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THE ADDISON OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up and complaint investigation 01/25/22, 01/26/22. The investigation was reopened on 02/02/22 with a desk review and onsite investigation on 02/03/22, 02/04/22, 02/07/22 and 02/08/22. Staff identified in the Statement of Deficiencies as Clinical Operations Specialists ("COS") are employees of the licensee's corporate office. Staff identified in the Statement of Deficiencies as agency staff are employees of staffing agencies with whom the facility contracted for staffing services, and are not employees of the facility.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION.	D 067		

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D 067	Continued From page 1 The Type B Violation was not abated. Based on observations and interviews, the facility failed to ensure 7 of 7 exit doors accessible by residents known to be disoriented were equipped with a sounding device that was activated when the door was opened and staff were not using pagers to receive alerts if these doors were opened. The findings are: Review of current FL-2 for residents in AL on 02/03/22 revealed there were 12 residents with diagnoses of dementia, cognitive disorder or were documented as intermittently confused. Observation of the facility on 01/25/22 at 12:39pm revealed there were 7 unlocked exit doors accessible to residents in the AL unit. Observation of the exit door on D hall on 01/25/22 from 7:48am-7:50am revealed: -There was sounding device equipment attached to the top of door. -The door was opened at 7:48am and there was no audible alarm that sounded. -There were 2 personal care aides (PCAs) in a resident's room delivering beverages for breakfast. -The PCAs did not respond to the door being opened. Observation of the exit door in the Media Room on 01/25/22 at 12:39pm revealed: -There were 2 staff sitting at the nurses' station. -There was sounding device equipment attached to the top of door. -The door was unlocked. -A resident was sitting in the media room.	D 067		

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-The door was opened at 12:39pm and no staff responded to the opened door.

Observation of the Activity Room on 01/25/22 from 10:45am to 11:15am revealed:
-The door leading outside to the front porch and parking lot was propped open by a staff member at 10:45am to let some cool air in.
-The door was closed when the room was cooled off at 11:15am.
-There was no audible alarm when the door was opened and door was left unattended by staff the entire time; no staff checked to see why the door was propped open.

Observation of an exit door on B hall from 1:00pm to 1:04pm revealed:
-The door led outside to a grassy area that was not fenced in.
-The door was found propped open with a piece of cardboard keeping it from closing or locking.
-There were no staff members supervising the door and no one came to see why the door was propped open.
-A resident entered the building from outside through the door at 1:04pm and propped the cardboard against the wall in the hallway shutting the door behind her.

Observation of A hall exit door on 01/25/22 at 7:40am revealed:
-The exit door was not locked, and no alarm was heard when the door was opened.
-There was sounding device equipment at the top right corner of the door.
-No staff responded to the opened door.

Observation of B hall exit door on 01/25/22 at 7:52am revealed:
-The exit door was not locked, and no alarm was

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heard when the door was opened.
-There was sounding device equipment at the top right corner of the door.
-No staff responded to the opened door.

Observation of the Nurses station on 01/25/22 at 8:00am revealed:
-There was a desk with a computer monitor.
-There were 3 pagers in the desk drawer.

Interview with an agency personal care aide (PCA) on 01/25/22 at 7:50am revealed:
-PCAs were supposed to have pagers on them during their shifts.
-The pagers for the facility had not been working since December 2021.
-PCAs had to go to the nurses' station to determine if any call bells or alerts were activated because they did not have the pagers.
-She made Clinical Operations Specialist #1 (COS #1) aware the pagers were not working (not sure of date).

Interview with a facility PCA on 01/25/22 at 8:00am revealed:
-There was an alert on the computer at the desk in the workstation where A and B Hall join.
-The door alarm system went through a pager system as well as the computer but at least 1 of the pagers did not have working batteries.
-He did not carry a pager because they were not working.
-The PCA could not say which staff should have been carrying a pager for the door alarms but there was one for each of the 3 AL halls.
-There was no audible alarm when the exit doors were opened and no one was assigned to monitor the computer at the desk.

Interview with the Resident Care Coordinator

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D 067	Continued From page 4 (RCC) on 01/26/22 at 9:10am revealed: -The pagers worked with the central system to alert staff when a residents' call bell was activated and when an exit door in the facility had opened. -The pagers were working on 01/12/22. -She expected staff to be aware of the residents who were going out of the doors. -She was made aware yesterday, 01/25/22, staff were not wearing their pagers. -The pagers were not working because the batteries were out. -She did not know how long the pagers were not working. -She expected staff to check the central system at the nurses' station when their pagers were not working. Interview with COS#1 on 01/25/22 at 8:00am revealed staff were to be alerted when a door was opened through an alert on a computer and through a mobile pager system. Second interview with COS#1 on 01/26/22 at 10:25am revealed: -There should have been 6 pagers in the facility for staff's use each shift. -She located 3 pagers that needed batteries in the drawer at the nurses' station on 01/25/22. -She found an additional 3 pagers in the executive director's office that needed batteries. _____ The facility failed to ensure 7 exit doors on the Assisted Living (AL) Unit were equipped with an audible sounding device alerting staff when activated. These doors were accessible to 12 residents with known intermittent confusion, cognitive impairment or dementia. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation.	D 067		

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D 067	Continued From page 5 The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/04/22 for this violation.	D 067		
D 102	10A NCAC 13F .0309 (d) Plan For Evacuation 10A NCAC 13F .0309 Plan For Evacuation (d) A written disaster plan, which has the written approval of or has been documented as submitted to the local emergency management agency and the local agency designated to coordinate special needs sheltering during disasters, shall be prepared and updated at least annually and shall be maintained in the facility. This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to develop a written Emergency Disaster Plan and have sufficient preparations for impending inclement weather, which resulted in only one staff on duty to provide care for 55 residents including 18 residents that resided on a Special Care Unit (SCU) for at least 10 hours. Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 96 beds including 60 beds for the assisted living (AL) area and 36 beds for the special care unit (SCU). Review of the facility's Emergency Preparedness and Response Policy and Procedure Manual	D 102		

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D 102	Continued From page 6 revealed: -There were two chapters titled "All Hazards Planning and Preparation" and "Severe Weather Preparation and Response". -There were no policies and procedures specific to the facility. -The manual referenced several documents to be completed by the facility which included the following: -A Hazards Vulnerability Assessment Tool. -A data collection worksheet. -A disaster agreement with other organizations or support agencies. -Staff training conducted on the community's emergency plans, policies and procedures. -Completed training exercises, drills and simulations for the facility. -Annual community disaster preparedness assessments. -A formalized agreement and emergency contingencies with alternate communities/facilities and services. -A record of emergency drills. -Documented minutes of monthly meetings for the facility's Safety Committee. Interview with the Administrator on 02/04/22 at 9:05am revealed: -There was no Hazards Vulnerability Assessment Tool available. -There was no data collection worksheet available. -There was no disaster agreement with other organizations or support agencies. -There was no documentation of staff training conducted on the community's emergency plans, policies and procedures. -There was no documentation of completed training exercises, drills and simulations for the facility.	D 102		

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D 102	Continued From page 7 -There was no documentation of annual community disaster preparedness assessments. -The was no documentation of a formalized agreement and emergency contingencies with alternate communities/facilities and services. -There was no record of emergency drills. -There were no documented minutes of monthly meetings for the facility's Safety Committee. -The facility was provided a guide from the corporate office that was be used to develop an individualized disaster plan specific for use at the facility. -The Administrator was responsible for developing and implementing the Disaster Plan but she had only become the administrator at that location on 01/31/22 and didn't know if the previous Administrator had completed the disaster plan. Telephone interview with an agency medication aide (MA) on 02/07/22 at 11:23am revealed: -She had worked at the facility since November 2021 primarily on the 11:00pm - 7:00 shift. -She had never received any training on what to do at the facility in case of a disaster or emergency. -She had never seen the facility's disaster plan or knew if the facility had a disaster plan. -Management contact numbers, which included the previous Administrator, the previous Resident Care Coordinator (RCC), the Corporate Office staff(COS), and the Regional Director of Operations, were posted at the nurse's station, but they were not up to date because the Resident Care Coordinator had recently quit and the Health and Wellness Director (HWD) was just hired. -If she needed help in case of an emergency or there was a disaster, she would call the HWD for directives.	D 102		

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D 102	Continued From page 8 Interview with a second agency MA on 02/07/22 at 5:08pm revealed she had never been trained at the facility about how to respond to disasters and did not know if the facility had a disaster plan. Second interview with the Administrator on 02/03/22 at 11:55am revealed the Emergency Disaster Plan for the facility did not address staffing concerns. Third interview with the Administrator on 02/03/22 at 6:40pm revealed: -The facility had a black notebook at the nurse's station that contained their disaster plan. -All of the management contact numbers were posted on the wall in the nurse's station for employee access. -Staff had access to the disaster plan and could read the book to know what needed to be done in case of a disaster. -Staff were supposed to sign-off on the disaster plan once they read it, but there were no copies of the staff sign-off sheets available. -She had just become the Administrator on 01/31/22 and she could not verify if the facility's disaster plan had been reviewed with the staff or who was responsible for ensuring staff reviewed the disaster plan. Interview with Clinical Operations Specialist #1 (COS#1) on 02/02/22 at 4:17pm revealed: -She began communicating with senior management regarding maintenance, dining services, plant operation, loss of electricity and how to get a generator in place on 01/14/22 due to the approaching winter weather forecast. -At least five staff were scheduled for the weekend of 01/21/22 through 01/23/22 with some working a double shift.	D 102		

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-Two medications aides (MAs) and three personal care aides (PCAs) were scheduled, all were from staffing agencies except one of the PCAs.
-At 2pm on 01/21/22, staff began to call out for the 2nd shift (3pm-11pm) and 3rd shift (11pm-7am) because of the inclement weather.
-She asked staff from the 1st shift (7am-3pm) on 01/21/22 if anyone would stay, but no one was willing to stay to cover the 2nd or 3rd shift.
-She and a PCA were the only two staff in the facility on the second shift on 01/21/22.
-She was the only staff in the facility on 3rd shift on 01/22/22.
-No one showed up on the 1st shift on 01/22/22 including kitchen staff, so she contacted the management team, other facilities and staff to arrange coverage around 7:15am.
-The Business Office Manager (BOM), the executive director (ED) from a sister facility, the dining services director, the utility director, and 2 PCAs came in around 10am to assist.
-She was the only one passing medications in the facility on 01/22/22.
-Some medications were late or not administered.
-She did not contact emergency management because she did not know that was an option.
-She contacted the Department of Social Services (DSS) on that Monday 01/24/22 to inform them of the events on 01/21/22 into 01/22/22.

Interview with COS #1 on 01/26/22 at 11:21am revealed:
-She was the only employee in the building on 01/21/22 from 11:00pm-7:00am due to call-outs from a snow storm.
-She spent approximately 6 hours on the SCU and 2 hours on the AL throughout the shift.
-It was a terrifying night because she was concerned she was going to miss someone

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ringing their call bell or be unable to supervise someone on the SCU while on the AL side.

Interviews with a resident who resided on the AL unit on 02/04/22 at 9:55am and 10:25am revealed:
-On 01/22/22, the facility was short staffed because of inclement weather conditions.
-He preferred to get up around 7:00am and needed staff assistance to get and out of bed.
-He activated his call bell, but no one came for about 45 minutes.
-No staff came to get him up until he was brought his breakfast around 10:00am on 01/22/22.

Interview with a resident on 02/04/22 at 8:45am revealed:
-On 01/22/22, a lot of staff did not show up for work due to inclement weather conditions.
-There was no one to administer medications on 01/22/22.
-She did not receive 6 of her medications the morning of 01/22/22.

Telephone interview with COS #1 on 02/03/22 at 12:55pm revealed:
-There was an emergency preparedness plan in the building somewhere, but she did not consult it at the time of the weather event when staff were calling out.
-She did not call emergency management because she did not know that was what she should do.

Third interview with COS #1 on 02/08/22 at 12:15pm revealed:
-The facility did not have a completed disaster plan.
-When they started looking through their policy and procedures earlier on 02/07/22, she

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D 102	Continued From page 11 discovered the disaster plan was incomplete and had not been reviewed annually. -They were working to complete the facility's disaster plan since they discovered it was incomplete. -Staff had been given general training on how to respond to COVID-19, hall assignments, and basic resident orientation when they first started working but no training on how to respond in a disaster. _____ The facility failed to ensure the there was an Emergency Disaster Plan resulting in 1 staff available to provide care to 55 residents during an adverse weather event. This resulted in a delay in personal care, medications not being administered, late medication administration and the Special Care Unit without staff and 17 SCU residents left unattended. The facility's failure resulted in risk for serious neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G S 131D-34 on 02/08/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 10, 2022.	D 102		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.	D 105		

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

Based on observations, record reviews, and interviews, the facility failed to ensure the facility's call system was operational as designed to ensure residents' calls for assistance would be received by staff resulting in at least one resident (#10) having to call 911 for assistance to get off the floor after falling.

The findings are:

Review of Resident #10's current FL-2 dated 12/23/21 revealed:
-Diagnoses included embolic cerebrovascular accident, paroxysmal atrial fibrillation, and hypertension.
-Resident #10 was non-ambulatory and incontinent of bladder.

Review of Resident #10's care plan dated 08/26/21 revealed:
-Resident #10 was alert and oriented.
-Resident #10 was ambulatory with use of a wheelchair.
-She was independent with transferring and toileting.

Review of an incident report for Resident #10 dated 02/01/22 revealed:
-Resident #10 had an unwitnessed fall in her room at 12:30am.
-The facility staff discovered Resident #10's incident after the resident called 911.
-Resident #10 was in her room with the door locked and attempted to get up to unlock the door and fell.
-Resident #10's emergency pendant was in her drawer (out of her reach), but Resident #10's

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phone was in reach.
-Resident #10 dialed 911 and self-reported her fall to county emergency management service (EMS) at 12:40am.
-Resident #10 was found on the floor of her room and assisted from the floor by EMS to her wheelchair with a two-person assist.
-She suffered a skin tear to her right arm and was oriented after her fall.

Observation of Resident #10 on 02/04/22 at 9:15am revealed:
-She was sitting in her wheelchair in her room.
-Resident #10 had two band-aids to her right forearm and she was not wearing an emergency pendant.

Observation of Resident #10's room on 02/04/22 at 9:15am revealed:
-Resident #10's room was located on the assisted living side of the facility on the D Hall.
-There was call bell located on the wall near the head of bed.
-There was a second call bell located on the bathroom wall near the toilet inside the bathroom of Resident #10's room.
-There was a portable phone on a stand located approximately 4 feet from the entrance door of Resident #10's room.

Interview with Resident #10 on 02/04/22 at 9:15am revealed:
-She fell forward on the floor of her bathroom one night earlier in the week.
-She could not specify the date, but it was dark outside.
-She could not get up from the floor of the bathroom without staff assistance.
-She pulled the call bell in her bathroom for help, but no staff responded.

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-She scooted across the floor on her buttocks from her bathroom to her bedroom and pulled the call bell that was next to her bed for staff assistance.
-Staff still not respond after she pulled the call bell.
-She could not find her emergency pendant in her nightstand drawer next to her bed to call for help.
-She scooted to the door of her room, opened the door, and yelled out in the hallway for staff assistance, but no staff came.
-She scooted back across the floor to her portable phone and called the facility phone, but no staff answered.
-She called 911 after she tried to call the facility because she could not get any staff response for assistance.
-She thought she had been on the floor for at least 30 minutes before she called 911.
-Her room door was not locked on the night she fell.
-When EMS arrived, they assisted her off the floor and the facility staff came into the room with EMS.
-She had two skin tears to her right arm and her right wrist was still sore from the fall.
-Her backside was still sore from the fall and having to scoot across the floor that night.
-It was a problem with getting staff to respond when she used her call bell or emergency pendant in the past (dates not specified).

Interview with a facility personal care (PCA) on 02/07/22 at 11:35am revealed:
-He worked on the 11pm - 7am shift when Resident #10 fell in her room on 02/10/22.
-Resident #10 had locked the door of her room because of a wandering resident.
-Resident #10 reported to him that the she did not have her emergency pendant when she fell on

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02/01/22.
-He had worn the pager since December 2021 because it was used to alert the staff when residents rang their call bells or used their emergency pendants on the assisted living side of the facility.
-His pager did not go off when Resident #10 activated her call bell on 02/01/22 during the 11pm-7am shift.
-There were only 2 working pagers on the assisted living side on 02/07/22 and sometimes the pagers were not accurate because staff could not tell from the pagers which resident's call bell was activated.
-He had not reported this issue to anyone in management and he could not explain why.
-Staff were expected to respond immediately to all call bell activations whether staff had the pagers or heard the resident's call bell activation on the computer at the nurse's station.

Interview with a medication aide (MA) on 02/07/22 at 5:08pm revealed:
-She was the MA for Resident #10 during the 11pm -7am shift on 01/31/22 going into 02/01/22.
-She did not hear Resident #10's call bell beeping from the computer at the nurse's station when she fell on 02/01/22.
-When residents activated their call bell, the alerts went to pagers and to the nurse's station
-The PCA was wearing the pager on 02/01/22 and he was responsible for answering the resident's call bell if it were activated.
-She did not know Resident #10 needed any help until she saw EMS coming to the front door.
-There was no other call bell system for residents to access to alert staff if they needed help.

Interview with the Administrator on 02/08/22 at 10:27am revealed:

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-No staff had reported to her that Resident #10 had any problems with her call bell not being answered when the resident fell on the 11pm-7am shift on 01/31/22.
-She expected staff to respond when residents activated their call bells.

Second interview with the Administrator on 02/08/22 at 11:15am revealed:
-She wanted to clarify regarding the fall with Resident #10 on 01/31/22.
-The Clinical Operations Specialist #1 (COS #1) spoke with the Resident #10 after the fall.
-She was not aware of any reports of the facility's call bell system not working prior to the survey.

Observation of Resident #10's room on 02/04/22 from 9:22am to 9:26am revealed:
-Resident #10's room was located on the assisted living side of the facility.
-Survey team staff pulled the call bell next to the head of the bed for Resident #10 at 9:22am.
-A red light on the call bell illuminated but there was no audible sound.
-A PCA entered Resident #10's room at 9:26am and asked the resident if she was okay.
-The PCA did not acknowledge the activated call bell or attempt to deactivate it.

Interview with a second PCA on 02/04/22 at 9:27am revealed:
-She did not know Resident #10's call bell had been activated.
-She was just walking down the hall and came to check on Resident #10.
-She was not responding to Resident #10's call bell being activated.
-The residents' call bells were connected to pagers worn by staff that were supposed to activate when residents pulled their call lights.

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-Staff were supposed to come to whatever resident's room activated the pager within 5 to 10 minutes to check on the resident.
-She did not have a pager, but the other PCA on the other hall was wearing the pager.
-The call bell activations were supposed to be going to that pager and the computer at the nurse's station.
-There were only two working pagers for the facility.
-There had been some problems with the pagers not being activated when the residents rang their call bells.
-She could not specify how long this had been an issue.
-She did not report this to any management, but all the staff knew the pagers and call bells were not working properly.
-She just walked the two halls that she was assigned to and she did not have specified time frame that she checked on the residents.

Observation of Resident 10's room on 02/07/22 from 9:56am to 10:16am revealed:
-The resident's room was on the assisted living
-Resident was in her wheelchair.
-The call bell in the resident's bathroom was activated at 9:56am; there was a red light at activation but no audible alarm could be heard.
-The Health and Wellness Director (HWD) walked to the medication cart that was on the same hall past Resident #10's room at 10:00am.
-The red light that indicated the call bell was functioning was still on in the resident's bathroom at 10:15am.

Interview with a third PCA on 02/04/22 at 10:45am revealed:
-She had the pager that was supposed to be connected to the residents' call bells for the D

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Hall.
-She had not gotten a page for Resident #10's call bell being activated this morning.
-Sometimes the pagers did not work when the residents activated their call bells.
-Staff tried to check on each resident as soon as possible when the pagers worked.

Observation of a resident's room B-8 on the B Hall on 02/07/22 from 9:30am to 9:47am revealed:
-The resident's room was located on the assisted living side of the facility.
-A resident was lying in bed in the room when the survey team staff activated the resident's call bell next to her bed at 9:32am.
-There was no response from staff and the survey team activated a second call bell in the resident's room at 9:35am and stepped outside of the resident's room into the hallway.
-There was no audible sound heard when either call bells were activated.
-There was a MA about midway the hall standing next to a medication cart.
-There was no response by staff to the two call bells being activated in the resident's room at 9:47am.

Observation of resident room B-1 on the B Hall on 02/07/22 from 9:30 to 9:42 revealed:
-The resident was sitting in his wheelchair, left arm was contracted, eating breakfast.
-The call bell over the bed was pulled at 9:30am with no audible sound when the call bell was activated.
-A MA walked past room B1, down the B hall at 9:31am.
-The MA and another staff walked to the medication cart at the end of B hall, passing room B-1 at 9:33am.

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-The COS walked to the medication cart at the end of B hall, passing room B-1, at 9:35am.
-The MA pulled the medication cart up the hall and began preparing medications just outside of room B-1 at 9:40am.
-Housekeeping staff and a PCA entered the room at 9:42am.

Interview with a second MA on 02/07/22 at 9:41am revealed:
-She did not know the call bells in the residents' rooms had been activated because she did not have to wear a pager.
-The PCAs were supposed to wear the pagers and respond to residents' calls when the pagers activated.
-She did not know about any problems with pagers or the residents' call bells because she had only been working at the facility for two days.

Interview with the third PCA on 02/07/22 at 10:20am revealed:
-She was assigned to work the assisted living side of the facility for the A Hall and part of B Hall.
-She had the pager that was supposed to be connected to the residents' call bells.
-She had not gotten a page from the resident's call bell being activated on the B Hall or D Hall.
-There were some problems with the pagers working properly when the residents' call bells were activated because the batteries were low or because of pagers malfunctioned.
-These problems had been going at least since July 2021 and it had been reported to the previous ED and the previous HWD (time not specified) but the call bell system was never fixed.
-She was "not sure if the Administrator knew about the problems with the pagers and the residents' call bells".

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-Staff had to go and check the computer at the nurse's station to see which residents' call bell were activated or the staff sometimes found out residents needed help if staff went to their rooms.
-She would go to the nurses station to check for unanswered call bells between tasks, such as bathing a resident which could take 30 minutes to 1 hour.
-There was no specific time or frequency that staff checked for unanswered call bells because they were short-staffed.
-There were only two working pagers for the facility now.

Second interview with the first facility PCA on 02/07/22 at 11:35am revealed:
-He was assigned to work the assisted living side of the facility for the D Hall and part of B Hall.
-He checked the pager frequently to check of residents' call bell being activated.
-The call bells were not activated on the pager and he did not think the pagers were working accurately.
-The pagers for the residents' call bells sometimes activated constantly.
-His pager was activated for 2 call bells from the resident's room B-8, but he did not go to the resident's room because he thought it was an error because the resident in B-8 never used her bell so he ignored the call bell activation even after he saw the call bell was showing activated at the nurse's station.

Interview with Clinical Operations Specialist #1 (COS #1) on 02/08/22 at 12:15pm revealed:
-Staff relied on their pagers to alert them when residents activated their call bells and emergency pendants to call for staff assistance.
-If staff were not wearing their pager or the batteries in the pagers were low then it seemed

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like the call bell system was not working because the staff was not responding to call bells.
-Management found out on 02/07/22 that the facility's call bell system had a delayed activation after the survey team reported it and management did a recheck of the call bell system.
-The call bells were activated but the pagers did not respond.
-She recalled once when a resident complained that staff did not respond when the resident used her call bell for about 4 hours (time not specified).
-She went to the staff and some of the staff reported the pagers were not working and they were not wearing the pagers (time not specified).
-She reprogrammed the pagers, gave the pagers back to the staff, but she did not check the call bell system to see if it was working properly.
-Some staff still would not wear the pagers after she reprogrammed them because staff reported the pagers were still not working.

Interview with the Administrator on 02/08/22 at 10:27am revealed:
-She did not know about problems with the facility's call bell system or that staff were slow to respond to residents calling for assistance until 02/07/22.
-She had called the provider of the facility's call bell system on 02/07/22 for repairs to the system.
-Staff sometimes did not understand how to respond when the pagers were activated by residents' call bells and needed to be shown how to use the pagers.
-There were approximately 10 pagers in the drawer of the nurse's station, and she had brought 20 additional pagers (time not specified).

The facility failed to ensure the facility's call system was operational as designed to ensure

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D 105	Continued From page 22 residents' calls for assistance were answered by staff when residents needed assistance resulting in Resident #10 having to call 911 because staff was unaware the resident required assistance getting up off the floor after a fall. The facility's failure placed Resident #10 and other residents at substantial risk of serious harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G S 131D-34 on 02/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 10, 2022.	D 105		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide	D 188		

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D 188	Continued From page 23 duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the assisted living (AL) area of the facility were met for 10 of 21 shifts sampled for 01/17/22, 01/21/22, 01/22/22 and 01/29/22 through 02/01/22. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 96 beds including 60 beds for the assisted living (AL) area and 36 beds for the special care unit (SCU).	D 188		

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D 188	Continued From page 24 Review of the facility's resident census reports dated 01/17/22, 01/21/22, 01/22/22 and 01/29/22 through 02/01/22 revealed there was a census of 37- 39 residents in the AL area, which required 16 staff hours on first shift, second shift and third shift. 1. Review of the employee timecards dated 01/17/22 (Monday) revealed there was a total of 14.5 staff hours provided on third shift in the AL area for a shortage of 1.5 hours. Interview with a medication aide (MA) on 01/26/22 at 12:16pm revealed: -The facility was short staffed on 01/17/22. -There was another aide clocked in working in the SCU. Interview with Clinical Operations Specialist #1 (COS #1) on 01/26/22 at 12:09pm revealed she was not certain what happened on 01/17/22 but they were short staffed. 2. Review of staff timecards dated 01/21/22 revealed: -There was a total of 16.25 staff hours provided on second shift for a shortage of 3.75 hours. -There was a total of 2 aide hours provided on third shift for a shortage of 14 hours. -There was no additional staff clocked in the facilty to cover the shortage. 3. Review of staff timecards dated 01/22/22 revealed: -There was a total of 14 aide hours provided on first for a shortage of 2 hours. -There was a total of 0 aide hours provided on third shift for a shortage of 16 hours. Interviews with a resident who resided on the AL	D 188		

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unit on 02/04/22 at 9:55am and 10:25am revealed:
-On 01/22/22, the facility was short staffed because of inclement weather conditions.
-He preferred to get up around 7:00am and needed staff assistance to get and out of bed.
-He activated his call bell, but no one came for about 45 minutes.
-No staff came to get him up until he was brought his breakfast around 10:00am on 01/22/22.

Interview with an agency medication aide (MA) on 02/05/22 at 3:30pm revealed:
-She was from a contracted staffing agency and had been a MA for about 4 years.
-She had worked at the facility "off and on" since October 2021 and the facility was consistently short staffed since she had worked there.
-She called out from work at the facility on 01/22/22 due to the inclement weather conditions.

Interview with COS #1 on 01/26/22 at 11:21am revealed:
-She was the COS #1 for the facility due to some recent staffing transition.
-She tried to call for staff to come in and help, but they were either unavailable or unable to get to the facility due to the snow.
-She called staff from the corporate offices and they would be able to provide relief the next morning.
-She spent approximately 6 hours on the SCU and 2 hours on the AL throughout the shift on 01/21/22 from 11:00pm-7:00am.
-It was a terrifying night because she was worried she was going to miss someone ringing their call bell or be unable to supervise someone on the SCU while on the AL side.
-She was able to pass medications and meet the residents' immediate needs, but she was unable

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to be readily available to all residents that might have needed her because there were so many of them and only one of her.

4. Review of staff timecards dated 01/29/22 revealed there was a total of 10 aide hours provided on second shift for a shortage of 6 hours.

Review of staff timecards dated 01/30/22 revealed:
-There was a total of 8 aide hours provided on first shift for a shortage of 8 hours.
-There was a total of 12 aide hours provided on second shift for a shortage 2 hours.

5. Review of staff timecards dated 01/31/22 revealed there was a total of 0 aide hours provided on first shift for a shortage of 16 hours.

6. Review of staff timecards date 02/01/22 revealed:
-There was a total of 0 aide hours provided on first shift for a shortage of 16 hours.
-There was a total of 0 staff hours provided on third shift for a shortage of 16 hours.

Review of an incident report for Resident #10 dated 02/01/22 revealed:
-Resident #10 had an unwitnessed fall in her room at 12:30am.
-The facility staff became aware of Resident #10's fall after the resident called 911.
-Resident #10 was in her room with the door locked and attempted to get up to unlock the door and fell.
-Resident #10's emergency pendant was in her drawer (out of her reach), but Resident #10's phone was in reach.
-Resident #10 dialed 911 and self-reported her

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fall to county emergency management service (EMS) at 12:40am.
-Resident #10 was found on the floor of her room and assisted from the floor by EMS to her wheelchair with a two-person assist.
-She suffered a skin tear to her right arm and was oriented after her fall.

Interview with Resident #10 on 02/04/22 at 9:15am revealed:
-She fell forward on the floor of her bathroom one night earlier in the week.
-She could not get up from the floor of the bathroom without staff assistance.
-She pulled the call bell in her bathroom for help, but no staff responded.
-She scooted across the floor on her buttocks from her bathroom to her bedroom and pulled the call bell that was next to her bed for staff assistance.
-Staff still not respond after she pulled the call bell.
-She scooted to the door of her room, opened the door, and yelled out in the hallway for staff assistance, but no staff came.
-She scooted back across the floor to her portable phone and called the facility phone, but no staff answered.
-She called 911 after she tried to call the facility because she could not get any staff response for assistance.
-She thought she had been on the floor for at least 30 minutes before she called 911.
-When EMS arrived, they assisted her off the floor and the facility staff came into the room with EMS.
-She had two skin tears to her right arm and her right wrist was still sore from the fall.
-Her backside was still sore from the fall and having to scoot across the floor that night.

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D 188	Continued From page 28 Interview with family member of a resident who resided on the Assisted Living unit on 02/08/22 at 1:30pm revealed: -The facility was consistently short staffed and could not provide adequate care to the resident based on his needs. -He required assistance with ambulation and he had fallen twice within the last month. -She had concerns regarding his continued care at the facility. Interview with a second resident residing on the AL unit 02/08/22 at 1:00pm revealed: -The facility was short staffed and were unable to provide him assistance as he needed. -He required assistance with ambulating and had fallen at least twice in the last 4 weeks. Interview with a personal care aide (PCA) on 01/26/22 at 10:00am revealed the AL unit was always short staffed and usually there were only 2 PCAs who worked the AL unit. Interview with the Resident Care Coordinator (RCC) on 01/26/22 at 10:19am revealed: -She completed the schedule monthly for the facility. -She verified staff were present daily in the facility. -She sent available shifts to staffing agencies to fill. -The facility was short staffed and much of the staff on duty were with an agency. -The AL unit needed 3 PCAs and 2 MAs (1 MA shared with SCU) on duty to meet the needs of the residents. Interview with Clinical Operations Specialist #2 (COS #2), an LPN on 01/25/22 at 7:48am	D 188		

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D 188	Continued From page 29 revealed: -He was administering medications within the facility today, 01/25/22. -He was brought into the facility to help train new MAs and the new Health and Wellness Director (HWD) that started yesterday (01/24/22). -The facility was currently staffed by agency staff (staff employed by an outside agency who contracted with the facility to fill staffing shortages and needs) 99% of the time due to frequent turn-over. -He sometimes had to jump into staffing roles when there were shortages or call-outs to help care for residents. Interview with COS #1 on 01/26/22 at 10:25am and 12:09pm revealed: -The AL needed 2 PCAs and 2 MAs, which one MA was shared with AL on duty for first and second shift. -There was 1 MA on duty on third shift for both AL and the SCU. -When the facility was short staffed, she expected the MA on duty to split their time between the SCU and AL but spend more time on the SCU. Interview with the Administrator on 02/08/22 at 12:15pm revealed: -The facility had a problem with being short-staffed (time not specified). -The facility was primarily staffed with contracted staffing agencies, but the staff from the staffing agencies were not reliable because they called out or would not pick up the phone for staffing assignments. _____ The facility failed to ensure the minimal staffing hour requirements for the Assisted Living (AL) unit of the facility were met for 10 of 21 shifts sampled. The facility's failure resulted in one staff	D 188		

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D 188	Continued From page 30 being alone in the facility from 01/21/22 from 11:00pm until 01/22/22 at 9:30am to provide care and supervision of the residents and a resident who had to call 911 herself on 02/01/22 following fall when no staff responded when she yelled and activated her call bell to request assistance from staff. The facility's failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 02/03/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 25, 2022.	D 188		
D 212	10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (a) On first and second shifts in facilities with a capacity or census of 31 or more residents and on third shift in facilities with a capacity or census of 91 or more residents, there shall be at least one supervisor of personal care aides, hereafter referred to as supervisor, on duty in the facility for less than 64 hours of aide duty per shift; two supervisors for 64 to less than 96 hours of aide duty per shift; and three supervisors for 96 to less than 128 hours of aide duty per shift. In facilities sprinklered for fire suppression with a capacity or census of 91 to 120 residents, the supervisor's time on third shift may be counted as required aide duty. (For staffing chart, see Rule .0606 of this Section.)	D 212		

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

Based on interviews and record reviews, the facility failed to ensure there was a supervisor on duty at all times to provide supervision of direct care staff and implementation of the facility's policies and procedures.

The findings are:

Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 96 beds including 60 beds for the assisted living (AL) area and 36 beds for the special care unit (SCU).

Interview with a personal care aide (PCA) on 02/07/22 at 11:35am revealed:
-Clinical Operations Specialist #1 (COS #1) usually left at 7:00pm during the week.
-After 7:00pm, the medication aide (MA) was the supervisor on duty for remainder of the shift for 3pm-11pm shift.
-The MA was responsible for the facility and administering the medications.
-The MA for third shift was the supervisor on duty for 11pm-7am shift and was responsible for the building and for administering medications.

Telephone interview with a medication aide (MA) on 02/07/22 at 11:23am revealed:
-The MAs were considered the supervisors for the facility when the Resident Care Coordinator (RCC) or Health and Wellness Director (HWD) were not in the building.

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-She assisted the PCAs with personal care for the residents, administered medications, and was responsible for the building.
-She had worked at the facility since November 2021 primarily on the 11:00pm - 7:00 shift.
-She had never received any training on what do at the facility in case of a disaster or emergency.
-She had never seen the facility's disaster plan and did not know if the facility had a disaster plan.
-Management contact numbers were posted at the nurse's station, but they were not up to date because the RCC had recently quit and the HWD was just hired.
-If she needed help in case of an emergency or there was a disaster, she would call the HWD for directives.

Interview with a second MA on 02/07/22 at 5:08pm revealed she had never been trained at the facility about how to respond to disaster and did not know if the facility had a disaster plan.

Interview with a third MA on 02/07/22 at 5:26pm revealed:
-She was an agency staff who had been working at the facility for approximately 3 weeks.
-She had not received training on the facility's policies and procedures regarding how to respond in the event of an incident.
-The MAs were often in charge after management left on second and third shifts.

Interview with a fourth MA on 02/05/22 at 3:30pm revealed:
-She was an agency staff.
-She had worked at the facility "off and on" since October 2021.
-She received no orientation or training before being assigned to a medication cart to administer medications to residents at the facility.

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D 212	Continued From page 33 -Her orientation to the facility consisted of her being "handed" the keys to the medication cart. -She was not oriented to the facility's policies and procedures. Interview with an agency personal care aide (PCA) on 02/04/22 at 4:15pm revealed she had not received any training or directions when she started working at the facility. Interview with the Administrator on 02/04/22 at 11:37am revealed: -Agency staff tended to leave at the end of their shift without communication of care information to the next shift. -She did not know how resident care needs were communicated to staff in the facility. -She did not know how agency staff were trained on how to respond in the event of an emergency. -The MA from an agency could be sent to the facility and would be the supervisor for the shift even if that was their first night in the facility. Interview with the Divisional Director of Operations (DDO) on 02/07/22 at 8:26am revealed there was no orientation in place for agency staff, but one was being developed. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care] _____ The facility failed to ensure a supervisor was on duty at all times to provide supervision of direct care staff and the overall operations of the facility. The facility's failure resulted in staff being unaware of the facility's policies and established procedures and how to respond in the event of an emergency. The facility's failure resulted in risk serious neglect and physical harm and constitutes a Type A2 Violation.	D 212		

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D 212	Continued From page 34 The facility provided a plan of protection in accordance with G.S. 131D-34 March 4, 2022 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 10, 2022.	D 212		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 3 of 7 sampled residents (#9, #11, #12) as related to failure to notify the primary care provider (PCP), emergency medical services (EMS) and hospice for a resident who was found on the floor and had changes in condition (#9); failure to notify the PCP of meal refusals, mobility status change, and complaints of not feeling well (#11); and failure to notify the PCP of a resident's hospitalization, not receiving insulin for 11 days, and completion of follow up appointments as ordered including a referral for occupational therapy/physical therapy (OT/PT) and follow-up with the PCP after a six day hospitalization (#12). Review of the facility's Emergency Procedures Standard dated 02/19/21 revealed: -This standard applied in the event of a resident	D 273		

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emergency situation such as, but not limited to, complaints of pain, change of consciousness, any fall, (witnessed or unwitnessed) with suspected or actual significant injury or head injury.
-The community shall recommend calling 911/emergency medical services ("EMS") for evaluation, treatment and potential transportation to a hospital in the event of a resident emergency situation.
-Non-licensed care staff (i.e., Med tech) were not permitted to assess a resident or determine significance of injury.
-Call the resident's physician to notify him or her about the incident.
-Notify the resident's family and/or responsible party.
-Notify the Assisted-Living Director, Executive Director, or designee.
-For residents under the care of a licensed hospice agency with suspected or actual injury, staff shall immediately notify the responsible hospice agency and request a registered nurse ("RN") to assess the resident's condition on site within two hours.
-If the hospice agency is unable to send an RN to make an on-site visit within two hours, staff will call 911 and the hospice agency and responsible party will be notified. Document all hospice notifications in the progress notes. Note the additional communication may be required under the agreement with the responsible hospice agencies.

1. Review of Resident #9's current FL-2 dated 12/16/21 revealed:
-Diagnosis included dementia.
-The resident was constantly disoriented.
-The resident was ambulatory.
-There was no documentation of any assistive devices required for the resident.

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Review of Resident #9's assessment and care plan dated 08/24/21 revealed:
-The resident was ambulatory without assistance.
-The resident was oriented to self.
-Resident #9 was independent with transferring and ambulation/locomotion, required supervision for eating, grooming/personal hygiene and toileting, limited assistance for dressing, and extensive assistance for bathing.

a. Review of the 24 - Hour Communication Report for the Special Care Unit (SCU) Community dated 01/29/22 revealed:
-There was a handwritten entry on the 3-11 shift that Resident #9 was found lying on the floor, an assessment was done by the medication aide (MA) and no injuries found.
-There was no documentation of the HWD, PCP, hospice, EMS, or POA's being notified regarding Resident #9's fall or any changes in her condition such as not eating, getting out of bed or not being able to ambulate.

Review of an agency personal care aide's (PCA) written statement dated 02/03/22 revealed:
-She worked on 01/29/22 from 3:30pm-2:30am.
-She and a facility PCA had found Resident #9, who resided on the special care unit (SCU), on the floor on 01/29/22.
-She reported to the MA that Resident #9 had been found on the floor.
-She, the facility PCA, and the MA put Resident #9 back to bed after the MA assessed Resident #9 for injuries.
-She wrote a report in the 24-hour communication book that Resident #9 was found on the floor on 01/29/22 for the 3-11pm shift.
-She did not recall the name of the MA with whom she had worked and reported the incident to on

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D 273	Continued From page 37 01/29/22. Review of a hospice Registered Nurse's service notes dated 01/31/22 at 12:20pm revealed: -She came to the facility to see Resident #9 for a routine visit. -She was notified by the hospice agency PCA prior to arriving at the facility that Resident #9 had an unwitnessed fall on Saturday 01/29/22. -The hospice PCA was told by the facility's staff on 01/30/22 that Resident #9 had been found on the floor on 01/29/22. -Upon arrival at the facility, Resident #9 was observed by the hospice Nurse lying in bed. -There was shortening and rotation present to Resident #9's lower left leg (LLE). -Resident #9 cried out with palpation of the left hip or with movement of the LLE. -Resident #9 "appeared" comfortable at rest unless the LLE was touched or moved. -She contacted the hospice primary care provider (PCP) of the probable left hip fracture and was given the telephone order to send Resident #9 to the hospital via emergency medical services (EMS). Telephone interview with Resident #9's primary care provider (PCP) on 02/07/22 at 1:21pm revealed: -She was not notified of Resident #9's fall on 01/29/22. -She expected to be notified when the resident fell. -She would expect them to send the resident out if an unwitnessed fall occurred since the resident was on the SCU and may not be able to tell them if she had hit her head or if she were in pain. Telephone interview with Resident #9's power of attorney (POA) on 02/04/22 at 9:17am revealed	D 273		

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she received a call on 01/31/22 from the hospice nurse about Resident #9's fall, possible hip fracture, and being sent to the hospital for evaluation.

Interview with the Health and Wellness Director (HWD) on 02/04/22 at 11:07am revealed:
-She started 01/24/22 as the HWD.
-The former Resident Care Coordinator (RCC) was the manager on duty the weekend of 01/29/22 and 01/30/22.
-She found out the RCC quit so she came in around 12:00pm on 01/29/22 and left before second shift got to the facility.
-She had not been informed of Resident #9's fall until 01/31/22.

Interview with the Administrator on 02/04/22 at 11:37am revealed:
-The MAs were the supervisors on 01/29/22 and 01/30/22.
-There was only one MA in the facility for first shift on 01/30/22 because the RCC had quit and she was scheduled to pass medication on that shift.
-Staff should have reported finding Resident #9 on the floor to the HWD and the hospice nurse immediately.

A second interview with the Administrator on 02/04/22 at 1:27pm revealed:
-She was not in the facility when Resident #9 fell on 01/29/22.
-She was told Resident #9 was found on the floor on 01/29/22 on 2nd shift on Monday 01/31/22.
-She was investigating the fall incident and had collected written statements from the staff who had worked the weekend of January 29-31, 2022.
-The information being relayed during the interview was from the statements that she had received from the staff.

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-Her motto was "when in doubt, send them out" meaning to call 911 to have EMS come and assess and to transport as needed to the ER.

Interview with the Divisional Director of Operations (DDO) on 02/07/22 at 8:26am revealed:
-Resident #9 fell on 01/29/22 on either first or second shift but was not sent out until 01/31/22 because the staff did not follow the facility's process for responding to accidents.
-Agency staff did not know the residents and did not respond appropriately.

b. Review of a facility's PCA's written statement dated 02/03/22 revealed:
-She worked on 01/29/22 from 11:00pm-7:00am on the SCU.
-She received report upon arriving to the SCU that Resident #9 had fallen on the previous shift.
-Resident #9 "did not even try to get out of the bed".

Review of an agency PCA's written statement dated 02/03/22 revealed:
-She worked on 01/30/22 from 3:00pm-11:00pm.
-Resident #9 "remained in bed all shift" which was unusual.

Interview with an agency PCA on 02/04/22 at 4:15pm revealed:
-She worked on 01/30/22 from 3:00pm-11:00pm.
-Resident #9 had remained in bed all shift and she had to feed Resident #9.
-She did not know to report Resident #9 was not getting out of her bed or having to feed her as she had not received any training or directions on who or what to report when she started working at the facility.

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Interview with the Administrator on 02/04/22 at 11:37am revealed:
-The MAs were the supervisors on 01/29/22 and 01/30/22.
-It was not normal for Resident #9 to stay in bed and not eat.

c. Review of an agency PCA's written statement (no date) revealed:
-She worked on 01/30/22 from 7:00am-3:00pm.
-She "realized Resident #9 was in pain" when she tried to provide personal care.
-"Resident #9 was in too much pain to get up to be changed or walked to the dining room".
-Resident #9 was fed breakfast in bed since she was not able to get up due to the pain.
-She "reported this to the MA on duty who said she was going to write it down and report it to the nurse".

Review of an agency PCA's written statement dated 01/31/22 revealed:
-She worked on 01/30/22 from 7:00am-3:00pm.
-She had observed Resident #9 had been "in a lot of pain when you touched her leg, mostly the hip and thigh area".
-She reported this to the hospice staff who arrived on 01/30/22 to provide personal care for Resident #9.

Review of an agency MA's written statement dated 02/03/22 revealed:
-She worked on 01/31/22 from 7:00am-3:00pm.
-When she arrived on the SCU to administer medications, it was reported to her that Resident #9 was complaining of pain.
-"The nurse (hospice nurse) walked up and heard it as well, she then began to assess the resident".

Telephone interview with Resident #9's primary

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D 273	Continued From page 41 care provider (PCP) on 02/07/22 at 1:21pm revealed: -She was not notified of Resident #9 was in acute pain until 01/31/22. -She expected to be notified if a resident was in acute pain. -If a resident could not express pain verbally, they may yell out or be combative when trying to move the affected area. -Resident #9 might not be able to tell you she was pain or that her hip was fractured but she would not be able to stand, may be hollering out, and would not able to walk. -The staff would not be able to turn and reposition Resident #9 in order to provide personal care without her yelling out when she was moved. Telephone interview with Resident #9's power of attorney (POA) on 02/04/22 at 9:17am revealed: -Resident #9 required hospital admission and surgery to repair the left hip fracture. -Resident #9 was able to stand to get out of her chair and ambulate throughout the special care unit prior to this hip fracture. -Resident #9 previously enjoyed being able to get up and walk around on her own. Second telephone interview with Resident #9's POA on 02/07/22 at 5:23pm revealed: -Resident #9 was still hospitalized and was recovering slowly. -Resident #9 was able to stand up at the bedside with assistance but was not taking any steps due to the pain. -This was a decline for Resident #9 since the fall; she was fully mobile and active prior to the fall and hip fracture. -The plan was to have her moved to a skilled nursing facility for rehabilitation.	D 273		

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D 273	Continued From page 42 Attempted telephone interview with Resident #9's hospice nurse on 02/04/22 at 3:10pm was unsuccessful. _____ Interview with the Administrator on 02/03/22 at 6:44pm revealed: -When there was an acute change in a resident's medical condition, the MA should notify the HWD immediately. -The HWD should assess the resident and determine if the resident should be sent to the hospital for medical evaluation and treatment. -The MA should document resident changes in the communication on the 24-hour log. A second interview with the Administrator on 02/04/22 at 11:37am revealed: -She did not know how agency staff were trained on how to respond in the event of an emergency. -Agency staff tended to leave at the end of their shift without handing off care information. -She did not know how resident care needs were communicated to staff in the facility. -The MA from an agency could be sent to the facility and would be the supervisor for the shift even if that was their first night in the facility. A third interview with the Administrator on 02/04/22 at 1:27pm revealed: -She was the full time Administrator for a sister facility and was only in this facility once a week on Thursdays. -She "wasn't sure how things were done in this facility, I only knew how things worked at my other facility". Interview with the Divisional Director of Operations (DDO) on 02/07/22 at 8:26am revealed there was no orientation in place for agency staff, but one was being developed.	D 273		

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D 273	Continued From page 43 Interview with Clinical Operations Specialist #1 (COS#1) on 02/08/22 at 12:26pm revealed staff were expected to follow the emergency guidelines and falls guidelines. 2. Review of Resident #11's current FL-2 dated 07/22/21 revealed: -Diagnoses included dementia, atrial fibrillation, hypertension and aphasia. -The resident was constantly disoriented. -The resident was semi-ambulatory with a walker. Review of Resident #11's assessment and care plan dated 12/16/21 revealed: -The resident was ambulatory without any problems. -The resident was oriented to self. -Resident #11 was independent in transferring and ambulation/locomotion, required supervision for eating, and required limited assistance for dressing, grooming/personal hygiene, toileting and bathing. Review of the 24-Hour Communication Report for the Special Care Unit (SCU) Community revealed: -There was a handwritten entry dated 02/02/22 on the 7 - 3 shift that read Resident #11 had stayed in bed all day and refused breakfast and lunch. -There was a handwritten entry dated 02/01/22 on the 7a - 3 shift that read Resident #11 refused to eat breakfast and lunch and refused to get out of bed all day. -There was a handwritten entry dated 01/31/22 on the 7 - 3 shift that read Resident #11 was given a shower but refused to eat breakfast and lunch. -There was a handwritten entry dated 01/28/22 on the 7 - 3 shift that read Resident #11 stayed in bed all day and did not want to get up or to eat,	D 273		

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"stated that she was not feeling too good".
-There was no documentation of the Health and Wellness Director (HWD), or primary care provider (PCP), EMS being notified regarding the changes in condition for Resident #11.

Interview with a facility personal care aide (PCA) on 02/03/22 at 1:40pm revealed:
-She worked full time for the facility on first shift.
-She had been telling the medication aides (MA) for 4-5 days (since the end of January 2022, but could not remember the exact date) that Resident #11 was not eating and not getting out of bed as she usually did.
-She told the corporate nurse on 02/02/22 that Resident #11 was not well (not eating and not getting out of bed), which was a change.
-Resident #11's left side became weak and the resident almost fell that morning 02/03/22; she had told the MA.

Interview with the corporate nurse (CN) on 02/03/22 at 4:46pm revealed:
-She worked in the facility as needed for the education needs and qualifications of the PCAs and MAs.
-Resident #11's primary care provider (PCP) was in the facility and was the one who sent Resident #11 out for evaluation on 02/03/22.
-She was informed yesterday (02/02/22) by a facility PCA that Resident #11 had not been feeling well and was not acting her normal self.
-She thought it was due to the resident having had COVID-19.
-She did not assess Resident #11 after receiving report from the PCA.

Telephone interview with Resident #11's primary care provider (PCP) on 02/07/22 at 1:21pm revealed:

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-She was not notified of Resident #11's change in condition.
-She expected to be notified when there was a change in a resident as in the changes with Resident #11 (not eating for several days and not getting out of bed).
-Her office had received a call from a MA about 30 minutes prior to her arrival to the facility on 02/03/22 regarding the change in Resident #11 and left sided weakness.
-She arrived in the facility she noticed Resident #11 was slurring her words and had left sided weakness, so she instructed the staff to call 911.
-Emergency Medical Services (EMS) arrived and transported Resident #11 to the local emergency room for further evaluation and treatment for stroke like symptoms.

Interview with the Administrator on 02/04/22 at 1:27pm revealed:
-She was the full time Administrator for a sister facility and was only in this facility once a week on Thursdays.
-She was not aware of the change in Resident #11's condition until the PCP called 911 to have the resident sent out for evaluation.

Attempted telephone interview with Resident #11's power of attorney on 02/07/22 at 5:30pm was unsuccessful.

Interview with the Administrator on 02/03/22 at 6:44pm revealed:
-When there was an acute change in a resident's medical condition, the MA should notify the HWD immediately.
-The HWD should assess the resident and determine if the resident should be sent to the hospital for medical evaluation and treatment.
-The MA should document resident changes in

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the communication on the 24-hour log.

A second interview with the Administrator on 02/04/22 at 11:37am revealed:
-She did not know how agency staff were trained on how to respond in the event of an emergency.
-Agency staff tended to leave at the end of their shift without handing off care information.
-She did not know how resident care needs were communicated to staff in the facility.
-The MA from an agency could be sent to the facility and would be the supervisor for the shift even if that was their first night in the facility.

A third interview with the Administrator on 02/04/22 at 1:27pm revealed:
-She was the full time Administrator for a sister facility and was only in this facility once a week on Thursdays.
-She "wasn't sure how things were done in this facility, I only knew how things worked at my other facility".

Interview with the Divisional Director of Operations (DDO) on 02/07/22 at 8:26am revealed there was no orientation in place for agency staff, but one was being developed.

Interview with Clinical Operations Specialist #1 (COS#1) on 02/08/22 at 12:26pm revealed staff were expected to follow the emergency guidelines and falls guidelines.

3. Review of Resident #12's FL-2 dated 10/28/21 revealed diagnoses included Type 2 diabetes mellitus, hypertension, and hyperlipidemia.

Review of Resident #12's hospital discharge summary dated 01/10/22 revealed Resident #12 was hospitalized from 01/05/22 to 01/11/22 for

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diagnoses including urinary tract infection (UTI) and sepsis (a life threatening infection in the bloodstream).

a. Review of Resident #12's hospital discharge summary dated 01/10/22 revealed there were instructions to follow-up with his primary care provider (PCP) in about a week.

Review of Resident #12's record revealed there was no documentation of follow-up with the PCP as ordered on the discharge summary dated 01/10/21.

Interview with Clinical Operations Specialist #1 (COS #1) on 02/08/22 at 2:15pm revealed:
-She did not review Resident #12's hospital discharge summary dated 01/10/22.
-She overlooked the hospital discharge summary dated 01/10/22 that had instructions to follow-up with the PCP in a week.
-During the weekdays, it was the responsibility of the Resident Care Coordinator (RCC) or the Health and Wellness Director (HWD) to review discharge summaries or medication orders and fax the order to the pharmacy.
-After 5:00pm on weekdays and on weekends, it was the responsibility of the medication aide (MA), the RCC, or the HWD to review discharge summaries and medication orders and fax the order to the pharmacy.
-She was concerned that the process for discharge or healthcare visit summaries was not followed.

Interview with Resident #12's PCP's nurse on 02/08/22 at 1:46pm revealed:
-The PCP was not notified of Resident #12's hospitalization from 01/05/22 to 01/11/22.
-The PCP did not receive a copy and had no

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knowledge of the hospital discharge summary report dated 01/10/22.
-The facility was responsible for notifying and submitting discharge and visit summaries to the PCP when Resident #12 received healthcare services.

b. Review of Resident #12's hospital discharge summary dated 01/10/22 revealed there were discharge instructions to continue insulin Glargine (Lantus) inject 55 units subcutaneously nightly. (Glargine (Lantus is used to lower blood sugar).

Review of Resident #12's progress note dated 01/21/22 at 1:34pm revealed:
-His 12:00pm blood sugar result was 551.
-He was transported to the emergency room (ER).

Review of Resident's #12's January 2022 electronic medication record (eMAR) revealed documentation that the resident did not receive insulin for 11 days from 01/11/22 to 01/21/22, as ordered and no documentation the primary care provider (PCP) was notified of the missed doses.

Review of Resident #12's records revealed there was no documentation the Resident #12's PCP was notfied that he did not receive insulin for 11 days.

Interview with COS #1 on 02/08/22 at 2:15pm revealed:
-She was aware that Resident #12 did not receive his insulin for 11 days because it was not available from the pharmacy.
-She had not notified Resident #12's PCP that he had not received his insulin for 11 days.
-Resident #12's record had not been updated in terms of the current PCP and she had been

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reaching out to the wrong PCP.

Interview with Resident #12's PCP's nurse on 02/08/22 at 1:46pm revealed:
-The PCP was not notified of Resident #12's hospitalization from 01/05/22 to 01/11/22.
-The PCP was not notified that Resident #12 did not receive his insulin from 01/11/22 through 01/21/22 (11 days) because it was not available from the pharmacy.
-The PCP was notified until 01/21/22 that Resident #12 had not received his insulin for 11 days.
-The resident was sent to the ER with a blood glucose level of 551 on 01/21/22.

c. Review of Resident #12's hospital discharge summary dated 01/10/22 revealed there were instructions for a referral to home health for physical/occupational therapy (PT/OT).

Review of Resident #12's records revealed there was no documentation of a referral for a PT/OT referral as noted on the hospital discharge summary dated 01/10/22.

Interview with COS #1 on 02/08/22 at 2:15pm revealed:
-She did not review Resident #12's hospital discharge summary dated 01/10/22 because it was overlooked.
-She did not know there were instructions on the hospital discharge summary regarding a referral to PT/OT.

Interview with Resident #12's primary care provider's (PCP) nurse on 02/08/22 at 1:46pm revealed:
-The PCP was not notified of Resident #12's hospitalization from 01/05/22 to 01/11/22.

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D 273	Continued From page 50 -The PCP did not receive a copy and had no knowledge of the hospital discharge summary report dated 01/10/22. -The facility was responsible for notifying and submitting discharge and visit summaries to the PCP when Resident #12 received healthcare services. The facility failed to ensure referral and follow-up with the PCP resulting in Resident #9 experiencing pain for three days after a fall which resulted in an observed change in condition including an inability to walk, grimacing in pain when moved and a decline in food intake and requiring to be fed. No notification was made until the hospice agency staff came in for a routine visit. The resident sustained a fractured hip resulting in hospitalization and surgery; Resident #11 had a change in condition including refusing to get out of bed for six days, not feeling well and refusing meals with no notification to the PCP by the facility; and no notification of the PCP after Resident #12 was hospitalized for 7 days for a urinary tract infection (UTI) and sepsis (a life threatening infection in the bloodstream). The PCP was not notified of the hospitalization and no follow up with the PCP occurred as ordered. The PCP was also not notified Resident #12 did not receive insulin as ordered for 11 days after the hospitalization. Resident #12 had to be sent back to the hospital on 01/21/22 for a blood sugar result of 511. The facility's failure resulted in a delay in evaluation, care, and treatment and serious physical harm and neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/03/22. CORRECTION DATE FOR THE TYPE A1	D 273		

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D 273	Continued From page 51 VIOLATION SHALL NOT EXCEED MARCH 10, 2022	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 6 sampled residents (#4) with a physician's order to recheck electrolytes in 3-4 days following discharge from a local hospital on 01/11/22. The findings are: Review of Resident #4's current FL-2 dated 1/11/22 revealed diagnoses included hypoxia, hypertension and incontinence. .Review of Resident #4's hospital discharge summary dated 01/11/22 revealed: -Resident presented to the local hospital emergency department on 01/05/22 with tachycardia (increased heart rate) and shortness of breath. -There was an order to recheck electrolytes magnesium, phosphorus and potassium in 3-4 days. (Electrolytes is a laboratory test of the blood which checks the amount magnesium,	D 276		

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phosphorus and potassium. Electrolytes help trigger and send electrical impulses to the heart. An imbalance in electrolytes can interfere with heart rate).

Review of Resident #4's record revealed there was were no laboratory results for electrolytes dated after the 01/11/22 hospital visit as ordered.

Review of a physician fax transmission sheet dated 01/17/22 revealed Physical Therapy (PT) staff reported Resident #4 had a heart rate of 130+ to the primary care provider (PCP). (Normal heart rate ranges from 60-100 beats per minute.)

Interview with Resident #4 on 01/26/22 at 9:04am revealed she was not short of breath and was not experiencing anything unusual with her heart.

Interview with the Clinical Operations Specialist #1 (COS) on 01/26/22 at 11:20am revealed the blood work for Resident #4 was not completed as ordered and she did not know why it had not been completed as ordered.

Second interview with the COS #1 on 02/08/22 at 4:12pm revealed:
-The Health and Wellness Director (HWD) and the Resident Care Coordinator (RCC) were responsible for ensuring lab orders were entered into the contracted laboratory request system.
-There was no HWD in the facility until 01/24/22 so the responsibility fell to the RCC.
-Laboratory orders for Resident #4 from the discharge summary from 01/11/22 were not put into the laboratory request computer system so the blood work was not completed.
-She was unable to locate documented vital signs that would include heart rate for Resident #4.

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D 276	Continued From page 53 Interview with Resident #4's primary care provider (PCP) on 01/26/22 at 11:58am revealed: -There was an order for electrolytes to be rechecked because Resident #4's electrolytes were not within normal range during her stay at the hospital. -She was not aware the blood work had not been completed as ordered. -She was concerned that electrolyte imbalance could cause abnormal and increased heart rates.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 4 of 6 sampled residents with 3 of 4 residents (#6, #7, #8) observed during the medication pass including errors in which the wrong form of a medication was administered (#6), medications almost administered to the wrong resident (#7), medications missed and omitted from the medication pass (#7), and a medication used to treat mental and mood disorders was administered two hours late (#8).	D 358		

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D 358	Continued From page 54 The findings are: Review of the facility's Medication Administration policy dated 05/25/21 revealed: -Each resident's electronic medication administration record (eMAR) should be accurate and up to date. -Each eMAR will be referenced when staff administer medications to obtain correct medication, time, dosage, and route of administration as ordered by the physician for each individual resident. -Each staff member should document a detailed explanation of any missed or refused medications on the eMAR. -State specific regulations applied. The medication error rate was 17% as evidenced by the observation of 5 errors out of 29 opportunities during the 8:00am/9:00am medication pass on 01/25/22. 1. Review of Resident #7's current FL-2 dated 11/23/21 revealed diagnoses included hypertension, osteoarthritis, macular degeneration, coronary artery disease, and neuropathy. a. Observation of the 8:00am/9:00am medication pass on 01/25/22 revealed: -At 7:15am, the medication aide (MA) prepared medications belonging to another resident for Resident #7 including a multivitamin (a vitamin supplement), Aspirin 81mg (used as a blood thinner), Hydrochlorothiazide 12.5mg (HCTZ - used to treat high blood pressure and fluid retention), Atenolol 50mg (used to treat high blood pressure), and Lisinopril 20mg (used to treat high blood pressure).	D 358		

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-The MA compared the medication labels resident identifier and instructions to the correct resident's eMAR verifying her name and room number prior to the administration and reviewing her picture on the eMAR.
-The MA asked another staff member where the resident's room was; the staff member replied the resident's room was down the hall and it was the room to the right.
-The MA walked down the hall and entered Resident #7's room on the left which was labeled with Resident #7's name, instead of the correct resident's room on the right which was labeled with the correct resident name.
-The MA entered Resident #7's room and called the resident by the wrong name stating she had her morning medications for her.
-Resident #7 looked confused but went to grab the medication cup with the pills in it to consume.
-The MA was prompted to stop the administration of the medications due to attempting to administer the medications to the wrong resident.
-The MA took the medications back from Resident #7 and out of the room to administer to the correct resident.

Interview with the MA on 01/25/22 at 7:50am and 9:10am revealed:
-She was an agency MA and this was her first day working at the facility as an MA (agency staff are temporary staff employed by an outside agency that contract with facilities to fill staffing needs and shortages within a facility).
-She had been a medication aide for 6 months and had received her training at another facility.
-She did not receive any training or orientation at this facility, except on how to log into the computer that morning (01/25/22), prior to starting the medication pass.
-The safe way to administer medications was to

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compare the medications being prepared to the resident's eMAR to ensure accurate and safe administration.
-The resident's name, picture, and room number were located on the eMAR and her door was labeled with her name to ensure accurate medication administration to the right person.
-She should have paid closer attention to what she was doing.
-Giving Resident #7 the wrong medications could have caused an adverse reaction or outcome.

Interview with Clinical Operations Specialist #2 (COS #2), a Licensed Practical Nurse (LPN on 01/25/22 at 7:48am and 4:01pm revealed all MAs were universally trained through basic MA training to verify residents' identity prior to medication administration for safety by comparing identifiers in the eMAR (photo and room number) to their name marked on their door and by using verbal confirmation.

Interview with the Resident Care Coordinator (RCC) on 01/25/22 at 1:07pm revealed MAs were able to ensure the right resident received their medications by viewing the resident's picture on the eMAR, checking the room number on the eMAR, reading the name on the doorway prior to entering the resident's room, and verifying the name with the resident prior to administration.

Interview with COS #1 on 01/25/22 at 1:27pm revealed she expected all MAs to use the processes in place to properly identify each resident prior to administering medications for resident safety using identifiers in the eMARs, on the resident doorways, and by asking the resident who they were.

Telephone interview with a pharmacist at the

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facility's contracted pharmacy on 01/26/22 at 9:50am revealed:
-If Resident #7 had been given the additional Aspirin 81mg ordered for her, it could have thinned her blood.
-If Resident #7 had been given the HCTZ, Atenolol, and Lisinopril, the medications could have dropped her blood pressure.
-Depending on the resident's medication history and co-morbidities, receiving those incorrect medications could have caused an adverse reaction or outcome for Resident #7.

Telephone interview with Resident #7's primary care provider (PCP) on 01/26/22 at 11:58am revealed:
-If Resident #7 had received the Aspirin, HCTZ, Atenolol, and Lisinopril, it could have caused adverse reactions and outcomes to include dropping her blood pressure too low and falls.
-Resident #7 had a recent history in November 2021 and December 2021 of low blood pressure issues and orthostatic hypotension (a sudden drop in blood pressure when standing), which had caused her to fall at that time.

Refer to interviews with COS #2 on 01/25/22 at 7:48am and 4:01pm.

Refer to interviews with the RCC on 01/25/22 at 1:07pm.

Refer to interviews with COS #1 on 01/25/22 at 1:27pm and 4:27pm.

Refer to telephone interviews with the agency staff supervisor on 01/25/22 at 4:55pm.

b. Review of Resident #7's current FL-2 dated 11/23/21 revealed:

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D 358	Continued From page 58 -There was an order for Aspirin 81mg daily (Aspirin is used as a blood thinner). -There was an order for AREDS2 one tablet daily. (AREDS2 is a vitamin supplement to aide with vision loss.) Review of a physician's order for Resident #7 dated 12/20/21 revealed: -There was an order to change the administration time of the Aspirin 81mg to 8:00am. -There was an order to change the administration time of the AREDS2 to 8:00am. Observation of the 8:00am/9:00am medication pass on 01/25/22 revealed: -The medication aide (MA) prepared Resident #7's morning medications at 8:17am. -The MA did not prepare Resident #7's Aspirin or AREDS2 to administer during the morning medication pass. -The MA administered all 8:00am/9:00am medications she prepared, but did not administer the Aspirin or AREDS2 to Resident #7. -The MA stated there were no other medications due for the 8:00am/9:00am medication pass. Observation of medications on hand on 01/25/22 at 8:17am revealed Resident #7 had Aspirin 81mg and AREDS2 were available on hand to be administered. Review of Resident #7's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg scheduled daily at 8:00pm. -The Aspirin 81mg was not documented as administered on 01/25/22. -There was an entry for AREDS2 once daily scheduled at 8:00pm.	D 358		

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D 358	Continued From page 59 -The AREDS2 was not documented as administered on 01/25/22. -There was no entry for Aspirin 81mg scheduled once daily at 8:00am. -There was no entry for AREDS2 scheduled once daily at 8:00am. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/26/22 at 9:42am revealed: -The pharmacy had not received an order dated 12/20/21 for Resident #7's Aspirin and AREDS2 administration time to be changed to 8:00am. -The facility had to the ability to change the administration time on their own, but they still expected the facility to fax all medication orders to the pharmacy in order to have an accurate record of resident medication orders. -She was unable to see the facility's eMARs, but Resident #7's order had originally been entered by the pharmacy for the Aspirin and AREDS2 to be administered at 8:00am and she was unsure why the administration time changed. Interview with COS #2 on 01/25/22 at 7:48am and 4:01pm revealed: -It was the responsibility of the Resident Care Coordinator (RCC), Health and Wellness Director (HWD), or the COS #1 to ensure orders were faxed to the pharmacy, and entered into eMARs to ensure resident's received their mediations accurately as ordered. -He was not sure how Resident #7's orders dated 12/20/21 for Aspirin and AREDS2 had been missed. -The facility had the capability to change the administration time of Resident #7's Aspirin and AREDS2 order internally without relying on the pharmacy, so that order should not have been overlooked.	D 358		

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D 358	Continued From page 60 Interview with the RCC on 01/25/22 at 1:07pm revealed: -It was the lead MA, her, or the HWD's responsibility to fax orders to the pharmacy for a resident as soon as possible upon receipt. -Once the pharmacy received the order, the pharmacy would enter the order onto the resident's eMAR, the facility would then review it for accuracy and approve it to become active on the eMAR or have it corrected before being approved. -Once an order had been approved by the facility, it was active on the resident's eMAR and the MAs were able to see the order to carry it out as written. -Resident #7's Aspirin and AREDS2 should have been administered as ordered at 8:00am but was missed. -She was not sure how or why the order dated 12/20/21 for Resident #7's Aspirin and AREDS2 had been missed, but it should have been implemented within 24 hours of receiving the order. -It was concerning that the order had been missed because the facility was expected to administer medications as ordered and the PCP ordered the administration of Resident #7's Aspirin and AREDS2 at specific times for a reason. Interview with COS #1 on 01/25/22 at 1:27pm revealed: -Medication orders were expected to be implemented as soon as received by the facility by faxing it to the pharmacy, the pharmacy then entered the order on a resident's eMAR, in which the facility would then review for accuracy and approve; it would then become active on a resident's eMAR for the MAs to administer	D 358		

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medications accurately as ordered.
-She was not aware that Resident #7's Aspirin and AREDS2 order dated 12/20/21 was missed and the facility should have caught that to ensure the resident's medications were administered as ordered by her primary care provider (PCP).
-Missing resident orders was concerning because it could result in a delay in care or treatment and could cause an adverse reaction or outcome to include death.

Telephone interview with Resident #7's PCP on 01/26/22 at 11:58am revealed:
-She expected the facility to implement and administer medications as ordered as soon as the order was received.
-She expected the facility to notify her when orders had been missed causing a medication error and seek a clarification from her on how to move forward.

Attempted interviews with the agency MA who failed to administer the Aspirin and AREDS2 on 01/25/22 at 1:00pm and telephone interview on 01/26/22 at 9:43am were unsuccessful.

Refer to interviews with COS #2 on 01/25/22 at 7:48am and 4:01pm.

Refer to interviews with the RCC on 01/25/22 at 1:07pm.

Refer to interviews with COS #1 on 01/25/22 at 1:27pm and 4:27pm.

Refer to telephone interviews with the agency staff supervisor on 01/25/22 at 4:55pm.

2. Review of Resident #8's current FL-2 dated 05/14/21 revealed:

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-Diagnoses included Alzheimer's disease with behaviors and insomnia.
-There was an order for Seroquel (used to treat mental and mood disorders) 25mg once every morning.
-There was an order for Seroquel 12.5mg once before bed.

Review of Resident #8's physician's orders dated 12/17/21 revealed:
-There was an order for Seroquel 25mg once every morning at 8:00am.
-There was an order for Seroquel 12.5mg once daily at 2:00pm.
-There was an order for Seroquel 12.5mg once daily at 8:00pm.

Observation of the 8:00am/9:00am medication pass on 01/25/22 revealed:
-The Clinical and Operations Specialist #2 (COS #2) began preparing Resident #8's morning medications at 9:20am.
-The COS #2 entered Resident #8's room at 9:29am to administer his medications but the resident was in the restroom.
-The COS #2 waited outside the restroom door and administered Resident #8's morning medications to the him when he exited the restroom at 9:58am.

Review of Resident #8's January 2022 eMAR revealed:
-There was an entry for Seroquel 25mg each morning at 8:00am.
-The Seroquel 25mg was documented as administered at 8:00am.
-There was an entry for Seroquel 12.5mg daily at 2:00pm.
-There was an entry for Seroquel 12.5mg once before bed at 8:00pm.

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D 358	Continued From page 63 Interviews with COS #2 on 01/25/22 at 7:48am and 4:01pm revealed: -He was a LPN who was there to train new medication aides. -All medications should be given on time, as ordered, no more than one hour before or after the scheduled administration time. -He came in at 8:06am on 01/25/22 after being called to come in and cover a staffing shortage. -This caused him to start passing medications late; if he had been scheduled, he would have begun passing morning medications at 7:00am. -He did not realize he had administered Resident #8's medications late which was concerning because the computer system should have alerted him the medications were being prepared and administered late and required him to put a reason why, which did not happen. -Giving Seroquel too close to the next dose could have over-medicated Resident #8 causing adverse reactions or outcomes such as drowsiness and inability to arouse which was considered a medication error. -If he had realized he made a medication error, he would have immediately notified the Resident Care Coordinator (RCC), the Executive Director (ED), and the resident's Primary Care Provider (PCP) for further guidance and orders to ensure the resident's safety and well-being. Interview with the Resident Care Coordinator (RCC) on 01/25/22 at 1:07pm revealed: -Medications were often late when there was a staffing call-out because the person they found to cover the call-out would have to come in and would start passing medications late. -Medications were not supposed to be administered more than one hour before or one hour after the scheduled time ordered on a	D 358		

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resident's eMAR.
-It was concerning that Resident #8's Seroquel had been administered late because it could have led to him having too much of the medication in his system when he received his next dose which could have caused overdose.
-She did not know if the late administration of Resident #8's Seroquel had been reported to his PCP.
-She was unsure if Resident #8 received his 2pm dose of Seroquel on time on 01/25/22.

Interview with COS #1 on 01/25/22 at 1:27pm revealed:
-She expected MAs to administer resident medications on time no more than one hour before or after the scheduled administration time on the eMAR.
-Giving Resident #8's Seroquel late could have caused a potential overdose, adverse side effects, or adverse outcomes, because it would have been too close to his next dose.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/26/22 at 9:50am revealed:
-Giving Seroquel to a resident late and too close to the time of the next dose could cause adverse reactions or outcomes to include lethargy and drowsiness.
-Giving medications more than one hour before or after a scheduled administration time was a medication error and should be reported to the pharmacy and the resident's PCP right away for resident safety.

Telephone interview with Resident #8's PCP on 01/26/22 at 11:58am revealed:
-She expected the facility to administer all medications no more than one hour before or

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after the scheduled administration time.
-She was not notified that Resident #8's 8:00am dose of Seroquel was administered late on 01/25/22.
-Seroquel was a time-based medication prescribed to Resident #8 to treat behaviors.
-Getting a dose of Seroquel too close to the next dose could have caused a potential overdose leading to sedation, drowsiness, and inability to arouse him.
-Not getting the Seroquel on time could also cause Resident #8 to have unpredictable behaviors that could have caused unnecessary medication changes to treat him that could have been harmful to him.
-If she had been notified of Resident #8's Seroquel having been administered late on 01/25/22, she would have ordered increased safety checks every 30 minutes for two hours to monitor for adverse signs and symptoms of Seroquel overdose.

Refer to interviews with COS #2 on 01/25/22 at 7:48am and 4:01pm.

Refer to interviews with the RCC on 01/25/22 at 1:07pm.

Refer to interviews COS #1 on 01/25/22 at 1:27pm and 4:27pm.

Refer to telephone interviews with the agency staff supervisor on 01/25/22 at 4:55pm...

3. Review of Resident #6's current FL-2 dated 09/08/21 revealed:
-Diagnoses included Parkinson's Disease, hypertension, chronic kidney disease, and hyperlipidemia.
-There was an order for Aspirin 81mg (used as a

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D 358	Continued From page 66 blood thinner) chewable tablets once daily. Observation of the 8:00am/9:00am medication pass on 01/25/22 revealed: -The medication aide (MA) prepared and administered an Aspirin 81mg enteric coated tablet (EC) to Resident #6 at 8:02am instead of an Aspirin 81mg chewable tablet as ordered. (Enteric coated is a substance that prevents a medication from being released until it reaches the small intestine.) -Resident #6 swallowed the aspirin when it was administered to her. Observation of Resident #6's medication on hand on 01/25/22 at 7:55am revealed: -There was a bottle of over the counter Aspirin 81mg EC with the resident's name written in marker. -There were 10 of 30 pills remaining in the bottle. -Aspirin 81mg chewable tablets were not on hand for administration. Review of Resident #6's January electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg chewable tablets once daily 8:00am. -The Aspirin 81mg chewable tablets were documented as administered on 01/25/22. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/26/22 at 9:42am revealed: -She was not sure why Resident #6 had Aspirin EC instead of chewable as the order was written. -The pharmacy had not filled Resident #6's order of Aspirin as it was requested to be obtained over the counter by the resident's family. -It was the facility's responsibility to ensure that	D 358		

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D 358	Continued From page 67 the resident had the correct form of Aspirin on hand to administer to the resident as ordered. Interview with the MA on 01/25/22 at 7:50am and 9:10am revealed: -She was an agency staff MA and this was her first day working at the facility as an MA (agency staff are temporary staff employed by an outside agency that contract with facilities to fill staffing needs and shortages within a facility). -She has been a medication aide for 6 months but did not receive any training or orientation at the facility except on how to log into the computer that morning (01/25/22) prior to starting the medication pass. -The safe way to administer medications was to compare the medication being prepared to the resident's eMAR to ensure accurate and safe administration. -She did not realize she administered the wrong form of Aspirin 81mg, she just looked at the name and dose of the medication, not the form of the pill. Interview with COS #2, a Licensed Practical Nurse on 01/25/22 at 7:48am and 4:01pm revealed: -All MAs were universally trained to compare the medication card to the eMAR prior to each medication administration for accuracy and safety. -Giving medications in the wrong form had the potential to cause absorption issues of the medication. -A medication cart audit should have caught this, but he was unsure how often cart audits were done in the facility. Interview with the Resident Care Coordinator (RCC) on 01/26/22 at 10:00am revealed:	D 358		

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-She was not aware that Resident #6 received the wrong form of Aspirin on 01/25/22.
-The wrong form of Aspirin should have been identified during mediation cart audits.
-Medication cart audits were supposed to be done weekly by the MAs, but she was unsure when they had last been completed as she had recently been out of the facility for an extended time period.

A second interview with COS #1 on 01/25/22 at 1:27pm revealed:
-Giving the wrong form of a medication could cause a possible absorption issue or adverse side effect and she expected the correct form of medications to be administered as ordered.
-She expected MAs to compare medication labels to the eMAR for accuracy prior to any medication administration for resident safety.
-She expected MAs to review new medications received to the resident's eMAR for accuracy prior to leaving the medication on the cart for administration for resident safety.
-Resident #6's inaccurate form of Aspirin should have been caught on weekly cart audits.
-She thought cart audits were last done on the previous night (01/24/22) but she was unable to find the documentation that they had been completed and would investigate it further.

Interview with COS #1 on 01/26/22 at 9:07am revealed:
-The staff had not documented the medication cart audit they were supposed to have done on 01/24/22.
-The last documented medication cart audit she was able to find was dated 12/08/21.
-Resident #6's form of Aspirin had not been addressed on the 12/08/21 cart audit.
-She did not know why medication cart audits had

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not been documented weekly as expected.
-She did not know why Resident #6's incorrect form of Aspirin had not been identified prior to 01/25/22.

Telephone interview with Resident #6's primary care provider (PCP) on 01/26/22 at 11:58am revealed:
-She expected the facility to administer medications as ordered to include having medications on hand in the correct form.
-She was not notified that Resident #6 has received the wrong form of Aspirin and expected to be notified to provide further orders.

Refer to interviews with COS #2 on 01/25/22 at 7:48am and 4:01pm.

Refer to interviews with the RCC on 01/25/22 at 1:07pm.

Refer to interviews with COS #1 on 01/25/22 at 1:27pm and 4:27pm.

Refer to telephone interviews with the agency staff supervisor on 01/25/22 at 4:55pm.

_____
Interview with COS #2, a Licensed Practical Nurse (LPN)/ on 01/25/22 at 7:48am and 4:01pm revealed:
-He was unsure what training agency staff received as he was not responsible for orienting agency MAs.
-The facility was currently staffed by agency staff (staff employed by an outside agency who contracted with the facility to fill staffing shortages and needs) 99% of the time due to frequent turn-over.
-All medications were expected to be administered as ordered for resident safety, no

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more than one hour before or after the scheduled administration time.
-All MAs were trained to compare the medication card to the eMAR prior to each medication administration for accuracy and safety.
-All medication errors should have been reported that to the resident's Primary Care Provider (PCP), COS #1, the Resident Care Coordinator (RCC), and the Health and Wellness Director (HWD) immediately for further guidance because it could have caused an adverse reaction or outcome.
-Having a 19% error rate in medication pass was concerning because he expected MAs to take their time and pay attention to what they were doing to administer mediations accurately as ordered and to ask questions and clarify as needed to ensure resident safety per their training.

Interview with the RCC on 01/25/22 at 1:07pm revealed:
-Currently the facility was primarily staffed by agency staffing.
-Agency staff who administered medications did not receive any training from the facility prior to administering medications to residents except on how to log into the computer.
-The contracted agency was responsible for ensuring agency MAs had training and clinical skills competency prior to sending them to the facility to fill staffing needs.
-It was concerning that there were errors made during the morning medication pass that day (01/25/22) because they had a lot of staff turnover and agency staff were not as familiar with the residents and did not receive any internal facility training which could lead to more mistakes.
-She expected all MAs, both employed by the

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D 358	Continued From page 71 facility or agency staff, to administer medications using the six rights (right resident, medication, time, route, dosage, and documentation) for resident safety as ordered. -The MAs were expected to compare the medication being prepared and administered to a resident to the eMAR to ensure the right route, dosage, and time were accurate prior to administration of the medication. -If a MA administered a medication that was incorrect according to the six rights of medication, it was considered a medication error and should be reported to her, the Administrator, and the resident's primary care provider (PCP) immediately in order to obtain further orders for the resident's safety. -It was important to administer medications as ordered to maintain safety for the resident. -Not administering medications as ordered by a resident's PCP could result in adverse reactions or outcomes to include overdose, hospitalization, or death. Interview with COS #1 on 01/25/22 at 1:27pm revealed: -She expected all MAs to administer medications per the six rights for resident safety. -Agency MAs received "minimal training" from the facility because the agency was responsible for ensuring they were competent to work. -The only training the staffing agency MA received was information on how to log into the computer, counting controlled substances in the medication cart, and how to document in the computer system quickly prior to their shift starting. -It was concerning that there were errors and near misses during the medication administration observation because it could have caused the residents' adverse side effects or outcomes.	D 358		

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D 358	Continued From page 72 -Any errors that occurred should have been reported to her, the RCC, and the resident's PCP so they could obtain and implement orders to closely observe the resident for any adverse side effects or outcomes for the resident's safety. -She expected MAs to compare medication labels to the eMAR for accuracy prior to any medication administration for resident safety. Telephone interview with the staffing agency staff supervisor on 01/25/22 at 4:55pm revealed: -The agency had provided staffing to the facility for approximately one week due to staffing shortages. -Agency staff were required to have training that was verified by the agency prior to their employment with the agency. -The agency MA was scheduled to work as a personal care aide (PCA) for the facility that day (01/25/22), not as an MA. -If the facility was going to change the role the agency staff to work as a MA instead of a PCA, she expected the facility to give the agency staff a 1-2-hour orientation prior to the shift to ensure they were comfortable passing medications per that facility's policy and procedure. -The agency MA had not received the 1-2-hour facility training but jumped in to fill the need to try and help. -She expected all agency MAs to compare the medication they administered to a resident's eMAR for accuracy and ensure they administered all medications according to the 6 medication rights. -Making errors during a medication pass were concerning for the residents' safety and she expected to be notified of errors made by agency staff to reeducate the agency MA and to avoid any adverse reactions or outcomes for the resident.	D 358		

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D 358	Continued From page 73 -She was not notified of any errors from 01/25/22. 4. Review of Resident #12's current FL-2 dated 10/28/21 revealed: -Diagnoses include Type 2 diabetes mellitus, hypertension, and hyperlipidemia. -There was an order for Semglee insulin inject 55 units subcutaneously daily at bedtime. (Semglee is a once daily long acting insulin Glargine (Lantus) used to control high blood sugar levels. Review of Resident #12's hospital discharge summary dated 01/10/22 revealed there were discharge instructions to continue insulin interchangeable with Glargine (Lantus) inject 55 units subcutaneously nightly. Review of Resident #12's progress notes dated 01/21/22 at 1:34pm revealed: -His 12:00pm blood sugar result was 551. -His primary care provider (PCP) was notified at that time. -He was transported to the emergency room (ER). Review of Resident #12's progress notes dated 01/21/22 at 8:38pm revealed: -Resident #12 returned to the facility with an order for insulin Glargine (Lantus) inject 0.5ml (50 units) under the skin nightly dated 01/21/22. -The order was faxed to the pharmacy. Review of Resident #12's emergency room (ER) visit summary report dated 01/21/22 revealed: -Resident #12 was seen in the ER and diagnosed with elevated blood glucose and high blood pressure disorder. -There was a physician's medication order dated 01/21/22 for insulin Glargine (Lantus) inject 0.5 ml (50 units total) under the skin nightly.	D 358		

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D 358	Continued From page 74 Review of a physician fax transmission communication dated 01/21/22 revealed the Clinical Operations Specialist (COS) submitted a communication to Resident #12's PCP requesting Semglee insulin to be discontinued since the medication was on back order and there was a new order for Lantus 50 units daily at night on the discharge summary from the ER dated 01/21/22. Interview with Resident #12 on 02/04/22 at 9:10am revealed: -He usually received Lantus 55 units at bedtime. -He was not familiar with the name "Semglee" insulin. -He had not received Lantus for 11 days since getting out of the hospital on 01/11/22 and prior to being sent to the ER on 01/21/22 with a blood sugar level greater than 500. -He felt "funny" so he knew something was "out of whack." -The facility did not know who his PCP was at that time and had been calling the wrong PCP. -He had informed a medication aide (MA) at the facility that they were calling the wrong PCP and that he had instructions to continue Lantus 55 units when he was discharged from the hospital on 01/11/22. -The MA told him around 01/12/22 that there was Lantus in the refrigerator from an "old order" or previous order but the medication had not been cleared by his PCP for her to administer the medication to him Review of Resident #12's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Semglee insulin inject 55 units subcutaneous at bedtime. -There was documentation that the Semglee was	D 358		

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administered from 12/01/21 through 12/31/21 except 12/04/21 and 12/05/21 which had the notation drug not available (DNA), and there was no documentation the medication was administered on 12/22/21 and 12/27/21.

Review of Resident #12's January 2022 eMAR revealed:
-On 01/11/22, the finger stick blood sugar (FSBS) was 272.
-On 01/12/22, FSBS ranged from 279 to 285.
-On 01/13/22, FSBS ranged from 235 to 302.
-On 01/14/22, FSBS ranged from 175 to 282.
-On 01/15/22, FSBS ranged from 116 to 301.
-On 01/16/22, FSBS ranged from 238 to 363.
-On 01/17/22, FSBS ranged from 250 to 325.
-On 01/18/22, FSBS ranged from 152-335
-On 01/19/22, FSBS ranged from 200-370.
-On 01/20/22, FSBS ranged from 300 to 414.
-On 01/21/22 at 8:00am, Resident #12's FSBS was 441.
-On 01/21/22 at 12:00pm, Resident #12's FSBS was 553.
-Semglee insulin was documented as not administered at 8:00pm because it was not available on 01/12/22, 01/13/22, 01/15/22, 01/16/22, 01/17/22, 01/20/22 , and 01/21/22; there was no documentation (time and date blank) on 01/14/22 and 01/19/22; and on 01/19/22 the medication was documented as administered when the medication was not available based on documentation before and after this date.
-There was an entry that Semglee insulin had been discontinued from 01/22/22 through 01/31/22.
-There was an entry for insulin Glargine (Lantus) for 50 units starting 01/22/22.
-Lantus 50 units was documented as administered at 8:00pm on 01/22/22.

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D 358	Continued From page 76 Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/04/22 at 9:32am revealed: -Resident #12 had an order for Semglee insulin for 55 units dated 10/27/21. -One box containing 1 vial of Semglee insulin containing 1500 units was dispensed on 11/02/21. -One box containing 1 vial of Semglee insulin containing 1500 units was dispensed on 12/05/21. -There was no Semglee insulin dispensed in January 2022 and February 2022. -The last time Semglee insulin was dispensed was on 12/05/21. -The pharmacy did not receive any orders dated 01/10/22 and 01/21/22 for insulin Glargine (Lantus) for Resident #12. -Resident #12's profile in the pharmacy system revealed the resident may receive medications from another pharmacy. Attempted telephone interviews with another pharmacy listed on Resident #12's Lantus insulin in the medication cart at multiple times on 02/04/22 at 2:30pm, 02/07/22 at 10:00am and 02/08/22 at 11:00am was unsuccessful. Interview with a medication aide (MA) on 02/08/22 at 1:10pm revealed: -She worked on second shift (3-11) on 01/12/22 when Resident #12 received his Semglee insulin at 8:00pm. -The Semglee insulin was not available on the medication cart to be administered on that date. -She made a refill request to the pharmacy. -She notified the Clinical Operations Specialist #1 (COS) that the Semglee insulin was not on the medication cart and that she had sent a medication refill request to the pharmacy.	D 358		

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D 358	Continued From page 77 -She notified COS #1 that Resident #12 had insulin Glargine (Lantus) in the refrigerator around 01/21/22. -COS #1 told her that she would contact Resident #12's PCP to get an order to administer the Lantus. -She first administered Lantus 50 units to Resident #12 on 01/22/22 at 8:00pm as ordered on 01/21/22. Observation of medications on hand for Resident #12 on 02/07/22 at 11:00am revealed: -There was a vial of insulin Glargine (Lantus) inject 55 units with a dispensed date of 06/08/21 and expiration date of 06/07/22 in the medication cart. -The sticker on the box containing the vial of insulin had not be changed to reflect the current order dated 01/21/22 for insulin Glargine (Lantus) inject 50 units at bedtime. (A change from 55 units to 50 units). Observation of the refrigerator where medications were stored on 02/07/22 at 1:00pm revealed there were nine vials of insulin Glargine (Lantus) containing 100 units (10ml) each, 1 vial had a dispensed date of 03/19/21 and expiration date of 03/18/22; 2 vials had a dispensed date of 06/08/21 and expiration date of 06/07/22; 3 vials had a dispensed date of 09/08/21 and expiration date of 09/07/22 and 3 vials had a dispensed date of 12/08/21 and expiration date of 12/07/22. Interview with a second MA on 02/05/22 at 3:30pm revealed: -She worked for a staffing agency. -She had worked at the facility "off and on" since October 2021. -Medication orders were consistently not updated in the eMAR system.	D 358		

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-Medications were consistently not available on the medication cart.
-Resident #12's Semglee insulin was not available during the times she was assigned to administer medications in January 2022.
-She usually worked every other day but could not recall the exact dates she worked on Resident #12's hall.
-During the times she had taken his blood glucose levels, the values ranged from 200 to 300.

Interview with COS #1 on 02/08/22 at 12:15pm revealed:
-Resident #12 received an order for Semglee insulin when he was discharged from the hospital around 10/28/21.
-She was aware that Resident #12 did not receive his Semglee insulin for eleven days from 01/11/22 through 01/21/22 prior to being sent to the ER on 01/21/22 with a blood sugar greater than 500.
-She contacted the pharmacy during that time by telephone multiple times and was told the medication was not available and on back order.
-She had not notified the PCP that Resident #12 had not received his insulin for eleven days.
-She had not reviewed Resident #12's discharge summary from the hospital dated 01/10/22 with instructions to continue Lantus insulin 55 units.
-During the weekday, it was the responsibility of the Resident Care Coordinator (RCC) or the Health and Wellness Director (HWD) to review discharge summaries or medication orders and fax the order to the pharmacy.
-After 5:00pm on weekdays and on weekends, it was the responsibility of the MA, the RCC, or the HWD to review discharge summaries and medication orders and fax the order to the pharmacy.
-She was not aware that there were nine boxes of

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D 358	Continued From page 79 Lantus insulin in the refrigerator with dispensed dates from 03/19/21 through 12/08/21 until around 01/21/22 when she was told by a MA. -The PCP listed in Resident #12's record had not been updated to his current PCP and she had been reaching out to the wrong PCP. -She was concerned that the facility did not follow the process for reviewing discharge summary reports and making sure medication orders were sent to the pharmacy. -She was concerned with the number of days that Resident #12 was not administered his insulin. -Not administering insulin as ordered could cause hyperglycemia (high blood glucose level) and even death. Interview with Resident #12's primary care provider's (PCP) nurse on 02/08/22 at 1:46pm revealed: -Resident #12 had been a patient of the PCP since July 2021. -The PCP was not notified of Resident #12's hospitalization from 01/05/22 to 01/11/22. -The PCP did not receive a copy and had no knowledge of the discharge summary report regarding the hospitalization on 01/05/22 through 01/11/22 that had orders. -The PCP was not notified that Resident #12 did not receive his Semglee insulin from 01/11/22 through 01/21/22 (11 days) because it was not available from the pharmacy. -Had the PCP been notified, the PCP could have determined the best course of action to ensure Resident #12 received his insulin. -The PCP was notified on 01/21/22 that Resident #12 had not received his insulin for 11 days and was sent to the ER with a blood glucose level of 551. -The PCP's records revealed an active order for insulin Glargine (Lantus) 55 units at bedtime.	D 358		

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-The facility was responsible for notifying and submitting discharge and visit summaries to the PCP when Resident #12 received healthcare services.

Review of a laboratory (lab) result from Resident #12 's hospital discharge summary dated 01/10/22 revealed:
-Resident #12's Hemoglobin AlC value was 10.0%. (Hemoglobin AlC is a blood test that provides the average blood sugar over a two to three month timeframe.
-The documented reference range for Hemoglobin AlC was less than 6.5%

Review of The American Diabetes Association (ADA) recommendations for individuals with a diagnosis of diabetes revealed:
-A recommended blood sugar result of 80-130 before meals.
-A recommended blood sugar result of 180 or less 1-2 hours after beginning a meal.
-A recommended Hemoglobin AlC value of less than 7% for adults.
-The higher the A1C value, the greater the risk of developing complications such as nerve damage, eye damage, heart disease, kidney disease, and other complications that can lead to death.
-High blood sugars should be treated as soon as they are detected.
-If left untreated, high blood sugar can lead to ketoacidosis (diabetic coma) which is a life threatening condition.

5. Review of Resident #6's current FL-2 dated 09/08/21 revealed diagnoses included Parkinson's disease, hypertension, coronary artery disease, and hyperlipidemia.

a. Review of a physician's order report dated

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D 358	Continued From page 81 09/08/21 revealed there was a medication order for Carbidopa-Levodopa 10-100mg take 1 and 1/2 tablets by mouth every 3.5 hours while awake. (Carbidopa-Levodopa is a time sensitive medication used to treat Parkinson's disease). Interview with Resident #6 on 02/03/22 at 8:45am revealed: -On 01/22/22, a lot of staff did not show up for work due to inclement weather conditions. -There was no one to administer medications on 01/22/22. -She was not administered 1 of her 5 doses of Carbidopa-Levodopa 10-100mg on 01/22/22. Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Carbidopa-Levodopa 10-100mg scheduled for administration at 7:00am, 10:30am, 2:00pm, 5:30pm, 9:00pm from 01/01/22 through 01/24/22 that was discontinued on 01/24/22. -There was an entry for Carbidopa-Levodopa 10-100mg scheduled for administration at 10:00am, 1:30pm, 5:00pm, 8:30pm from 01/24/22 through 01/31/22. (There was a change from 5 doses to 4 doses). -Carbidopa-Levodopa 10-100mg was not documented as administered at 10:30am on 01/22/22 and at 10:00am and 1:30pm on 01/30/22. Attempted telephone interview with Resident #6's primary care provider on 02/08/22 at 2:00pm was unsuccessful. b. Review of a physician's order report dated 09/08/21 revealed there was a medication order for Atenolol 10mg daily. (Atenolol is used to treat	D 358		

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high blood pressure, chest pain, and can reduce the risk of death after a heart attack).

Interview with Resident #6 on 02/04/22 at 8:45am revealed:
-On 01/22/22, a lot of staff did not show up for work due to inclement weather conditions.
-There was no one to administer medications on 01/22/22.
-She was not administered the Atenolol 50 mg at the 8:00am on 01/22/22 and 01/30/22.

Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Atenolol 50mg scheduled for administration at 8:00am.
-Atenolol 50mg was documented as not administered at 8:00am on 01/22/22 and 01/30/22.

Attempted telephone interview with Resident #6's primary care provider on 02/08/22 at 2:00pm was unsuccessful.

c. Review of a physician's order report dated 09/08/21 revealed there was a medication order for Lisinopril 20mg daily. (Lisinopril is a medication used to treat high blood pressure and heart failure).

Interview with Resident #6 on 02/04/22 at 8:45am revealed:
-On 01/22/22, a lot of staff did not show up for work due to inclement weather conditions.
-There was no one to administer medications on 01/22/22.
-She was not administered the Lisinopril 20mg on 01/22/22.

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Review of Resident #6's January 2022 eMAR revealed:
-There was an entry for Lisinopril 20mg scheduled to be administered at 8:00 am.
-Lisinopril 20mg was documented as not administered at 8:00am on 01/22/22 and 01/30/22.

Attempted telephone interview with Resident #6's primary care provider on 02/08/22 at 2:00pm was unsuccessful.

d. Review of a physician's order dated 09/08/21 revealed there was a medication order for Hydrochlorothiazide 12.5 daily.
(Hydrochlorothiazide is used to treat high blood pressure and fluid retention.)

Interview with Resident #6 on 02/04/22 at 8:45am revealed:
-On 01/22/22, a lot of staff did not show up for work due to inclement weather conditions.
-There was no one to administer medications on 01/22/22.
-She was not administered the Hydrochlorothiazide 12.5mg on 01/22/22.

-Review of Resident #6's January 2022 eMAR revealed:
-There was an entry for Hydrochlorothiazide 12.5mg scheduled to be administered at 8:00am.
-Hydrochlorothiazide 12.5 mg was documented as not administered at 8:00am on 01/22/22 and 01/30/22.

Attempted telephone interview with Resident #6's primary care provider on 02/08/22 at 2:00pm was unsuccessful.

e. Review of a physician's order report dated

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D 358	Continued From page 84 09/08/21 revealed there was a medication order for aspirin 81mg daily. (Aspirin is used as a blood thinner to reduce the risk of a heart attack). Interview with Resident #6 on 02/04/22 at 8:45am revealed: -On 01/22/22, a lot of staff did not show up for work due to inclement weather conditions. -There was no one to administer medications on 01/22/22. -She was not administered the aspirin 81mg on 01/22/22. Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 81mg scheduled to be administered at 8:00am. -Aspirin 81mg was documented as not administered at 8:00am on 01/22/22 and 01/30/22. Attempted telephone interview with Resident #6's primary care provider on 02/08/22 at 2:00pm was unsuccessful. f. Review of a physician's order report dated 09/08/21 revealed there was a medication order for Centrum gummies 1 by mouth once a day. (Centrum Gummies is a multi-vitamin used as a supplement). Interview with Resident #6 on 02/04/22 at 8:45am revealed: -On 01/22/21, a lot of staff did not show up for work due to inclement weather conditions. -There was no one to administer medications on 01/22/22. -She was not administered the Centrum gummies on 01/22/22.	D 358		

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D 358	Continued From page 85 Review of Resident #6's January 2022 electronic MAR revealed: -There was an entry for Centrum gummies scheduled to be administered at 8:00am. -The Centrum gummies was documented as not administered at 8:00am on 01/22/and 01/30/22. Attempted telephone interview with Resident #6's primary care provider on 02/08/22 at 2:00pm was unsuccessful. _____ Interview with COS #1 on 02/08/22 at 12:15pm revealed: -Scheduled staff did not come in to work on 01/22/22 due to inclement weather conditions. -She was the only one in the facility passing medications to residents on 01/22/22. -Resident #6's medications were not administered as ordered on 01/22/22 due to limited staff. _____ The facility failed to ensure medications were administered as ordered to 3 of 4 residents observed during the 8:00am/9:00am morning medication pass on 01/25/22 involving errors in almost administering the wrong medications to a resident which could cause decreased blood pressures and potential falls (#7); administering Seroquel two hours late and close to the next scheduled dose resulting in the potential of overdose, adverse outcomes, and unsafe future medication changes (#8); failing to administer insulin to a resident for at least 10 days which resulted in his blood sugar being greater than 500 and required hospitalization; and failure to administer 6 medications to a resident on two occasions (#6). The facility's failure resulted in substantial risk of physical harm and serious neglect and constitutes a Type A2 Violation.	D 358		

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D 358	Continued From page 86 The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/25/22 and 02/09/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 10, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of medication administration records for 1 of 8	D 367		

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sampled residents (#14) related to documentation by staff of the administration of at least four medications that were left at the resident's bedside for self-administration.

The findings are:

Review of Resident #14's current FL-2 dated 10/28/21 revealed:
-Diagnoses included coronary heart disease, gastroesophageal reflux disease (GERD), calcium deficiency, and Vitamin D deficiency.
-There were medication orders for Amlodipine 5mg twice daily, calcium 600mg twice daily, Ursodiol 300mg twice daily, and Vitamin D3 once daily at bedtime (Amlodipine is used to treat hypertension and CAD. Ursodiol is used to GERD. Vitamin D and Calcium are nutritional supplements).

Observation of Resident #14's room on 02/07/22 at 9:35am revealed:
-Resident #14 was lying in bed.
-A medicine cup with Resident #4's first name on it was on a table next to her bed.
-The medicine cup contained 4 pills which were identified as Amlodipine, Ursodiol, Vitamin D, and calcium were inside the cup.

Review of the Resident #14's February 2022 electronic medication administration record (eMAR) on 02/07/22 revealed:
-There was a computer entry for Amlodipine 5mg scheduled for 8:00am and 8:00pm that was documented as administered from 02/01/22 to 02/06/22.
-There was a computer entry for Calcium 600mg scheduled for 8:00am and 8:00pm that was documented as administered from 02/01/22 to 02/06/22.

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D 367	Continued From page 88 -There was a computer entry for Ursodiol 300mg scheduled for 8:00am and 8:00pm that was documented as administered from 02/01/22 to 02/06/22. -There was a computer entry for Vitamin D3 - 29 mcg scheduled for 8:00pm that was documented as administered from 02/01/22 to 02/06/22. Interview with Resident #14 on 02/07/22 at 9:36am revealed: -She did not know about the medications in the cup that was left at her bedside. -She did not know how long the medications had been on the table at her bedside. -She "self-administered" her medications and the medication aide (MA) left her medications at her bedside and then she took them later. -She could not remember if she had taken any medications that the MA had left for her to take from the previous night. -She had not taken any medications this morning, so she did know where the medications on her table came from. Interview with a medication aide (MA) on 02/07/22 at 9:41am revealed: -She had not administered any medications to Resident #14 on 02/07/22. -Resident #14 self-administered her medications but the MAs had to bring the medications to Resident #14 from the medication cart. -When she administered medications to Resident #14, she took the medications to Resident #14's room in a medication cup and left the medications at the resident's bedside. -She did not verify if Resident #14 took the medications she left for the resident at her bedside, but she documented she administered the medications to Resident #14 once she left the medications at her bedside.	D 367		

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D 367	Continued From page 89 -She was told by another MA to administer Resident #14's medications like this because Resident #14 had problem taking medications in front of staff. -She could not remember who told her to this or when she was told. Interview with a second MA on 02/08/22 at 1:10pm revealed: -She was the MA who worked the 3:00pm - 11:00pm shift on 02/06/22. -The MAs always brought Resident #14 her medications from the medication cart. -Sometimes, Resident #14 refused to take her medications when the MAs attempted to administer them. - "Sometimes she (the resident) would take the medications from her (the MA) and sometimes she (the resident) would not". -She set the cup of medications on the table in Resident #14's room during her evening medication pass on 02/06/22 so the resident could take her medications. -The medication cup was labeled with Resident #14's first name and her 8:00pm medications (Amlodipine, Ursodiol, Vitamin D, and calcium) were in the cup. -She went back later to Resident #14's room and verified the resident had taken the medications. -She did not see any medicine cups or medications remaining in Resident #14's room. -She documented the administering the medications on Resident #14's eMAR after verifying the medications had been taken by Resident #4. -Resident #14 did not have a history of not taking the medications that the MAs left at her bedside for her to self-administer. -She had never found any medications left in Resident #14's room after the MAs left the	D 367		

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D 367	Continued From page 90 medications for the resident to take. Telephone interview with Resident #14's family member on 02/08/22 at 11:50am revealed: -Resident #14 had some issues with not wanting to take medications when the MAs tried to administer them that started around last Thanksgiving because her anxiety and paranoia. -Resident #14's primary care provider (PCP) had written an order around last Christmas for Resident #14 to self-administer her medications. -The MAs then started to bring Resident #14's medications to her in a medicine cup and leaving on the table next to her bed for her to take own her. -The MAs did not leave Resident #14's inhaler at her bedside because that was against state regulations. -She would be concerned about medications left at the bedside for Resident #14 to take on her own if there was no MAs who went back to verify Resident #14 had taken the medications. Review of a physician fax transmission/phone order for Resident #14 dated 12/17/21 revealed the order read 'Family agrees to have an order for resident to self-administer daily medications' and it was signed by the PCP. Review of the facility's medication policy last updated 01/17/22 revealed: -The licensed nurse or appropriate staff must refer to MAR to obtain correct medication, time, dosage, and route of administration as ordered by the physician for each individual resident. -Each dose administered is properly recorded in the MAR as indicated by the MA's initials in the appropriate block or in electronic health record. Review of the facility's self-medication	D 367		

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administration policy last updated 05/26/21 revealed the method of storing the medication is acceptable by state regulations and can be maintained in the resident's living area without endangering other residents.

Interview with the Administrator on 02/07/22 at 10:05am revealed:
-She was not aware of medications being left at Resident #14's bedside by the MAs.
-She had spoken with Clinical Operations Specialist #1 (COS #1) and they believed that Resident #14 self-administered medications.
-Resident #14 was paranoid about taking medications in front of the MAs and her primary care provider (PCP) had written an order for Resident #14 to self-administer her medications (date not specified).
-Resident #14 was not allowed to keep medications in her room for self-administration because the resident did not have lock box yet.
-She had no idea of how Resident #14 could self-administer her medications and the MAs documented that they administered Resident #14's medications without verifying Resident #14 took the medications.

Interview with COS #1 on 02/07/22 at 4:18pm revealed:
-Resident #14 was supposed to be self-administering her medications but the resident was not allowed to keep medications in her room because she did not have a locked box.
-The MAs were supposed to bring Resident #14's medications from the medication cart and give the medication to the resident for her to self-administer.
-She did not know when the MAs documented Resident #14's medication administration after the MAs left the medications at the resident's

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D 367	Continued From page 92 bedside. -She would have to follow-up with the MAs about the documentation on the eMAR for administration of the medications for Resident #14. Second interview with COS #1 on 02/08/22 at 1:33pm revealed: -The MAs should not be documenting that they are administering medications that are left at Resident #14's bedside because they can't verify the resident actually took the medications. -She thought it was okay for the MAs to leave Resident #14's medications at the bedside and then document the MAs had administered it, but now she did not think that was the correct directive. -She would consult her corporate office to discuss what to do about Resident #14's unique situation.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication pass on 01/25/22 by 1 of 2 medication aides (MA) observed who failed to wash or	D 371		

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sanitize her hands prior to preparing and after administering multiple medications to multiple residents after adjusting her face mask with ungloved hands further placing the residents at risk of transmission of pathogens and contamination for COVID-19 due to a current and confirmed outbreak of COVID-19 in the facility that began on 01/05/22.

The findings are:

Review of the facility census report on 01/25/22 revealed 39 residents resided in the Assisted Living (AL) unit and 16 residents resided in the Special Care Unit (SCU).

Review of the Centers for Disease Control (CDC) hand hygiene guidelines for healthcare settings dated 01/08/21 revealed:
-Multiple opportunities for hand hygiene may occur during a single care episode.
-The following are the clinical indications for hand hygiene with an alcohol-based hand sanitizer or soap and water: immediately before touching a patient, when hands are visibly soiled, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices.
-Before moving from work on a soiled body site to a clean body site on the same patient.
-After known or suspected exposure to spores.
-After touching a patient or the patient's immediate environment.
-After contact with blood, body fluids or contaminated surfaces.
-Immediately after glove removal.
-When using alcohol-based hand sanitizer staff should, put product on hands and rub hands together, cover all surfaces until hands feel dry, this should take around 20 seconds.

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D 371	Continued From page 94 -When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. -Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. -Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. -Glove use was recommended as follows: -Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. -Gloves are not a substitute for hand hygiene. -If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. -Perform hand hygiene immediately after removing gloves. -Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. -Never wear the same pair of gloves in the care of more than one patient. -Carefully remove gloves to prevent hand contamination. Review of the facility's Community Infection Control policy dated 12/21/21 revealed:	D 371		

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-The Administrator or operator of the facility shall provide a safe, sanitary, and comfortable environment for residents.
-The Administrator shall ensure ongoing development of policies and implementation of procedures to prevent the spread of infections.
-The facility was expected to observe transmission-based precautions per the Centers for Disease Control (CDC) recommendation.
-Facility staff were expected to perform hand hygiene before and after any resident care.
-It was the Administrator's responsibility to ensure training upon hire and annually thereafter to all staff regarding the facility's infection control policy.

Review of the facility's Hand Washing and Glove Use policy dated 09/06/19 revealed:
-Guidelines for hand washing and glove use were expected to be observed through the facility to promote safe and sanitary conditions as a priority for infection control.
-Hands were expected to be washed prior to beginning work and following contact with any unsanitary surface.
-Hand hygiene should be observed prior to donning gloves and whenever gloves were doffed or changed.

Interview with the acting Clinical Operations Specialist #1 (COS #1) on 01/25/22 at 7:10am revealed:
-The facility had an active COVID-19 outbreak on both the AL unit and the SCU that was identified on 01/06/22.
-As of that day, there were a total of 8 residents between the two units and 4 staff with a positive and active COVID-19 infection.
-The facility last tested all negative residents for COVID-19 infection yesterday (01/24/22) and

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were expecting to receive the results that day (01/25/22).
-There was no dedicated staff to care for the residents who tested positive for COVID-19.
-All staff were expected to use hand washing/sanitization and PPE properly to ensure COVID-19 was contained and not spread from resident to resident in between care.

Interview with the acting COS #1 01/25/22 at 4:15pm revealed there were 3 additional residents who tested positive for COVID-19 on 01/25/22 and 1 staff who tested positive for COVID-19 on 01/24/22.

Observation of the 8:00am/9:00am on the AL unit medication pass on 01/25/22 revealed:
-It was unknown which residents were COVID-19 positive and there was no additional PPE donned or doffed for any medication pass observed.
-There was a bottle of hand sanitizer on the medication cart next to the computer.
-The agency medication aide (MA) approached the medication cart, logged into the computer, pushed the cart down the hall toward the resident's rooms, did not sanitize or wash her hands, donned gloves and began to prepare medications for a resident at 7:55am (Agency MAs were MAs that were employed by a third party company to provide staff to the facility).
-The agency MA doffed gloves and did not sanitize or wash her hands at 7:59am.
-The agency MA knocked and entered the wrong resident's room and almost administered the medications to the resident at 8:01am touching the resident's hands and assisting her in getting a cup of water that was located on the side table.
-The agency MA exited the resident's room, did not sanitize or wash her hands, and entered the right resident's room and administered the correct

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resident her medications at 8:02am.
-The agency MA returned to the medication cart at 8:05am to check an order for the correct resident in the computer for a medication the resident refused; she did not wash or sanitize her hands.
-The agency MA donned gloves to return the medication to the original packaging at 8:13am-8:14am.
-The agency MA doffed gloves at 8:14am and did not wash or sanitize her hands.
-The agency MA then donned new gloves at 8:17am and began preparing medications for another resident.
-The agency MA administered the resident's pills, one pill under the tongue using her right hand, at 8:21am.
-The agency MA doffed her right glove at 8:22am.
-The agency MA then administered nasal spray to the resident using her left hand at 8:23am.
-The agency MA then doffed her left glove.
-The agency MA adjusted her mask with gloved and ungloved hands multiple times during this observation.

Interview with Clinical Operations Specialist #2 (COS #2), a Licensed Practical Nurse on 01/25/22 at 7:48am and 4:01pm revealed:
-He was unsure which residents on the AL unit were COVID-19 positive.
-All staff were expected to use hand sanitizer before and after medication preparation and interaction with each individual resident.
-All staff were expected to wash their hands with soap and water after interaction with every six residents or whenever visibly soiled or having to don gloves and encountering any bodily fluids.
-It was important for all staff to observe hand hygiene practices to prevent the potential contamination and spread of pathogens that

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could cause illness or adverse outcome from one resident to another.
-It was especially concerning that staff had not performed proper hand hygiene during the medication pass because there were several residents in the facility with an active infection of COVID-19.

Interview with the Resident Care Coordinator (RCC) on 01/25/22 at 1:07pm revealed:
-Hand sanitizer was always on each medication cart to ensure MAs had access to it .
-Each staff member was expected to wash or sanitize hands before and after each medication pass or interaction with any residents or when visibly soiled.
-MAs should wear gloves in addition to hand hygiene whenever they encounter bodily fluids or touch medications.
-It was important for staff to perform hand hygiene per facility policy to ensure the safety of the residents and staff to prevent cross-contamination of pathogens and the risk of infection.

Interview with COS #2 on 01/25/22 at 1:27pm revealed:
-She expected all staff to perform hand hygiene with hand sanitizer per facility policy to include upon arrival at the facility and before or after any resident care or interaction.
-In addition to hand hygiene, she expected staff to don gloves if they touch medications, administer any medications such as eye drops, nasal sprays, or injections and anytime they encounter bodily fluids.
-She expected staff to wash hands with soap and water whenever visibly soiled.
-It was important for all staff to observe strict hand hygiene procedures for safety purposes to

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prevent the risk of contamination or spread of pathogens that could cause illness, especially with the facility having a current outbreak of COVID-19.

Telephone interview with the agency staff supervisor on 01/25/22 at 4:55pm revealed:
-All agency staff were expected to review a facility's infection control policy and follow the guidelines as appropriate.
-All agency staff were expected to sanitize or wash their hands with soap and water before and after every resident interaction, when they had to don/doff gloves, or when visible soiled.
-It was concerning that hand hygiene practices were not maintained because the facility had active cases of COVID-19 and all staff were expected to protect the residents from contamination of pathogens and illness.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/26/22 at 11:58am revealed:
-She expected the facility to use proper hand hygiene upon entry to the facility before and after interaction with each individual resident.
-It was concerning that proper hand hygiene was not being observed during medication administration because the facility had residents with active COVID-19 illness in the building and she wanted to protect the other residents' safety from contamination and risk of pathogen transmission to them.

Attempted interview with the agency MA on 01/25/22 at 1:00pm and a telephone interview on 01/26/22 at 9:43am were unsuccessful.

_____

The facility failed to ensure hand hygiene was maintained in a manner to prevent transmission

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D 371	Continued From page 100 of infection during the 8:00am/9:00am morning medication pass on 01/25/22. The facility was in outbreak status with 8 residents and 4 staff positive of COVID-19 infection. This failure placed the residents at risk for contracting COVID-19 and other infections and was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance to G.S. 131D-34 on 01/25/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 25, 2022.	D 371		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the special care unit (SCU) for 7 of 9 shifts sampled on 01/17/22,	D 465		

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D 465	Continued From page 101 01/21/22 and 01/22/22. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 96 including a special care unit (SCU) with a capacity of 36. Interview with Clinical Operations Specialist #1 (COS #1) on 01/25/22 at 7:43am revealed staffing shortages were a persistent problem and she frequently had to fix the shortages at the last minute due to call-outs. Review of the facility's resident census report revealed the SCU census was 18 on 01/17/22 which required 18 aide hours on first and second shifts and 14.4 aide hours on 3rd shift. Review of staff timecards dated 01/17/22 revealed there was a total of 6 staff hours provided on third shift for a shortage of 8.8 hours. Interview with a medication aide (MA) on 01/26/22 at 12:16pm revealed: -The facility was short staffed on 01/17/22. -There was 1 personal care aide (PCA) clocked in to work in the SCU and 1 PCA clocked in to work in the assisted living. Interview with the COS #1 on 01/26/22 at 12:09pm revealed she was not certain what happened on 01/17/22 but they were short staffed. Interview with a PCA on 01/26/22 at 11:00am revealed the SCU was short staffed and there was only 1 aide on duty in the SCU every weekend.	D 465		

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Review of the facility's resident census report revealed the SCU census was 18 on 01/21/22 which required 18 aide hours on first and second shifts and 14.4 hours on third shift.

Review of staff timecards dated 01/21/22 revealed:
-There was a total of 16 staff hours provided on first shift for a shortage of 2 hours.
-There was a total of 8.75 staff hours provided on second shift for a shortage of 9.25 hours.
-There was a total of 6.75 staff hours provided on third shift for a shortage of 7.65 hours.

Interview with a PCA on 02/04/22 at 3:30pm revealed:
-He and the COS #1 were the only staff on duty on second shift 01/21/22.
-He was assigned to the SCU and most residents were incontinent.
-Residents in the SCU had to wait longer than usual for assistance with needs on 01/21/22 because he was the only staff on duty.
-There were 2 residents in SCU that try to swing at staff or throw things at staff.
-There was usually no supervisor in the building on 2nd shift after 6:00pm when he worked.
-There was no orientation of agency staff unless they asked questions while on duty.

Interview with a COS #2, a Licensed Practical Nurse (LPN), on 01/25/22 at 7:48am revealed:
-He was brought into the facility to help train new MAs and the new Health and Wellness Director (HWD) that started yesterday (01/24/22).
-The facility was currently staffed by agency staff (staff employed by an outside agency who contracted with the facility to fill staffing shortages and needs) 99% of the time due to frequent

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D 465	Continued From page 103	D 465		

turn-over.
-He sometimes had to jump into staffing roles when there were shortages or call-outs to help care for residents.

Interview with the COS #1 on 01/26/22 at 11:21am revealed:
-She was COS #1 for the building due to some recent transitions.
-She was the only employee in the building on 01/21/22 from 11:00pm-7:00am due to call-outs from a snow storm.
-She tried to call for staff to come in and help, but they were either unavailable or unable to get to the facility due to the snow.
-She called staff from the corporate offices and they were able to come provide relief the next morning.
-She spent approximately 6 hours on the SCU and 2 hours on the AL throughout the shift.
-It was a terrifying night because she was concerned she was going to miss someone ringing their call bell or be unable to supervise someone on the SCU while on the AL side.
-She was able to pass medications and meet resident's immediate needs, but she was unable to be readily available to all residents that might have needed her because there were so many of them and only one of her.
-She was unsure what agency staff had been on the AL or SCU on 01/21/22 during first and second shift because she was unable to get time cards from the staffing agency.
Review of the facility's resident census report revealed the SCU census was 18 on 01/22/22 which required 18 aide hours on first and second shifts and 14.4 aide hours on third shift.

Review of staff timecards dated 01/22/22 revealed there was a total of 0 aide hours

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provided on third shift for a shortage of 14.4 aide hours.

Interview with the COS #1 on 01/26/22 at 11:30am revealed:
-All scheduled staff called out for first shift on 01/22/22 due to adverse winter weather.
-She asked the first shift to stay on duty when staff began calling out on second shift 01/21/22 but all refused which left her the only staff in the building until some agency staff reported on the morning of 01/22/22 at around 9:30am-10:00am.
-She did not have timecards available for the agency staff.
-The timecard provided reflecting 0 hours reflected time for facility staff, not agency staff.

Review of the facility's resident census report revealed the SCU census was 18 on 01/29/22 which required 18 aide hours on first and second shifts and 14.4 aide hours on third shift.

Review of staff timecards dated 01/29/22 revealed:
-There was a total of 16 aide hours provided on second shift for a shortage of 2 aide hour.
-There was a total of 8 aide hours provided on third shift for a shortage of 6.4 aide hours.

Review of the facility's resident census report revealed the SCU census was 18 on 01/30/22 which required 18 aide hours on first and second shifts and 14.4 aide hours on third shift.

Review of staff timecards dated 01/30/22 revealed:
-There was a total of 0 aide hours provided on first shift for a shortage of 18 aide hours.
-There was a total of 8 aide hours provided on third shift for a shortage of 6.4 aide hours.

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D 465	Continued From page 105 Review of the facility's resident census report revealed the SCU census was 18 on 01/30/22 which required 18 aide hours on first and second shifts and 14.4 aide hours on third shift. Review of staff timecards dated 01/31/22 revealed: -There was a total of 0 aide hours provided on first shift for a shortage of 18 aide hours. -There was a total of 7.75 aide hours provided on second shift for a shortage of 10.25 aide hours. -There was a total of 0 aide hours provided on third shift with for a shortage of 14.4 aide hours. Review of the facility's resident census report revealed the SCU census was 18 on 02/01/22 which required 18 aide hours on first and second shifts and 14.4 aide hours on third shift. Review of staff timecards date 02/01/22 revealed: -There was a total of 0 aide hours provided on first shift for a shortage of 18 aide hours. -There was a total of 16 aide hours provided on second shift for a shortage of 2 aide hour. -There was a total of 0 aide hours provided on third shift for a shortage of 14.4 aide hours. Interview with an agency MA on 02/03/22 at 8:30 am revealed: -There was one resident on the SCU that required total assistance from staff for care. -There were three residents that could be combative so two staff were needed to attend to care needs to ensure safety. Interview with the Resident Care Coordinator (RCC) on 01/26/22 at 10:19am revealed: -She completed the schedule monthly for the facility.	D 465		

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D 465	Continued From page 106 -She verified staff were present daily in the facility. -She sent available shifts to agencies to fill. -The facility was short staffed and much of the staff on duty were agency staff. -The SCU unit needed 3 PCAs and 1 MAs (who was shared with AL) on duty to meet the needs of the residents. Interview with Clinical Operations Specialist #1 on 01/26/22 at 10:25am and 12:09pm revealed: -The SCU needed 2 PCAs and 1 MA who was shared with AL on duty for first and second shift. -There was 1 MA on duty on third shift for both AL and the SCU. -When the facility was short staffed, she expected the MA on duty to split their time between the SCU and AL but spend more time on the SCU. _____ The facility failed to ensure the SCU was staffed to meet minimal staffing requirements for 7 of 9 shifts sampled resulting in the SCU being understaffed at times by 1 or more care staff for the entire shift. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 February 3, 2022 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 25, 2022.	D 465		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing	D 466		

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D 466	Continued From page 107 (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week to oversee resident care, which included coordinating, supervising, and evaluating resident services to ensure each resident received care and services appropriate to each resident's needs. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 96 beds including 60 beds for the assisted living (AL) area and 36 beds for the special care unit (SCU). Interview with a personal care aide (PCA) on 01/25/22 at 7:30am revealed the facility had a SCU director but she left before Christmas but she could not remember the exact date. Observations in the SCU on 02/03/22 from 8:45am to 9:30am revealed: -There were 16 residents residing in the SCU. -There were 2 PCAs on duty in the SCU; one was a full-time facility employee and the other PCA was agency staff. -The medication aide (MA) administered medications in the SCU along with medications	D 466		

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on one AL hall.
-There was an office designated for the SCU coordinator but there was no coordinator observed on the SCU.

Interview with a facility PCA on 02/03/22 at 9:15am revealed there were currently 16 residents in the SCU; one resident was currently in the hospital.

Observations in the SCU on 02/07/22 from 8:57am to 9:35am revealed:
-There were 15 residents who resided in the SCU.
-There were 2 residents who were currently in the hospital.
-There were 2 PCAs were on duty in the SCU who worked for a staffing agency.
-The MA administered medications in the SCU along with medications on D hall of the AL side.
-The was no SCU coordinator and no other staff on the SCU unit.

Telephone interview with a medication aide (MA) on 02/07/22 at 11:23am revealed:
-The MAs were considered the supervisors for the facility when the Resident Care Coordinator (RCC) or Health and Wellness Director (HWD) were not in the building.
-The Resident Care Coordinator had recently quit and the Health and Wellness Director (HWD) was just hired and there was not a care coordinator for the SCU.

Interview with an agency PCA on 02/07/22 at 9:08am revealed:
-If there were any problems with a resident, she would report it to the MA (she was not sure of her name).
-She was not aware of a SCU Coordinator; she

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D 466	Continued From page 109 had never seen anyone. Interview with the Divisional Director of Operations on 02/07/22 at 8:26am revealed: -The facility was currently recruiting and hiring for several management positions. -The SCU manager position was filled and to start on 03/07/22 provided the criminal background check came back without any findings to prevent them from being hired.	D 466		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to physical environment, personal care aide and other staffing, medication administration, and special care unit staffing. The findings are: 1. Based on observations and interviews, the facility failed to ensure 7 of 7 exit doors accessible by residents known to be disoriented were equipped with a sounding device that was activated when the door was opened and staff were not using pagers to receive alerts if these	D912		

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D912	Continued From page 110 doors were opened. [Refer to Tag D067, 10A NCAC 13F .0305 (h)(4) (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the assisted living (AL) area of the facility were met for 10 of 21 shifts sampled for 01/17/22, 01/21/22, 01/22/22 and 01/29/22 through 02/01/22. [Refer to Tag D188, 10A NCAC 13F .0604 (2) Personal Care and Other Staffing (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication pass on 01/25/22 by 1 of 2 medication aides (MA) observed who failed to wash or sanitize her hands prior to preparing and after administering multiple medications to multiple residents after adjusting her face mask with ungloved hands further placing the residents at risk of transmission of pathogens and contamination for COVID-19 due to a current and confirmed outbreak of COVID-19 in the facility that began on 01/05/22. [Refer to Tag D 371, 10A NCAC 13F .1004 (n) Medication Administration (Type B Violation)]. 4. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the special care unit (SCU) for 7 of 9 shifts sampled on 01/17/22, 01/21/22 and 01/22/22. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights	D914		

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D914	Continued From page 111 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect and as related to an emergency plan, other requirements, staffing of personal care aide supervisors, health care, medication administration, and implementation. 1. Based on interviews and record reviews, the facility failed to develop a written Emergency Disaster Plan and have sufficient preparations for impending inclement weather, which resulted in only one staff on duty to provide care for 55 residents including 18 residents that resided on a Special Care Unit (SCU) for at least 10 hours. [Refer to Tag D102, 10A NCAC 13F .0309 (d) Plan for Evacuation (Type A2 Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to ensure the facility's call system was operational as designed to ensure residents' calls for assistance would be received by staff resulting in at least one resident (#10) having to call 911 for assistance to get off the floor after falling. [Refer to Tag D105, 10A NCAC 13F .0311(a) Other Requirements (Type A2 Violation)]. 3. Based on interviews and record reviews, the facility failed to ensure there was a supervisor on duty at all times to provide supervision of direct care staff and implementation of the facility's	D914		

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policies and procedures. [Refer to Tag D212, 10A NCAC 13F .0605 (a) Staffing of Personal Care Aide Supervisors (Type A2 Violation)].

4. Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 3 of 7 sampled residents (#9, #11, #12) as related to failure to notify the primary care provider (PCP), emergency medical services (EMS) and hospice for a resident who was found on the floor and had changes in condition (#9); failure to notify the PCP of meal refusals, mobility status change, and complaints of not feeling well (#11); and failure to notify the PCP of a resident's hospitalization, not receiving insulin for 11 days, and completion of follow up appointments as ordered including a referral for occupational therapy/physical therapy (OT/PT) and follow-up with the PCP after a six day hospitalization (#12). [Refer to Tag D273, 10A NCAC 13F .0902(b) (Type A1 Violation)].

5. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 4 of 6 sampled residents with 3 of 4 residents (#6, #7, #8) observed during the medication pass including errors in which the wrong form of a medication was administered (#6), medications almost administered to the wrong resident (#7), medications missed and omitted from the medication pass (#7), and a medication used to treat mental and mood disorders was administered two hours late (#8). [Refer to Tag D 358, 10A NCAC 13F .1004 (a) Medication Administration (Type A2 Violation)].

6. Based on observation, interviews and record reviews, the facility failed to ensure staff were

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D914	Continued From page 113 available and trained to maintain the overall operations of the facility, meet the heath care and other needs of the residents, and ensure care and services were delivered in a safe manner for a total facility census of at least 55 residents which included a Special Care Unit (SCU) with a census of 17. [Refer to Tag D980, GS 131D-25 Implementation (Type A1 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, interviews and record reviews, the facility failed to ensure staff were available and trained to maintain the overall operations of the facility, meet the heath care and other needs of the residents, and ensure care and services were delivered in a safe manner for a total facility census of at least 55 residents which included a Special Care Unit (SCU) with a census of 17. The findings are: Telephone interview with Clinical Operations Specialist #1 on 02/03/22 at 12:55pm revealed: -The weakness within the facility was their dependence on agency staff. -They only had 7 facility staff of their own.	D980		

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D980	Continued From page 114 -She was assigned to the building in October and she generally worked 10 days on and 4 days off. -She returned home to a different state when her rotation was over and had been rotating in and out of this building since October 2022. -This time she came in 01/03/22 and she was in the building through 01/27/22. -There was another COS (COS#3) in the same role and COS #3 was in the building on when she was on leave. -COS #3 usually rotated into a facility for 5 days, Monday through Friday. -The was an Administrator over another sister facility who functioned as the Administrator. Interview with the Administrator on 02/04/22 at 1:27pm revealed: -She was the full time Administrator for a sister facility and was only in this facility once a week on Thursdays. -She "wasn't sure how things were done in this facility, I only knew how things worked at my other facility". Interview with the Administrator on 02/08/22 at 12:15pm revealed: -The facility had a problem with being short-staffed (time not specified). -The facility was primarily staffed with agency staff, but the staff from the staffing agencies were not reliable because they called out or would not pick up the phone for staffing assignments. Interview with the Resident Care Coordinator (RCC) on 01/26/22 at 10:19am revealed: -She sent available shifts to staffing agencies to fill. -The facility was short staffed and much of the staff on duty were with an agency.	D980		

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D980	Continued From page 115 Interview with a medication aide (MA) on 02/07/22 at 5:26pm revealed: -She had not received training on the facility's policies and procedures regarding how to respond in the event of an incident. -The MAs were often in charge after management left on second and third shifts. Interview with a MA on 02/05/22 at 3:30pm revealed: -She was an agency staff. -She had worked at the facility "off and on" since October 2021. -She received no orientation or training before being assigned to a medication cart to administer medications to residents at the facility. -Her orientation to the facility consisted of her being "handed" the keys to the medication cart. -She was not oriented to the facility's policies and procedures. 1. Based on observations and interviews, the facility failed to ensure 7 of 7 exit doors accessible by residents known to be disoriented were equipped with a sounding device that was activated when the door was opened and staff were not using pagers to receive alerts if these doors were opened. [Refer to Tag D067, 10A NCAC 13F .0305 (h)(4) (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to develop a written Emergency Disaster Plan and have sufficient preparations for impending inclement weather, which resulted in only one staff on duty to provide care for 55 residents including 18 residents that resided on a Special Care Unit (SCU) for at least 10 hours. [Refer to Tag D102, 10A NCAC 13F .0309 (d) Plan for Evacuation (Type A2 Violation)].	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092220	A. BUILDING: _____ B. WING _____	R 02/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

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D980	Continued From page 116 3. Based on observations, record reviews, and interviews, the facility failed to ensure the facility's call system was operational as designed to ensure residents' calls for assistance would be received by staff resulting in at least one resident (#10) having to call 911 for assistance to get off the floor after falling. [Refer to Tag D105, 10A NCAC 13F .0311(a) Other Requirements (Type A2 Violation)]. 4. Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the assisted living (AL) area of the facility were met for 10 of 21 shifts sampled for 01/17/22, 01/21/22, 01/22/22 and 01/29/22 through 02/01/22. [Refer to Tag D188, 10A NCAC 13F .0604 (2) Personal Care and Other Staffing (Type B Violation)]. 5. Based on interviews and record reviews, the facility failed to ensure there was a supervisor on duty at all times to provide supervision of direct care staff and implementation of the facility's policies and procedures. [Refer to Tag D212, 10A NCAC 13F .0605 (a) Staffing of Personal Care Aide Supervisors (Type A2 Violation)]. 6. Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 3 of 7 sampled residents (#9, #11, #12) as related to failure to notify the primary care provider (PCP), emergency medical services (EMS) and hospice for a resident who was found on the floor and had changes in condition (#9); failure to notify the PCP of meal refusals, mobility status change, and complaints of not feeling well (#11); and failure to notify the PCP of a resident's hospitalization, not receiving insulin for 11 days, and completion of follow up appointments as	D980		

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D980	Continued From page 117	D980		

ordered including a referral for occupational therapy/physical therapy (OT/PT) and follow-up with the PCP after a six day hospitalization (#12). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

5. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 4 of 6 sampled residents with 3 of 4 residents (#6, #7, #8) observed during the medication pass including errors in which the wrong form of a medication was administered (#6), medications almost administered to the wrong resident (#7), medications missed and omitted from the medication pass (#7), and a medication used to treat mental and mood disorders was administered two hours late (#8). [Refer to Tag D 358, 10A NCAC 13F .1004 (a) Medication Administration (Type A2 Violation)].

7. Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication pass on 01/25/22 by 1 of 2 medication aides (MA) observed who failed to wash or sanitize her hands prior to preparing and after administering multiple medications to multiple residents after adjusting her face mask with ungloved hands further placing the residents at risk of transmission of pathogens and contamination for COVID-19 due to a current and confirmed outbreak of COVID-19 in the facility that began on 01/05/22. [Refer to Tag D 371, 10A NCAC 13F .1004 (n) Medication Administration (Type B Violation)].

8. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs

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D980	Continued From page 118 of residents residing in the special care unit (SCU) for 7 of 9 shifts sampled on 01/17/22, 01/21/22 and 01/22/22. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)]. The facility failed to ensure staff were available and trained to meet the health and safety needs of the residents residing in the facility. Staff were left in charge of the facility who had not been trained on the policies and established procedures of the facility. The facility's failure resulted in medication errors and medications not being administered on time or omitted; delays in response to residents' call bells; delays in response to acute changes in heath care needs and conditions; and staff being unaware of how to respond in the event of an emergency and inclement weather. The facility's failure resulted in serious physical harm and neglect which constitutes a Type A1 violation. A Directed Plan of Protection was issued to the facility on 02/07/22. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 10, 2022.	D980		