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	HAL065045	A. BUILDING: _____ B. WING _____	C 09/15/2021

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MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on September 08, 2021 - September 10, 2021 and September 14, 2021 - September 15, 2021.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazardous substances and chemicals left accessible to the 22 residents including personal hygiene items stored unsecured in multiple residents' bathrooms in the form of liquids, solids, pastes and aerosols, cleaning agents stored in two residents' bathrooms, paints, adhesives and aerosols stored in an unlocked closet and cabinet, and a fabric freshener spray in the kitchen not monitored by staff. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed with a capacity of 101 residents with a Special Care Unit (SCU) capacity of 28 residents.	D 079		

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D 079	Continued From page 1 Review of the facility's resident roster revealed the facility's SCU rooms were from room #224 - room #243. Review of the facility's undated policy and procedures for Storage of Chemicals revealed the policy did not provide processes how toiletries and chemicals were stored to protect the residents residing on the SCU. Observation in the bathroom of resident room #240 on 09/08/21 at 10:58am revealed: -There was a 7-ounce bottle of body lotion with approximately ½ of the lotion remaining, stored on the sink. -There was a clear container with a pump dispenser labeled as soap containing approximately 1/4th of a red colored liquid stored on the sink. -There was an 8-ounce bottle of body lotion with approximately ½ remaining, stored on the sink. -There was a 10-ounce bottle of body lotion with approximately ¼ remaining, stored on the sink. -There was a 24.5-ounce bottle of body lotion with approximately ½ remaining, stored on the sink. -There was a 1.5-ounce container of a solid antiperspirant with labeled instructions for external use only. -There were three opened tubes of toothpaste and a container of liquid makeup stored in a cup beside the sink. -There were approximately 18 different sized containers ranging from creams, lotions and shampoos stored in baskets and a 32-ounce spray bottle of cleaner with bleach with less than ¼ remaining on a two-drawer cabinet positioned next to the shower. -The bottle of cleaner with bleach had a warning label that the product caused eye irritation, rinse	D 079		

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eyes cautiously with water for several minutes and if eye irritation persists, get medical attention, wash hands thoroughly after handling and if swallowed, drink a glass of water, call a physician immediately and for sensitive skin or prolonged use, wear gloves.
-There was a resident assigned to resident room #230 lying on the bed, visiting the two residents assigned to resident room #240.
-There was no staff in the room to supervise the toiletry items stored in the residents' bathroom.

Observation in the bathroom of resident room #230 on 09/08/21 at 11:11am revealed:
-There was a 13.5-ounce bottle with a hand pump dispenser of liquid hand mango and peach scented soap with approximately ¼ remaining stored on the sink. There were labeled directions "THIS IS NOT FOOD". "DO NOT EAT, DO NOT APPLY ON EYES OR AROUND LIPS".
-There was a 16.9-ounce bottle of liquid soap with a pump dispenser with 3/4th of the soap remaining stored on the sink. There were labeled directions if the product encountered the eyes to rinse with water.
-There was a 2.06 ounce of solid deodorant stored on the sink with labeled instructions for external use only.
-There was a 28-ounce bottle of conditioner with less than ½ remaining, stored on the sink.
-There was an 8-ounce bottle of body lotion store on the sink.
-There was an 8-ounce bottle of creamed lotion with a skin protectant additive with approximately ½ remaining and labeled directions for external use only and do not get into the eyes, stored on the sink.
-There was a 2.5-ounce bottle of liquid shampoo with less than ½ remaining stored on the sink.
-There was an 8-ounce bottle of body spray mist

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with approximately ½ remaining stored on the sink.
-There was a large tube of toothpaste with mouthwash with approximately 3/4th remaining with labeled directions if more than used for brushing was accidentally swallowed, get medial help or contact a Poison Control Center right away.
-There was a bottle of fruit scented conditioner with 3/4th remaining and a bottle of fruit scented shampoo with approximately ¼ remaining stored in the shower.
-There was one resident sitting in a chair in the room and a second resident assigned to resident room #230 walked back into the room.
-There was no staff in the room to supervise the residents with the toiletry items stored in the residents' bathroom.

Observation in the hallway of the SCU on 09/08/21 intermittently between 10:11am - 11:15am revealed staff were in an out of residents' rooms and some residents were walking out of their rooms and into the hallway without staff.

Interview with a personal care aide (PCA) on 09/08/21 at 11:40am revealed:
-The residents' personal hygiene items were not supposed to be left in the resident bathrooms.
-The residents' personal hygiene items were previously stored in the room located beside the medication aide room however the floor was damaged from a commode leak and staff had not been able to use the room to store the residents' toiletry items for approximately 3-4 months or more.
-There were at least two named residents that wandered in and out of rooms and would pick up items (One resident named by the PCA with

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wandering behaviors was assigned to resident room #230 and observed lying in another resident's bed, visiting the two residents assigned to room #240 on 09/08/21 at 10:58am).

Interview with a housekeeper on 09/08/21 at 12:05pm revealed:
-She saw toothpaste, powders, lotions and soaps stored in the residents' bathrooms in the SCU.
-All toiletry items were supposed to be locked inside a room next to the medication room on the SCU however because of the flooring in that room, staff had been unable to use the room to store the residents' toiletries for 3 - 4 months or more.

Confidential interview with a staff revealed:
-There were residents with wandering behaviors and residents with severe dementia residing on the SCU.
-There was a risk of a resident being harmed from the toiletries being left unsecured if a resident picked up an item and possibly ingested a product; "You never know" what could happen.

Interview with the interim Administrator on 09/08/21 at 12:10pm revealed:
-He would immediately ensure all toiletry items and cleansers were secured and not accessible to the residents on the SCU.
-He would review the facility's policies and provide a copy of the facility's procedures/processes for securing toiletries and chemicals on the SCU.
-It was possible that a resident on the SCU could ingest a product that could have been harmful since the toiletry items or cleaning products were left unsecured and not supervised by staff.

Observation of the bathroom in resident room

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D 079	Continued From page 5 #225 on 09/08/21 at 4:30pm revealed: -There was a 16.9- ounce bottle of mouth rinse with approximately 3/4th remaining with labeled instructions "do not swallow" stored on the sink. -There was a 7-ounce container of liquid soap with approximately 3/4th remaining stored on the sink. -There was a small travel size tube of toothpaste with approximately ½ remaining stored on the sink. -There was a container of 100 count wet wipes with approximately ½ remaining with labeled instructions for external use only, stored on the sink. -The resident assigned the the room was lying on the bed. -There was no staff in the room to supervise the resident with the toiletry items stored in the residents' bathroom. Observations of the bathroom in resident room #226 on 09/08/21 at 4:42pm revealed: -There was an 84-count boxed container of denture cleanser tablets with approximately ½ of the tablets remaining. -There were labeled caution instructions on the denture cleanser box to keep those at risk from swallowing the tablet or solution, do not place the tablets or solution in the mouth. Do not drink the cleansing solution or use it as a mouthwash, if swallowed call Poison Control Center or a doctor, wash hands thoroughly after handling the tablets and the product caused serious eye irritations, if in the eyes rinse cautiously with water for several minutes. If eye irritation persists, get medical advice and/or attention. -There was a 32-ounce spray bottle of cleaner with bleach with approximately ¼ remaining with a warning label the product caused eye irritation, rinse eyes cautiously with water for several	D 079		

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minutes and if eye irritation persists, get medical attention, stored on the sink beside two bottles of lotion.
-There was a bottled toothpaste with labeled warning instructions if more than used for brushing was accidentally swallowed, get medical help or contact a Poison Control Center right away.
-There were two 12-ounce bottles of body lotion stored on the sink.
-There was a bottle of body wash with a pump dispenser stored on the back of the toilet.
-There were 4 bottles of hair care products consisting of shampoo and conditioner stored on a rack in the bathroom.
-There was a 12.6-ounce bottle of shampoo with approximately ½ remaining, stored in the shower.

Observations of the bathroom in resident room #224 on 09/08/21 at 4:52pm revealed there was a container of solid deodorant with labeled directions for external use only, stored on the sink.

Observations of the bathroom in resident room #228 on 09/08/21 at 4:53pm revealed:
-There was a small container of deodorant on the sink.
-There were two tubes of toothpaste on the sink and a third tube of toothpaste with 3/4th of the contents remaining with labeled instructions if more than used for brushing was accidentally swallowed, get medial help or contact a Poison Control Center right away.
-There was a 1.35-ounce container of lotion on the sink and a second bottle of lotion stored on the sink.
-There was a 6.5-ounce bottle of "juicy orange" liquid hand wash, and an aerosol canister of dry shampoo stored on a storage container.

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D 079	Continued From page 7 Interview with the second PCA on 09/08/21 at 4:35pm revealed: -She was informed today, (09/08/21) when she first arrived for duty by first shift staff to remove all the resident's toiletries and secure those items in the locked medication room. -She and the other PCA assigned to the SCU had not had time yet to collect all the items because of assisting the residents with their needs. Observation of the SCU kitchen on 09/08/21 at 4:57 revealed: -The door to the kitchen was unlocked. -There was a 1-quart container of sanitizing fabric refresher with less than ½ of the contents remaining and labeled precautionary instructions the product caused moderate eye irritation, avoid contact with eyes and skin, wash hands thoroughly after use; first aid instructions were provided if the product came in contact with the eyes and skin and instructions to call a Poison Control Center or doctor for treatment advice. -There was no staff in the kitchen, hallway or dining room leading to the kitchen. -There was one resident walking in the dining room adjacent to the kitchen without staff supervision. Observation of an unlocked two-door closet in the SCU dining room on 09/08/21 at 5:05pm revealed: -There were multiple activity items stored in the closet. -There was a 4-ounce canister of spray adhesive with approximately ½ of the contents remaining with labeled instructions for first aid if the contents encountered the eyes to flush with tap water for 5-10 minutes, if irritation persists, seek medical care; if inhalation symptoms occurred move to	D 079		

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fresh air, if symptoms persist, see a physician and for further health information contact a Poison Control Center.
-There were two storage containers with multiple tubes of acrylic paints.

Observation of an unlocked activity room adjacent to the kitchen of the SCU on 09/08/21 at 5:09pm revealed:
-There was a box containing ten 2.5-ounce bottles of multi-surface paints stored in an unlocked cabinet.
-There were no staff monitoring the unlocked room.

Interview with the interim Administrator 09/08/21 at 5:55pm revealed he had instructed staff to remove and secure all toiletries and cleaning supplies from the SCU areas that were accessible to the residents earlier today, (09/08/21).

Interview with the interim Administrator on 09/09/21 at 8:00am revealed he had verified all toiletries and hazardous items had been removed and stored in a locked room on the SCU.

Observation of an unlocked activity room adjacent to the kitchen of the SCU on 09/09/21 at 8:17am revealed:
-There was a box containing ten 2.5-ounce bottles of multi-surface paints stored in an unlocked cabinet.
-There was a second box containing 18 small containers of paint stored in an unlocked cabinet.

Observations of the bathroom in resident room #234 on 09/09/21 at 9:19am revealed:
-There were 2 tubes of toothpaste and a solid deodorant stored on the sink.

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D 079	Continued From page 9 -There were 3 large containers of hair care products stored in the shower. Interview with the interim Administrator on 09/09/21 at 10:10am revealed: -He was unable to remove the toiletry items from the bathroom in resident room #234 because the resident had become upset when attempting to remove the items. -There were residents who had wandering behaviors in the SCU that could pick up toiletries that were stored in the resident's rooms. Interview with the interim Administrator on 09/15/21 at 5:02pm revealed: -He expected all hazards which included toiletries, cleaning supplies, and art supplies to be always locked up in a separate closet within the SCU. -The residents' toiletries should only be removed from the locked closet when they were being assisted with a bath or shower. -He had concerns with residents' toiletries, cleaning supplies, art supplies not being locked up. -A resident who was confused could wander and ingest the hazards which could cause harm to them or even death. -He was not sure if there was a process to ensure staff were monitoring and keeping hazards locked up out of residents' reach. _____ The facility failed to secure hazardous substances to protect the residents diagnosed with dementia in a Special Care Unit (SCU) and at least two residents with wandering behaviors including cleaning products containing bleach; and a fabric freshener, paints, aerosol adhesives, toiletries consisting of liquids, paste, lotions, deodorants and aerosols. This failure was	D 079		

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D 079	Continued From page 10 detrimental to the health, safety, and welfare of the residents in the SCU and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 09/08/21 with an addendum on 09/14/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2021 .	D 079		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure transfer assistance for 1 of 6 sampled residents (#6) related to a resident, who had a history of degenerative joint disease with a recent back injury and pain, was left waiting for staff assistance while sitting on the toilet for 88 minutes. The findings are: Review of Resident #6's current FL-2 dated 07/21/21 revealed diagnoses included wedge	D 269		

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compression fracture of vertebrae, low back pain and vitamin D deficiency.

Review of Resident #6's care plan dated 04/28/20 revealed:
-She was ambulatory with a rollator and required supervision with ambulation and bathing.
-She was independent with toileting and transfers.

Review of Resident #6's electronic progress notes dated 06/04/21 through 07/04/21 revealed:
-On 07/04/21 at 1:05pm, the resident was sent to the emergency room (ER) via emergency medical services (EMS) due to extreme back and chest pain.
-On 07/04/21 at 1:11pm, per the family member, the resident was being admitted to the hospital for compression of disks in her back.
-On 06/04/21 at 2:45pm, the resident was seen by the podiatrist on 06/03/21.

Review of Resident #6's Emergency Department Provider note dated 07/04/21 at 10:08am revealed:
-She presented with chest wall and back pain and did not recall any specific event where she injured herself.
-She was adamant she did not fall.
-She was able to get to the bathroom today but was there waiting for over an hour and a half for staff.
-She was unable to get out of bed after staff put her back in bed.
-A computed topography (CT) scan showed compression fractures of L1 and L2.
-The L1 fracture was not healed and was possibly acute.
-The L2 fracture was likely chronic.

Review of Resident #6's hospital discharge

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summary dated 07/07/21 revealed she was discharged to a skilled nursing facility.

Review of Resident #6's electronic progress notes dated 07/05/21 through 08/23/21 revealed there was no documentation as to when she returned to the facility.

Telephone interview with Resident #6's family member on 09/08/21 at 4:20pm revealed:
-At approximately 4:00am on 07/04/21, Resident #6 was in the bathroom and unable to get up from the toilet on her own.
-She pulled the call bell cord, and no one showed up for 88 minutes.
-He knew it was 88 minutes because the call bell system time stamped when a cord was pulled and when the call was canceled in the room by staff answering the call.
-The family member was not given an explanation of what happened until 4 weeks later (07/26/21).
-The medication aide (MA) assigned to work on Resident #6's hall went to another area of the building without the call system pager and did not know about the call.
-Later during the morning of 07/04/21, Resident #6 was not able to get out of bed due to back pain.
-She was sent to the emergency room and found to have cracked vertebrae in her back.
-There was no way to know for certain if that was a direct result of sitting on the toilet for nearly 90 minutes.
-Resident #6 had mobility issues from bilateral broken hips prior to admission to the facility.
-She used a walker for ambulation.
-Her bones were brittle with compression issues in her spine which caused a collapsing of her spine.
-She was still sharp mentally and could recall

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incidents accurately.
-She was moved out of the facility to a skilled nursing facility (08/26/21).

Review of Resident #6's Resident Event Report dated 07/03/21 to 07/04/21 revealed:
-On 07/03/21 a call occurred from the pendent at 8:14pm and was answered at 8:47pm for a response time of 42 minutes.
-On 07/03/21 a call occurred from the bathroom at 8:17pm and was answered at 10:42pm for a response time of 144 minutes.
-On 07/04/21 a call occurred from the pendent at 12:45am and was answered at 1:19am for a response time of 33 minutes.
-On 07/04/21 a call occurred from the pendent at 4:27am and was answered at 6:51am for a response time of 143 minutes.
-On 07/04/21 a call occurred from the pendent at 4:29am and was answered at 5:58am for a response time of 88 minutes.

Telephone interview with Resident #6 on 09/14/21 at 3:25pm revealed:
-In March 2021, she was in the bathroom and was trying to save herself from falling and sliced her lower leg on her walker.
-She pulled the call bell because she was bleeding badly from the wound.
-It took 20 minutes for staff to respond because all the staff were in the dining room helping residents.
-The facility had a home health agency come and care for the wound twice weekly for 3 - 5 weeks.
-There was another time staff did not respond in July 2021.
-She sat on the toilet for an hour and a half waiting for staff to help her.
-She was tempted to fall onto the floor, but she did not want to break anything.

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-Laying on the floor would have been better than sitting on the hard toilet seat.
-She was told the MA left the hall she was on and went to the special care unit (SCU) without the call bell pager.
-The MA did not know she was calling.
-She went to the ER later that same morning (07/04/21) because she had back pain.
-Her back was hurting before sitting on the toilet for 90 minutes but that morning she was not able to get up.
-She did not remember the name of staff who helped her in March and July 2021.

Upon request 09/09/21, 09/10/21, 09/14/21 and 09/15/21, there were no written or electronic progress notes for Resident #6 prior to 03/31/21 available for review.

Upon request 09/09/21, 09/10/21, 09/14/21 and 09/15/21, there were no PCP or home health visit notes for Resident #6 dated 02/01/21 through 08/26/21 available for review.

Telephone interview on 09/15/21 at 4:56pm with the PCA assigned to work second shift on 07/03/21 revealed she sometimes missed calls on the pager because she set her pager to vibrate when she was working.

Telephone interview on 09/15/21 at 5:09pm with the MA assigned to work third shift on 07/03/21 revealed:
-She worked 6:00pm on 07/03/21 until 6:00am 07/04/21 and was assigned to the SCU and the second floor of the assisted living (AL).
-The facility was frequently staffed with only 3 staff for the entire building from 10:00pm until 6:00am.
-She did not specifically remember the incident

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D 269	Continued From page 15 involving Resident #6 sitting on the toilet for an hour and a half. -Agency staff frequently did not know how to use the pagers for the call bell system and just sat at the nursing station all night. Interview on 09/15/21 at 11:17am with the MA assigned to work on the second floor of the AL for first shift on 07/04/21 revealed: -Resident #6 needed assistance in and out of the shower and partial assistance with bathing. -She did not remember working with Resident #6 for either March 2021 or on 07/04/21. -All staff were expected to carry a pager connected to the call bell system. -When a call bell was pulled, all pagers received the call. -The pager showed the room number and resident name the call came from. -If the assigned staff was not available, they were supposed to use their walkie talkie to ask another team member to help. -Pagers continued with call alerts until the call bell was cleared or canceled in the resident room. -Two to five minutes was a reasonable response time to answer a call bell. Telephone interview with the former Director of Resident Care (DRC) on 09/15/21 at 12:11pm revealed: -Resident #6 was sitting on the toilet waiting for staff for 90 minutes. -She knew it was 90 minutes because there was a record of the call which included the time, the call bell was pulled and the time it was answered. -She went to the receptionist to get a copy of the call bell record. -The investigation completed by the former Administrator and Corporate DRC concluded the MA was assigned to both areas of the second	D 269		

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floor and left the AL area without getting a PCA to cover that hall.
-The MA went to the SCU without her pager.
-Call bell alerts should go to the pagers of all staff on duty.
-The problem was not all staff always had pagers due to pagers going missing or not working.
-If staff did not have a pager, they would not know a resident needed assistance unless they went around and checked.
-Staff were expected to physically check residents when they did not have a pager.
-Staff were inserviced at every monthly meeting on going around and checking residents.
-Staff were not always able to check residents due to short staffing.
-There had been a problem with the pagers off and on the entire time she worked at the facility (01/15/21 - 08/03/21).
-The facility was in the process of ordering pagers for a third or fourth time when she left.

Interview with the interim Administrator on 09/15/21 at 5:02pm revealed:
-The staff response times for Resident #6 call were concerning to him.
-He was aware of a call bell going unanswered for 88 minutes but unsure why and he was still investigating.
-He expected the staff to answer residents' call bells immediately which meant right away.
-For example, if the staff was in the middle of a medication pass, he expected staff to put the medications back into the medication cart, lock the medication cart, and answer a resident's call bells.
-It was important to answer residents' call bell for multiple reasons.
-The resident could be having chest pain, a resident could have fallen, a resident could be

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D 269	Continued From page 17 bleeding, and would need immediate assistance from staff. -Every resident's pendant call should be treated as an emergency call. Attempted interview on 09/15/21 at 4:48pm with the PCA assigned to work on the second floor AL area for first shift on 07/04/21 was unsuccessful. Attempted interviews with Resident #6's PCP on 09/14/21 at 10:01am was unsuccessful.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to notify the primary care physician for 2 of 5 sampled residents (#3, #2) related to a change in a resident's health status (#3); and for blood pressure readings and fingerstick blood sugar results as per ordered parameters (#2). The findings are: 1.Review of Resident #3's current FL-2 dated 07/09/21 revealed: -Diagnoses included dementia, hypertension, major depressive disorder, and type 2 diabetes mellitus. -She was a resident in the Special Care Unit. -She was constantly disoriented, -She required total care with personal care.	D 273		

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D 273	Continued From page 18 -She was non-ambulatory. Review of Resident #3's senior living resident evaluation dated 05/14/21 revealed: -This document identified the resident's level of care. -She was non-ambulatory/bed bound or dependent on staff for her ambulation needs. -She used a wheelchair. -She was a moderate or high risk for falls based on her fall assessment. -She was bed bound or dependent on staff for transfers on a regular basis. -She required assistance with transfers with 1 care team member. Review of Resident #3's Resident Register dated 07/19/19 revealed she needed prompting, stability, and was a fall risk. Review of Resident #3's personal care physician authorization and care plan dated 07/09/21 revealed: -She required extensive assistance with ambulation. -She was totally dependent on staff for all ADLs. Review of Resident #3's Licensed Health Professional Support (LHPS) dated 07/09/21 revealed: -Her personal care tasks were transferring semi-ambulatory or non-ambulatory residents and ambulation using assistive devices that required physical assistance. Review of Resident #3 August 2021 electronic progress notes revealed there were no primary care provider (PCP) notifications till 08/30/21. Review of Resident #3's electronic progress	D 273		

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notes dated 08/30/21 at 6:29pm revealed:
-Resident #3's PCP was informed of Resident #3's complaints of pain to her left hip.
-Resident #3 was noted not to have fallen recently.
-Resident #3's family member was also notified.
-Resident #3's family member stated she would prefer to have a mobile x-ray completed at the facility.
-Resident #3 was ordered to have Oxycodone as needed for pain/discomfort (Oxycodone is used as a narcotic pain medication used to treat moderate to severe pain).
-Resident #3's PCP was made aware of Resident #3's family member's request for the completion of a mobile x-ray.
-Resident #3's PCP would email order for the mobile x-ray to be completed.
-If Resident #3's pain got worse, she would be sent to the hospital.

Review of Resident #3's electronic progress notes dated 08/31/21 at 12:35pm revealed:
-An order for a mobile X-ray was received from Resident #3's PCP and was sent to the x-ray company via fax.
-The x-ray technician would be coming out to the facility on 08/31/21.

Review of Resident #3's electronic progress notes dated 09/01/21 at 12:27pm revealed:
-Resident #3's mobile x-ray had not been completed yet.
-The x-ray company was backed up on orders from yesterday (08/31/21).
-A technician should be to the facility that afternoon (09/01/21) to facilitate Resident #3's mobile x-ray.
-Resident #3's family member agreed with the plan if the mobile x-ray was not completed by the

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end of the afternoon, Resident #3 would be transported to the Emergency Department (ED).

Review of Resident #3's electronic progress notes dated 09/01/21 at 5:56pm revealed:
-The x-ray company was unable to get a technician out to the facility to complete a mobile x-ray for Resident #3 until the evening.
-Resident #3's family member was updated and approved be sent to the ED for an evaluation.
-A medication aide (MA) called 911, and Resident #3 was transported to the ED at the local hospital for evaluation on 09/01/21 at 4:00pm.

Review of Resident #3's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone HCL 5 mg tablet give 0.5 tablet every 8 hours as needed for pain.
-Oxycodone HCL 5 mg tablet (0.5 tablet) was documented as administered on 08/30/21 at 9:54pm for pain level of 5.
-There was an entry for Acetaminophen tablet 500 mg tablet give 1 tablet every 6 hours as needed for pain (Acetaminophen is used to relieve pain).
-Acetaminophen tablet 500 mg was administered to Resident #3 on 08/31/21 at 9:13pm for pain level of 9 (The numerical pain scale ranges from 0 to 10, 0 means there is no pain, 1 to 3 means mild pain, 4 to 7 is considered moderate pain, and 8 and above is severe pain.)

Review of Resident #3's September 2021 eMAR revealed:
-There was an entry for Oxycodone HCL 5 mg tablet give 0.5 tablet every 8 hours as needed for pain.
-Oxycodone HCL 5 mg tablet (0.5 tablet) was

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documented as administered to Resident #3 on 09/01/21 at 10:41am for pain level of 7.

Review of Resident #3's electronic Emergency Medical Services (EMS) communications event report revealed:
-The EMS call was received on 09/01/21 at 4:01pm.
-The nature of event was trauma injury not dangerous.
-The event happened greater than 6 hours, there was no bleeding now, Resident #3 was completely alert.
-The caller's statement was a sore hip, possibly broken.
-EMS arrived at the facility on 09/01/21 at 4:09pm.
-Resident #3 was transported to the local hospital on 09/01/21 at 4:31pm.

Review of Resident #3's ED encounter dated 09/01/21 revealed:
-Resident #3's chief complaint was an unwitnessed fall, she did hit her head, she had a hematoma (a solid swelling of clotted blood within the tissues) to her right posterior head.
-Staff reported Resident #3 was alert and at her baseline.
-She had a history of dementia.
-Resident #3 stated she remembered falling and hitting the back of her head.
-She denied loss of conscious.
-She had complaints of pain to the back of her head but denied nausea or dizziness.
-She denied neck pain or any other injuries.
-Her history of present illness included left hip shortening deformity as well as bruising on her left wrist with pain of the left arm.
-Her left leg was painful for her to move.
-The x-ray revealed there was a left femoral

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fracture.
-There was left arm bruising, and a concern for non-accidental trauma.

Review of Resident #3's Orthopedic history and physical dated 09/01/21 revealed:
-Resident #3 was brought to the ED with complaints of left wrist and hip pain.
-There was a concern for resident abuse at the facility.
-Resident #3's left leg was shortened and externally rotated.
-The hospitalist was consulted for pre-operative optimization and medical management.
-The orthopedic trauma service would be consulted for definitive care.

Telephone interview with the county department of social services (DSS) Adult Home Specialist (AHS) on 09/08/21 at 10:54am revealed:
-She came to the facility on 09/03/21 to conduct staff interviews for the complaint investigation.
-She completed an interview with a personal care aide (PCA) on 09/03/21 at 1:00pm.
-The interview with a PCA revealed she worked as a PCA on the special care unit (SCU) on 08/28/21 and 08/29/21 on first shift from 6:00am-2:00pm.
-Resident #3 was able to bear some weight with assistance.
-She was able to verbalize her needs and discomfort.
-When she left work on Saturday, 08/28/21, at 2:00pm, Resident #3 was fine, there were no concerns or complaints.
-She came back to work on Sunday, 08/29/21, at 7:00am.
-Resident #3 told a PCA on the SCU, she had broken her hip.
-She was not sure if the other PCA had reported

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this complaint to the medication aide (MA) working on the SCU which was facility protocol to report any resident accident/incidents.
-After lunch she went to provide care to Resident #3 who was in bed.
-Resident #3 did not get out of bed on 08/29/21, and she thought she was just tired.
-When she changed her on Sunday, 08/29/21, there were no concerns.
-She placed her hand on Resident #3's hip area on both sides and there were no concerns or discomfort shown.
-She did not report to the MA the conversation that took place between Resident #3 and the other PCA working on the SCU.
-She got busy with duties and the conversation should have been reported to the MA before she exited her shift on 08/29/21.
-She also completed an interview with the interim Director of Resident Care (DRC) on 09/03/21 at 11:55am.
-The interview with the interim DRC revealed Resident #3 used a wheelchair and was non-ambulatory.
-On 08/30/21, Resident #3 complained of pain to her left hip when touched.
-Her family member did not want to send her to the Emergency Department (ED) due to COVID-19 and her history of dementia.
-On 08/31/21, she received an order from Resident #3's PCP for a mobile x-ray; she called them, but they could not give her an estimated time of arrival to the facility.
-On 09/01/21, she called the x-ray company, and they were backed up with orders and would be at the facility that afternoon.
-She called Resident #3's family member and she agreed with the plan to send her to the ED.
-Resident #3 was sent to the ED on 09/01/21 via EMS due to the x-ray company not showing up on

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D 273	Continued From page 24 09/01/21 to perform the mobile x-ray. -She was conducting staff interviews, there were no falls reported to her. -Resident #3 could not get herself up if she had fallen, she would have needed assistance getting up. Telephone interview with Resident #3's family member on 09/08/21 at 4:18pm revealed: -Resident #3 was confused at times. -She always required two staff to assist her with her personal care and transferring. -She was non-ambulatory but could stand, pivot, and transfer with the assistance of staff to her wheelchair. -The family member received a phone from the interim DRC on 08/30/21 at 6:30pm stating Resident #3 had complaints of left hip pain. -The interim DRC stated Resident #3 needed to go to the hospital for an evaluation of her hip pain. -She had hesitation about Resident #3 going to the ED for an evaluation. -During a previous hospitalization, Resident #3 exhibited increased confusion and agitation. -The interim DRC suggested they could request an order from Resident #3's PCP for a mobile x-ray and she was agreeable with this plan. -On 08/31/21, she requested to come to the facility to see Resident #3 for a visit. -During her visit on 08/31/21, Resident #3 had no complaints of pain, however, while at the facility the interim DRC reported Resident #3's complaints of hip pain were on and off. -She observed Resident #3 had bruising and swelling to her left wrist and an abrasion to her left knee. -The bruises were black and blue in color. -The abrasion to her left knee was the size of a quarter.	D 273		

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-Resident #3 would not let her see her left hip during the visit on 08/31/21.
-She received another phone call from the interim DRC on 09/01/21 at 2:30pm that Resident #3's mobile x-ray had not been completed yet.
-The interim DRC requested to send Resident #3 to the ED for evaluation due to the x-ray not having been completed and she agreed.
-Resident #3 did not go to the hospital until approximately 4:30pm on 09/01/21 due to the facility's computer systems being "down," no additional details were provided.
-She was told by the interim DRC the facility would complete an internal investigation to determine the cause of Resident #3's unknown injury.
-She was confused that no one at the facility knew what happened to Resident #3 because she required a two-person assist with her transfers.

Interview with a MA on 09/09/21 at 10:50am revealed:
-He was the MA working on the SCU on 08/30/21 from 6:00am-6:00pm.
-On 08/30/21, after breakfast, he could not recall the exact time, he was notified by a PCA working with Resident #3 that it was difficult to complete incontinent care with her.
-Resident #3 could not turn in her bed for the PCA to complete incontinent care due to complaints of left hip.
-After he was notified by the PCA, he went into Resident #3's room to evaluate her condition.
-She had left forearm bruising from her left wrist to her left elbow and an abrasion, the size of a "dot", to her left knee.
-There were no bruises to her head.
-She was in "so much" pain.
-The physical pain symptoms he observed were

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she was holding her left upper abdomen and she would not let him come near her.
-After his evaluation, he faxed and called Resident #3's PCP about these findings and notified the interim DRC.
-During change of shift, he had not received any reports that Resident #3 had a fall or that she was having any pain during third shift on 08/29/21 into his shift on Monday, 08/30/21.

Interview with the interim DRC on 09/09/21 at 2:36pm revealed:
-On 08/30/21, the MA working first shift in the SCU came downstairs to her office to tell her Resident #3 was having left hip pain, she could not recall the exact time.
-The MA also informed her before coming down to the first floor where she was, he had already notified Resident #3's PCP of her complaints of left hip pain.
-The PCA stated she was not herself.
-The MA had given Resident #3 her as needed Oxycodone to address her pain.
-On 08/30/21, she completed an assessment of Resident #3, but she was not sure if she completed Resident #3's assessment in the morning or evening time.
-Her assessment included discoloration to her left inner wrist and a scab the size of a quarter to her left knee.
-There was no bruising to her left upper leg.
-She could not rate her pain level, but Resident #3 was protective of her left hip.
-She did not want to transfer out of her bed to her wheelchair.
-From Friday 08/27/21, to Sunday, 08/29/21, she received no reports or updates that Resident #3 had a fall or was having any pain.
-If Resident #3 was having pain, could not turn in her bed for incontinent care, or could not transfer

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from her bed to the wheelchair, she was not at her baseline.
-If there was a change in Resident #3's health status the MA should have completed an evaluation on 08/29/21.
-The MA should have notified Resident #3's PCP, interim DRC, and Resident #3's family member on 08/29/21.
-From a clinical standpoint, if Resident #3 was not at her baseline she should have been sent to the ED sooner than 09/01/21.
-It was important for the MA to follow these steps to ensure the residents' safety and to maintain the quality of care for residents.

Second interview with a MA on 09/10/21 at 11:48am revealed:
-She worked on the SCU on 08/27/21 from 6:00am-6:00pm.
-Resident #3 knew her name and her family member name, and required assistance with all activities of daily living except feeding.
-She was able to pivot with the assistance of one staff from her bed to her wheelchair.
-She was able to voice her needs and complaints to the facility staff.
-On 08/27/21, she first saw Resident #3 at approximately 7:00am when she entered her room to administer her morning medications.
-She remembered Resident #3 was sitting in her wheelchair in the doorway throughout her shift on 08/27/21.
-She had no complaints of pain.
-Staff assisted her with dressing, grooming, and toileting needs without any difficulty.

Interview with a PCA on 09/10/21 at 3:30pm revealed:
-She worked with Resident #3 on 08/28/21 on second shift from 2:00pm-10:00pm.

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-Resident #3 would answer questions to the best of her ability.
-She required the assistance of 1 with dressing, bathing, and transfers.
-On 08/28/21 and 08/29/21, she had no complaints of pain and no visible bruises when her shift ended.
-When she returned to work on Monday, 08/30/21, another PCA who was working with Resident #3 told her Resident #3 was having left hip pain and she was not able to get her out of bed to her wheelchair at 2:00pm.

Second interview with the interim DRC on 09/10/21 at 3:52pm revealed:
-She was a licensed practical nurse.
-Resident #3's assessment was completed by the current DRC and herself on 08/30/21.
-Her assessment findings included a yellow bruise to her left wrist interiorly, and a scab to her left knee approximately the size of a quarter.
-She could not recall any left leg abnormalities noted during her assessment of Resident #3 on 08/30/21.
-She did not report to the Resident #3's PCP her left leg was shortened, or her left foot was externally rotated because she did not make these observations during her assessment of Resident #3 on 08/30/21.

Telephone interview with a local EMS Paramedic on 09/14/21 at 11:35am revealed:
-She responded to and provided care for Resident #3 on 09/01/21.
-Upon arrival to the facility, Resident #3 was laying in a supine position in her bed.
-Staff informed her Resident #3 had been having "excruciating" pain for 2 days and they thought she had broken her hip.
-Staff had requested a mobile x-ray be completed

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prior to today but the x-ray company was not able to come to the facility, so they decided to send Resident #3 to the ED for evaluation.
-Resident #3 had all the classic assessment signs of a broken hip.
-There was a swelling at her hip, her foot was laterally rotated, and her leg was shortened.
-There was bruising to one of her lower arms.
-When Resident #3 was moved she was in pain, from her observation the facility staff present in the room wanted to make her comfortable.
-Staff reported the resident, who was wheelchair bound and required transfer assistance, likely had a broken hip but the staff could not report how it occurred.

Second telephone interview with a first shift PCA on 09/14/21 at 3:20pm revealed:
-She worked on the SCU on 08/28/21 and 08/29/21 on first shift from 6:00am-2:00pm.
-On 08/29/21, after lunch Resident #3 could not turn on her left hip to complete her incontinent care.
-She touched Resident #3's left hip but she did not complain of pain to her left hip.
-She also had 2 skin tears to left lower leg.
-She could not recall if Resident #3 had any swelling or bruising to her left hip on 08/29/21.
-She did not think Resident #3 not turning on her left hip was "serious" until she found out about the fracture when she returned to work on Thursday, 09/02/21.
-On 09/02/21, she found out Resident #3 was sent to the hospital on 09/01/21.
-She should have reported to the first shift SCU MA Resident #3 had left hip pain on 08/30/21.
-She knew anytime a resident had increased pain, unusual behaviors, the resident would not transfer or was not turning in bed; it was considered a change in resident's status.

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D 273	Continued From page 30 Telephone interview with the Supervisor/MA on 09/14/21 at 3:23pm revealed: -She worked as the Supervisor/MA on 08/27/21 and 08/29/21 from 6:00pm-6:00am. -She did not receive any reports from staff that Resident #3 had any falls, injuries, or had increased pain. -She would expect the staff to report any change in resident's status to her so she could evaluate the resident and notify the resident's PCP and the DRC of any changes. Third interview with a MA on 09/15/21 at 11:17am revealed: -She worked in the SCU on 08/28/21 and 08/29/21 from 6:00am-6:00pm. -Resident #3 could stand and pivot with the assistance of 1 staff member to her wheelchair. -She could self-propel her wheelchair through the hallways of SCU. -She could voice her needs to the staff. -She had a history of previous falls, but she could not recall the dates. -On 08/28/21, the MA remembered handing Resident #3 her dinner tray because they were short on dietary aides. -On 08/29/21, Resident #3 was sitting in her bed. -On 08/28/21 and 08/29/21, she did not observe Resident #3 having any bruises, abrasions, or abnormalities to her left leg or foot. -She did not receive any updates from the PCAs working with Resident #3 or off-going staff on 08/28/21 or 08/29/21 that she had a fall or an increase in her pain level. -She would have expected to receive an update from the PCA when Resident #3 reported she had broken her hip or when Resident #3 reported to another PCA she had pain when turning in bed on 08/29/21.	D 273		

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-She would have expected staff working with her in the SCU to notify her because she did not want the resident lying in bed for 3 days with a broken hip.
-She would have completed an evaluation of Resident #3, notified the interim DRC, notified the on-call management staff member, and Resident #3's PCP on 08/29/21 if she had received the updates that the resident reported she had a broken hip or would not turn in the bed due to left hip pain.

Third telephone interview with a PCA on 09/14/21 at 4:53pm revealed:
-She worked in the SCU on 08/27/21 on third shift from 10:00pm-6:00am.
-Resident #3 did not have any falls, complaints of pain, and was able to turn in her for incontinent care.

Interview with the current DRC on 09/15/21 at 4:11pm revealed:
-Her first day on the "floor" at the facility was 08/30/21.
-On 08/31/21, she was in the facility but was not on the floor; she was in new staff orientation.
-After lunch on 08/30/21, she and the interim DRC went to Resident #3's room to complete an assessment.
-Resident #3 had complaints of left leg pain.
-The interim DRC looked her over while she observed.
-From her observations, Resident #3 had dried blood to her left knee and bruises to left upper extremity.
-She could not recall the exact details of the bruising, what the appearance and size of the bruising was on 08/30/21.
-The interim DRC notified Resident #3's PCP later that afternoon on 08/30/21.

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-She expected all staff to report if there was something wrong with the resident such as a resident having a fall, any deviation from their baseline, for example, bruises, not turning for staff to complete care.
-It was important for the staff to notify the resident's PCP so they could provide a medical intervention to take care of the resident.
-She did not know why the PCP was not notified of Resident's change in health status till 08/30/21.

Interview with Resident #3's PCP on 09/10/21 at 12:52pm revealed:
-Resident #3 was oriented to her name, had minimal awareness of her surroundings, and was not oriented to time.
-She was able to transfer with the assistance of 1 from her bed to her wheelchair.
-She was not consistent with her ability to perform of her activities of daily living.
-The last time she saw Resident #3 was on 07/30/21.
-The purpose of her onsite visit on 07/30/21 was Resident #3 was being discharged from hospice and she assessed her for the need of a high back reclining wheelchair, an over the bed table, and a hospital bed.
-On 08/30/21, she was made aware Resident #3 was having left hip pain and she ordered a mobile x-ray.
-She currently did not have access to her electronic notes, so she was unable to provide the time of the notification from the facility on 08/30/21.
-She did not receive any notifications about Resident #3 having a fall or having complaints of left hip pain from the facility prior to 08/30/21.
-On 08/30/21, the interim DRC assessed Resident #3 and reported to her Resident #3's left leg was shortened, and her left foot was

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externally rotated.
-She informed Resident #3's family member of the interim DRC's assessment findings of her leg being observed to be shortened and her left foot externally rotated.
-Resident #3's family was asked which route she wanted to proceed with, it would be the hospital versus hospice, and she agreed to having a mobile x-ray of the left hip completed at the facility.
-From the facility's updates from the interim DRC, she was informed the x-ray company was backlogged and Resident #3's x-ray was not completed on 08/30/21-09/01/21.
-It was decided on 09/01/21 to send Resident #3 to the hospital for evaluation.
-There were no notifications from the facility prior to 08/30/21 that Resident #3 had a change in her ability to transfer or that on 08/29/21 that she reported she had broken her hip.
-She expected to be notified by the facility if Resident #3 was having pain, would not turn in bed to complete her incontinent care and was not at her normal ambulation status on 08/29/21.
-It was important to her to be current on her resident's health status so she could provide medical interventions and discuss the resident being sent to the ED with the resident's responsible party/power of attorney.

Interview with the interim Administrator on 09/10/21 at 1:31pm revealed:
-He expected staff to notify the resident's PCP immediately by phone if there was a change in a resident's health status, but it could depend on the "severity" of the change.
-If a resident had a fall, increase in their pain level, and the resident was not at their "normal" activity level staff should call the resident's PCP and the DRC immediately.

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-It was important for staff to follow these steps, so the resident received proper care and was safe.
-He first became aware of Resident #3 complaints of pain on Monday, 08/30/21, when the MA working on the SCU reported she was having pain to her left hip the morning of 08/30/21.
-He was not aware Resident #3 had reported to a PCA on 08/29/21 during first shift she had broken her hip.
-He was not aware Resident #3 was also having pain to her left hip on first shift on 08/29/21 when turning in her bed during incontinent care.
-He was not aware this was not reported to the MA working on 08/29/21.
-He would have expected both PCAs to report these findings to the MA working first shift on the SCU on 08/29/21.
-On 08/29/21, he would have expected the findings reported to the MA to evaluate Resident #3, the MA to notify her PCP along with the DRC.
-When Resident #3 was having increased pain and she was not mobile the staff should have called EMS to transport her to the ED or even to have EMS personnel to come to the facility to complete a medical evaluation.

Attempted telephone interview with a PCA who worked on 08/28/21 on second shift (2:00pm-10:00pm) on 09/14/21 at 2:51pm was unsuccessful.

2. Review of Resident #2's current FL-2 dated 09/09/21 revealed diagnoses included Type II diabetes mellitus, essential primary hypertension, and chronic obstructive pulmonary disease.

a. Review of a signed medication review report dated 05/26/21 revealed instructions to call MD if Resident #2's systolic blood pressure (SBP) was

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D 273	Continued From page 35 greater than 150 (one time a day). Review of Resident #2's electronic progress notes for July 2021 revealed: -On 07/01/21, 07/05/21, 07/23/21, 07/28/21, and 07/29/21 there were entries for SBPs that exceeded the parameters with a range of 158-180. -There was no documentation that the primary care provider (PCP) was notified of the SBPs that exceeded the ordered parameters during July 2021. Review of Resident #2's electronic progress notes for August 2021 revealed: -On 08/11/21, 08/12/21, 08/13/21, 08/15/21, 08/17/21, 08/18/21, 08/19/21, 08/20/21, 08/26/21, 08/29/21, 08/30/21, and 08/31/21 there were entries for SBPs that exceeded the parameters with a range of 151-190. -There was no documentation that the PCP was notified that the SBPs exceeded the ordered parameters during August 2021. Review of Resident #2's electronic progress notes for 09/01/21 through 09/13/21 revealed: -On 09/01/21, 09/03/21, 09/04/21, 09/08/21, and 09/13/21 there were entries for SBPs that exceeded the parameters with a range of 152-166. -There was no documentation that the PCP was notified that the SBPs exceeded the ordered parameters. Interview with the medication aide (MA) on 09/15/21 at 3:00 pm revealed: -He did not remember Resident #2's SBP being 156/68 on 09/04/21. -He must have made a mistake when he entered the BP in the progress notes.	D 273		

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-It was important to notify the PCP if the resident's SBP exceeded the ordered parameters because Resident #2 had heart failure and a pacemaker.

Interview with the Director of Resident Care (DRC) on 09/15/21 at 4:15 pm revealed:
-She expected the MA to notify the PCP and her if a BP exceeded the ordered parameters.
-It was important to notify the PCP if the BP exceeded the ordered parameters because he may need to make changes to the medication order.

Interview with the interim Administrator on 09/15/21 at 5:00 pm revealed:
-He expected PCP orders to be followed.
-He expected the MA to notify the PCP and the DRC if a BP exceeded the ordered parameters.
-It was important to notify the PCP if the BP exceeded the ordered parameters because there could be adverse reactions, serious health consequences or even death.

Attempted telephone interview with the PCP on 09/15/21 at 3:30 pm was unsuccessful.

b. Review of a signed medication review report dated 05/26/21 revealed instructions to call MD if Resident #2's blood sugar (BS) was 0-69 or 401 and greater.

Review of Resident #2's electronic progress notes for July 2021 revealed:
-There was an entry documenting a blood sugar (BS) of 69 on 07/26/21 at 6:30 am.
-There was an entry on 07/26/21 that the resident was given orange juice and breakfast for the BS of 69.
-There was no documentation that the PCP had

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D 273	Continued From page 37 been notified. Review of Resident #2's electronic progress notes for September 2021 revealed: -There was an entry documenting a blood sugar of 59 on 09/02/21 at 6:30 am. -There was no documentation that the PCP had been notified. Interview with the medication aide (MA) on 09/15/21 at 11:17 am revealed: -She thought Resident #2's BS order had parameters but did not remember. -She did not remember that Resident #2's BS was outside the ordered parameters on 07/26/21 -If a resident's BS was outside the ordered parameters, she would notify the PCP, notify the DRC, and document actions taken on the electronic progress notes. Attempted telephone interview with the PCP on 09/15/21 at 3:30 pm was unsuccessful. Interview with the DRC on 09/15/21 at 4:15 pm revealed: -She expected the MA to notify the PCP and her if a BS was outside the ordered parameters. -It was important to notify the PCP if the BS was outside the ordered parameters because he may need to make changes to the medication order. Interview with the interim Administrator on 09/15/21 at 5:00 pm revealed: -He expected PCP orders to be followed. -He expected the MA to notify the PCP and the DRC if a BS was outside the ordered parameters. -It was important to notify the PCP if the BS was outside the ordered parameters because there could be adverse reactions, serious health consequences or even death.	D 273		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 38 The facility failed to ensure PCP notification for 2 of 5 sampled residents including a delay in reporting Resident #3's inability to turn in bed and a change in the ability to transfer due to severe hip pain which delayed the resident receiving medical intervention for a fractured hip from 08/29/21 to 08/31/21, which was later confirmed via an x-ray; a resident with orders to notify the PCP for systolic blood pressure (SBP) readings greater than 150 with SBP results greater than 150 on 29 occasions from 07/01/21 through 09/03/21; and orders to notify the PCP for fingerstick blood sugars (FSBS) below or equal to the parameter of 69 with FSBS results equal or below 69 on 2 occasions from 07/01/21 through 09/03/21 (#2). The facility's failure resulted in substantial risk of serious physical harm and serious neglect and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 09/14/21 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 15, 2021.	D 273		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer	D 433		

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D 433	Continued From page 39 form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on interviews and record review the facility failed to maintain resident records in an orderly manner and readily available for review for 5 of 6 sampled residents (#1, #2, #3, #5 and #6).	D 433		

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D 433	Continued From page 40 The findings are: Interview with the Lifestyle Director on 09/15/21 at 3:08pm revealed: -She was the Activities Director for the assisted living side of the facility, she would provide staff coverage for the facility's receptionist during lunch time. -The last time she assisted with the scanning of hard copies of the residents' records was approximately six months ago. -She infrequently scanned the residents' medical records into the facility's database but knew the scanning was delayed and there was a lot of documents still left to scan. -Scanning was delayed due to changes in management at the facility. -The former Administrator left the end of July 2021 and the interim Administrator came to the facility the middle of August 2021. -The former Director of Resident Care (DRC) left her position recently; the interim DRC started her position around the same timeframe as the interim Administrator. -Other factors that affected the scanning of residents' records were information technology (IT) issues; the scanner used to input the residents' records into the facility database would not connect to the facility's computer system. -The facility staff had to provide care to their residents and staff had to be responsive to the needs or requests of residents' families. -There were staff shortages which also contributed to the delay in scanning residents' records. Interview with the Sales and Marketing Manager on 09/15/21 at 3:51pm revealed: -In January 2020, the facility began the transition	D 433		

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D 433	Continued From page 41 from paper residents' records to electronic residents' records. -It was difficult for the facility to start a new system during the pandemic and provide care to the residents. -There were "different" methods to complete the filing with each new nurse that worked at the facility. -With each new staffing change there were different methods for the scanning of the paper residents' records into electronic records. -For example, the former Administrator, the former DRC, and the Corporate DRC all had different methods to complete the scanning of residents' records. -It was hard to complete the transition to electronic records and to maintain consistent management. Review of the Facility Request for Information form provided to the facility on 09/08/21 at 9:10am revealed: -A list of staff on duty for all 3 shifts today. 09/08/21 and on 09/09/21 with the staff titles. -A list of residents with the following: oxygen, catheter, pressure ulcers and/or restraints. -A list of residents receiving 3rd party services (Home Health/Hospice, Rehab and/or Mental Health). Review of a handwritten facility request for information provided to the facility dated 09/08/21 at 3:55pm revealed: -A request was made for four resident records. -A request was made for July 2021 - September 2021 electronic medication administration records (eMARS), all staff progress notes for the last 6 months, incident and accident reports and primary care provider notes for the last 6 months for the four residents.	D 433		

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D 433	Continued From page 42 Review of a handwritten facility request for information provided to the facility dated 09/08/21 at 4:15pm revealed: -A request was made for two resident records who had been discharged from the facility and a request was made for a fifth resident's record to include accident and incident reports from February 2021 - current, staff charting notes, provider notes. -A request was made for a sixth resident's record, accident and incident reports from March 2021-current date and July 2021 - September 2021 eMARS. Review of a handwritten facility request for information provided to the facility dated 09/09/21 at 9:09am revealed: -A request was made for staff schedules for 08/29/21 and 08/30/21, and a second request for staff schedules for 09/09/21 and 09/10/21. -A request was made for 2 resident records who were observed during a meal observation to include the current FL-2, subsequent diet orders, current assessment and care plan and the resident registers. Review of a handwritten facility request for information provided to the facility dated 09/09/21 at 10:03am revealed a request was made for 4 residents' records for the medication pass observed. Interview with the Director of Operations on 09/14/21 at 8:35am revealed the Director of Clinical and himself would be present be for the reminder of the survey to facilitate any document requests from the survey team. 1. Review of a handwritten facility request for	D 433		

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D 433	Continued From page 43 information provided to the facility dated 09/09/21 at 10:36am revealed a request was made for Resident #1's responsible party contact number, current diet order, incident and accident reports, speech therapy evaluation, physical therapy and occupational therapy evaluation, medication reviews, Licensed Health Professional support reviews, if the resident was seen by mental health, primary care provider (PCP) progress notes from March 2021 - 09/08/21, 2-step tuberculosis testing, quarterly pharmacy reviews with the list of residents with pharmacy review recommendations, clarification for the residents' assessment and care plans, and SCU disclosure statement, pre-screening, diagnosis, 30 day profile and quarterly profiles thereafter for the SCU for Resident #1. Review of a handwritten facility request for information provided to the facility dated 09/09/21 at 5:03pm revealed a request was made for Resident #1's current and previous FL-2s, Resident Register, two step tuberculosis testing, quarterly pharmacy reviews with the pharmacy review recommendations for the last two quarters, Licensed Health Professional Support reviews for the last two quarters, mental health provider notes if applicable, weights for May 2021 to current, PCP notes for the past six months, facility care notes for the past 6 months, care plan and assessment, and SCU disclosure statement, pre-screening, diagnosis, 30 day profile and quarterly profiles thereafter for the SCU. Refer to the interview with the interim Director of Resident Care (DRC) on 09/09/21 at 10:08am. Refer to the second interview with the interim DRC on 09/09/21 at 12:33pm.	D 433		

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D 433	Continued From page 44 Refer to the third interview with the interim DRC on 09/09/21 at 2:35pm. Refer to the telephone interview with the former DRC on 09/15/21 at 12:11pm. Refer to the review of the "Items needed to complete an order" instructions posted on the wall in the facility's Nursing station. Refer to the observation of the facility's Nursing station on 09/09/21 at 4:51pm. Refer to the Review of the "Order Processing/Tracking system" with an effective date of 04/20/20 posted on the wall in the facility's Nursing station. Refer to the interview with the interim Administrator on 09/15/21 at 5:02pm. 2. Review of a handwritten facility request for information provided to the facility dated 09/09/21 at 10:36am revealed a request for Resident #2's current FL-2. (The FL-2 provided was dated 08/05/20 and was out of date), 2-step tuberculosis testing, quarterly pharmacy reviews with the list of residents with pharmacy review recommendations, Licensed Health Professional Support reviews, clarification for the residents' assessment and care plans. Interview with the interim Director of Resident Care (DRC) nurse on 09/09/21 at 10:45am revealed: -Resident #2's FL-2 dated 08/05/20 was currently the only FL-2 available at the facility. -She was attempting to locate a current FL-2 for Resident #2. -She would contact Resident #2's primary care	D 433		

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provider's (PCP's) office to see if there was an updated and annual FL-2 completed and on file.

Review of Resident #2's FL-2 dated 09/09/21 revealed there was a faxed time stamp on 09/09/21 at 11:37am at the top of the FL-2 form.

Review of a handwritten facility request for information provided to the facility dated 09/09/21 at 5:03pm revealed a request was made for Resident #2's quarterly pharmacy reviews with the pharmacy review recommendations for the last two quarters, Licensed Health Professional Support reviews for the last two quarters, mental health provider notes if applicable, weights for May 2021 to current, PCP notes for the past six months, facility care notes for the past 6 months, care plan and assessment

Refer to the interview with the interim Director of Resident Care (DRC) on 09/09/21 at 10:08am.

Refer to the second interview with the interim DRC on 09/09/21 at 12:33pm.

Refer to the third interview with the interim DRC on 09/09/21 at 2:35pm.

Refer to the telephone interview with the former DRC on 09/15/21 at 12:11pm.

Refer to the review of the "Items needed to complete an order" instructions posted on the wall in the facility's Nursing station.

Refer to the observation of the facility's Nursing station on 09/09/21 at 4:51pm.

Refer to the Review of the "Order Processing/Tracking system" with an effective

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D 433	Continued From page 46 date of 04/20/20 posted on the wall in the facility's Nursing station. Refer to the interview with the interim Administrator on 09/15/21 at 5:02pm. 3. Review of a handwritten facility request for information provided to the facility dated 09/09/21 at 9:09am revealed: -A request was made for Resident #3's medication orders for Depakote, Omeprazole, Seroquel and Lorazepam. (Depakote is a medication used to treat seizures and bipolar disorder. Omeprazole is a medication used to treat acid reflux. Seroquel is a medication used to treat mental/mood disorders. Lorazepam is a medication used to treat anxiety). -A request was made for Resident #3's nutritional supplement orders, an order for oxygen, Licensed Health Professional support reviews. -A request was made for Resident #3's current diet order, medication reviews, if the resident was seen by mental health, primary care provider (PCP) progress notes from March 2021 - 09/08/21 and Special Care Unit (SCU) disclosure statement, pre-screening, diagnosis, 30-day profile and quarterly profiles thereafter for the SCU for Resident #3. Review of a handwritten facility request for information provided to the facility dated 09/09/21 at 10:36am revealed a request was made for Resident #3's for 2-step tuberculosis testing, quarterly pharmacy reviews with the list of residents with pharmacy review recommendations, Licensed Health Professional Support reviews, Resident #3's assessment and care plans, and SCU disclosure statement, pre-screening, diagnosis, 30 day profile and quarterly profiles thereafter for the SCU.	D 433		

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D 433	Continued From page 47 Review of a handwritten facility request for information provided to the facility dated 09/09/21 at 5:03pm revealed a request was made for Resident #3's current and previous FL-2s, Resident Register, two step tuberculosis testing, quarterly pharmacy reviews with the pharmacy review recommendations for the last two quarters, Licensed Health Professional Support reviews for the last two quarters, mental health provider notes if applicable, weights for May 2021 to current, PCP notes for the past six months, facility care notes for the past 6 months, care plan and assessment, and SCU disclosure statement, pre-screening, diagnosis, 30 day profile and quarterly profiles thereafter for the SCU. Refer to the interview with the interim Director of Resident Care (DRC) on 09/09/21 at 10:08am. Refer to the second interview with the interim DRC on 09/09/21 at 12:33pm. Refer to the third interview with the interim DRC on 09/09/21 at 2:35pm. Refer to the telephone interview with the former DRC on 09/15/21 at 12:11pm. Refer to the review of the "Items needed to complete an order" instructions posted on the wall in the facility's Nursing station. Refer to the observation of the facility's Nursing station on 09/09/21 at 4:51pm. Refer to the Review of the "Order Processing/Tracking system" with an effective date of 04/20/20 posted on the wall in the facility's Nursing station.	D 433		

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D 433	Continued From page 48 Refer to the interview with the interim Administrator on 09/15/21 at 5:02pm. 4. Review of a handwritten facility request for information provided to the facility dated 09/09/21 at 10:36am revealed a request was made for Resident #5's FL-2, tuberculosis testing, pharmaceutical review for last two quarters, Licensed Health Professional Support review for last 2 quarters, subsequent orders from date of current FL-2 (none dated prior to April 2021 received), clarification for the residents' assessment and care plans and weights from May 2021 - the current date. Review of a handwritten facility request for information provided to the facility dated 09/09/21 at 5:03pm revealed a request was made for Resident #5's current and previous FL-2s (received 09/10/21), subsequent orders (received orders dated April 2021 through September 2021 on 09/10/21), Resident Register (received 09/10/21), two step tuberculosis testing (received 09/10/21), quarterly pharmacy reviews with the pharmacy review recommendations for the last two quarters (received 09/10/21), Licensed Health Professional Support reviews for the last two quarters (not available for review), mental health provider notes if applicable (not available for review), weights for May 2021 to current (not available for review), PCP notes for the past six months (not available for review), facility care notes for the past 6 months (received 09/09/21) and care plan and assessment (not available for review). Review of Resident #5's current FL-2 dated 11/12/19 (available for review on 09/10/21) revealed:	D 433		

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-Diagnoses included mild cognitive impairment, atherosclerotic heart disease, skin excoriation disorder, left lower extremity cellulitis, hypertension and low back pain.
-Medication orders included losartan 100mg daily (antihypertensive), Systane 1 drop each eye 4 times daily (lubricant) and docusate 100mg twice daily (for constipation).

a. Interview with a social worker from Resident #5's former primary care provider's (PCP's) office on 09/14/21 at 11:24pm revealed:
-The office was notified on 08/26/21 that Resident #5 had changed to another PCP.
-He was first seen by the PCP on 01/28/21 and last seen on 07/29/21.
-There was no record of orders for losartan, docusate and Systane in the resident's record.

Review of Resident #5's July, August and September 2021 electronic medication administration records (eMARs) revealed:
-There were no entries for losartan, docusate or Systane.
-There was an entry for Lubiprostone 24mcg twice daily starting 07/10/21 through 09/08/21 (used for constipation).
-There was an entry for doxycycline 100mg twice daily 08/04/21 through 08/09/21 (antibiotic).

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/15/21 at 4:19pm revealed:
-The pharmacy did not have an order to discontinue losartan, docusate and Systane.
-The order for losartan remained active on the pharmacy profile.

Interview with a medication aide (MA) on 09/09/21 at 11:35am revealed:

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-Resident #5 was easily frustrated with licensed providers.
-When treatments and medications did not work, he would change his primary care provider (PCP).
-Each new PCP added more medications and the cycle repeated resulting in Resident #5 having many medications.

Upon request on 09/08/21, 09/09/21 and 09/10/21 there were no subsequent orders for losartan, docusate, Systane, Lubiprostone or doxycycline for Resident #5 available for review.

b. Review of Resident #5's Consultant Pharmacist's Medication Reviews dated 01/28/21 and 07/30/21 revealed there was recommendation to update the resident's FL-2.

Telephone interview with the former Director of Resident Care (DRC) on 09/15/21 at 12:11pm revealed:
-Resident #5's FL-2 was updated and signed by the primary care provider (PCP).
-She could not remember the date the FL-2 had been signed by the PCP and returned by fax to the facility.
-The updated FL-2 needed to be scanned and uploaded to the resident's electronic record.
-She did not fax the updated FL-2 to the pharmacy; she only faxed the pharmacy review recommendation for nursing with a note it was done.

Upon request on 09/08/21, 09/09/21 and 09/10/21 there was no signed FL-2 dated after 11/12/19 for Resident #5 available for review.

c. Upon request on 09/08/21, 09/09/21 and 09/10/21 there were no primary care provider

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(PCP) visit notes, mental health provider (MHP) visit notes, home health visit notes or licensed health professional support reviews for Resident #5 available for review.

Refer to the interview with the interim Director of Resident Care (DRC) on 09/09/21 at 10:08am.

Refer to the second interview with the interim DRC on 09/09/21 at 12:33pm.

Refer to the third interview with the interim DRC on 09/09/21 at 2:35pm.

Refer to the telephone interview with the former DRC on 09/15/21 at 12:11pm.

Refer to the review of the "Items needed to complete an order" instructions posted on the wall in the facility's Nursing station.

Refer to the observation of the facility's Nursing station on 09/09/21 at 4:51pm.

Refer to the Review of the "Order Processing/Tracking system" with an effective date of 04/20/20 posted on the wall in the facility's Nursing station.

Refer to the interview with the interim Administrator on 09/15/21 at 5:02pm.

5. Review of Resident #6's current FL-2 dated 07/21/21 revealed diagnoses included wedge compression fracture of vertebrae, low back pain, vitamin D deficiency, moderate protein calorie malnutrition, hypertension, atrioventricular heart block and right bundle branch block.

Review of a handwritten facility request for

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information provided to the facility dated 09/09/21 at 9:09am revealed a request was made for Resident #6's staff progress notes from February 2021 - March 2021, licensed health professional support reviews quarterly reviews for 2021 and incident and accident reports for February 2021-August 2021.

Interview with the Director of Clinical Services on 09/15/21 at 9:27am revealed:
-There were no written or electronic progress notes or home health visit notes for Resident #6.
-She was working on locating primary care provider (PCP) visit notes.

Upon request on 09/08/21, 09/09/21, 09/10/21, 09/14/21 and 09/15/21, there was no resident register, PCP visit notes dated 02/01/21 through 08/26/21, progress notes dated prior to 03/31/21, and home health visit notes dated 02/01/21 through 08/26/21 for Resident #6 available for review.

Refer to the interview with the interim Director of Resident Care (DRC) on 09/09/21 at 10:08am.

Refer to the second interview with the interim DRC on 09/09/21 at 12:33pm.

Refer to the third interview with the interim DRC on 09/09/21 at 2:35pm.

Refer to the telephone interview with the former DRC on 09/15/21 at 12:11pm.

Refer to the review of the "Items needed to complete an order" instructions posted on the wall in the facility's Nursing station.

Refer to the observation of the facility's Nursing

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D 433	Continued From page 53 station on 09/09/21 at 4:51pm. Refer to the Review of the "Order Processing/Tracking system" with an effective date of 04/20/20 posted on the wall in the facility's Nursing station. Refer to the interview with the interim Administrator on 09/15/21 at 5:02pm. _____ Interview with the interim Director of Resident Care (DRC) on 09/09/21 at 10:08am revealed: -Medication aides (MAs) were able to enter orders on electronic medication administration records (eMARs). -Orders came into the facility via a central fax that received all faxes for the facility. -Orders were frequently set aside in undesignated areas of the nursing station on Hall 2. -MAs were responsible for getting faxes off the fax machine, faxing the orders to the pharmacy and placing the orders in the box by the copier in the nursing station on Hall 2. -The Licensed Practical Nurse (LPN) Supervisor on first and second shifts were responsible for reviewing orders from the box in nursing station on Hall 2. -The DRC was responsible for checking to make sure the process was done correctly. Second interview with the interim DRC on 09/09/21 at 12:33pm revealed: -There were many different people removing incoming documents from the fax machine which caused things to be misplaced. -There was no system to make sure orders taken off the fax machine were followed up on. Third interview with the interim DRC on 09/09/21	D 433		

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D 433	Continued From page 54 at 2:35pm revealed: -She was unable to review orders scanned into the system by medication aides (MAs) when she started at the facility on 08/13/21. -The scanned orders went to the DRC's email which she did not have access to until 08/30/21. -She checked the physical scan pile in the box and the scanned orders which were emailed to her. -Some MAs were able to scan, email and upload orders into the electronic system. -All orders were put in the scan pile after being faxed to the pharmacy. -She was not sure what system was in place prior to her employment. -She had to ask the MAs about the system of processing orders; MAs did not all say the same thing. -MAs did not have anything to do with resident FL-2s. -She was not able to access the electronic evaluation forms which included quarterly assessments and licensed health professional support (LHPS). -The DRC was responsible for ensuring documentation was in the residents' electronic record.. -The Business Office Manager (BOM) and Wellness Coordinator also assisted in scanning paper records into to the electronic record. Telephone interview with the former Director of Resident Care (DRC) on 09/15/21 at 12:11pm revealed: -She worked at the facility from 01/15/21 until 08/03/21. -She was not able to complete clinical paperwork such completing follow up on quarterly pharmacy reviews due to working as direct care staff and lack of access to resident records.	D 433		

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D 433	Continued From page 55 -She was able to get updated FL-2s, care plans and quarterly profiles caught up but could not get them scanned and upload to resident records. -The facility was transitioning to complete electronic resident records. -Scanned and unscanned documents were stored unorganized in boxes in various areas. -She did not have a dedicated scanner and there was no staff designated to scanning documents into the residents' electronic records. -There was a Corporate DRC that helped with completing some of the paperwork but there were too many hindrances to getting caught up. -Medication aides (MAs) were responsible for entering orders on the electronic medication administration record (eMAR), faxing to pharmacy, scanning into the electronic record and placing the orders in the DRC box in the nursing station. -Orders did not always make it into the DRC box for review, one person puts them here and another there. -The unorganized system caused things to fall through the cracks. -She could not take care of things if she did not know about them. -There was no system processing orders or who was responsible for them. Observation of the facility's Nursing station on 09/09/21 at 4:51pm revealed; -There was a stackable file folder with a shelf labeled as "Incident Reports", a second shelf labeled as "Signed Prescriptions", a third shelf labeled as "Physician Communication, Follow Up", and a fourth shelf labeled as "Faxed Refill Request". -There were documents stored on each shelf. -There was a file folder stored on top of the stackable file shelving that contained several	D 433		

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documents.
-There were posted instructions on the wall adjacent to the stackable file shelving titled as "Items needed to complete an order" with no date and a second form labeled "Order Processing/Tracking system" with an effective date of 04/20/20.

Review of the "Items needed to complete an order" instructions posted on the wall in the facility's Nursing station revealed:
-#1 -Written order from physician, #2-put order into the named electronic filing system, #3-document in progress note: Received order from MD and call responsible person to update on the new order or change in condition with two examples provided.
-Document new orders or change in condition in the Communication section of the named electronic filing system and if there was an order for a new medication, fax the medication order to the pharmacy.

Review of the "Order Processing/Tracking system" with an effective date of 04/20/20 posted on the wall in the facility's Nursing station revealed:
-All orders and or requests from the physician would be processed through the new system consisting of 3 colored folders: (1) Yellow (2) Red and (3) Green.
-The yellow folder was for orders that had already been faxed to the residents' contracted pharmacy, transcribed to the medication administration record, and awaiting a resolutions of some kind such as medication to arrive or an appointment scheduled.
-There were instructions for the MA to make an entry of initials and date on the lower right corner of the order to indicate the completion of this step

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prior to placing in the yellow folder.
-All requests faxed to the physician should have confirmation attached and placed in the yellow folder to await a response.
-All shifts were responsible for following up on each item in the folder and indicate having done so by adding their date and initials to the lower right corner.
-The green folder was for orders or communication that had been completed and ready to be filed (scanned into the named electronic filing system). When an ordered medication arrived and the order process confirmed complete, the order was pulled from the yellow folder and placed in the green folder to indicate the medication was received and the process was complete. Either a named person or a nurse would scan the order into the residents' electronic file after reviewing each order for accuracy of transcription and availability of the medication.
-The red folder was for orders and communication with problems or awaiting resolution.
-Each MA was responsible for checking their mailboxes at least three times per shift to look for new and/or communications.
-After following the above process, each item above would have a corresponding note in the residents' electronic progress notes as well as the communication log. Refer to "Hot Box documentation "process.

Interview with the interim Administrator on 09/15/21 at 5:02pm revealed:
-The DRC was responsible for the transition of the paper residents' records to electronic residents' records.
-He was aware there files "everywhere" in the facility.

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D 433	Continued From page 58 -He was not aware if there were any specific resident issues related to the resident files being everywhere in the facility. -He would not be able to identify if a resident at the facility required a new FL-2. -There was no consistent method from the management team to transition from the residents' hard copies to the facility database. Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision Refer to Tag 451 10A NCAC 13F .1212(a) Reporting Accidents and Incidents	D 433		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report to the North Carolina Health Care Personnel Registry (NC HCPR) and have documented evidence they investigated the injury and protected the resident from harm during investigation for 1 of 1 sampled residents with injuries of unknown origin (Resident #3). The findings are: Review of Resident #3's current FL-2 dated 07/09/21 revealed: -Diagnoses included dementia, hypertension,	D 438		

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major depressive disorder, and type 2 diabetes mellitus.
-She was a resident in the Special Care Unit.
-She was constantly disoriented,
-She required total care with personal care.
-She was non-ambulatory.

Review of Resident #3's Resident Register dated 07/19/19 revealed she admitted to the facility on 07/12/19.

Review of Resident #3's NC HCPR 24-hour initial report dated 09/02/21 revealed:
-The allegation/incident was an injury of unknown source.
-The incident date and time were 08/30/21 at 11:30am.
-The allegation description included Resident #3 complained of pain/discomfort to her left leg.
-Resident #3's primary care provider (PCP) was notified, and an x-ray was ordered.
-On 09/01/21, Resident #3 was sent to the Emergency Department at the local hospital for evaluation.
-The description of physical harm included a fractured femur; there was no documentation of the arm brusing.
-The form was signed and dated by the interim Director of Resident Care (DRC) on 09/02/21.

Review of Resident #3's NC HCPR 5-day report dated 09/03/21 revealed:
-The allegation/incident was an injury of unknown source.
-The incident date was 08/30/21.
-The time facility became aware of the incident was 12:00am.
-Resident #3 complained of pain to her left leg to a medication aide (MA) when touched, and when extremity was moved.

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-A MA notified Resident #3's PCP and the nurse, the interim DRC.
-The incident resulted in a fractured femur.
-Resident #3 was alert, oriented, with noted confusion.
-The summary of the facility investigation documented, they were still conducting the investigation. They contacted all staff who had contact and provided care for Resident #3.
-There were no reports or claims of injury.
-The corrective actions following incident were documented as performing resident checks and staff education concerning complaints for pain or discomfort.

Review of an email message to the county department of social services (DSS) social worker (SW) from the interim Director of Resident Care (DRC) dated 09/03/21 at 1:27pm revealed:
-She was submitting an incident report, regarding an occurrence with one of their residents.
-The resident sustained an injury of an unknown origin.
-The investigation had been facilitated.
-The email attachment contained the NC HCPR 24-hour initial allegation report.

Telephone interview with the county DSS SW on 09/08/21 at 10:54am revealed facility was not aware where to send the NC HCPR 24-hour report.

Interview with the current DRC on 09/15/21 at 4:11pm revealed:
-Her only involvement with Resident #3 was she participated in the completion of the NC HCPR 5-day report.
-She did not fax the report to the NC HCPR.
-The interim DRC or the Administrator were

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D 438	Continued From page 61 supposed to fax the reports to the NC HCPR. -She assisted with staff interviews related to Resident #3's unknown injury, she could not provide the number of staff interviews she completed. -From the staff interviews she completed, none of the staff knew what had happen to Resident #3. Interview with the interim Administrator on 09/15/21 at 5:02pm revealed: -It was his responsibility as the interim Administrator to complete the NC HCPR 24-hour initial and 5-day reports and submit the reports within the required timeframe. -He was not aware the NC HCPR 24-hour initial report was not sent to the NC HCPR until 09/03/21. -He was not aware the NC HCPR 5-day report did not include the details related to Resident #3's bruise to her left arm or left knee abrasion. -He expected all the details related to the resident's injury including all bruises, abrasions, and any skin observations to be included in the reports to the NC HCPR. -It was important to include all details to provide an "accurate" picture for someone not working in the building to make them aware of what "transpired" at the facility.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical	D 451		

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evaluation, hospitalization, or medical treatment other than first aid.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) of incidents resulting in injury requiring emergency medical evaluation and medical treatment for 2 of 2 residents sampled (#3 and #6).

The findings are:

Review of Resident #3's current FL-2 dated 07/09/21 revealed:
-Diagnoses included dementia, hypertension, major depressive disorder, and type 2 diabetes mellitus.
-She was a resident in the Special Care Unit.
-She was constantly disoriented,
-She required total care with personal care.
-She was non-ambulatory.

Review of Resident #3's incident/accident (I/A) reports, resident care notes, communication notes, and the hospital visit note revealed Resident #3 required evaluation by emergency medical services (EMS) for an incident dated 09/01/21 which required a visit to the emergency department (ED) resulting in a diagnosis of a left hip fracture, left arm bruising, and a concern for non-accidental trauma.

Review of Resident #3's electronic progress notes dated 09/01/21 at 17:56pm revealed:
-There was an order dated 08/31/21 for a mobile x-ray of the hip.
-The x-ray company was unable to get a technician out to the facility to complete a mobile x-ray for Resident #3 until the evening.

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D 451	Continued From page 63 -A medication aide (MA) called 911, and Resident #3 was transported to the ED at the local hospital for evaluation on 09/01/21 at 4:00pm. Review of Resident #3's I/A reports revealed no report was provided for the incident on 09/01/21 and no documentation the county department of social services (DSS) was notified. Review of an email message to the county DSS social worker (SW) from the interim Director of Resident Care dated 09/03/21 at 1:27am revealed: -She was submitting an incident report, regarding an occurrence with one of our residents. -The resident sustained an injury of an unknown origin. -The investigation had been facilitated. -The email attachment contained the NC HCPR 24-hour initial allegation report. Telephone interview with the county DSS AHS on 09/08/21 at 10:54am revealed her office had not received any I/A reports dated 09/01/21 for Resident #3. Interview with a medication aide (MA) on 09/15/21 at 11:17am revealed: -The MAs were responsible for completing an I/A report when a resident had a fall, if a resident went to the hospital, or if a resident hit their head. -The I/A should be completed immediately after the resident's I/A or prior to the end of their shift. Interview with the former DRC on 09/15/21 at 12:11pm revealed the MAs were responsible for completing an I/A report for any fall whether there was an injury or not prior to the end of their shift. Interview with the interim Administrator on	D 451		

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09/15/21 at 5:02pm revealed:
-He was not aware that an I/A report was not completed for Resident #3 when she was sent to the ED on 09/01/21.
-He was not aware the I/A report was different from the North Carolina Health Care Personnel Registry (NC HCPR) initial 24-hour report and the 5-day report.
-He knew the interim DRC had completed the NC HCPR initial 24-hour report and the 5-day report, but he was not aware an I/A report needed to be completed and sent to DSS.
-He was not aware he was responsible for the completion and sending I/A reports to DSS.
2. Review of Resident #6's current FL-2 dated 07/21/21 revealed diagnoses included wedge compression fracture of vertebrae, low back pain, vitamin D deficiency, moderate protein calorie malnutrition, hypertension, atrioventricular heart block and right bundle branch block.

Telephone interview with Resident #6's family member on 09/08/21 at 4:20pm revealed:
-Resident #6 fell in the bathroom in March 2021 and injured her knee.
-She had to have a home health agency come in to take care of the wound and it took months to heal.

Telephone interview with Resident #6 on 09/14/21 at 3:25pm revealed:
-In March 2021, she was in the bathroom and was trying to save herself from falling and sliced her lower leg on her walker.
-She pulled the call bell as she was bleeding badly from the wound.
-The facility had a service come and care for the wound twice weekly for 3 - 5 weeks.

Upon request 09/09/21, 09/10/21, 09/14/21 and

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D 451	Continued From page 65 09/15/21, there were no written or electronic progress notes for Resident #6 prior to 03/31/21 available for review. Upon request 09/09/21, 09/10/21, 09/14/21 and 09/15/21, there were no primary care provider (PCP) or home health visit notes for Resident #6 dated 02/01/21 through 08/26/21 available for review. Interview with a MA on 09/14/21 at 3:58pm revealed she remembered Resident #6 injured her leg and had a terrible wound, but she could not remember the details of what happened. Upon request on 09/09/21, 09/10/21, 09/14/21 and 09/15/21, there were no incident and accident reports for Resident #6 available for review. Review of a list of incident reports received in March 2021 by the local Department of Social Services revealed there was no incident/accident report for Resident #6. Interview with a medication aide (MA) on 09/15/21 at 11:17am revealed: -Accident and incident reports were completed by MAs when a resident fell, was sent out to the hospital and/or had injuries. -Completed accident and incident reports were given to the Director of Resident Care (DRC). Telephone interview with the former Director of Resident Care (DRC) on 09/15/21 at 12:11pm revealed: -Accident and incident reports were only done for falls. -Medication aides (MAs) were responsible for completing accident and incident reports before	D 451		

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D 451	Continued From page 66 the end of their shift. -Completed accident and incident reports were placed in a box at the nursing station for the DRC. Interview with the Administrator on 09/15/21 at 5:45pm revealed: -He did not know accident and incident reports were different than 24 hour and 5 Day investigation reports. -He did not know the requirements for ensuring reporting of accidents and incidents to the local department of social services when a resident experienced an injury and required more than first aide.	D 451		
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, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings. The findings are: Based on observations, interviews, and record reviews the facility failed to ensure the Special	D912		

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D912	Continued From page 67 Care Unit (SCU) was free of hazardous substances and chemicals left accessible to the 22 residents including personal hygiene items stored unsecured in multiple residents' bathrooms in the form of liquids, solids, pastes and aerosols, cleaning agents stored in two residents' bathrooms, paints, adhesives and aerosols stored in an unlocked closet and cabinet, and a fabric freshener spray in the kitchen not monitored by staff. [Refer to Tag D0079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (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 health care and implementation. The findings are: 1. Based on interviews and record reviews, the facility failed to notify the primary care physician for 2 of 5 sampled residents (#3, #2) related for a change in a resident's health status (#3); and for blood pressure readings and fingerstick blood sugar results as per ordered parameters (#2). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D914		

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D914	Continued From page 68 2. Based on observations, interviews, and record reviews, the Administrator failed to ensure the overall management, operations, policies and procedures and total operations of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to health care, resident records and housekeeping and furnishings, all of which were the responsibility of the Administrator. [Refer to Tag D0980, GS131D-25 Implementation (Type A2 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 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.	D935		

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D935	Continued From page 69	D935		

(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:
Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled medication aides (MAs) (Staff A and Staff F) had completed the clinical skills evaluation conducted by a registered nurse (RN) or pharmacist.

The findings are:

1. Review of Staff A's personnel record revealed:
-She was hired on 07/07/21 as a MA.
-The clinical skills evaluation checklist for the MA was signed by the former Director of Resident Care (DRC) on 07/20/21, who was a licensed practical nurse (LPN).

Review of a facility's eMAR's from July 2021 through September 2021 revealed:
-Staff A documented administering medications on 07/30/21.
-She documented administering medications on 08/09/21, 08/23/21 and 08/27/21.
-She documented administering medications on

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D935	Continued From page 70 09/03/21, 09/06/21 and 09/08/21. Telephone interview with the former DRC on 09/15/21 at 12:00 pm revealed: -She was an LPN. -She provided the clinical skills validation training for Staff A. -She was not aware that this training had to be provided by a registered nurse (RN) or a pharmacist. Refer to the interview with the Business Office Manager (BOM) on 09/15/21 at 10:39 am. 2. Review of Staff F's personnel record revealed: -He was hired on 06/01/21 as a MA. -The clinical skills evaluation checklist for the MA was signed by the former DRC on 06/08/21 who was an LPN. Review of a facility's eMAR's from 07/01/21-09/07/21 revealed: -Staff F documented administering medications on 07/01/21, 07/02/21, 07/07/21, 07/09/21, 07/10/21, 07/15/21, 07/18/21, 07/21/21, 07/22/21, 07/25/21, 07/27/21, and 07/30/21. -He documented administering medications on 08/04/21, 08/07/21, 08/08/21, 08/13/21, 08/21/21, 08/22/21, 08/24/21, 08/26/21, and 08/31/21. -He documented administering medications on 09/02/21, 09/04/21, 09/05/21, and 09/07/21. Telephone interview with the former DRC on 09/15/21 at 12:10 pm revealed: -She was an LPN. -She provided the clinical skills validation training for Staff F. -She was not aware that this training had to be provided by a registered nurse (RN) or a pharmacist.	D935		

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D935	Continued From page 71 Refer to the interview with the Business Office Manager (BOM) on 09/15/21 at 10:39am _____ Interview with the Business Office Manager (BOM) on 09/15/21 at 10:39 am. -Her responsibilities included coordinating new employee orientation and training and maintaining personnel records in the facility for review. -It was the responsibility of the nurse to ensure the clinical skills validation training for the medication aides. -She was not responsible to ensure the training staff were qualified to validate training for the medication aides at the facility.	D935		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the overall management, operations, policies and procedures and total operations of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to health care, resident records and housekeeping and furnishings, all of which were the responsibility of the Administrator.	D980		

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D980	Continued From page 72 The findings are: Interview with the interim Administrator on 09/08/21 at 9:07am revealed: -He was the interim Administrator covering the facility until a permanent Administrator was in place. -He had been at the facility for approximately two weeks. -A traveling nurse was covering as the interim Director of Resident Care (DRC) started at the same time he did. -Eighty residents were in the facility with a few out in the hospital, rehabilitation centers or with family. -The facility was just getting through an active COVID-19 outbreak where there was one staff and two residents who tested positive for COVID-19. -He was not exactly sure about the resident census, details of the residents out of the facility and management of the COVID-19 outbreak. A second interview with the interim Administrator on 09/08/21 at 9:26am revealed: -Seventy four residents were at the facility. -The COVID-19 outbreak did not involve any staff. -There were two residents that tested positive. -It had been two weeks since the positive tests and the residents no longer had symptoms. -The interim DRC would know more about the residents out of the facility. Interview with the Sales and Marketing Manager on 09/08/21 at 9:34am revealed: -Three residents were out of the facility hospitalized or in rehabilitation centers. -Three additional residents were paying for beds but had not physically moved in.	D980		

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D980	Continued From page 73 -There were 80 paying residents, 70 in the facility with 22 in the special care unit (SCU) and 48 in assisted living (AL). Based on observations during tour of the facility and review of the facility's resident roster on 09/08/21 there were 68 residents at the facility. Interview with the interim Director of Resident Care (DRC) on 09/08/21 at 9:38am revealed: -She was temporarily staffed at the facility from an agency and was leaving on 09/10/21. -Resident records were in the process of being 100% electronic but there were still some hard copy records. Telephone interview with a resident's family member on 09/08/21 at 4:20pm revealed: -The family member was not given an explanation of what happened related to a call bell being activated for 88 minutes until 4 weeks later (07/26/21). -The Administrator resigned from the facility 2 weeks after explaining the call bell incident. -The family member was not notified of the change in Administrator, he found out on 08/26/21 while at the facility. Interview with the interim Director of Resident Care (DRC) on 09/09/21 at 2:35pm revealed: -A Corporate DRC was at the facility during the first week she worked (08/13/21). -She did not receive any training on facility policies and procedures. -She was hired to cover the role of DRC. -She was not given sign in credentials to access parts of the electronic record and reporting system until the beginning of last week (08/30/21). -She was not able to access documents and	D980		

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reports on the clinical side of the electronic record and reporting system like accident and incident reports.
-She was unable to review orders scanned into the system by medication aides (MAs).
-Prior to last week she only had access to the electronic medication administration records (eMARs) and progress notes.
-Her primary responsibility while working at the facility was completing the schedule and daily assignment sheet.
-There was a Wellness Coordinator who did the schedule and worked as a MA, but he had not returned to work for a week and half.
-The Wellness Coordinator had completed the master schedule through 09/22/21 but there were vacancies and holes.
-She had to work on filling staffing shortages and completing the daily assignment sheet each day.
-It was not clear who was responsible for schedules, assessments and evaluations.
-Due to staff turnover, the Business Office Manager (BOM) and Activities Director (AD) had been covering areas related to care of the residents.
-She did not know if they had been instructed to do resident assessments and evaluations.
-She was able to call the Corporate DRC or a corporate training person if she had questions.
-The interim Administrator had experience in the daily operations of running a facility, but he was not a resource for her.
-He was not familiar with the company specific policies and procedures.
-He was accessible to staff and residents.
-She knew he completed facility rounds when he first started but she had not seen him complete a lot of facility rounding recently.

Interview with the Administrator of a sister facility

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D980	Continued From page 75 on 09/10/21 at 10:16am revealed: -Resident record information should have been available and provided for review on 09/08/21. -There was a miscommunication with the interim Administrator, interim DRC and her. -She did not know of the specific issues with getting information addressing concerns until the evening of 09/08/21. Interview with the Director of Operations on 09/14/21 at 9:04am revealed: -The interim Administrator was responsible for the facility and reported to him. -He was at the facility since 09/13/21 to assist and support. Telephone interview with a second family member on 09/14/21 at 2:29pm revealed: -In the past the facility had been good about sending regular updates via email especially related to COVID-19 and visitation at the facility. -It had been 4 - 5 months since an update had been sent. -She did not know the former Administrator was no longer there or when she left. -She did not know the name of the Interim Administrator. Telephone interview with a third family member on 09/14/21 at 7:27pm revealed: -There was no nurse or director at the facility. -She did not know the head person's name because she never came out of the office. -She did not know what was going on at the facility. -None of the management was there anymore and she did not know who to go to or what to do. -The staff who worked at the facility did not know what was going on in the facility.	D980		

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D980	Continued From page 76 Interview with the Business Office Manager (BOM) on 09/15/21 at 9:57am revealed: -The former Administrator's last day was 08/12/21 and was at the facility for almost one year. -The interim Administrator started in mid-August 2021. -The former DRC worked at the facility from January 2021 until August 2021. -There was no formal letter sent to residents and family members regarding changes in management. -The facility had experienced frequent turnover of management in the past 18 months, including Administrators and DRCs. -There had been three Administrators and three to four DRCs over the past 18 months. -There was a Corporate DRC at the facility from April 2021 until August 2021. Telephone interview with the former DRC on 09/15/21 at 12:11pm revealed: -She worked at the facility from 01/15/21 until 08/03/21. -She frequently worked 16 hour shifts as direct care staff due to high staff turnover and staffing shortages. -She was not able to complete clinical paperwork such as completing follow up on quarterly pharmacy reviews due to working as direct care staff and lack of access to resident records. -There was a Corporate DRC that helped with completing some of the paperwork but there were too many hindrances to getting caught up. -In addition to staffing shortages, there were significant resident care and safety issues that required investigation and follow up by the Corporate DRC and Administrator. Non-compliance was identified at violation levels in the following areas:	D980		

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D980	Continued From page 77 1. Based on interviews and record reviews, the facility failed to notify the primary care physician for 2 of 5 sampled residents (#3, #2) related for a change in a resident's health status (#3); and for blood pressure readings and fingerstick blood sugar results as per ordered parameters (#2). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazardous substances and chemicals left accessible to the 22 residents including personal hygiene items stored unsecured in multiple residents' bathrooms in the form of liquids, solids, pastes and aerosols, cleaning agents stored in two residents' bathrooms, paints, adhesives and aerosols stored in an unlocked closet and cabinet, and a fabric freshener spray in the kitchen not monitored by staff. [Refer to Tag D0079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 3. Based on interviews and record review the facility failed to maintain resident records in an orderly manner and readily available for review for 5 of 6 sampled residents (#1, #2, #3, #5 and #6). _____ The Administrator, who was responsible for the overall management, administration, supervision, and operation of the facility, failed to ensure primary care provider (PCP) notification for 2 of 5 sampled residents including a delay in reporting Resident #3's inability to turn in bed and a change in the ability to transfer due to severe hip pain which delayed the resident receiving medical intervention for a fractured hip from 08/29/21 to	D980		

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MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

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D980	Continued From page 78 08/31/21, which was later confirmed via an x-ray; a resident with orders to notify the PCP for systolic blood pressure (SBP) readings greater than 150 with SBP results greater than 150 on 29 occasions from 07/01/21 through 09/03/21; and orders to notify the PCP for fingerstick blood sugars (FSBS) below or equal to the parameter of 69 with FSBS results equal to or below 69 on 2 occasions from 07/01/21 through 09/03/21; failure to maintain resident records in an orderly manner with no consistent method from the management team to transition from the residents' hard copies to the facility database; and failed to secure hazardous substances to protect the residents diagnosed with dementia in a Special Care Unit (SCU) including cleaning products containing bleach, paints, and aerosol adhesive and toiletries. The Administrator's failure resulted in risk for serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 09/14/21 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 15, 2021.	D980		