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D 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on September 24, 25 and 26, 2019.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 5 sampled resident (#1) related to falls. The findings are: 1. Review of Resident #1's current FL-2 dated 06/10/19 revealed: -Diagnoses included frequent falls, depression, type 2 diabetes mellitus, hypertension, hyperlipidemia, and overactive bladder. -Resident #1 needed assistance with bathing and dressing. -Resident #1 was documented as semi-ambulatory and there was no documentation for an assistive device. -There was an order for physical therapy (PT) three times a week, there was no documentation for a length of time for PT services. Review of Resident #1's Resident Register revealed no specific admission date and was	D 270		

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signed by Resident #1's power of attorney on 05/09/19.

Review of Resident #1's Care Plan dated 06/17/19 revealed:
-The care plan documented Resident #1 needed checks "every two hours."
-The care plan documented Resident #1 had a history of falls within the past 3 months, was currently working with PT, incontinent of bladder and bowel and used disposable briefs, used an assistive device (walker), and independent with transfers.

Review of the facility's resident care Fall Risk Program revealed:
-Residents were to be "screened before and upon admission to the facility.
-Residents were "screened" again if they had a change in condition, when care plans were updated, and after an event.
-The instructions listed after the first fall were as follows: obtain and document the resident's vital signs, complete and document a skin assessment, check the resident's room for environmental hazards, complete incident/accident report, notify and document the residents physician of the fall via fax, obtain fax confirmation, and notify and document the resident's authorized representation of the fall.
-The instructions listed after the second fall within 30 days included all the first fall instructions and obtain an order for a urinalysis, culture and sensitivity, physical therapy assessment for fall prevention.
-The instructions after the third fall within 30 days included all the first fall instruction and arrange for physician's office visit for assessment and blood work; place the resident on hourly checks for 72 hours (the checks will consist of pushing the

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resident's pendant and resetting upon leaving the resident to generate a log); if the system was down, use paper to document checks; and after 72 hours document in the resident's chart that hourly checks were completed.
-The instructions listed after the fourth fall within 30 days included all the first fall instructions and place resident on 30 minute checks for the next 24 hours, then hourly checks for 72 hours; after 24 hours document in the resident chart that 30 minute checks were completed and after the subsequent 72 hours document in the resident's chart that hourly checks were completed; and arrange a care conference with the family and key care team members to develop an individualized plan of care to prevent falls.

Review of an incident/accident report for Resident #1 dated 09/02/19 revealed:
-Resident #1 fell during the evening shift at 10:30 pm.
-Resident #1 fell in her living room and was found lying on the floor.
-Resident #1 was reaching for her walker and complained of soreness; the location of soreness was not documented.
-Resident #1 was not sent to the hospital.
-There was no documentation of any injuries after the fall for Resident #1.
-There was no documentation in the section listed for "Corrective Measures."

Review of Resident #1's progress notes dated 09/02/19 revealed:
-There was a note documented at 11:52 pm by the Medication Aide (MA) who responded to Resident #1's fall.
-There was documentation Resident #1 had no injuries.
-There were no subsequent notes for 09/02/19

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and no documentation of fall prevention interventions.

Review of Resident #1's resident care plan September 2019 summary notes revealed:
-There was documentation that Resident #1 was on every 2 hour checks.
-There were no written notes documented for 09/02/19 on the caregiver notes page.

Interview with the medication aide (MA) who completed the incident/accident report dated 09/02/19 on 09/25/19 at 5:10 pm revealed:
-The MAs were to document for 72 hours after a fall for all resident falls on each shift.
-She did not recall when Resident #1 fell on 09/02/19.
-The MAs completed an incident/accident report for all falls, notified the physician via faxed notification, notified the family and called emergency medical services (EMS) if the resident hit their head or could not get up without assistance.
-There were no interventions put into place after Resident #1's 09/02/19 fall that she could recall.
-Resident #1 was reminded to use her pendant to call for assistance with toileting, ambulating or any needs.

Interview with Resident #1 on 09/24/19 at 11:51 am revealed:
-Staff told her to use her pendant when she wanted to ambulate or use the restroom.
-She used a rollator walker and often the rollator walker was to far ahead of her, she reached for it and fell into her recliner and then went down to the floor.
-She had bruises on her legs prior to admission, but she was not injured after the 09/02/19 fall.
-Staff reminded her to use her walker and use her

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pendant to call for help.
-Staff checked on her but she did not know exactly how often.

Review of an incident/accident report for Resident #1 dated 09/03/19 revealed:
-Resident #1 fell during first shift at 11:40 am.
-Resident #1 fell in the hallway ambulating to the dining room.
-Resident #1's walker was ahead of her and she was not moving her feet.
-Staff saw that the walker was too far ahead of the resident but were not able to reach Resident #1 in time to prevent the fall.
-Resident #1 was able to stand back up after she fell.
-EMS was not called and there was no documentation Resident #1 had injuries.
-There was no documentation in the section for "Corrective Measures."

Review of Resident #1's progress notes dated 09/03/19 revealed:
-The MA who witnessed Resident #1's 09/03/19 fall wrote a note at 12:48 pm.
-Resident #1 fell in the hallway in route to the dining room and landed on her left side.
-Resident was able to stand after the fall.

Review of Resident #1's resident care plan September 2019 summary notes revealed:
-There was documentation that Resident #1 was on every 2 hour checks.
-There were no written notes documented for 09/03/19 on the caregiver notes page.

Interview with a MA who completed the incident/accident report dated 09/03/19 on 09/25/19 at 2:36 pm revealed:
-She recalled Resident #1's fall on 09/03/19 and

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she was not able to reach Resident #1 in time to prevent the fall in the hallway.
-She saw Resident #1 ambulating in the hallway coming towards the dining room and Resident #1's rollator walker was too far ahead of her body.
-She started towards Resident #1 as she fell but was not able to reach her.
-Resident #1 had no injuries, EMS was not called, and Resident #1 did not hit her head.
-There were no interventions put into place to prevent Resident #1 from falling after the 09/03/19 fall.

Interview with Resident #1 on 09/25/19 at 10:53 am revealed:
-She was embarrassed by the fall in the hallway.
-Her feet sometimes did not move when she thought they were moving.
-She was told by staff to use her pendant to call for assistance.

Review of an incident/accident report for Resident #1 dated 09/04/19 revealed:
-Resident #1 fell on night shift at 4:30 am.
-Resident #1 fell on her way from the bathroom and was found on the floor.
-Resident #1 did not have any documented injuries and there was documentation she did not hit her head.
-There was no documentation in the section for "Corrective Measures."

Review of Resident #1's progress notes dated 09/04/19 revealed:
-PT completed a note that documented fall prevention education and Resident #1 complained of back and lower extremity stiffness.
-There was no time documented for the note written by PT.
-The MA who responded to Resident #1's fall on

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09/04/19 documented Resident #1 fell coming from the bathroom.
-Resident #1 used her pendant to notify staff that she fell and was able to stand up after the fall.
-Resident #1 did not have any documented injuries.
-Another MA on day shift documented Resident #1 did not have any pain during the day shift.

Review of Resident #1's resident care plan September 2019 summary notes revealed:
-There was documentation that Resident #1 was on every 2 hour checks.
-There was one written note documented for 09/04/19 indicating Resident #1 fell and was not using her walker on the caregiver notes page.
-There was documentation in the note that Resident #1 was trying to get to the bathroom in an urgent manner on the caregiver notes page.

Attempted telephone interview with MA who completed the incident/accident report for 09/04/19 on 09/25/19 at 6:58 am was unsuccessful.

Interview with Resident #1 on 09/25/19 at 10:53 am revealed:
-She did not think the staff understood when she had to use the bathroom she was not able to wait.
-She did use her pendant but it took several minutes for the staff to arrive to assist her.
-She often went to the bathroom without staff assistance.

Review of an incident/accident reports for Resident #1 revealed there was no incident report provided dated 09/12/19.

Review of Resident #1's progress notes dated 09/12/19 revealed there was one note written by

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a MA at 9:30 pm documenting Resident #1 fell and EMS was called to evaluate Resident #1.

Review of Resident #1's resident care plan September 2019 summary notes revealed:
-There was documentation that Resident #1 was on every 2 hour checks.
-There was no written note for 09/12/19 documenting Resident #1 fell on the caregiver notes page.

Interview with a MA who documented the progress note dated 09/12/19 on 09/25/19 at 2:54 pm revealed:
-Resident #1 was first responded to by the personal care aide (PCA).
-The PCA came and reported Resident #1's fall.
-Resident #1 was trying to remove her socks while sitting at the foot of the bed and fell over.
-Resident #1 was found on the floor at the foot of the bed and EMS was called, but Resident #1 refused to go to the emergency room.
-EMS came and assisted Resident #1 off of the floor.
-Resident #1 had no injuries but Resident #1 told her she was not able to get up from the floor without help, so she called EMS.
-Staff were not allowed to get a resident up from a fall if the resident could not assist.
-When a pendant was pressed by a resident, the call was sent to PCAs first, then it escalated to MAs after 4 minutes, after 8 minutes the call was received on the pagers of the Wellness Coordinators, after 12 minutes the call was received by the Resident Care Manager (RCM).
-Staff checked Resident #1 every 2 hours and after her 9/13 and 9/14 falls she was checked every hour to hour and half.
-The checks were not documented by staff and she was never instructed to document the

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D 270	Continued From page 8 checks. Interview with Resident #1 on 09/25/19 at 10:53 am revealed she did not recall a fall on 09/12/19 because she had so many falls. Review of an incident/accident report for Resident #1 dated 09/13/19 revealed: -Resident #1 fell and the time of day was not documented. -Resident #1 fell while ambulating in hallway with a family member. -Resident #1's family member assisted her to stand. -Resident #1 denied pain and injury. -There was no documentation in the section for "Corrective Measures." Review of Resident #1's progress notes dated 09/13/19 revealed: -There was a note written by a night shift MA at 5:40 am documenting Resident #1 did not have any issues during the shift. -There was a note written by a day shift MA at 3:33 pm documenting Resident #1's fall in the hallway. -Resident #1 was returning from an orthopedic appointment when she fell in the hallway with a family member. -Resident #1 denied injuries and refused to be sent to the local emergency room. -There was a note written by the Assisted Living (AL) Wellness Coordinator documenting Resident #1 fell on 09/12/19 but declined EMS. -The AL Wellness Coordinator also documented Resident #1 was taken to an orthopedic appointment on 09/13/19 and returned with the diagnosis of fracture to the right wrist and wearing a soft cast.	D 270		

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Review of Resident #1's record revealed there was note from the orthopedic clinic signed by the physician indicated Resident #1 had a wrist fracture, required a cast, and was to have decreased use of the affected hand.

Review of Resident #1's resident care plan September 2019 summary notes revealed:
-There was documentation that Resident #1 was on every 2 hour checks.
-There was written note for 09/13/19 documenting Resident #1 fell, hit her head, and was transferred via EMS on the caregiver notes page.

Interview with the Memory Care Unit (MCU) Wellness Coordinator/MA who completed the incident/accident report dated 09/13/19 on 09/26/19 at 9:55 am revealed:
-She was covering the facility while the other management staff were at training on 09/13/19.
-She heard staff over the radio system request assistance on the second floor and she responded.
-Resident #1 fell in the hallway with a family member by her side.
-Resident #1 was helped to stand by her family member and both Resident #1 and the family member refused EMS transport.
-She told the AL Wellness Coordinator about the fall via telephone.
-Resident #1 denied injuries and she was wearing a cast from her appointment with the orthopedic physician.
-She was not familiar with the falls policy and was still in training and learning the falls policy.
-She was not aware of any interventions put into place for Resident #1 after the 09/13/19 fall.

Interview with Resident #1 on 09/25/19 at 10:53 am revealed:

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D 270	Continued From page 10 -A family member took her to see the orthopedic physician on 09/13/19 and she was told she had broken her wrist and hand in two places. -When her family member brought her back to the facility, she fell in the hallway, she got tired sometimes after ambulating for a while. -She was told to use her pendant to call for assistance. -PT ordered a support bracket for her broken wrist so she could continue to use her walker. Review of an incident/accident report for Resident #1 dated 09/14/19 revealed: -Resident #1 fell on the night shift at 11:15 pm. -Resident #1 fell in her room and was found on the floor. -Resident #1 was putting on a disposable brief and lost her balance. -Resident #1 did not have any documented injuries. -There was no documentation in the section listed for corrective measures. Review of Resident #1's progress notes dated 09/14/19 revealed: -There was a note written by a MA at 6:00 am that Resident #1 did not have any issues during the shift. -There was a note written by a MA at 11:56 am that Resident #1 did not have any issues during the shift. -There was a note written by a MA at 3:00 pm that Resident #1 had "no complaints of pain from previous fall". -There was a note written by a MA at 10:54 pm that Resident #1 had no complaints of pain during the shift. -There was a note written by a MA at 11:20 pm that Resident #1 was found on the floor at shift change.	D 270		

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-Resident #1 was trying to get ready for bed and put on a disposable brief.
-Resident #1 did not have any injuries.

Review of Resident #1's resident care plan September 2019 summary notes revealed:
-There was documentation that Resident #1 was on every 2 hour checks.
-There was written note for 09/14/19 documenting Resident #1 had no issues during the shift since previous fall and Resident #1 was using her pendant more to obtain staff assistance on the caregiver notes page.

Interview with the MA who completed the incident/accident report dated 09/14/19 on 09/26/19 at 6:49 am revealed:
-The facility had a "no lift policy" and any resident who was not able to stand up after a fall had EMS called to assess the resident and assist them off of the floor.
-The falls policy required the MA to document 48 hours after a resident fell.
-She did recall Resident #1's fall on 09/14/19.
-Resident #1 was found on the floor, but she did not have any injuries.

Interview with Resident #1 on 09/25/19 at 10:53 am revealed she did not recall the fall on 09/14/19.

Review of an incident/accident report for Resident #1 dated 09/15/19 revealed:
-Resident #1 fell at 5:05 am on night shift.
-Resident #1 was found in her shower holding the back of her head, shaking, but without complaint of pain.
-Resident #1 was bleeding from the back of her head and EMS was called.
-Resident #1 was transported to the emergency

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room.
-There was no documentation in the section listed for corrective measures.

Review of Resident #1's hospital discharge summary dated 09/15/19 revealed:
-Resident #1 reported falling after walking to the bathroom but she did not lose consciousness.
-Resident #1 had dried blood to the back of the head and a 1.5 centimeter abrasion versus very superficial laceration.
-Resident #1 did not require stitches and was discharged back to the facility from the emergency room (ER).

Review of Resident #1's progress notes dated 09/15/19 revealed:
-At 5:05 am, Resident #1 was found on the shower floor holding her head and Resident #1's head was bleeding.
-Resident #1 was transported to the ER via EMS.
-There was a note written by a MA at 3:00 pm documenting Resident #1 returned from the ER without any new orders.
-At 3:00 pm, Resident #1 needed to be assisted to the restroom and to meals.
-At 10:00 pm, Resident #1 had complaint of right arm pain and had a over the counter pain reliever.
-Resident #1 reported struggling with needing assistance because she was used to being independent.

Review of Resident #1's resident care plan September 2019 summary notes revealed:
-There was documentation that Resident #1 was on every 2 hour checks.
-There was no written note for 09/15/19 on the caregiver notes page.

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D 270	Continued From page 13 Interview with the MA who completed the incident/accident report for Resident #1 dated 09/15/19 on 09/26/19 at 6:49 am revealed: -Resident #1 was transferred to the ER because her head was bleeding. -Resident #1 got up without using her pendant on 09/15/19. -There were no specific instructions given concerning Resident #1 falling. -There were no new orders from the hospital. -There were no new interventions for Resident #1 after the falls on 09/14/19 and 09/15/19. Interview with Resident #1 on 09/25/19 at 10:53 am revealed: -She recalled going to the emergency room but not the exact date. -She did fall in the shower and did not know her head was bleeding until she sat up and saw the blood on the floor of the shower. -The physician did not know if she needed stitches or not until right before she was discharged back to the facility. -She did not have stitches but had a small knot on her head and the knot had improved since the fall. -She was told by staff to use her pendant to call for assistance. Review of incident/accident report dated 09/21/19 revealed: -Resident #1 fell on day shift at 7:15 am. -Resident #1 fell in the bathroom and was found face down on the bathroom floor. -Resident #1 did not know how she fell and EMS were called but Resident #1 refused transport. -Resident #1 did not have any injuries. -There was no documentation in the section listed for corrective measures.	D 270		

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Review of Resident #1's progress notes revealed:
-There was a note dated 9/17/19 written by the AL Wellness Coordinator that Resident #1's family member was contacted about obtaining a sitter because Resident #1 had two falls after 09/13/19.
-The note documented the family member would call the agency that would provide the sitter.
-There was a note dated 09/18/19 written by a MA documenting Resident #1's rollator walker was switched to a regular walker.
-There was a note written on 09/21/19 that Resident #1 fell and did not have any documented injuries.

Review of Resident #1's resident care plan September 2019 summary notes revealed:
-There was documentation that Resident #1 was on every 2 hour checks.
-There was written note for 09/21/19 documenting Resident #1 fell, after slipping in the bathroom on the caregiver notes page.

Interview with the MA who completed the incident/accident report dated 09/21/19 on 09/25/19 at 2:54 pm revealed:
-Resident #1 fell at change of shift and was initially found on the floor by a PCA.
-Resident #1 was face down in the shower, EMS was called and assisted Resident #1 to stand after she was assessed.
-Resident #1 refused transport to the local ER.
-Resident #1 had the splint in place and EMS did not report any injuries from the 09/21/19 fall.
-There were no new interventions put into place after the 09/21/19 fall.

Interview with Resident #1 on 09/25/19 at 10:53 am revealed:
-She refused transport often because they always wanted to send her to the ER but she was not

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injured.
-She told her family member that she did not agree with having a sitter because of the cost.
-She did not know what happened to make her fall in the past few days.
-Staff had been coming in during the night shift to check her more often the last few days, but she could not recall how often.

Review of an incident/accident report for Resident #1 dated 09/23/19 revealed:
-Resident #1 fell on night shift at 6:50 am.
-Resident #1 was found on the floor of her bedroom.
-Resident #1 reported she was trying to use the bathroom.
-Resident #1 did not have any documented injuries.
-There was no documentation in the section listed for corrective measures.

Review of Resident #1's progress notes dated 09/23/19 revealed;
-There was a note written at 6:50 am by a MA that Resident #1 fell without injuries.
-Resident #1 was trying to reach the bathroom.

Review of Resident #1's resident care plan September 2019 summary notes revealed:
-There was documentation that Resident #1 was on every 2 hour checks.
-There was no written note for 09/23/19 on the caregiver notes page.
-There was a noted dated 09/25/19 indicating "remind resident to use call pendant due to falls" on the caregiver notes page.

Interview with Resident #1 on 09/25/19 at 10:53 am revealed:
-She fell a few days ago trying to get to the

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bathroom.
-She had accidents with regard to toileting in the past and when she had to get to the bathroom it was hard to wait for someone to respond to the pendant.
-She had waited for several minutes at a time for staff to respond to her pendant call in the past, it felt like an hour sometimes.
-She left her room door unlocked now because staff were coming in at night to check her more often.

Attempted telephone interview with Resident #1's physician on 09/25/19 at 3:52 pm and 09/26/19 at 9:34 am were unsuccessful.

Interview with the RCM on 09/25/19 at 4:35 pm revealed:
-She expected the MA to assess residents when they fell to determine if the resident was injured.
-If a resident hit their head, EMS was called and if the resident did not have any injuries they did not go to the local ER.
-The MAs notified the resident's physician and family member.
-She was responsible for looking at the circumstances surrounding the fall and reviewing the incident/accident reports.
-Interventions were put into place based on the circumstances of the fall.
-"Sitters were recommended as a last resort."
-She expected staff to follow the falls policy for residents who fell frequently.
-The resident call pendants caused the staff pagers to alert when the pendants were pressed.
-The first staff alerted were PCAs, then when four minutes passed without resetting the pendant the MAs were alerted, then in four more minutes the AL Wellness Coordinator would be alerted, and if the pendant was not reset she would be alerted

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via a phone call.
-There was an "at risk meeting" held each month that included the Wellness Coordinators, PT, and herself.
-The last meeting was held in August 2019 and Resident #1 was doing better at that time related to falls.
-There was an "at risk meeting" planned for September 2019.

Interview with PT on 09/26/19 at 10:21 am revealed:
-PT worked with Resident #1 on balance, gait strength, and coordination since June 2019.
-Resident #1 had improved but Resident #1 was non-compliant with using her walker and pendant.
-Resident #1's assistive device was changed after the 09/23/19 fall from a rollator to a regular walker.
-A platform for Resident #1's right arm was ordered so that the walker could be used easily with the cast.
-In response to Resident #1's frequent falls, assistive device training was completed with staff and Resident #1, a reminder to Resident #1 to use the pendant consistently, and request assistance for mobility.
-Resident #1 was very independent.
-She had sent numerous notes to Resident #1's physician and left several messages but had not received a response.
-She met with the care managers monthly at the at -risk meeting to discuss residents who had falls.
-She met with Resident #1 one time per week.

Interview with AL Wellness Coordinator on 09/26/19 at 12:35 pm revealed:
-When a resident fell, she investigated the cause of the fall and the resident was discussed at the

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at risk meetings.
-Staff tried to discuss the falls with the resident's physician, may order labs to check for a urinary tract infection, and discuss interventions at the at risk meeting that was held every other week.
-She did not know Resident #1 had fallen nine times in the past 26 days and she thought she had fallen 5 or 6 times.
-Resident #1 was monitored and encouraged to use her pendant to call for assistance.
-Staff documented resident falls on the resident care summary notes, the 24 hour report and in the resident record.
-When Resident #1 fell on 09/02/19, 09/03/19, and 09/04/19, Resident #1 was encouraged to use her pendant to call for assistance and continued working with PT.
-When Resident #1 fell on 09/12/19, she refused transport by EMS to the local ER and attended an orthopedic appointment on 09/13/19 with her family member.
-Resident #1 fell upon returning from the appointment.
-There were no new interventions put into place after the 09/12/19 and 09/13/19 falls.
-On 09/14/19, she spoke with staff to tell them to do hourly checks on Resident #1 but it was not documented anywhere because staff pressed a button on the wall of the resident's room indicating the checks were completed.
-After the 09/15/19 fall there were no new interventions put into place.
-She called the family on 09/23/19 to discuss setting up a meeting due to a need for a plan of care after the repeated falls.
-The meeting was scheduled for 09/26/19 at 1:30 pm.
-A sitter was discussed with Resident #1's family but it was declined.
-Resident #1's neurologist was not notified about

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the falls or asked about interventions.
-Resident #1 was not placed on every 30 minute checks as indicated in the falls policy after the fourth fall.
-Staff was expected to document each shift for 48 hours after a fall, but she did not review the progress notes to ensure staff were documenting.

Second interview with the RCM on 09/26/19 at 2:39 pm revealed:
-She and the Administrator reviewed the incident/accident reports for each resident.
-She knew the staff did not know the falls policy and did not follow the falls policy because it had only been reviewed for staff upon hire.
-She knew there were no new interventions implemented after each of Resident #1's falls.
-She was responsible for ensuring the training was provided to staff on the falls policy.
-She was responsible for ensuring interventions were implemented to assist preventing Resident #1 from falling.
-Resident #1 was doing well and then began to fall again suddenly in September 2019.

Interview with Administrator on 09/26/19 at 4:10 pm revealed:
-The RCM was responsible for ensuring interventions were put into place to assist Resident #1 from falling.
-She expected staff to complete incident/accident reports when residents fell and to notify the family and physician.
-Staff were expected to remind residents to use their pendants, PT should get involved, as well as the families.
-She knew Resident #1 fell frequently prior to her admission to the assisted living and that was the reason for her admission to assisted living.
-She expected staff to check on Resident #1

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D 270	Continued From page 20 more often due to the number of falls the resident had. -She expected the RCM to track the falls and the number of falls a resident had to utilized for a plan to prevent the resident from falling. _____ The facility failed to supervise Resident #1 who had a history of frequent falls, a diagnosis of dementia, and used walkers to assist with ambulation. This failure resulted in Resident #1 experiencing 9 falls between 09/02/19 - 09/23/19 resulting in a broken right wrist, scalp abrasion and multiple bruises. The facility's failure resulted in substantial risk of serious injury to Resident #1 and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/26/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 26, 2019	D 270		
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 B VIOLATION	D 358		

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D 358	Continued From page 21 Based on interviews and record reviews, the facility failed to administer medication to 1 of 5 sampled residents (Resident #2) as ordered by a licensed prescribing provider related to administering a nonsteroidal anti-inflammatory medication (Ibuprofen) after it was ordered to be discontinued. The findings are: Review of Resident #2's current FL-2 dated 05/07/19 revealed diagnoses including hypertension, generalized weakness, Parkinson's disease and non-insulin dependent diabetes mellitus. Review of a physician's note dated 07/24/19 revealed: -The resident was seen by the facility's primary care provider (PCP) for complaints of back pain. -There was an order for Ibuprofen 400mg three times a day. -The ibuprofen was to be given routinely. Review of a Physician's Order form dated 07/25/19 revealed there was an order to increase Ibuprofen to 800mg three times a day to be given routinely. Review of a physicians note dated 07/31/19 revealed: -The resident was seen by the PCP for acute kidney injury. -There was an order to discontinue Ibuprofen. -There were instructions to encourage fluids and avoid nephrotoxins (substances injurious to the kidneys). Review of a Physician Order form dated 07/31/19 revealed there was an order to discontinue Ibuprofen.	D 358		

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D 358	Continued From page 22 Review of laboratory blood test results dated 07/26/19 revealed the resident's BUN/creatinine ration was 27 (normal reference range is 6-22) [elevated BUN/creatinine ration can indicate kidney damage]. Review of Resident #2's eMAR (electronic Medication Administration Record) for July 2019 revealed: -There was an electronic entry dated 07/24/19 for ibuprofen 400mg to be administered three times a day at 8:00am, 2:00pm and 9:00pm. -Ibuprofen 400mg was documented as administered at 8:00pm on 07/24/19 and once on 07/25/19 at 8:00am. -There was an electronic entry dated 07/25/19 for Ibuprofen 800mg to be administered three times a day at 8:00am, 2:00pm and 9:00pm. -There were 19 doses of Ibuprofen 800mg documented as administered 07/25/19 through 07/31/19. Review of Resident #2's eMAR for August 2019 revealed: -There was an electronic entry for Ibuprofen 800mg to be administered three times a day at 8:00am, 2:00pm and 9:00pm. -There were 92 doses documented as administered from 08/01/19 through 08/31/19. Review of Resident #2's eMAR for September 2019 revealed: -There was an electronic entry for Ibuprofen 800mg to be administered three times a day at 8:00am, 2:00pm and 9:00pm. -There were 31 doses documented as administered from 09/01/19 through 09/11/19. -There was an electronic entry for Ibuprofen 800mg to be discontinued 09/12/19 at 8:00am.	D 358		

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D 358	Continued From page 23 Telephone interview with a representative from the contracted pharmacy on 09/26/19 at 12:08pm revealed: -On 07/24/19 a physician's order was received for Ibuprofen 400mg to be administered three times a day to Resident #2. -On 07/25/19 a physician's order was received for Ibuprofen 800mg to be administered three times a day to Resident #2. -Pharmacy records documented 180 tablets of Ibuprofen 200mg were dispensed and delivered on 07/24/19. -Pharmacy records documented 90 tablets of Ibuprofen 400mg were dispensed and delivered to the facility on 07/25/19. -Pharmacy records documented 90 tablets of Ibuprofen 800mg were dispensed and delivered on 08/22/19. Interview with the Resident Care Manager (RCM) on 09/25/19 at 4:10pm revealed: -Once orders were received, the Resident Care Coordinator (RCC) sent the new order to the contracted pharmacy. -The pharmacy entered the medication order into the eMAR system. -Once the new order appeared in the eMAR system, the RCC reviewed and accepted the order. -The new order would then be available to the medication aides (MAs). -The RCM could not explain how two separate orders dated 07/31/19 to discontinue Resident #2's Ibuprofen were not sent to the pharmacy. Interview with the RCC on 09/26/19 at 12:35pm revealed: -When new medication orders were written on site in the facility by the PCP, she would fax the	D 358		

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D 358	Continued From page 24 order to the contracted pharmacy. -She would review the new order in the eMAR system once the pharmacy entered it. -If the order was correct the RCC would accept it and the new order would appear on the eMAR for the medication aides (MAs). -She "must have missed" the discontinue orders for Resident #2's Ibuprofen. -She was not aware Resident #2 was treated for acute kidney injury on 07/31/19. Attempted interview with Resident #2 on 09/24/19 at 3:20pm was unsuccessful. Attempted telephone interview with Resident #2's PCP on 09/25/19 at 2:50pm and on 09/26/19 at 9:17am were unsuccessful. _____ The facility failed to follow medication orders as written by the PCP and administered 123 doses of Ibuprofen to Resident #2 after the medication was ordered discontinued resulting in potential for further kidney damage. The facility's failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2019.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications	D 375		

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D 375	Continued From page 25 (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to obtain self-administer medication physician's order for 1 of 1 sampled resident (#1) who self-administered medications. The findings are: Review of Resident #1's current FL-2 dated 06/10/19 revealed: -Diagnoses included frequent falls, depression, type 2 diabetes mellitus, hypertension, hyperlipidemia, and overactive bladder. -There was a medication order for losartan potassium 100 mg (used to treat hypertension) one tablet daily. -There was a medication order for vitamin B12 1000 mg (used to treat vitamin B 12 deficiency) one tablet daily. -There was a medication order for magnesium 500 mg (used to treat magnesium deficiency) one tablet twice daily. -There was a medication order for vitamin D3 2000 mg (used to treat vitamin D deficiency) two	D 375		

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tablets daily.
-There was a medication order for Centrum (used to treat vitamin deficiency) one tablet daily.
-There was a medication order for prilosec 20 mg (used to treat gastric reflux) one tablet daily.
-There was a medication order for slow iron 45 mg (used to treat iron deficiency) one tablet daily.
-There was a medication order for Culturelle (used to aid digestion) one tablet daily.
-There was a medication order for Trintellix 20 mg (used to treat depression) one tablet daily.
-There was a medication order for trazadone 150 mg (used to treat insomnia) one tablet daily.
-There was a medication order for quetiapine fumarate 300 mg (used to treat bipolar depression) one tablet daily.
-There was a medication order for bupropion 150 mg (used to treat depression) daily.
-There was a medication order for bupropion 300 mg (used to treat depression) take along with 150 mg tablet daily.
-There was a medication order for hydroxyzine HCL 25 mg (used to treat anxiety) two tablets daily.
-There was a medication order for diazepam 10 mg (used to treat anxiety) three tablets twice daily.
-There was a medication order for prazosin 1 mg (used to treat hypertension) two tablets daily.
-There was a medication order for Namzaric 10 mg (used to treat dementia) one tablet daily.
-There was a medication order for Sinemet 25-100 (used to treat Parkinson's disease) one tablet daily.
-There was no order for self-administration of medications.

Review of subsequent physician orders for Resident #1 revealed there was a medication order dated 06/26/19 for tolterodine 4 mg (used to

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	150152	A. BUILDING: _____ B. WING _____	C 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTONWOOD LAKE BOONE	3560 HORTON STREET RALEIGH, NC 27607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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treat overactive bladder) at bedtime.

Review of Resident #1's Care Plan dated 06/18/19 revealed:
-Resident #1 was assessed on 06/17/19 by the Resident Care Manager (RCM).
-Resident #1 was assessed as able to self-administer medications.

Review of Resident #1' July, August, and September 2019 electronic medication administration records (eMARs) revealed:
-There were entries for each of Resident #1's medication and in the location of the scheduled time there was documentation indicating not given by facility, with a specific time.
-There was printed documentation of "self-administer" after the entry for each medication.

Review of the facility's resident self-administration policy revealed:
-The first step on the policy was the resident's physician must write a specific order for the resident to self-administer medications.
-The physician's order for self-administration of medications for any resident was reviewed and validated by the Resident Care Manager (RCM).

Interview with Resident #1 on 09/24/19 at revealed:
-She gave herself her own medications.
-She was told by the RCM when she resided in independent living that she would have to be "tested" in order to continue administering her own medications.
-She passed the test and had administered her own medications since admission to assisted living in June 2019.
-Her physician was aware that she was

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administering her own medications and she was sure he wrote the order for her to self-administer medications.

Attempted telephone interviews with Resident #1's physician on 09/25/19 at 3:52 pm and on 09/26/19 at 9:34 am was unsuccessful.

Interview with representative from the facility's contracted pharmacy on 09/25/19 at 10:38 am revealed:
-Resident #1's medication orders were placed into the eMAR system.
-Self-administer and not given by facility was documented in the eMAR system because a note was faxed and received from the facility that Resident #1 self-administered her medication.
-The note was not signed by Resident #1's physician and was dated 06/18/19.

Review of faxed note to the facility's contract pharmacy for Resident #1 revealed:
-The note was dated 06/18/19 and there was documentation that the note was from the facility's "wellness team".
-There was documentation Resident #1 was admitted on 06/18/19 and self-administered her medications.
-There was documentation that Resident #1's FL-2 and face sheet were faxed to the pharmacy.

Interview with Assisted Living Wellness Coordinator on 09/26/19 at 12:35 pm revealed:
-The RCM completed the assessment of residents who requested to self-administer their medications.
-She did not know residents had to have a physician's order in order to self-administer their own medication.
-She thought only an assessment had to be

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D 375	Continued From page 29 completed for residents who requested to self administer medications. Interview with the RCM on 09/26/19 at 2:39 pm revealed: -She thought she had obtained a physician's order for Resident #1's self-administration of medication. -She had multiple FL-2s for Resident #1 prior to Resident #1's admission and after having the last one clarified, the previous FL-2 was misplaced. -She thought Resident #1's previous FL-2 had the self-administer medication order on it. -She was responsible for ensuring a physician's order was obtained for residents who self-administered medications. Interview with the Administrator on 09/26/19 at 4:10 pm revealed: -She did not know Resident #1 did not have a physician's order to self-administer medications. -She knew this was an important aspect for quality of care to Resident #1 and Resident #1 was assessed to determine her ability to administer her own medications. -The RCM was responsible for following the self-administration medication policy. -She expected the resident to be assessed to determine if the resident was capable of administering their own medications.	D 375		
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.	D912		

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D912	Continued From page 30 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision and medication administration. 1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) related to falls. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)] 2.Based on interviews and record reviews, the facility failed to administer medication to 1 of 5 sampled residents (Resident #2) as ordered by a licensed prescribing provider related to administering a nonsteroidal anti-inflammatory medication (Ibuprofen) after it was ordered to be discontinued. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]	D912		