-There was an order for Depakote DR Sprinkle 125mg, take 1 capsule every evening.
-There was an order for Levothyroxine 25mcg take 1 ½ tablets (37.5mcg) every morning.
-There was an order for Seroquel 50mg 1 tablet

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at bedtime.
-There was an order for Lorazepam 0.5mg 1 tablet 3 times a day.

Review of Resident #2's mental health provider (MHP) visit note dated 09/14/20 revealed:
-Staff reported the resident was non-compliant with medications.
-The resident continued with delusional thought content, visual hallucinations, and hyper-religiosity.
-Instructions were to continue current medications and continue to monitor.

Review of Resident #2's MHP visit note dated 11/11/20 revealed:
-Staff reported the resident was compliant with medications.
-The resident continued with delusional thought processing but improved mood with less paranoia and psychosis.
-The resident had less irritability and staff was able to redirect with ease.
-Instructions were to continue current medications and continue to monitor.

Review of Resident #2's MHP visit note dated 12/09/20 revealed:
-Staff reported the resident was compliant with medications.
-The resident continued with confusion, visual hallucinations and delusional thought processing of religious and persecutory nature.
-Staff reported the resident had sleep disturbances with sleep patterns as the resident was "running" through the halls at night.
-The MHP added Seroquel at night that may help with sleep.

Review of Resident #2's January 2021 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Depakote DR Sprinkle 125mg take 1 capsule every evening for mood (may open and sprinkle on food) scheduled for administration at 4:00pm.
-Depakote was not documented as administered on 01/29/21 due to being refused.
-There was an entry for Levothyroxine 25mcg take 1 ½ tablets (37.5mcg) every morning at 6:00am.
-Levothyroxine was documented as refused on 26 of 31 days from 01/01/21 - 01/31/21.
-Levothyroxine was documented as refused from 01/01/21 - 01/06/21, 01/08/21 - 01/16/21, 01/18/21 - 01/21/21, and 01/23/21 - 01/29/21.
-There was an entry for Lorazepam 0.5mg 1 tablet 3 times daily for anxiety scheduled to be administered at 8:00am, 12:00pm, and 8:00pm.
-Documentation for the administration of Lorazepam started on 01/21/21.
-Lorazepam was documented as refused on 8 occasions from 01/21/21 - 01/31/21.
-Lorazepam was documented as refused on 01/21/21 at 8:00am and 12:00pm; 01/23/21 at 8:00am and 12:00pm; 01/24/21 at 8:00am, 12:00pm and 8:00pm; and 01/25/21 at 8:00pm.
-There was an entry for Seroquel 50mg 1 tablet at bedtime for psychosis scheduled to be administered at 8:00pm.
-Seroquel was documented as refused on 5 days from 01/01/21 - 01/31/21.
-Seroquel was documented as refused on 01/09/21, 01/10/21, 01/13/21, 01/24/21, and 01/25/21.

Review of Resident #2's record revealed there were no medication refusal notification forms for any of the resident's refusals in January 2021.

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D 273	Continued From page 73 Review of Resident #2's February 2021 eMAR revealed: -There was an entry for Depakote DR Sprinkle 125mg 1 capsule every evening for mood (may open and sprinkle on food) scheduled for administration at 4:00pm. -Depakote was documented as refused on 5 occasions including 02/06/21, 02/07/21, 02/11/21, 02/12/21, and 02/28/21. -There was an entry for Levothyroxine 25mcg take 1 ½ tablets (37.5mcg) every morning at 6:00am. -Levothyroxine was documented as refused on 21 of 28 days from 02/01/21 - 02/28/21. -Levothyroxine was documented as refused from 02/03/21 - 02/15/21, 02/19/21 - 02/21/21, and 02/24/21 - 02/28/21. -There was an entry for Lorazepam 0.5mg 1 tablet 3 times daily for anxiety scheduled to be administered at 8:00am, 2:00pm, and 8:00pm. -Lorazepam was documented as refused on 6 occasions from 02/01/21 - 02/28/21. -Lorazepam was documented as refused on 02/05/21 at 2:00pm; 02/09/21 at 8:00pm; 02/17/21 at 2:00pm and 8:00pm; 02/18/21 at 8:00am, and 02/28/21 at 8:00am. -There was an entry for Seroquel 50mg 1 tablet at bedtime for psychosis scheduled to be administered at 8:00pm. -Seroquel was documented as refused on 3 days from 02/01/21 - 02/28/21. -Seroquel was documented as refused on 02/09/21, 02/17/21, and 02/24/21. Review of Resident #2's record revealed there were no medication refusal notification forms for any of the resident's refusals in February 2021. Review of Resident #2's MHP visit note dated 02/24/21 revealed:	D 273		

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-Staff reported the resident was compliant with medications and activities of daily living.
-The resident was frequently falling due to impulsively jumping from her seat and "running" through the halls of the facility.
-The resident continued with confusion, delusional thought content, and visual hallucinations.
-Instructions were to continue current medications and continue to monitor.

Review of Resident #2's March 2021 eMAR revealed:
-There was an entry for Levothyroxine 25mcg take 1 ½ tablets (37.5mcg) every morning at 6:00am.
-Levothyroxine was documented as refused on 7 of 10 days from 03/01/21 - 03/10/21.
-Levothyroxine was documented as refused from 03/01/21 - 03/08/21.

Review of Resident #2's record revealed there were no medication refusal notification forms for any of the resident's refusals in March 2021.

Observation of Resident #2's medications on hand on 03/11/21 at 3:54pm revealed:
-There was one bubble card of Levothyroxine 25mg whole tablets dispensed on 02/24/21 with 30 of 30 tablets remaining.
-There was a second bubble card of Levothyroxine 25mg half tablets dispensed on 02/24/21 with 30 of 30 half tablets remaining.
-None of the Levothyroxine tablets dispensed on 02/24/21 had been used.
-There was one weekly multidose pack of Depakote DR Sprinkle 125mg capsules with a start date of 03/11/21 and 6 of 7 capsules remained.
-There was one weekly multidose pack of

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Seroquel 50mg tablets with a start date of 03/11/21 and 7 of 7 tablets remained.
-There was a supply of Lorazepam 0.5mg tablets dispensed on 02/25/21 with 59 of 90 tablets remaining.

Review of Resident #2's lab reports revealed:
-The resident's TSH level was 4.46 (reference range 0.27 - 4.20) on 08/28/20. (TSH is a lab test used to measure thyroid stimulating hormone. High TSH levels indicate an underactive thyroid, hypothyroidism. Levothyroxine is used to treat hypothyroidism.)
-There was no other documentation of additional TSH levels for the resident in the lab reports dated after 08/28/20.

Interview on 03/11/21 at 1:05pm with a medication aide (MA) who had documented medication refusals for Resident #2 revealed:
-Resident #2 refused a lot of medications.
-If a resident refused a medication during a medication pass and had refused it the day before, she would notify the PCP.
-She would have documented her contact with the PCP in the electronic progress notes if she had notified the PCP.
-Sometimes the MAs would just fax notification to the PCP and file it in the resident's record.

Telephone interview on 03/17/21 at 3:33pm with a second MA who had documented medication refusals for Resident #2 revealed:
-She started working at the facility about a month ago and Resident #2 was refusing some of her medications.
-She had to get another staff person to help her this morning, 03/17/21, because the resident refused at first but took the medication later.
-If a resident refused a medication, she would try

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to administer it 3 times.
-She would let the Memory Care Manager (MCM) know about the refusal after the third try and the MCM would instruct her to document it as refused.
-She was not aware of a medication refusal form and did not notify the PCP of any refusals.
-She did not know if the MCM notified the PCP of refusals.

Telephone interview on 03/17/21 at 11:45pm with a third MA who had documented medication refusals for Resident #2 revealed:
-If a resident refused a medication, the MAs were supposed to fill out a refusal form and notify the PCP.
-A lot of times, they would try to get a different MA to administer the medication if a resident refused.
-They were supposed to try 3 times before documenting a medication as refused.
-They should notify the PCP after each refusal because the PCP may want to change the medication to liquid form.
-Resident #2 refused medications and said the medications were going to kill her.
-She had to try 3 times to get the resident to take the medications.
-She thought she had filled out a few medication refusal forms but she could not recall.

Telephone interview with the MCM on 03/16/21 at 2:12pm revealed:
-In October 2020 and November 2020, Resident #2 was refusing some of her medications but the resident did not usually refuse medications when the MCM administered them to her.
-The MAs had not reported any medication refusals for the resident since the November 2020 refusals.
-She was not aware the resident had been

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refusing Levothyroxine, Depakote, Lorazepam, and Seroquel.
-It was "totally unacceptable" for the MAs not to report the medication refusals because those were very important medications for the resident to take especially since the resident was exhibiting "behaviors", including running up and down the halls.
-The MAs should have notified the resident's PCP and MHP immediately after they finished the medication pass when the resident refused.
-She checked eMAR reports daily for medications not administered due to medications being unavailable but she did not check the eMARs for refusals.
-She would start including checks for medication refusals when she did her daily reviews of the eMAR reports.

Telephone interview with the MCM on 03/18/21 at 12:43pm revealed:
-She always called Resident #2's MHP and let them know about any she refusals she was aware of.
-The MAs should complete the medication refusal forms and notify the providers according to the facility's policy.

Telephone interview with Resident #2's MHP on 03/18/21 at 10:18am revealed:
-Resident #2 was receiving an antipsychotic injection monthly because she had a history of refusing medications.
-When she visited the resident at the facility in February 2021, the MCM reported the resident was taking most of her oral medications most of the time.
-She also sometimes received texts from the facility regarding the resident.
-She did not recall getting any refusal forms and

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she was not sure what the facility's refusal policy was for medications.
-She would like to know when the resident refused her medications.

Telephone interview with Resident #2's PCP on 03/16/21 at 9:33am revealed:
-The facility had reported the resident refused medications over 6 months ago.
-To his knowledge, most recently the resident had been compliant with medications.
-He was not aware the resident had refused Levothyroxine, Depakote, Seroquel, or Lorazepam in the last 3 months.
-He was especially concerned about the refusals of Levothyroxine because thyroid levels had to be controlled.
-Not receiving Levothyroxine as ordered could affect the resident's vital signs such as pulse, could cause intolerance to temperature changes, and excessively dry skin.
-He would write an order to have the resident's thyroid levels checked on Friday, 03/19/21.
-Refusal of the Seroquel, Depakote, and Lorazepam could contribute to the resident's behaviors and psychosis; those medications were supposed to help curve the resident's unpredictable behaviors including behaviors that could be contributing to her falls.
-He expected the facility to notify him of any refusals no matter how many of any medication.

Telephone interview with the Administrator on 03/16/21 at 11:15am revealed:
-The medication refusal policy was if a resident refused a medication "they really need", then the provider needed to be notified immediately.
-The MCM should know when a resident was refusing medications and the MCM needed to talk to the PCP about it to see if there was an

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alternative way for the resident to take the medication.
-She would like for the PCP to be notified after 1 refusal because some residents were seizure-type medications.
-Staff should document when they notified the PCP of refusals but she was not sure where it should be documented.
-She was aware Resident #2 was refusing medications because if she was walking through the facility, a MA might say the resident did not take "so and so" today.
-Sometimes she could talk to the resident and get her to take the medication.
-The last time she was notified of Resident #2 refusing anything was possibly when the resident was in the COVID-19 unit around 01/25/21.
-The resident's PCP should be called or faxed for any medication refusals and the MHP should be notified for psychiatric medication refusals also.

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

Refer to telephone interview with the Administrator on 03/18/21 at 1:30pm.

3. Review of Resident #6's current FL-2 dated 04/10/20 revealed:
-Diagnoses included Alzheimer's disease, unspecified.
-He was constantly disoriented and was incontinent of bowel and bladder.

Review of Resident #6's Special Care Unit Resident Profile and Care Plan dated 02/24/21 revealed:
-Resident was incontinent and required staff assistance with toileting needs and hygiene.

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-Resident was to be assisted with toileting every 2 hours.

a. Review of Resident #6's Emergency Department Encounter dated 02/01/20 revealed:
-Resident #6 was noted at the facility to be walking hunched over, and was transported to the emergency department for abdominal pain.
-Computed tomography (CT) scan of the abdomen showed moderate pan-colonic constipation.
-There was an order for Resident #6 to follow up with his gastrointestinal (GI) provider.

Resident #6's hospital records for current hospitalization requested and not received at the time of survey exit.

Telephone interview with the Memory Care Manager (MCM) on 03/16/21 at 2:11pm revealed:
-It was the responsibility of the transporter to schedule appointments with specialty providers.
-The transporter or the resident's family member provided transport appointments with specialty providers.
-The transporter obtained the office visit notes and new orders after the appointment and gave them to the medication aide (MA) on duty for processing.
-It was the responsibility of the MCM to follow up with any office visit notes or new orders that were not available on the appointment date.
-It was the responsibility of the MCM to ensure that all appointments were scheduled.

Second telephone interview with the MCM on 03/18/21 at 9:53am revealed:
-She did not have documentation from a visit with a GI provider for Resident #6.
-She would have to check the calendar to see if

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D 273	Continued From page 81 appointment was missed or rescheduled. Telephone interview with the transporter on 03/18/21 11:52am revealed: -She transported Resident #6 to see a GI medical provider before the coronavirus pandemic but was unsure of the exact date. -Resident #6's family member accompanied them to the appointment and spoke with the GI provider. -Resident #6 and the transporter returned to the facility and she gave the GI provider notes to the MA. -She could not remember the MA that she gave the GI provider notes to. Third telephone interview with the MCM on 03/18/21 at 12:43pm revealed she was still unable to locate an appointment date or documentation for a GI provider visit for Resident #6. Review of Resident #6's progress notes and medical provider visit notes revealed there was no documentation of a GI visit after the 02/01/20 hospital visit. Telephone interview with the Administrator on 03/18/21 at 1:35pm revealed: -She was not aware that Resident #6 did not follow up with the GI provider as ordered from the hospital visit on 02/01/20. -The staff should have scheduled the follow up GI appointment for Resident #6 so that resident's condition could have been monitored closer. Based on observations, interviews, and record reviews, it was determined Resident #6 was not available for interview.	D 273		

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Attempted telephone interview with Resident #6's power of attorney (POA) on 03/12/21 at 10:17am, 03/17/21 at 10:18am and 03/17/21 at 10:22am was unsuccessful.

Telephone interview with Resident #6's primary care physician (PCP) on 03/17/21 at 5:15pm revealed he did not recall Resident #6 following up with a GI medical provider as ordered from a hospital visit on 02/01/20.

Refer to telephone interview with the Administrator on 03/18/21 at 1:30pm.

b. Review of an Accident/Incident report for Resident #6 dated 02/27/21 revealed:
-The incident was documented as "other."
-On 02/27/21 at 7:37am, Resident #6 was observed in the hallway to be leaning over while sitting in a chair.
-He was transported to the hospital at 8:00am by emergency medical services (EMS) and was admitted.
-The primary care physician (PCP), the power of attorney (POA) and his family member were notified.

Review a progress note for Resident #6 dated 02/27/21 revealed:
-He was transported to the hospital by EMS for an illness.
-The PCP and responsible party were notified.

Resident #6's hospital records for current hospitalization requested and not received at the time of survey exit.

Telephone interview with the Memory Care Manager (MCM) on 03/18/21 at 12:43pm revealed:

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-On 02/25/21, Resident #6 had to be prompted to eat his meals but ate 100% of each meal with prompting; there were no changes to his ambulation and no signs of abdominal pain, such as bending over, displayed.
-On 02/26/21, Resident #6 was observed to be bending over with facial grimacing and not ambulating as frequently as he normally did; the medication aide (MA) administered Milk of Magnesia per standing orders around lunch time.
-On 02/26/21, she was not sure how much breakfast Resident #6 consumed; he consumed less than 100% of lunch and consumed approximately 50% of supper.
-The Resident Care Coordinator (RCC) reported these findings to the PCP on 02/26/21 at approximately 1:30pm.
-She was not sure if the RCC documented the changes observed in Resident #6 or the communication with the PCP.
-She did not see Resident #6 prior to departing on 02/26/21 and was unsure if the Milk of Magnesia was effective.
-On 02/27/21 at approximately 10:00am, she observed Resident #6 continuing to ambulate bent over with facial grimacing.
-Resident #6 was transported to the hospital on 02/27/21.

Telephone interview with a personal care aide (PCA) on 03/18/21 at 10:42am revealed:
-Resident #6 had a decreased appetite and ambulated bent over during episodes of constipation.
-The first episode occurred prior to February 2021; she was not sure of the exact date.
-Resident #6 was bending over and needed more encouragement to get out of the bed.
-She notified the MA of change and the MA administered some medication for constipation.

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-She could not remember which MA she reported findings too.
-Resident #6 usually consumed 100% of all meals but consumed less than 100% for breakfast; she could not remember the exact amount and consumed 100% of lunch.
-Resident #6 had a large bowel movement by the end of her shift.
-The second time she observed Resident #6 bending over was sometime in February 2021.
-She was not sure of the exact date, but the incident was prior to Resident #6's current hospitalization.
-She notified the MA and Resident #6 was transported to the emergency room (ER).
-She was not sure how long Resident #6 was in the hospital and not sure when Resident #6 was readmitted to the facility.
-The last time she observed Resident #6 bending over was at the end of February 2021.
-She worked with Resident #6 the last week he was at the facility and was not sure of the last date she worked with Resident #6.
-Resident #6 was in a wheelchair and was not ambulating independently as he had usually done.
-She observed Resident #6 with a decreased appetite and he needed assistance with meals.
-She observed Resident #6 to be bending over and reported these findings to the MA.
-She checked on Resident #6 about every 15 minutes for the remainder of the shift.
-She was not sure if Resident #6 was transported to the hospital on that date, but he was not in the facility when she returned for her next scheduled shift; dates were not provided.
-She was not sure of the exact date the change in status started for Resident #6.
-There was an occasion that Resident #6 had diarrhea, this occurred approximately 1-2 weeks

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prior to this recent hospitalization.
-She reported the findings to the MA and was not sure if the PCP was notified.

Telephone interview with a second PCA on 03/18/21 11:52am revealed:
-Resident #6 was usually ambulatory and was always moving around.
-She saw Resident #6 sometimes bending over, holding his knees with facial grimacing and would assist him to the bathroom.
-Facial grimacing improved and Resident #6 would stop holding his knees after moving his bowels.
-She notified the MA when she observed Resident #6 straining during bowel movements.
-Resident #6's bowel movements appeared to be hard.
-No diarrhea was observed with Resident #6.
-Prior to a recent hospitalization, Resident #6 sat down more, bent over and fell asleep more frequently than he usually did.

Telephone interview with a MA on 03/18/21 at 12:25pm revealed:
-She was made aware by a PCA that Resident #6 was sitting on the floor holding his stomach.
-She was unsure of the exact date of the incident but thought that it occurred after Valentine's Day 2021.
-She checked on Resident #6 and administered an as needed medication for constipation per standing physician's orders.
-She was not sure if the medication was effective because she administered the medication towards the end of her shift.
-She assisted Resident #6 with toileting and he usually had a bowel movement after breakfast, after lunch and after supper.
-She would have notified Resident #6's PCP if he

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did not have a bowel movement in 24 hours.
-She had not contacted Resident #6's PCP regarding symptoms of constipation, diarrhea or abdominal pain.
-During Resident #6's last week at the facility at the end of February 2021, she observed that he was not walking around as much as he normally did, he was more tired than usual, and needed assistance during meals.
-Resident #6 was usually ambulatory throughout the day without devices and independent with meals.
-She did not report the changes observed in Resident #6's status to his PCP and was not sure why she did not report findings to PCP.
-There were no reports received from other staff related to a change in Resident #6's status.
-The PCP should be notified if a change was noted from a resident's "baseline."

Telephone interview with Resident #6's primary care physician (PCP) on 03/17/21 at 5:15pm revealed:
-Missed doses of Resident #6's laxatives could cause a bowel obstruction to occur over a 1-2 week time period.
-He expected to be notified by staff if Resident #6 had not had a bowel movement in 3 days.

Telephone interview with the Administrator on 03/18/21 at 1:35pm revealed:
-On 02/27/21, she observed that Resident #6 was not acting as his usually acts.
-She observed Resident #6 to be sitting down with his arms across his stomach.
-She questioned staff if he had a bowel movement and staff advised that he had not.
-She notified the MCM of these findings and Resident #6 was transported to the ER.
-She expected the MA to report changes in a

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resident's condition to the PCP and the MCM when changes first observed.

Based on observations, interviews, and record reviews, it was determined Resident #6 was not available for interview.

Attempted telephone interview with Resident #6's POA on 03/12/21 at 10:17am, 03/17/21 at 10:18am and 03/17/21 at 10:22am was unsuccessful.

Attempted telephone interview with the Resident Care Coordinator (RCC) on 03/17/21 at 2:54pm and 3:30pm was unsuccessful.

Refer to telephone interview with the Administrator on 03/18/21 at 1:30pm.

c. Telephone interview with the Memory Care Manager (MCM) on 03/16/21 at 2:11pm revealed:
-There was no routine documentation of bowel movement charting done at the facility.
-The personal care aides (PCAs) were usually scheduled with the same residents, would track residents' bowel movements, and communicated this information during end of shift report to the oncoming PCAs.
-No concerns voiced about the facility not completing routine bowel movement charting.
-Resident #6 was transported to the hospital on 02/27/21 related to signs of abdominal pain and possible constipation.
-The staff were not able to determine when Resident #6's last bowel movement was prior to 02/27/21.

Telephone interview with a personal care aide (PCA) on 03/17/21 at 2:23pm revealed:
-She had never documented a bowel movement

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episode for Resident #6.
-She used to administer medications at the facility and during that time period there was no place in the electronic medical records (eMARs) to document bowel movements.
-She document a resident's bowel movement in the progress notes.
-It was the responsibility of the PCAs to monitor resident's bowel movements and report any constipation or diarrhea to the MAs.
-It was the responsibility of the MAs to follow up with any abnormal bowel patterns, such as constipation or diarrhea, notify the primary care physician (PCP), and document findings and orders in a progress note.
-She was aware that Resident #6 had a history of constipation, but she was not sure of his normal bowel movement patterns.
-There had been an incident when she was a MA in which a PCA reported that Resident #6 had not had a bowel movement in 3 days; she was unsure of the exact dates.
-She checked on Resident #6 and observed him to be bending over as if he was in pain.
-She notified the PCP and received an order to administer Miralax; she was not sure if she received any additional orders from the PCP.
-She administered the Miralax as ordered but she was not sure if the medication was effective.
-She was not sure if she documented this episode of constipation and the new orders received from the PCP in Resident #6's progress notes; this should have been documented in Resident #6's progress notes.

Telephone interview with a second PCA on 03/18/21 at 10:42am revealed:
-Resident #6 was incontinent of bowel and bladder and used an adult brief.
-Resident #6 would sometimes pull/tug at his

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pants that indicated the need for assistance with incontinent care.
-She would check Resident #6 for incontinence at least hourly.
-She documented each resident's bowel movements on a piece of paper and discussed with the MA and PCA during end of shift report.
-This piece of paper was not a facility form used for documentation.

Telephone interview with a third PCA on 03/18/21 11:52am revealed:
-Resident #6 was incontinent of bowel and bladder and was not able to communicate his needs verbally.
-She assisted Resident #6 with toileting after breakfast and after lunch.
-She reported Resident #6's bowel movements to the MA.
-She was not sure how the MAs documented this information.
-She had not completed any routine documentation related to any residents' bowel movements or patterns.

Telephone interview with a MA on 03/17/21 at 3:32pm revealed:
-It was the responsibility of the PCAs to monitor residents for constipation or diarrhea and report the findings to the MAs.
-The PCAs did not document bowel movements anywhere.
-The PCAs communicated verbally with other PCAs during the end of shift reporting which residents were having constipation or diarrhea.
-It was the responsibility of the MAs to document the constipation or diarrhea in the resident's progress notes and communicate these findings during end of shift reporting to the oncoming shift.
-She was not aware of Resident #6 having

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complaints of abdominal pain.
-She had not received any reports from PCAs that Resident #6 had constipation or diarrhea.

Telephone interview with a second MA on 03/18/21 at 12:25pm revealed:
-Resident #6 was incontinent of bowel and bladder and was not verbal.
-It was the responsibility of the PCAs to monitor resident's bowel patterns and report any constipation or diarrhea to the MA.
-It was the responsibility of the MA to follow up with the residents and notify the PCP of findings.

Based on observations, interviews, and record reviews, it was determined Resident #6 was not available for interview.

Telephone interview with the Administrator on 03/18/21 at 1:35pm revealed:
-It was the responsibility of the PCA to monitor resident's bowel patterns and report patterns to the MA.
-It was the responsibility of the MA to document resident's bowel patterns in a progress note.
-Resident's bowel patterns were tracked using the progress notes created by the MA.

Telephone interview with Resident #6's primary care physician (PCP) on 03/17/21 at 5:15pm revealed:
-His last visit with Resident #6 was after resident's last fall, was unsure of the exact date but visit was before this current hospitalization.
-He noted that Resident #6 was not walking around as he usually did and was lethargic; thought this was related to the recent fall.
-He asked the staff about Resident #6's intake and bowel movements; he could not recall what the staffs' responses to the questions were.

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D 273	Continued From page 91 -He expected to be notified by staff if Resident #6 had not had a bowel movement in 3 days. -He had not received any reports from staff that Resident #6 was having abdominal pain, constipation or diarrhea. -He was not aware of Resident #6 having missed doses of his laxatives. -Missed doses of Resident #6's laxatives could cause a bowel obstruction to occur over a 1-2 week time period. Attempted telephone interview with Resident #6's POA on 03/12/21 at 10:17am, 03/17/21 at 10:18am and 03/17/21 at 10:22am was unsuccessful. Attempted telephone interview with the Resident Care Coordinator (RCC) on 03/17/21 at 2:54pm and 3:30pm was unsuccessful. Resident #6's hospital records for current hospitalization requested and not received at the time of survey exit. Refer to telephone interview with the Administrator on 03/18/21 at 1:30pm. _____ Telephone interview with the Administrator on 03/18/21 at 1:30pm revealed: -She expected physician referral and follow-up to be completed by staff members in a "timely" manner. -New physician orders should be carried out "immediately". -For any changes in a resident's health care status, the primary care provider (PCP) should be notified immediately by phone or fax. -The resident would not receive "help" if the PCP was not notified. -For any changes in a resident's health care	D 273		

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status during after hours, staff members were expected to notify the facility's on-call PCP by phone.
-She had concerns "anytime" someone dropped the ball with not implementing a PCP's order.
-The facility had a protocol and procedure in place if there were resident's health status changes.
-She expected staff members to follow the facility's protocol and procedure for physician notification and follow-up.

_____

The facility failed to ensure referral and follow up for acute and routine health care needs for 3 of 6 sampled residents. The facility failed to notify Resident #4's primary care provider (PCP) when the resident missed 13 of 20 doses of an antibiotic for a urinary tract infection (UTI) in October 2020 resulting in the resident being hospitalized for septic shock on 11/15/20 secondary to a UTI; and for an incident when the resident choked on a hot dog in February 2021 placing the resident at risk for aspiration. The facility failed to notify Resident #2's PCP of a skin rash and itching and refusals of multiple medications including medications for hypothryoidism which placed the resident at risk for a slowed heart rate, intolerance to temperature changes and excessively dry skin; and refusals of medications for mood disorders, anxiety, and agitation which placed the resident at risk of continued behaviors and psychosis resulting in the resident's unpredictable behavior of running up and down the halls leading to falls with injuries; Resident #2 did not receive physical therapy/occupational therapy (PT/OT) as ordered on 01/23/21 and continued to have multiple falls with injuries required treatment at the hospital, including lacerations repaired with staples, sutures, and/or skin glue; and a 24 to 36-hour

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D 273	Continued From page 93 delay in reporting and seeking care for Resident #2's change in health status including not eating or drinking, lethargy, and weakness which led to resident requiring evaluation and treatment at the hospital. The facility facility failed to coordinate care for Resident #6 who did not have a gastrointestinal (GI) appointment per hospital orders received on 02/01/20; failed to notify Resident #6's PCP of a change in health status immediately and failed to document bowel movements. The facilty's failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/16/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 17, 2021.	D 273		
D 274	10A NCAC 13F .0902(c)(1) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care; This Rule is not met as evidenced by:	D 274		

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Based on observations, record reviews, and interviews the facility failed to implement physician orders for 2 of 5 sampled residents (Residents #1 and #3), there was a 20-day delay in implementing a physician order for Thrombo-Embolus Deterrent (TED) knee high stockings (Resident #3) and there was no implementation for a physician order related to a right leg brace (Resident #1).

The findings are:

1. Review of Resident #3's current FL-2 dated 12/16/20 revealed diagnoses included Alzheimer's dementia unspecified without behavior disturbances, delusional disorder, anxiety disorder, Type 2 diabetes, hypothyroid, gastroesophageal reflux disease, hyponatremia, and chronic pain.

Review of Resident #3's primary care provider (PCP)'s order dated 11/19/20 revealed Thrombo-Embolus Deterrent (TED) knee high stockings (TED stockings help prevent blood clots and swelling in the legs).

Review of Resident #3's sizing form dated 12/09/20 revealed:
-It was a fax form for the facility's contracted pharmacy.
-Within the comments section, there was TED knee high stockings measurements of 17 inches long and 18 inches wide.

Review of Resident #3's PCP's order dated 12/10/20 revealed there was an order clarification to apply the TED stockings in the am and remove them at night.

Review of Resident #3's pharmacy dispensing

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records revealed Resident #3's TED hose stockings quantity of 2 were dispensed to the facility on 12/10/20.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/15/21 at 1:04pm revealed:
-Resident #3's order for TED hose stockings was received on 12/10/20.
-Resident #3's TED hose stockings were dispensed to the facility on 12/10/20.

Telephone interview with the Memory Care Manager (MCM) on 03/16/21 at 2:11pm revealed:
-On 11/19/20, she expected the medication aide (MA) on duty to process Resident #3's PCP's order for TED hose knee high stockings by completing the resident's leg measurements.
-Her expectation was for the order to have at least be processed by 11/20/20.
-She was not aware the night shift (10:00pm-6:00am) MA did not process/complete Resident #3's PCP order dated 11/19/20 until 12/09/20.
-She did not follow up to verify Resident #3's PCP order dated 11/19/20 was not implemented within the expected 24-hour time.
-On 12/09/20, she completed Resident #3's leg measurements for her TED stockings knee high and the measurements were sent to the facility's contracted pharmacy.
-It was important for Resident #3 to have her TED stockings knee high because she was experiencing bilateral lower extremity swelling.
-She expected new resident's orders to be processed within a 24-hour time period which meant faxing to the facility's contracted pharmacy or contacting the resident's PCP for order clarification.

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Telephone interview with Resident #3's primary care provider on 03/17/21 at 5:15pm revealed:
-He was not aware his order dated 11/19/20 for Resident #3's TED knee high stockings were not completed close to "thirty days" after the order was written.
-He had concerns with the delay Resident #3 not receiving her TED stockings because Resident #3 had bilateral lower extremities swelling and this could have increased without the application of the TED stockings.
-He expected all resident's orders to be implement within a 24-48 timeframe.

Telephone interview with the Administrator on 03/18/21 at 1:30pm revealed:
-She was not aware of Resident #3's PCP's order dated 11/19/20 for TED knee high stockings.
-She was not aware the measurements for Resident #3's TED knee high stockings were not completed till 12/09/20.
-She expected staff members to implement Resident #3's PCP's order dated 11/19/20 for TED knee high stockings within 24-48 hours of the order being written.

2. Review of Resident #1's current FL-2 dated 06/26/20 on 03/11/21 revealed:
-Diagnoses included Alzheimer's dementia, hypothyroidism, depression and gastroesophageal reflux disease.
-The resident was intermittently disoriented.
-The resident was ambulatory.
-The resident's recommended level of care was documented as Special Care Unit (SCU).

Review of Resident #1's Resident Register revealed an admission date of 02/27/20.

Review of Resident #1's patient encounter with

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PCP on 02/24/21 revealed:
-Resident #1 was generally weak.
-The resident was documented to have a mild right foot drop.
-The PCP ordered a right ankle foot orthosis (AFO) brace.

Observation of Resident #1 at various times on 03/10/21 from 11:00am-6:00pm revealed the resident did not have on a right AFO brace.

Observation of Resident #1 at various times on 03/11/21 from 7:45am-6:00pm revealed the resident did not have on a right AFO brace.

Review of Resident #1's electronic Medication Administration Record (eMAR) for February 2021 and March 2021 revealed no documentation for an order for a right AFO brace.

Telephone interview with the MCM on 03/16/21 at 2:11pm revealed:
-The MCM was aware that Resident #1's PCP wrote an order on 02/24/21 for a right AFO brace.
-The MCM sent the order for the right AFO brace to a medical supplier after the 02/24/21 order.
-The MCM was not aware Resident #1 did not have the right AFO brace as ordered and would get the brace ordered.
-The facility never received Resident #1's AFO brace from the medical supplier therefore the order was not implemented.
-The MCM did not follow up on with the medical supplier regarding Resident #1' AFO brace.

Telephone interview with Resident #1's PCP on 03/16/221 at 9:33am revealed:
-The PCP ordered a RT AFO brace for Resident #1 due to the resident having a slight foot drop.
-The PCP felt the RT AFO brace would help the

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D 274	Continued From page 98 resident. -The PCP would expect the facility to implement the order for the RT AFO brace. Telephone interview with the Administrator on 03/18/21 at 1:30pm revealed: -The Administrator was not aware Resident #1's PCP ordered a right AFO brace on 02/24/21 and that the resident did not have the brace. -The Administrator expected Resident #1's order for the AFO brace to be implemented as ordered. Based on observation, interviews, and record reviews it was determined that Resident #1 was not interviewable.	D 274		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diet (pureed) was served as ordered for 1 of 3 residents sampled (Resident #4), who had dysphagia with a history of choking.	D 310		

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D 310	Continued From page 99 The findings are: Review of Resident #4's current FL-2 dated 11/27/20 revealed: -Diagnoses included Alzheimer's Dementia, Down's Syndrome, hypothyroidism, and hypertension. -There was an order for a mechanical soft diet. -The resident resided in a special care unit (SCU). Review of Resident #4's SCU profile and care plan dated 02/25/21 revealed Resident #4 ate independently after staff set up for meals and snacks. Review of the facility's therapeutic diet list on 03/10/21 revealed Resident #4 was listed to receive a mechanical soft diet with double portions. Review of a signed order for Resident #4 dated 03/10/21 revealed: -The home health speech therapist (ST) to evaluate and assist. -Please start pureed diet. Observation of the breakfast meal on 03/11/21 from 7:00am - 8:15am revealed: -Resident #4 was served chopped sausage, scrambled eggs, grits, apple juice, milk and water. -Resident #4 ate meal independently and ate 75% of his meal which took over one hour to finish. -The resident had difficulty spooning food from plate to his mouth, often dropping the food off of his spoon. Interview with the facility's Dietary Manager on	D 310		

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D 310	Continued From page 100 03/11/21 at 11:30am revealed: -When the facility received an order for a new diet/diet change, the memory care manager (MCM) delivered a copy of the new diet order to her or the cook if she was not available. -If the order was received after all of the dietary had left for the evening, the diet order was slipped under the Dietary Manager's office door. -The next morning the new diet order was placed in the diet order binder on which was kept on her desk and the 2 therapeutic diet lists which were kept on the side of the refrigerator for the dietary staff and on the wall at the dining room door for the personal care staff were updated immediately. -There were 3 new diet orders on the floor of her office this morning, but Resident #4 did not have a new diet order. Interview with the MCM on 03/11/21 at 11:40am revealed: -The primary care provider (PCP) gave her new diet orders for 4 residents on 03/10/21. -A copy of the diet orders was placed under the Dietary Manager's office door because all of the dietary staff left at 6:00pm on 03/10/21. -A copy of Resident #4's diet order which changed his diet from mechanical soft to pureed was placed under the Dietary Manager's office door on 03/10/21 after 6:00pm. -The MCM checked the Dietary Manager's office and her diet order manual and the new diet order was not found. Observation of the lunch meal on 03/11/21 from 12:00pm until 1:00pm revealed: -Resident #4 was served a pureed meal which included pureed ham, pureed pinto beans, and pureed corn bread. -The resident ate 100% the pureed meal without	D 310		

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problem.

Telephone interview with Resident #4's family member on 03/12/21 at 9:45am revealed:
-The resident always ate well, he always cleaned his plate.
-All of the resident's teeth were extracted about a year ago and the resident was choking when eating and he was placed on a pureed diet (about a year ago).
-The resident was given a hot dog last month (February 2021) during a meal and choked. A facility staff called the family member and reported the choking.
-The resident was not transported to the emergency room (ER).
-The family member was informed at that time the resident was ordered a mechanical soft diet but was served a hot dog. He should not have been given a hot dog.
-When the resident was receiving a pureed diet, he cleaned his plate and did not choke.

Telephone interview with Resident #4's personal care provider (PCP) on 03/16/21 at 9:35am revealed:
-The resident should not have been on a mechanical soft diet due to his dysphagia and his history of choking.
-He corrected the resident's diet order on 03/10/21 when at the facility.
-He left all of the orders with the facility's MCM on 03/10/21 around 6:00pm and expected Resident #4's new diet order to be implemented immediately at the next meal due to the resident's risk for choking.
-The resident should not be given whole hot dogs to eat due to he was at risk for choking.

Telephone interview with the facility's

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CASTLE CREEK MEMORY CARE	4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429

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Administrator on 03/16/21 at 11:16am revealed;
-She was aware Resident #4 had a diagnosis of dysphagia and had a history of choking.
-She expected orders for diet changes to be implemented immediately.
-The MCM should deliver the new diet orders to dietary (the Dietary Manager) immediately and the Dietary Manager should update the therapeutic diet list in the kitchen.

Review of an after-visit summary from a local emergency room (ER) for Resident #4 dated 09/13/20 revealed:
- The reason for the visit included choking.
-The resident was discharged from the ER with written instructions/information to prevent choking.

-Review of a communication note from a registered dietitian to Resident #4's PCP dated 09/16/20 revealed:
-Resident #4 would benefit from speech therapy to address dysphagia as staff had reported several choking episodes, also to assess proper diet.
-The resident's PCP ordered speech therapist (ST) to evaluate and assist.

Review of a diet order for Resident #4 dated 09/16/20 revealed an order for pureed diet.

Review of a ST progress report for Resident #4 dated 9/18/20 revealed:
-ST goals were for Resident #4 to exhibit tolerance to mechanically soft solids and thin liquids by treating the resident's swallowing dysfunction and oral function for feeding and increase safety of swallowing to resume mechanical soft diet.
-The resident was assessed with mild to

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moderate swallowing deficits.

Review of a previous FL-2 for Resident #4 dated 10/29/20 revealed an order for a pureed diet.

Review of a hospital discharge order for Resident #4 from a hospitalization from 11/15/20 - 11/26/20 revealed an order for regular pureed diet.

Review of a PCP visit note for Resident #4 dated 12/16/20 revealed:
-The resident was evaluated for dysphagia and dementia.
-Since the resident returned from being hospitalized, he had been experiencing increased dysphagia.
-The resident had been evaluated by ST with a diet clarification of a pureed diet and thin liquids.
-The ST indicated to encourage the resident to eat slowly, small bites and small sips of liquids.
-Due to the resident's level of mentation and cognitive status, he was unable to do so.

Review of a ST diet recommendation (to the PCP) for Resident #4 dated 01/27/21 revealed the ST recommended a diet upgrade (which was signed by the PCP) to mechanical soft textures with thin liquids, distant supervision with meals to encourage slow rate, small bites, sips, and intermittent liquid wash.

A second telephone interview with the Administrator on 03/18/21 at 1:30pm revealed:
-She expected staff members to follow the primary care provider's resident's current diet order, it was "extremely" important.
-It was "extremely" important because the resident could choke, the resident could have an emergency and required hospitalization.
-She expected staff members to provide the

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D 310	Continued From page 104 resident the correct diet order, it was "critical" to avoid residents having untoward effects. _____ The failure of the facility to serve the diet as ordered for 1 of 4 sampled residents (#4) who had a diagnosis of dysphagia and a history of choking resulted in the resident having a reported choking episode after being served a hot dog and being at risk for repeated choking and was detrimental to the health, safety, and welfare of Resident #4 and constitutes a Type B Violation. _____ _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/11/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 21.	D 310		
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 A1 VIOLATION Based on observations, interviews, and record	D 358		

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reviews, the facility failed to ensure medications were administered as ordered for 5 of 6 residents sampled (#1, #2, #3, #4, #6) including errors with administering and requesting refills for a laxative (#6); administering an antibiotic (#4); administering and requesting refills for eye drops (#3); administering a topical prescription cream for a skin rash/itching without a physician's order (#2); and errors with clarifying a medication used to treat anxiety and a vitamin (#1).

The findings are:

Review of the facility's Medication Management policy dated July 2020 revealed:
-Medication cart audits were completed every Wednesday to ensure medications were available for administration.
-The designated staff were to remove expired medications, check for restocking of medications and medications that were held as ordered had a corresponding physician's order.
-Medications on hand were checked for all refusals to ensure medications were available.
-The designated staff were to ensure that the primary care physician (PCP) was notified for more than 3 occurrences of missed or refused medications and documentation of notification was completed.
-The medication refusal form should be completed, faxed to the PCP and documented in the resident's chart each time a resident refused a medication.

1. Review of Resident #4's current FL-2 dated 11/27/20 revealed:
-Diagnoses included Alzheimer's dementia, Down's Syndrome, hypothyroidism, and hypertension.
-The resident was ambulatory and was

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disoriented intermittently.
-The resident resided in a special care unit (SCU).

Review of an incident/accident report for Resident #4 dated 10/19/20 at 12:00pm revealed:
- Resident #4 complained of a headache, was off balance and his blood pressure was low.
-The resident was transported to the local emergency room (ER) via emergency medical services (EMS).
-The resident returned from the ER with a diagnosis of a urinary tract infection (UTI).

Review of an ER summary visit report for Resident #4 dated 10/19/20 revealed:
-A urinalysis was completed, and the resident was diagnosed with bacteria in his urine and a abrasion on his head.
-The resident's urine showed an unexpectedly high amount of bacteria and was treated for a UTI.
-The resident was ordered Ciprofloxacin 500mg tablet (an antibiotics used to treat bacterial infections), take 1 tablet every 12 hours for 10 days.

Telephone interview with the facility's pharmacy technician on 03/15/21 revealed Ciprofloxacin 500mg, 20 tablets were delivered to the facility on 10/19/20 and no tablets were returned.

Review of Resident #4's electronic medication administration record (eMAR) for October 2020 revealed the resident was administered 13 of the 20 ordered doses of the ordered Ciprofloxacin:
- On 10/19/20, the Ciprofloxacin was not administered at 9:00am and 9:00pm because the facility was waiting for the pharmacy to deliver the medication.

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-On 10/22/20, the Ciprofloxacin was not administered at 9:00pm because the resident was not available.
-On 10/24/20 (at 9:00pm) 10/25/20 (at 9:00am and 9:00pm), and 10/26/20 (at 9:00am), the ciprofloxacin was not administered at 9:00pm because the resident refused the Ciprofloxacin.
-On 10/29/20 (the 10th day), there was no documentation that the resident was administered the ciprofloxacin or documented exception.

Review of Resident #4's eMARs documentation and electronic progress notes revealed no documention that the resident's PCP was iinformed of the missed ciprofloxacin doses.

Review of hospital admission/discharge records dated 11/15/20 - 11/26/20 for Resident #4 revealed:
-The resident was admitted to the local hospital with diagnoses of sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), septic shock (a potentially fatal medical condition that occurs when sepsis, which causes organ injury in response to infection) secondary to Escherichia coli (E. Coli) bacteremia infection (UTI) and Pyelonephritis (inflammation of the kidney due to bacterial infection, acute kidney failure), hypotension and a temperature of 105.9 degrees F.
-Resident #4 was treated in the critical care unit with intravenous (IV) antibiotics, vasopressors (antihypertensive agents) and IV fluids.

Telephone interview with Resident #4's primary care provider (PCP) on 03/16/21 at 9:33am revealed:
-He was aware Resident #4 had repeated UTIs and was placed on antibiotics to treat the

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infections.
-The resident was diagnosed with a UTI on 10/19/20 at the local ER and was ordered an antibiotic to treat the infection.
-He expected the facility to complete the entire regimen of antibiotic to successfully treat the UTI.
-The PCP expected the facility to inform him if the resident refused the medication or if the regimen was not completed as ordered.
-If the antibiotics were not completed or if there was a gap in administration of the medication, bacteria in the resident's bladder would grow and take over again, infecting other organs and the blood stream, causing sepsis or septic shock, which would be life threatening to the resident.
-If the facility notified PCP of the antibiotic regimen not completed, he would have ordered another regimen of antibiotics to prevent sepsis and septic shock.
-The facility did not notify him the resident did not complete his ordered antibiotic regimen.

Telephone interview with Resident #4's family member on 03/12/21 at 9:45am revealed:
-About 3 weeks before the hospitalization (October 2020), Resident #4 was treated with antibiotics for a UTI, but the hospital medical providers questioned whether the first UTI was completely gone.
-The resident was hospitalized for almost 2 weeks in November 2020 because the resident became septic from a UTI.
-The resident was treated in the hospital with IV antibiotics to assure the resident's infection was clear and he would not be treated with oral antibiotics when discharged.

Telephone interview with the Administrator on 03/16/21 at 11:16am revealed:
-She was not aware Resident #4 missed multiple

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doses of his antibiotic which was ordered on 10/19/20.
-The medication aides (MA) should have informed the Memory Care Manager (MCM) of the missed doses and the PCP should have been informed.
-The Administrator did not know if the MAs had reported the missed doses to the MCM.
-She was aware Resident #4 was hospitalized on 11/15/20 for treatment of septic shock and hypotension.

Telephone interview with the MCM on 03/16/21 at 2:05pm revealed:
-She was aware of that Resident #4 was transported to the ER on 10/19/20 and was ordered antibiotics to treat a UTI. The resident had been treated for UTIs multiple times.
-She was not aware Resident #4 did not receive the full antibiotic regimen ordered on 10/19/20 until 03/12/21.
-The MAs did not report the medication refusals to her and she did not know if staff offered Resident #4 the antibiotic 3 times before documenting "refusal" on his eMAR per facility policy.
-If the resident refused a dose of an antibiotic, the PCP should have been notified immediately of the refusals by the MAs.
-The MAs were responsible for notifying the PCP of medication refusals and notifying the MCM.

Telephone interview with a personal care aide (PCA) who was a former medication aide on 03/17/21 at 2:00pm revealed:
-She was working as a MA in October 2020 and remembered Resident #4 being transported to the ER and diagnosed with a UTI on 10/19/20. The resident was ordered Cipro every 12 hours.
-She did not remember why the resident refused

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the medication, but medication refusals where to be reported to the PCP.
-When Resident #4 refused his antibiotic, she attempted a second and third time before documenting the refusal but did not remember if she reported the refusals to the resident's PCP.

2. Review of Resident #6's FL-2 dated 04/10/20 revealed diagnoses included Alzheimer's disease, unspecified and he was constantly disoriented.

Review of Resident #6's signed physician's orders dated 04/10/20 revealed:
-There was an order for Polyethylene Glycol mix 17grams(g) in 8 ounces(oz) of water and drink twice daily. (Polyethylene Glycol is a laxative used to treat and prevent constipation).

Review of Resident #6's pharmacy dispensing records received on 03/17/21 revealed:
-On 04/21/20, there were 2 separate entries of Polyethylene Glycol powder 510g showing as dispensed; each entry was for a 15 day's supply.
-On 05/03/20, there were 2 separate entries of Polyethylene Glycol powder 510g showing as dispensed; each entry was for a 15 day's supply.

Review of Resident #6's April 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for Polyethylene Glycol 17g mix in 8oz of water and drink twice daily with scheduled administration times at 8:00am and 8:00pm.
-There were 7 of 60 doses of Polyethylene Glycol that were not documented as administered for April 2020.
-On 04/05/20 at 8:00pm and 04/23/20 at 8:00pm,

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Polyethylene Glycol was documented as not administered due to "loose bowels."
-On 04/10/20 at 8:00am, 04/10/20 at 8:00pm, 04/15/20 at 8:00am and 04/16/20 at 8:00am, Polyethylene Glycol was documented as not administered due to "refusal."
-On 04/21/20 at 8:00pm, Polyethylene Glycol was documented as not administered due to "discontinued."

Review of Resident #6's May 2020 eMAR revealed:
-There was an entry for Polyethylene Glycol 17g mix in 8oz of water and drink twice daily with scheduled administration times at 8:00am and 8:00pm.
-There were 7 of 62 doses of Polyethylene Glycol that were not documented as administered for May 2020.
-On 05/04/20 at 8:00pm, 05/05/20 at 8:00am, 05/09/20 at 8:00pm, and 05/25/20 at 8:00pm, Polyethylene Glycol was documented as not administered due to "refusal."
-On 05/05/20 at 8:00pm, Polyethylene Glycol was documented as not administered due to "resident unavailable."
-On 05/06/20 at 8:00pm and 05/16/20 at 8:00pm, Polyethylene Glycol was documented as not administered due to "loose bowels."

Resident #6's eMAR for June 2020 was requested on 03/17/21 and 03/18/21 and was not provided at the time of survey exit.

Resident #6's eMAR for July 2020 was requested on 03/17/21 and 03/18/21 and was not provided at the time of survey exit.

Review of Resident #6's August 2020 eMAR revealed:

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D 358	Continued From page 112 -There was an entry for Polyethylene Glycol 17g mix in 8oz of water and drink twice daily with scheduled administration times at 8:00am and 8:00pm. -There were 3 of 62 doses of Polyethylene Glycol that were not documented as administered for August 2020. -On 08/10/20 at 8:00am, 08/19/20 at 8:00am and 08/24/20 at 8:00pm, Polyethylene Glycol was documented as not administered due to "refusal." Review of Resident #6's September 2020 eMAR revealed: -There was an entry for Polyethylene Glycol 17g mix in 8oz of water and drink twice daily with scheduled administration times at 8:00am and 8:00pm. -There were 2 of 60 doses of Polyethylene Glycol that were not documented as administered for September 2020. -On 09/03/20 at 8:00pm and 09/06/20 at 8:00pm, Polyethylene Glycol was documented as not administered "due to condition." Review of Resident #6's October 2020 eMAR revealed: -There was an entry for Polyethylene Glycol 17g mix in 8oz of water and drink twice daily with scheduled administration times at 8:00am and 8:00pm. -There were 5 of 62 doses of Polyethylene Glycol that were not documented as administered for October 2020. -On 10/06/20 at 8:00pm, 10/13/20 at 8:00pm and 10/22/20 at 8:00pm, Polyethylene Glycol was documented as not administered due to "loose bowels." -On 10/18/20 at 8:00pm, Polyethylene Glycol was documented as not administered "due to condition."	D 358		

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D 358	Continued From page 113 -On 10/22/20 at 8:00am, Polyethylene Glycol was documented as not administered due to "resident sedated." Review of Resident #6's November 2020 eMAR revealed: -There was an entry for Polyethylene Glycol 17g mix in 8oz of water and drink twice daily with scheduled administration times at 8:00am and 8:00pm. -There were 4 of 60 doses of Polyethylene Glycol that were not documented as administered for November 2020. -On 11/14/20 at 8:00am, Polyethylene Glycol was documented as not administered "due to condition." -On 11/18/20 at 8:00am, Polyethylene Glycol was documented as not administered due to "loose bowels." -On 11/19/20 at 8:00pm and 11/20/20 at 8:00pm, Polyethylene Glycol was documented as not administered due to "refusal." Review of Resident #6's December 2020 eMAR revealed: -There was an entry for Polyethylene Glycol 17g mix in 8oz of water and drink twice daily with scheduled administration times at 8:00am and 8:00pm. -There were 2 of 62 doses of Polyethylene Glycol that were not documented as administered for December 2020. -On 12/11/20 at 8:00pm, Polyethylene Glycol was documented as not administered due to "pharmacy." -On 12/28/20 at 8:00pm, Polyethylene Glycol was documented as not administered due to "refusal." Review of Resident #6's January 2021 eMAR revealed:	D 358		

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D 358	Continued From page 114 -There was an entry for Polyethylene Glycol 17g mix in 8oz of water and drink twice daily with scheduled administration times at 8:00am and 8:00pm. -There were 3 of 62 doses of Polyethylene Glycol that were not documented as administered for January 2021. -On 01/05/21 at 8:00am, Polyethylene Glycol was documented as not administered due to "loose bowels." -On 01/15/21 at 8:00am, Polyethylene Glycol was documented as not administered "due to condition." -On 01/25/21 at 8:00pm, Polyethylene Glycol was documented as not administered due to "refusal." Review of Resident #6's February 2021 eMAR revealed: -There was an entry for Polyethylene Glycol 17g mix in 8oz of water and drink twice daily with scheduled administration times at 8:00am and 8:00pm. -There were 7 of 56 doses of Polyethylene Glycol that were not documented as administered for February 2021. -On 02/15/21 at 8:00pm and 02/27/21 at 8:00am, Polyethylene Glycol was documented as not administered "due to condition." Observation of Resident #6's medications on hand on 03/11/21 at 9:51am revealed: -There was 1 bottle of Polyethylene Glycol 510 grams dispensed on 04/10/20 observed on the medication cart with an expiration date of 08/2022. -The directions on the medication label for Polyethylene Glycol were to mix 17g in 8oz of water and drink twice daily. -On 03/11/21, there was approximately 2 doses of Polyethylene Glycol that remained from the	D 358		

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supply dispensed on 04/10/20.
-There were no other bottles of Polyethylene Glycol observed on the medication cart.

Telephone interview with the Memory Care Memory (MCM) on 03/16/21 at 2:11pm revealed it was the responsibility of the Resident Care Coordinator (RCC) to complete the weekly medication cart audits for all residents.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 03/17/21 at 1:10pm revealed:
-She reviewed the dispensing record for Resident #6's Polyethylene Glycol and confirmed the last date the pharmacy dispensed this medication was on 05/03/20.
-Polyethylene Glycol was not on cycle/automatic refill and the facility was required to request refills of the medication from the pharmacy in order for it to be refilled.
-There were refills that were available.
-She did not see where the facility requested refills for the Polyethylene Glycol since 05/02/20.
-She clarified that the 2 entries for the Polyethylene Glycol dispensed on 04/21/20 and 05/03/20 were not 2 bottles of Polyethylene Glycol sent on the same date.
-On 04/21/20, one entry was for the dispensing of the 15 day's supply of Polyethylene Glycol and the second entry was for the billing of that same medication.
-On 05/03/20, one entry was for the dispensing of the 15 day's supply of Polyethylene Glycol and the second entry was for the billing of that same medication.
-There was only a 15 day's supply of Polyethylene Glycol dispensed on 04/21/20 and a 15 day's supply of Polyethylene Glycol dispensed on 05/03/20.

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D 358	Continued From page 116 -She was not sure why the Polyethylene Glycol was dispensed in 15 day's supply increments. -She was concerned that the Polyethylene Glycol had not been administered as ordered because the last dispensed date was on 05/03/20 for a 15 day's supply and there was a physician's order for Polyethylene Glycol 17g twice daily. -Not receiving bowel medications as ordered could have affected his bowel movement pattern. Telephone interview with the Director of Clinical Instruction (DCI) on 03/17/21 at 3:14pm revealed: -Resident #6's Polyethylene Glycol powder was not dispensed by another pharmacy. -Resident #6's family did not supply the Polyethylene Glycol powder. -The facility did not purchase the Polyethylene Glycol powder from over the counter. Telephone interview with a medication aide (MA) on 03/17/21 at 3:32pm revealed: -She administered Resident #6's Polyethylene Glycol once daily on day shift and he consumed 100% each time. -She was not sure how many times Polyethylene Glycol was scheduled each day and was not sure how much Polyethylene Glycol was on hand at the facility. -There had never been a time when the Polyethylene Glycol was not available. -Resident #6's family had never supplied the Polyethylene Glycol however she was not sure if medication was dispensed using a different pharmacy. A second telephone interview with the MCM on 03/18/21 at 12:43pm revealed: -She was not aware that Resident #6's Polyethylene Glycol was last dispensed on 05/03/20.	D 358		

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D 358	Continued From page 117 -There were several individual packets of single dosed Polyethylene Glycol in the medication room. -The individual packets of Polyethylene Glycol were dispensed from the pharmacy and not dispensed for a specified resident. -She was not sure why there were individual packets of Polyethylene Glycol. -Polyethylene Glycol should have been dispensed from the pharmacy for each resident with an active order. -Polyethylene Glycol was not included in the physician's standing orders. -Resident #6's Polyethylene Glycol was not dispensed by another pharmacy. -Resident #6's family did not supply Polyethylene Glycol. -Polyethylene Glycol should have been reordered from the pharmacy for Resident #6 after the 30 day supply was finished. -She was concerned that the Polyethylene Glycol was not being administered as ordered. Telephone interview with the Administrator on 03/18/21 at 1:35pm revealed: -She had concerns about Resident #6 getting the proper medications. -She was aware that Resident #6 was prescribed 3 medications for constipation and was currently hospitalized with a bowel obstruction. Telephone interview with Resident #6's primary care physician (PCP) on 03/17/21 at 5:15pm revealed: -He was not aware that Resident #6's Polyethylene Glycol was last dispensed on 05/03/20. -He was not aware of any issues related to dispensing Resident #6's Polyethylene Glycol. -Missed doses of Polyethylene Glycol could	D 358		

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cause a bowel obstruction to occur over a 1-2 week time period.
-He expected to be notified by staff if Resident #6 had not had a bowel movement in 3 days.

Based on observations, interviews and record review it was determined that Resident #6 was not available for interview.

Attempted telephone interview with Resident #6's POA on 03/12/21 at 10:17am, 03/17/21 at 10:18am and 03/17/21 at 10:22am was unsuccessful.

Attempted telephone interview with the RCC on 03/17/21 at 2:54pm and 3:30pm was unsuccessful.

3. Review of Resident #3's current FL-2 dated 12/16/20 revealed diagnoses included Alzheimer's dementia unspecified without behavior disturbances, delusional disorder, anxiety disorder, Type 2 diabetes, hypothyroidism, gastroesophageal reflux disease, hyponatremia, and chronic pain.

Review of Resident #3's Ophthalmologist visit note dated 01/12/21 revealed:
-She presented for evaluation of diabetic eye exam in the right and left eye.
-She had a history of non-proliferative diabetic retinopathy (NPDR) left eye (NPDR is an early stage of diabetic retinopathy, in this stage tiny blood vessels within the retina leak blood or fluid. The leaking fluid causes the retina to swell or to form deposits called exudates), peripheral vascular disease to both eyes, and dry eye syndrome (DES).
-She reported having intermittent horizontal

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double visual acuity in the left eye over the last year or year and half.
-Right now, she was experiencing the double visual acuity.
-Blinking sometimes helped to clear the double visual acuity or she could tilt her head to her left side to make the double visual acuity go away.
-She also had complaints blurry visual acuity yo both eyes.
-There was a physician order for Refresh Optive 0.5-0.9% eye drops apply by ophthalmic route twice to four times daily to both eyes for dry eye.

Observation of Resident #3's medications on hand on 03/11/21 at 9:26am revealed there was no Refresh Optive 0.5-0.9% eye drops on hand.

Interview with Resident #1 on 03/10/21 at 11:35am revealed:
-There was only one medication aide (MA) who would give her ordered eye drops.
-She had not received her ordered eye drops for "a while."
-She could not recall how long it had been.

Review of Resident #3's pharmacy dispensing records revealed:
-Refresh Optive drops 0.5-0.9% eye drops: 15 ml were dispensed on 01/13/21 for a 37.5-day supply.
-Refresh Optive drops 0.5-0.9% eye drops: 15 ml were dispensed on 03/10/21 for a 37.5 day supply.

Review of Resident #3's January 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Refresh Optive drops 0.5-0.9% instill one drop into both eyes four times daily for dry eyes with scheduled administration

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times of 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The first dose of Refresh Optive drops was documented as administered at 8:00am on 01/14/21.
-Refresh Optive drops were documented as administered four times a day for 18 days from 01/14/21 - 01/31/21, for a total of 72 doses.
-There were 72 of 72 ordered doses of Refresh Optive documented as administered.

Review of Resident #3's February 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Refresh Optive drops 0.5-0.9% instill one drop into both eyes four times daily for dry eyes with scheduled administration times of 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Refresh Optive drops were documented as administered four times a day for 28 days from 02/01/21 - 02/28/21, for a total of 112 doses.
-There were 112 of 112 ordered doses of Refresh Optive documented as administered.

Review of Resident #3's March 2021 electronic medication administration record (eMAR) revealed:
-The run date and time of the eMARs was documented as 03/10/21 at 4:19pm.
-There was an entry for Refresh Optive drops 0.5-0.9% instill one drop into both eyes four times daily for dry eyes with scheduled administration times of 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Refresh Optive drops were documented as administered four times a day for 10 days from 03/01/21 at 8:00am - 03/10/21 at 8:00am, for a total of 37 doses.
-On 03/10/21 at 11:36am, the Refresh Optive eye drops were documented as "not administered on hold" with the comment "waiting on pharmacy".
-There were 37 of 38 ordered doses of Refresh

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D 358	Continued From page 121 Optive documented as administered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/15/21 at 1:04pm revealed: -The pharmacy received the Refresh Optive eye drop order from the facility on Wednesday (01/13/21). -The pharmacy dispensed the Refresh Optive eye drops to the facility on Wednesday (01/13/21). -The Refresh Optive eye drops dispensed to the facility on Wednesday (01/13/21) was a 37.5-day supply for Resident #3. -The next medication refill request for the Refresh Optive eye drops was sent Wednesday, 03/10/21. Telephone interview with a certified ophthalmic assistant at Resident #3's Ophthalmologist's office on 03/17/21 at 12:41pm revealed: -Resident #3 was last seen at the Ophthalmologist's office on 01/12/21. -Resident #3 was given a prescription for Refresh Optive. -She was not aware Resident #3 was dispensed a 37.5-day supply of Refresh Optive eye drops on 01/13/21 and there was not another medication refill of the Refresh Optive eye drops requested by the facility until 03/10/21. -She had concerns with Resident #3 running out of her supply of her Refresh Optive eye drops mid-day on 02/21/21. -Resident #3 had Meibomian Gland Dysfunction (MGD) which affected the glands in her eyes. -With MGD, the glands would not secrete enough oil or when they did secrete oil, it would be poor quality. -If Resident #3 was not administered her Refresh Optive eye drops her vision could be hazy or blurry, and she could have corneal damage due to excessive blinking.	D 358		

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D 358	Continued From page 122 Telephone interview with the Memory Care Manager (MCM) on 03/16/21 at 2:11pm revealed: -When the facility received an order for a new medication order, the medication aide (MA) on duty, the Resident Care Coordinator (RCC), or the MCM were supposed to fax the order to the facility's contracted pharmacy. -The contracted pharmacy usually entered the medication orders into the eMAR system. -The RCC or the MCM had to approve the orders in the eMAR system before they became active. -The MCM could approve orders in the eMAR system remotely. -The MAs were responsible for ordering medication refills for the residents within 7 days of the medication being unavailable to the resident. -The MA would pull the medication label and place the medication label on the refill/re-order sheet, and fax to the facility's contracted pharmacy. -If there were no refills remaining on the resident's medication, the MA was responsible for contacting the resident's primary care provider (PCP). -The RCC completed medication cart audits on both carts once/week. -The RCC did not bring the absence of Resident #3's Refresh Optive eye drops to her attention. -She believed the Refresh Optive eye drops were thrown out because they did not have an open date noted on container. -She was not aware Resident #3 was dispensed a 37.5-day supply of Refresh Optive eye drops on 01/13/21 and there was not another medication refill of the Refresh Optive eye drops requested by the facility until 03/10/21. -She confirmed her initials were present on Resident #3's March 2021 eMAR on 03/01/21 and on 03/03/21 at 12:00pm, on 03/03/21, on	D 358		

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D 358	Continued From page 123 03/05/21, and on 03/08/21 at 4:00pm, and on 03/03/21 and on 03/05/21 at 8:00pm. -She would not document the administration of Resident #3's Refresh Optive eye drops on 03/01/21, 03/03/21, 03/05/21, and 03/08/21 if she did not administer the medication. -It was possible there was a still supply of Resident #3's Refresh Optive eye drops on the medication cart in March 2021 because the MAs were not consistently administering Resident #3's Refresh Optive eye drops four times a day. Telephone interview with a MA on 03/18/21 at 9:25am revealed: -She confirmed her initials were present on Resident #3's March 2021 eMAR on 03/05/21, on 03/08/21- 03/10/21 at 8:00am, on 03/02/21, on 03/04/21-03/05/21, and on 03/08/21- 03/09/21 at 12:00pm, and on 03/01/21- 03/02/21 at 4:00pm. -She documented Resident #'s Refresh Optive eye drops as not administered on hold with the comment waiting on pharmacy on 03/10/21 at 12:00pm on the eMAR. -She would not document the administration of Resident #3's Refresh Optive eye drops if she did not administer the medication. -She was not aware Resident #3 was dispensed a 37.5-day supply of Refresh Optive eye drops on 01/13/21. -She requested the medication refill of the Refresh Optive on 03/10/21. -She believed Resident #'s Refresh Optive eye drops were thrown out on Wednesday, 03/10/21, because there was not an open date labeled on the container. -It was possible there was a still supply of Resident #3's Refresh Optive eye drops on the medication cart in March 2021 because the MAs were not consistently administering Resident #3's Refresh Optive eye drops four times a day.	D 358		

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D 358	Continued From page 124 Telephone interview with Resident #3's PCP on 03/17/21 at 5:15pm revealed he expected medications to be administered as ordered. Telephone interview with the Administrator on 03/18/21 at 1:30pm revealed: -She expected the right resident to receive the right medication at the right time. -She expected medication refills to be requested prior to the resident's medication running out. -She expected the eMARs to accurately reflect when a medication was administered to a resident. -It was possible there was a still supply of Resident #3's Refresh Optive eye drops on the medication cart in February-March 2021 because the MAs were not consistently administering Resident #3's Refresh Optive eye drops four times a day. 4. Review of Resident #2's current FL-2 dated 03/10/21 revealed diagnoses included Alzheimer's dementia, schizophrenia, brief psychotic disorder/psychosis, anxiety disorder, and paranoia. Observation of Resident #2 on 03/10/21 at 11:55am revealed: -The resident was sitting up on her bed. -The resident was pulling up her shirt and scratching her stomach, trunk, and breast area vigorously. -There were small red circular dots on the resident's stomach and multiple scratch marks and scabbed areas on her stomach, trunk, and breasts. -The resident did not respond verbally when spoken to.	D 358		

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D 358	Continued From page 125 Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Interview with a medication aide (MA) on 03/10/21 at 11:56am revealed: -She just saw the rash on Resident #2's stomach that morning, 03/10/21. -She thought the resident had the rash a while because she had seen her scratch "on and off" for 2 weeks, -She borrowed some cream from another resident and applied it to Resident #2's rash on 3 occasions over the last 2 weeks. -The cream did not seem to help the rash or itching. -She had not notified the resident's primary care provider (PCP) about the rash or scratching because she planned to tell the PCP when he came to the facility today (03/10/21) for his weekly visits. Observation on 03/10/21 at 11:56am of the cream applied by the MA to Resident #2's rash revealed: -There was a 1-pound jar of Triamcinolone Acetonide Cream (TAC) 0.01% dispensed to another resident on 11/09/20. (TAC is a prescription topical steroid used to inflammation and itching skin conditions.) -The jar was approximately half full. Review of Resident #2's physician's orders revealed there was no order for TAC or any other topical cream for skin rashes. Interview with the Memory Care Manager (MCM) on 03/10/21 at 5:03pm revealed: -Resident #2's rash "comes and goes" and it was usually around her stomach area. -She was not aware of the resident receiving any	D 358		

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medications for the rash.
-She was not aware a MA was applying another resident's prescription cream, TAC, to Resident #2's rash.
-There was no order for Resident #2 to receive TAC and a cream should not be borrowed because of contamination risks.

Interview with Resident #2's PCP on 03/10/21 at 5:40pm revealed:
-He was at the facility to see residents but he had not seen any residents yet today, including Resident #2.
-The MA told him this afternoon when he arrived to the facility about Resident #2 having a skin rash and scratching.
-He was not notified prior to today, 03/10/21, but he would have expected the facility staff to notify him as soon as they saw the rash or saw the resident itching and scratching.
-He was not aware the MA was applying TAC that belonged to another resident to Resident #2's rash.
-He was concerned because it was administered without an order and the risk of cross-contamination.
-He was concerned that a different type of medication, such as an antifungal cream may be needed depending on what may be causing the rash and itching.

Review of Resident #2's PCP visit notes dated 03/10/21 revealed:
-The resident was being evaluated for pain and rash.
-The PCP noted the resident had an abdominal rash with dried, flaky skin and poor skin turgor as she was chronically dehydrated.
-The resident had multiple self-induced scratch marks to her abdomen and flanks bilaterally.

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D 358	Continued From page 127 -The resident had been observed scratching, most likely pruritis (itchy skin) associated with chronic dehydration and dried skin. -The PCP ordered Hydrocortisone Cream 1% to be applied to the rash 3 times a day for 7 days. -If the condition deteriorated, the PCP would order moisturizing cream and re-evaluate and follow-up with dermatology if indicated. Telephone interview with Resident #2's PCP on 03/16/21 at 9:33am revealed: -He saw the resident on 03/10/21 and the skin rash was mostly on her abdomen and was mostly dried skin. -He ordered Hydrocortisone Cream as a first line of defense. Review of Resident #2's physician's order dated 03/10/21 revealed an order for Hydrocortisone Cream 1% apply to rash 3 times a day for 7 days. (Hydrocortisone is a topical steroidal cream used to treat swelling, itching, and irritation of the skin.) Review of Resident #2's March 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Hydrocortisone Cream 1%, apply topically to rash 3 times daily for 7 days with scheduled times of 8:00am, 1:00pm, and 8:00pm. -The start date was documented as 03/10/21 and the end date was documented as 03/16/21. -Documentation for administration of the Hydrocortisone Cream started on 03/11/21. -Hydrocortisone Cream was not documented as administered on 03/11/21 at 8:00am, 1:00pm, or 8:00pm due to "new order, awaiting med". -Hydrocortisone Cream was not documented as administered on 03/12/21 at 1:00pm due to the resident being unavailable.	D 358		

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-The last documented dose of Hydrocortisone Cream was on 03/16/21 at 1:00pm.

Observation of Resident #2's medications on hand on 03/11/21 at 3:54pm revealed there was a supply of two tubes of Hydrocortisone Cream 1% dispensed on 03/10/21 and neither tube had been opened.

Interview with the Administrator on 03/10/21 at 5:53pm revealed:
-The MAs were not allowed to administer any medication without an order.
-The MAs were not supposed to borrow medications to her knowledge.
-She was not aware a MA had been applying another resident's prescription cream to Resident #2.

5. Review of Resident #1's current FL-2 dated 06/26/20 on 03/11/21 revealed diagnoses included Alzheimer's dementia, hypothyroidism, depression and gastroesophageal reflux disease.

Review of Resident #1's subsequent physician's order dated 10/05/20 revealed there was a verbal order for Vistaril (a medication used as a sedative to treat anxiety and tension) 25mg take half tablet to make 12.5mg twice daily prn for "aggertation."

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/17/21 at 10:40am revealed:
-There was a note on Resident #1's profile that the medication could not be cut in half and came in 25mg and not 12.5mg.
-On 10/05/20, the pharmacy tech spoke with a facility MA and informed the MA the Vistaril did not come in 12.5mg.
-The Vistaril order dropped off Resident #1's

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medication profile on 11/13/20.
-The pharmacy never received a clarification order or a discontinuation order for the Vistaril.
-The Vistaril medication was not dispensed to the facility.

Review of Resident #1's January 2021 electronic medication administration record (eMARs) revealed there was no entry for Vistaril 12.5mg.

Review of Resident #1's February 2021 eMARs revealed there was no entry for Vistaril 12.5mg.

Review of Resident #1's March 2021 eMARs revealed there was no entry for Vistaril 12.5mg.

Observation of Resident #1's medications on hand for administration on 03/11/21 at 10:05am revealed there were no Vistaril tablets on hand for administration if needed.

Review of Resident #1's Accident/Incident (A/I) Report dated 10/05/20 at 9:44am revealed:
-Resident #1 pulled hair of another resident, hit roommate, and pulled a staff member's hair.
-Resident #1 had medications orders and was to be monitored for 72 hours starting from 10/05/20 to 10/08/20.

Interview with two personal care aides (PCAs) on 03/11/21 at 7:40am and 7:56am revealed:
-Resident #1 had anxiety at times and got combative at times with staff when redirected.
-The PCAs were not aware if Resident #1 had medications for anxiety.
-The PCAs redirected Resident #1 when the resident became combative.

Interview with a medication aide (MA) on 03/11/21 at 10:10am revealed:

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-Resident #1 had anxiety at times and would try to hit staff when redirected.
-The MA spoke with the MCM the previous week about Resident #1's combative behaviors.
-The MA was not aware of any medication orders to address Resident #1's behaviors.
-The MA was only instructed by the MCM to redirect Resident #1 when the resident was combative.

Telephone interview with a MA on 03/17/21 at 2:20pm revealed:
-The MA recalled Resident #1's order dated 10/05/20 regarding Vistaril, because the MA had never had to write a half tablet of a medication (that is why the MA recalled the order).
-The MA spoke with the pharmacy on 10/05/20 regarding the Vistaril and that the medication did not come in 12.5mg.
-The MA spoke with Resident #1's PCP regarding the Vistaril did not come in 12.5mg but could the MA did not recall what the PCP instructions were.
-The MA thought she called the pharmacy back regarding the Vistaril did not come in 12.5mg but the MA could not recall for sure if she spoke with the pharmacy.
-The MA could not recall if she informed the MCM that the Vistaril did not come in 12.5mg.

Telephone interview with the MCM on 03/17/21 at 1:15pm revealed:
-The MCM was aware of Resident #1's order for Vistaril dated 10/05/20 for agitation.
-The MCM was aware the Vistaril did not come in 12.5mg.
-The MCM was not aware the Vistaril had not been dispensed to the facility from the pharmacy.
-The MCM would expect Resident #1 to have medication on hand and to be available for administration if the medication had not been

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D 358	Continued From page 131 discontinued. Telephone interview with Resident #1's PCP on 03/17/21 at 5:15pm revealed: -He remembered writing a "smaller" dose of Vistaril as needed (prn) for Resident #1's agitation, he had written the "smaller" dose of Vistaril with the purpose of having a "benign" effect. -He could not recall if he was notified by the facility or the facility's contracted pharmacy for a medication clarification for Resident #1's Vistaril. -He was not aware the facility's contracted pharmacy was unable to obtain a medication clarification from the facility after three attempts for Resident #1's ordered Vistaril so the medication was discontinued from her medication profile. -He expected the facility to notify him of required medication clarifications within a 24-48-hour timeframe so he could clarify the medication for resident's use. -He expected medications to be administered as ordered to the residents. Telephone interview with the Administrator on 03/18/21 at 1:30pm revealed: -The Administrator was not aware of Resident #1's 10/05/20 order for Vistaril and that the resident had not received Vistaril as ordered. -The Administrator expected medications to be administered as ordered to the residents. Based on observation, interviews, and record reviews it was determined that Resident #1 was not interviewable. _____ The facility failed to ensure medications were administered for 5 of 6 residents sampled as ordered which resulted in a laxative not being	D 358		

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D 358	Continued From page 132 dispensed since 05/03/20 and resident being hospitalized with a diagnosis of bowel obstruction (#6); several doses of an antibiotic used to treat a urinary tract infection were missed and the resident was later hospitalized with a diagnosis of septic shock (#4); a topical prescription steroid cream was borrowed from another resident and administered without a physician's order which delayed treatment and led to the resident continuously scratching causing multiple scratch marks and scabbed areas all over her body (#2); an anti-anxiety medication was not clarified and not dispensed and the resident continued to have behaviors (#1). This failure resulted in serious physical harm and serious neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/16/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 17, 2021.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant	D912		

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D912	Continued From page 133 federal and state laws and rules and regulations as related to health care and adult care home medication aides training and competency evaluation requirements. 1. Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diet (pureed) was served as ordered for 1 of 3 residents sampled (Resident #4), who had dysphagia with a history of choking. [Refer to Tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure 2 of 3 staff sampled (A, B) who administered medications had passed the written medication administration aide exam in the required timeframe. [Refer to Tag 935, G.S. 131D-4.5(B)(b) Adult Care Home Medication Aides; Training and Competency Evaluation (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect as related to personal care and supervision, health care, medication administration, and implementation. The findings are:	D914		

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D914	Continued From page 134 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs for 2 of 6 sampled residents (#2, #4), residing on an Alzheimer's Special Care Unit, who sustained multiple falls with injuries including Resident #2 who required treatment at the emergency room for 8 of 9 falls with multiple head injuries requiring sutures, staples, and wound adhesion and a displaced fracture of the C2 vertebra; and Resident #4 who sustained head injuries and facial fractures and was found eating non-food materials such as feces. [Refer to Tag 270,10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for acute and routine health care needs for 3 of 6 sampled residents (#2, #4, #6) including follow up with the primary care provider (PCP) for missed doses of an antibiotic and a choking episode (#4); tracking bowel movement patterns and notifying the PCP of a change in condition (#6); notifying the PCP of a skin rash and itching, refusals of multiple medications, obtaining physical therapy/occupational therapy (PT/OT) as ordered for multiple falls with injuries, and a delay in reporting and seeking care for change in condition including not eating or drinking, lethargy, and weakness (#2). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 5 of 6 residents sampled (#1, #2, #3, #4, #6) including errors with administering and requesting refills for a laxative (#6); administering an antibiotic (#4);	D914		

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D914	Continued From page 135 administering and requesting refills for eye drops (#3); administering a topical prescription cream for a skin rash/itching without a physician's order (#2); and errors with clarifying a medication used to treat anxiety and a vitamin (#1). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)]. 4. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, total operations, and policies and procedures were implemented to maintain each resident's right and to receive appropriate and adequate care and services and to be free from serious physical harm and neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, personal care and supervision, medication administration, nutrition and food service, and adult care home medication aides qualifications. [Refer to Tag 980, G.S. 131D-25 Implementation (Type A1 Violation)]	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the	D935		

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D935	Continued From page 136 Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 3 staff sampled (A, B) who administered medications had passed the written medication administration aide exam in the required timeframe. The findings are:	D935		

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D935	Continued From page 137 Review of the facility's job description for Medication Aide (MA) revealed: -Provide resident medication administration, treatments, and resident oversight in accordance with doctor's orders, state regulations and company policy including but not limited to: taking accurate orders, processing orders, ordering and securing medication, pouring, preparing, administering, providing ordered treatments and assuring accurate documentation. -Successfully complete Department Health Service Regulation Medication Aide training requirements including Medication Aide Clinical Skills check off (return demonstration/medication pass) and successful passing of the State Medication Aide test within 60 days of skills check off. 1. Review of Staff A's personnel record revealed: -Staff A was hired on 01/31/18 as a cook. -There was no documentation within Staff A's personnel record when she transitioned to a medication aide (MA). -There was a Certificate of Completion dated 05/26/20 for "Medication Administration 5-Hour Training Course for Adult Care Homes." -There was a Certificate of Completion dated 10/24/20 for "Medication Administration 10-Hour Training Course for Adult Care Homes." -There was a Medication Administration Clinical Skills Checklist signed and dated on 06/10/20. -There was no documentation Staff A passed the MA written exam within 60 days of hire. Review of a resident's June 2020 -August 2020, and October 2020-December 2020 electronic medication administration records (eMARs) revealed: -Staff A administered medications on 15 of 30 days from 06/01/20-06/30/20 prior to passing the	D935		

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written exam within the required timeframe.
-Staff A administered medications on 9 of 31 days from 07/01/20-07/31/20 prior to passing the written exam within the required timeframe.
-Staff A administered medications on 12 of 31 days from 08/01/20-08/31/20 prior to passing the written exam within the required timeframe.
-Staff A administered medications on 16 of 31 days from 10/01/20 -10/31/20 prior to passing the written exam within the required timeframe.
-Staff A administered medications on 10 of 30 days from 11/01/20 -11/30/20 prior to passing the written exam within the required timeframe.
-Staff A administered medications on 15 of 31 days from 12/01/20 -12/31/20 prior to passing the written exam within the required timeframe.

Review of a residents' January 2021 and February 2021 electronic medication administration records (eMARs) revealed:
-Staff A administered medications on 4 of 31 days from 01/01/21 - 01/31/21, including 01/21/21, 01/23/21, 01/24/21, and 01/30/21.
-Staff A administered medications on 4 of 28 days from 02/01/21 - 02/28/21, including 02/01/21, 02/18/21, 02/19/21, and 02/24/21.

Interview with Staff A on 03/11/21 at 1:05pm revealed:
-She started working at the facility 3 ½ years ago as a cook, then the dietary manager, then a personal care aide (PCA), and then a medication aide (MA).
-She started working as a MA and administering medications "almost a year ago" (could not recall exact date).
-When she started as a MA, she was trained on the medication cart with another MA (not a Registered Nurse) for a few days but she could not recall which MA.

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D935	Continued From page 139 -She also took the 5-hour and 10-hour medication training courses online but she could not recall the dates. -After training with the MA, a Registered Nurse (RN) observed her doing a medication pass administering medications and included observations such as insulin, inhalers, eye drops, and nasal sprays. -She failed the MA written exam "a couple of months ago" (could not recall date). -She continued to administer medications after she failed the written exam and she had not retaken the exam. -The Administrator was aware she failed the written exam and never instructed her to stop administering medications. -The Administrator would just ask her when she was going to take the written exam again. -After she failed the exam, she completed two more applications to take the exam in January 2021 and the beginning of February 2021 but she did not receive confirmation to take those exams until after the exam dates had passed. -She was instructed by the facility's Director of Clinical Instruction (DCI) not to administer medications "about 2 weeks ago", so she had not administered any medications since then. -The DCI also told her she would be retaking the 5-hour and 10-hour medication training courses. -She just received a letter indicating she could re-register to take the exam on 03/14/21 so she planned to retake the exam. -After she passed the written exam, she planned to start administering medications again. Telephone interview with the Administrator on 03/18/21 at 1:30pm revealed: -She was aware Staff A had not passed the MA written test. -There were a "limited" number of opportunities	D935		

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D935	Continued From page 140	D935		

offered for Staff A to take the MA written test.
-One opportunity she located for Staff A to take the MA written test was around four hours away.
-She continued to allow Staff A to administer medications to residents out of "desperation."
-She really did not know why she allowed Staff A to continue to administer medications to residents without passing the MA written test, "it should not have happened."

Staff A's transition dates to a personal care aide and a MA, and her written MA test were requested on 03/16/21 and 03/18/21 but were not received prior to the survey exit on 03/18/21.

Refer to the telephone interview with the Administrator on 03/18/21 at 1:30pm.

2. Review of Staff B's personnel record revealed:
-Staff B was hired on 09/24/18 as a personal care aide (PCA).
-There was a Certificate of Completion dated 06/12/20 for "Medication Administration 5-Hour Training Course for Adult Care Homes."
-There was a Certificate of Completion dated 06/13/20 for "Medication Administration 10-Hour Training Course for Adult Care Homes."
-There was a Medication Administration Clinical Skills Checklist signed and dated on 06/17/20.
-There was no documentation Staff B passed the MA written exam within 60 days of 06/2020.
-Staff B passed the MA written exam on 10/22/20.

Review of Resident #6's June 2020 -August 2020, and October 2020 electronic medication administration records (eMARs) revealed:
-Staff B administered medications on 1 of 30 days from 06/01/20 - 06/30/20 prior to passing the written exam within the required timeframe.
-Staff B administered medications on 6 of 82 days

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D935	Continued From page 141 from 08/01/20 - 10/21/20 prior to passing the written exam within the required timeframe. Telephone interview with Staff B on 03/18/21 at 9:25am revealed: -Her hire date as a MA at the facility was 04/22/20. -In July 2020, she began her training as MA. -She failed her written MA test in September 2020. -She passed her written MA test on 10/22/20. -She could not take the written MA test sooner than October 2020 due to COVID-19, there were only 8 to 9 available dates for MA written tests which filled up quickly. -She continued to administer medications to residents at the facility prior to passing the MA written test. -She was not aware that she should have stopped administering medications until another MA at the facility told her she should not be administering medications since she did not pass the written MA exam; however; she continued to administer medications to residents at the facility. -The management team did not remove her from the medication cart. Telephone interview with the Administrator on 03/18/21 at 1:30pm revealed: -She was not aware Staff B did not pass the MA written test in September 2020 and continued to administer medications to residents. -She did not pull Staff B from administering medications prior to passing the exam on 10/22/20. Refer to the telephone interview with the Administrator on 03/18/21 at 1:30pm. Telephone interview with the Administrator on	D935		

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D935	Continued From page 142 03/18/21 at 1:30pm revealed: -The Business Office Manager and herself were responsible for maintaining personnel records. -The Business Office Manager and herself audited the personnel files by generating a "perpetual" log which would outline for the auditor the completion date of required annual trainings. -The frequency of the audit of personnel records was not provided. - The Business Office Manager was responsible for obtaining all relevant documentation related to MAs qualifications to administer medications and documentation was on file. -She acknowledged the rules and regulations related MA qualifications were not followed within the required timeframe of 60 days. _____ The facility failed to ensure 2 of 3 medication aides (MAs) sampled met the qualifications to administer medications to the 38 residents residing in the facility. Two of the MAs did not pass the written MA exam within 60 days of hire and continued to administer medications beyond the 60 days' timeframe. The facility's continued failure to assure MAs met training requirements prior to the administration of medications 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 03/18/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 2, 2021.	D935		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation	D980		

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D980	Continued From page 143 Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, total operations, and policies and procedures were implemented to maintain each resident's right and to receive appropriate and adequate care and services and to be free from serious physical harm and neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, personal care and supervision, medication administration, nutrition and food service, and adult care home medication aides qualifications. The findings are: Telephone interview with the Administrator on 03/18/21 at 1:30pm revealed: -She had been the facility's Administrator for 7 months. -Her work schedule was 8:30am-5:30pm but she usually worked 6:30am-7:00pm Monday through Friday. -She was off on the weekends, but she would work weekends at the facility for "whatever" staffing need was identified. -For example, on the weekends she would assist with food service by serving meals or was "entertainment" for the residents. -She would complete rounds daily at the facility.	D980		

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D980	Continued From page 144 -The process she had in place to ensure the facility's established policies/procedures and rules and statues were implemented and maintained within substantial compliance was to reference the policies and procedures manuals within the facility. -She also maintained "a lot" of notebooks with notes made about the policies and manuals. -On the "clinical side" of the facility, she was still in the "learning" process. -There was education needed on her part related to the physician notification and follow up. -If there was a question related to a resident's health status, she would talk in "general terms" with what she knew or would refer the question to the facility's MCM or primary care provider. -She would reach out to the appropriate people to obtain an answer to the question. -She could not identify the process or staff member who would check behind the MCM related to new primary care provider's orders, referrals, or new medication orders. -The MCM and her worked "together." -She was not aware of any specific process in place to check behind the MCM. -She completed resident record audits once per week even though she was still learning the clinical side of the facility. -Through the completion of her resident's record audits she had not identified any issues/concerns brought to her attention by the survey team. Telephone interview with the Administrator on 03/16/21 at 11:15am revealed: -Staff sometimes gave residents' bath sheets to her or the Memory Care Manager (MCM). -She did not answer any questions about whether she reviewed the bath sheets and instead deferred any questions related to bath sheets to the MCM.	D980		

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D980	Continued From page 145 Interview with the Administrator on 03/10/21 at 5:53pm revealed: -She was not aware a medication aide was administering medications without an order to one resident that was borrowed from another resident. -She did not think the MAs should borrow medications but she did not know what the facility's policy for borrowing medications. -That was "clinical" and that would be a question for the MCM. Noncompliance was identified at violation level in the following rule areas: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs for 2 of 6 sampled residents (#2, #4), residing on an Alzheimer's Special Care Unit, who sustained multiple falls with injuries including Resident #2 who required treatment at the emergency room for 8 of 9 falls with multiple head injuries requiring sutures, staples, and wound adhesion and a displaced fracture of the C2 vertebra; and Resident #4 who sustained head injuries and facial fractures and was found eating non-food materials such as feces. [Refer to Tag 270,10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for acute and routine health care needs for 3 of 6 sampled residents (#2, #4, #6) including follow up with the primary care provider (PCP) for missed doses of an antibiotic and a choking episode (#4); tracking bowel movement patterns and notifying the PCP of a change in condition (#6); notifying the PCP of a skin rash and itching,	D980		

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D980	Continued From page 146 refusals of multiple medications, obtaining physical therapy/occupational therapy (PT/OT) as ordered for multiple falls with injuries, and a delay in reporting and seeking care for change in condition including not eating or drinking, lethargy, and weakness (#2). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 5 of 6 residents sampled (#1, #2, #3, #4, #6) including errors with administering and requesting refills for a laxative (#6); administering an antibiotic (#4); administering and requesting refills for eye drops (#3); administering a topical prescription cream for a skin rash/itching without a physician's order (#2); and errors with clarifying a medication used to treat anxiety and a vitamin (#1). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)]. 4. Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diet (pureed) was served as ordered for 1 of 3 residents sampled (Resident #4), who had dysphagia with a history of choking. [Refer to Tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)]. 5. Based on interviews and record reviews, the facility failed to ensure 2 of 3 staff sampled (A and B) who administered medications had passed the written medication administration aide exam in the required timeframe. [Refer to Tag 935, G.S. 131D-4.5(B)(b) Adult care home medication aides; training and competency evaluation (Type B Violation)].	D980		

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D980	Continued From page 147 The Administrator, who was responsible for the overall operations of the facility, failed to ensure systems were implemented and maintained to ensure the safety and well-being of residents for personal care and supervision which resulted in Resident #2 sustaining 9 falls with injuries from 11/09/20 through 03/12/21 with required evaluation by emergency medical services and transport to the emergency room for 8 of the 9 falls, Resident #2's injuries included a displaced fracture of the C2 vertebra, a closed head injury, abrasions to her right arm, skin tears to her right arm, lacerations above her right and left eyebrows and to the back of her head, swelling to the back of her head, bruising to her face, forehead, and knees, hematomas (pocket of blood under the skin) to left side of her forehead and to her right scalp, which required the following medical interventions sutures, wound adhesive (skin glue), and staples; Resident #4 sustained 5 falls with head and multiple facial fractures and 1 visit for exposure to Hepatitis C from eating a resident's feces who had a history of Hepatitis C from 01/09/2021 through 03/02/2021. The Administrator failed to ensure follow up for the acute and routine health care needs necessary to maintain the resident's health such as there was no follow up with the primary care provider (PCP) for missed doses of an antibiotic to treat a urinary tract infection which resulted in the resident being hospitalized for septic shock and a choking episode not reported to the PCP for a resident who had a history of dysphagia and was ordered a pureed diet (#4); failed to notify Resident #2's PCP of a skin rash and itching and refusals of multiple medications including medications for hypothyroidism, mood disorders, anxiety, and agitation; Resident #2 did not receive physical therapy/occupational therapy (PT/OT) as ordered on 01/23/21 and continued to	D980		

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D980	Continued From page 148	D980		

have multiple falls with injuries required treatment at the hospital, including lacerations repaired with staples, sutures, and/or skin glue; and a delay in reporting and seeking care for Resident #2's change in health status including not eating or drinking, lethargy, and weakness; and a referral appointment with a gastrointestinal provider was not scheduled, and there was no PCP notification for a change in condition related to bowel movement patterns which resulted in a current hospitalization for a bowel obstruction with the placement of a new colostomy (#6). The Administrator failed to ensure medications were administered as ordered including failure to request a refill for a laxative for approximately an 8 month time frame which was last dispensed to the facility on 05/03/20 which resulted in a current hospitalization with a diagnosis of bowel obstruction for the resident with the placement of a new colostomy (#6); several doses of antibiotic for a treatment of a urinary tract infection were not administered which resulted in the resident being hospitalized for septic stock (#4); a topical medication was borrowed from another resident and administered without a physician's order delaying appropriate treatment resulting in the resident itching and scratching causing scratch marks and scabbed areas all over her body (#4); an anti-anxiety medication was not clarified with the pharmacy and was not dispensed due to the pharmacy's inability to obtain clarification from the facility after several contact attempts and the resident continued to have behavioral problems (#1). The Administrator failed to ensure the correct diet order for a pureed diet was served to a resident who had cognitive impairment and a history of choking episodes (#4). The Administrator failed to ensure 2 medication aides met the qualifications to administer medications to the 38 residents residing in the facility. Two of

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D980	Continued From page 149 the MAs did not pass the written MA exam within 60 days of hire and continued to administer medications beyond the 60-day timeframe which resulted in Staff A not administering several doses of Resident #4's ordered antibiotic in November 2020 to treat a urinary tract infection which resulted in the resident being hospitalized for septic shock. The Administrator's failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/18/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 17, 2021.	D980		