STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047011	A. BUILDING: ______ B. WING ______	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT WAYSIDE	**8398 FAYETTEVILLE ROAD RAEFORD, NC 28376**

(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 and the Hoke County Department of Social Services conducted an initial survey on August 11-13, 2015.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 5 sampled residents (Resident #2) was tested for tuberculosis (TB) disease upon admission in compliance with the control measures adopted by the Commission for Health Services. The findings are: Review of Resident #2's current FL-2 dated 4/8/15 revealed: -Diagnoses included gastro-esophageal reflux disease, arthritis, lumbar stenosis, hypertension, and diabetes. -Resident #2 was admitted to the facility on 5/4/15. Record review revealed no documentation of TB	D 234		

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D 234	Continued From page 1 skin tests (admission or subsequent TB testing) Interview with the facility Interim Executive Director (IED) on 8/12/15 on 11:37am revealed: -Resident #2 did not have any documentation of TB skin testing in the current record. -According to policy, upon admission, a resident must have documentation of at least 1 negative TB skin test. -The IED, who was the previous marketing person, remembered seeing documentation for a TB skin test for Resident #2 prior to the resident's admission. -The IED had not been able to locate the documentation on Resident #2's initial TB skin test. No information regarding TB skin test for Resident #2 was presented for review.	D 234		
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 B Violation Based on record review and interviews the facility failed to assure referral and follow-up for 1 of 3 sampled residents with falls (Resident #2) by not sending the resident out for medical evaluation after an unwitnessed fall.	D 273		

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The findings are:

Review of Resident #2's FL-2 dated 4/8/15 revealed:
-Resident #2's diagnoses included gastro-esophageal reflux disease, lumbar stenosis, arthritis, hypertension, and diabetes mellitus.
-The resident was semi-ambulatory and used a wheelchair.

Review of Resident #2's care plan dated 06/17/2015 revealed:
-Resident #2 required one person assistance activities of daily living including toileting, ambulation, and transfers.
-Resident #2 needed frequent reminders to utilize call bell for assistance.
-Resident #2 attempts to complete tasks such as transferring without assistance and is very unsteady on her feet.

Review of Daily Log communication notes dated "07/26/15" 11-7 shift revealed:
-Resident #2 "fell out of bed hit her head on the heat[er]."
-Resident #2 had a "scrape to the forehead and was light bleeding".

Review of an Incident/Accident Report dated 07/27/15 for Resident #2 revealed:
-Resident #2 had an unwitnessed fall in the resident's room on 07/27/15 at 3:15am.
-Resident was observed lying on floor next to the air conditioning unit.
-Type of injury noted was scratch/abrasion to forehead.
-Resident #2 complained of pain to left side.
-No first aid was administered.
-Resident #2 was not transferred to the hospital.

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Review of Daily Log communication notes dated 07/28/15 7-3 shift revealed:
-Resident #2 complained of pain.
-Resident #2 "was sent out due to fall. Resident returned around 11am."

Review of local hospital documents dated 07/28/15 for Resident #2 revealed:
-Resident #2 was transported via emergency medical services to the local hospital on 07/28/15.
-The report documented Resident #2 arrived at the local hospital at 9:00am and was discharged at 10:50am.
-The primary complaint of Resident #2 was fall with onset of 2 days prior to arrival and contusion of chest.
-A chest x-ray was done on 07/28/15 which revealed remote left-sided fractures and no acute displaced fractures.

Interview with Interim Executive Director (IED) on 8/12/15 at 11:37am revealed:
-Resident fell getting out of bed unassisted "after 3:00am" on 7/27/15.
-The Resident's Power of Attorney and doctor were notified on 7/27/15 "in the morning", but was unsure of exact time of notification.
-The resident was sent to the local emergency room for medical care on 7/28/15.
- According to facility policy a resident is sent out for medical care immediately if the resident falls and hits his/her head, if there is any question that the fall resulted in injury, or there is a change in vital signs.
-There had been in service training to identify when residents are to be sent out of the facility for medical care.
-She is unsure of the training dates or specifics.

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Interview with Resident #2's caregivers on 08/12/2015 at 3:35pm revealed:
-Facility called to inform caregiver of the resident's fall on 7/27/15 at 6:35am.
-Caregiver was told resident was not sent out of the facility for medical care because there "was no broken skin".
-Caregiver visited resident on 7/27/15 "after 6:00" pm.
-Caregiver observed a bruise on resident's head.
-Resident reported to the caregiver she fell getting out of bed and complained of left side pain, "near the ribs".
-Caregiver took pictures of resident's right foot showing abrasions on toes 2,3,and 5 and a red spot on the great toe.
-Executive Director initiated a conversation with the caregiver on 7/28/15 at 8am and said resident would be sent to the hospital and should have been sent out for medical care on 7/27/15.
-Emergency Medical services were called on 7/28/15 and resident was transported to a local hospital.

Telephone interview with a Medication Aide (Medication Aide #2) on 08/12/2015 at 7:30pm revealed:
-The Medication Aide (MA)was working at the facility on the 11pm to 7am shift on 07/26/2015 when Resident #2 fell.
-The MA had not been to work at the facility since the fall occurred.
-"Ten minutes before she [Resident #2] fell", the resident rang her call bell for assistance, the MA went to see, took her to bathroom, put on dry incontinent brief, and put the resident back in bed.
-The MA "heard a loud boom by the time got back to nurses station, about 15 minutes, when got to her [Resident #2] room, she was on the floor and

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D 273	Continued From page 5 brief was off by her feet under air conditioning unit". -The MA asked Resident #2 "what are you doing, called [staff named] to help, we got her up together". -The MA asked Resident #2 "what happened". -Resident #2 had a "little scrape across her forehead, asked her if she was alright, she said she was fine". -The MA completed the incident report and documentation. -The other MA filled out fax to go to the doctor. -The other MA faxed the paperwork to the doctor. -The MA did not remember the name of the doctor the paperwork was faxed to. -The MA went home when she got off that morning. Telephone interview with the same Medication Aide on 08/12/2015 at 8:35pm revealed: -The MA did not think anyone at the facility had said anything about the facility policy on falls. -The MA knew from a previous job, when a resident falls, to find out if the resident was hurt bad, call the family member, call the doctor to find out if wanted resident to be sent out. -The MA did not send Resident #2 out to the hospital for evaluation because resident #2 said she was not hurting and was not complaining. -The MA considered "hurt bad" to mean "bump their head, complaining of back hurting, bleeding if real bad - pouring out blood". -The area on Resident #2's forehead had "a little bit of blood right in the middle of forehead" and when wiped, it didn't bleed anymore. -The MA was told by the IED on a Wednesday, when the MA went to the facility to talk to the IED, that Resident #2 was sent out because the resident started complaining. -The MA did not know when Resident #2 started	D 273		

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complaining nor did the MA know what day the resident was sent to the hospital for evaluation.

Interview with the previous Executive Director (ED) on 08/12/2015 at 8:00pm revealed:
-Resident #2's caregivers visited everyday.
-Resident #2's caregiver came to him with concerns on 07/28/2015.
-The previous ED and Resident #2's caregiver had "an open relationship. Think he was hesitant to say anything."

Interview with the IED on 08/13/15 at 12:45pm revealed:
-Staff were to call the Executive Director for directions on who would get sent out for evaluation from a fall.
-The Resident Care Director (RCD) would be responsible to provide direction to staff supervised which included medication aides.
-The facility had not had a RCD since mid-June 2015.
-Staff would be responsible to call the IED for direction since there was no one in the RCD position now.

Review of the facility's fall policy revealed the policy included:
- A fall included if a resident is found on the floor, slides to the floor unassisted, or rolls out of bed or chair onto the floor.
-All findings will be reported to the resident's physician, supervisor, and family when the incident occurs once the resident is deemed safe.
-The individual completing the notification will document in the resident's record, all notifications and responses.
-all incidents will be reported to the appropriate agencies within the timeframe as required by state.

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D 273	Continued From page 7 Interview with the Primary Care Provider's nurse on 8/13/15 at 9:46am revealed: -The doctor received a telephone call from the facility on 7/28/15 stating that the resident had fallen on 7/27/15 and was taken to the emergency room on 07/28/15. -The facility had reported previous falls by the resident when the resident leaned forward reaching for things or not asking for assistance. Interview with Medication Aide #1 on 8/13/15 at 3:58pm revealed: -She was called by another Medication Aide (Medication Aide #2) to assist in Resident #2's room after Resident #2 fell on 7/27/15 at about 3:15am. -When Medication Aide #1 went into the room to assist, Resident #2 was in the bed with a cut across the forehead, "the length of a fingernail". -The cut was bleeding but stopped bleeding when Medication Aide #2 "wiped it with a cloth". -The Medication Aide observed a "small amount of blood". The Medication Aide examined the resident's rib area, legs, arms, and upper body for injuries. -The resident told the Medication Aide that she fell taking off her incontinent brief. -The resident was not sent out because "all she had was just that little cut". -At the time of the fall the Medication Aide was not aware a resident with a fall resulting in a head injury, needed to be sent out for medical evaluation. -Medication Aide #2 called the manager on duty but did not get an answer, when Resident #2 fell. -On 7/28/15 the Executive Director met with the Medication Aide and discussed when a resident is to be sent out of the facility for medical care. -On 7/28/15 the Medication Aide was given a fall	D 273		

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D 273	Continued From page 8 protocol sheet telling when residents are to be sent out of the facility for medical care. Interview with Resident #2 on 08/13/2015 at 4:45pm revealed: -Resident #2 got out of bed, got to the end of the bed and fell on left side. -The resident had a bump on her forehead that was bleeding a little bit. ____________________ The Plan of Protection dated 08/13/2015 submitted by the facility inluded the following: -The Executive Director or designee will conduct an immediate fall review of all residents. -When a fall occurs, incident report and post fall investigation will be completed. -Family member, physician, and county monitor will be notified for any fall resulting in injury requiring more than first aid. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 27, 2015.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to the manner in which a staff member (Medication	D 338		

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Aide) spoke to residents.

The findings are:

Confidential interview with a resident revealed:
-The resident rang the call bell for help after falling.
-A Medication Aide came into the room and "she was mad".
-When the resident called for help, the Medication Aide raised her voice and asked "what do you want", with fist clinched.
-Resident was afraid to ask for help because the Medication Aide was "a fireball".

Confidential interview with the resident's caregiver revealed:
-The resident reported to the caregiver that one facility staff member had been "rude" to resident.
-Resident reported to the caregiver that the same staff member yelled at the resident "Go to bed, go to bed, when she was already in bed."
-Resident reported to the caregiver that the staff member yelled at resident with "fist clinched".

Confidential interview with a second resident revealed:
-Staff were "usually pretty good, couple that don't talk decent."
-A "lady at night - not seen in a while - talks to like dirt ".
-Overall, staff were respectful.

Confidential interviews with two staff members revealed:
-The Medication Aide was "a little rough around the edges" in the manner in which she spoke.
-Staff had not heard the Medication Aide speak roughly to a resident in a manner of being mean to anyone, but the Medication Aide talked the way

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she talked.

Confidential interviews with five additional residents revealed:
-Residents were treated good by staff working at the facility.
-Residents were not afraid of any staff working at the facility.

Interview with a former employee on 08/12/2015 revealed:
-The Medication Aide had been reported as being "verbally rough - as far as demanding orders" with a resident.
-The Medication Aide stated to the resident "I'm getting tired of coming down to your room".
-Another family member stated the Medication Aide stated in a "gruff" way "I'm very busy right now, I'll get to it when I can".
-The former employee stated the Medication Aide "has abrasive personality, very simple down to earth with gruff personality".

Interview with the staff member (Medication Aide) on 08/12/2015 at 7:30pm revealed:
-The staff member had never done anything to anybody.
-Everybody thought she was mean because of the way she talked.
-The staff member had been told by "people" that the way she talked, it sounded like she was being mean.
-The staff member never talked mean to anybody, "everybody tells me I need to lower my voice, it's the way I talk."
-The staff member stated "no" when asked if she had ever yelled at a resident.
-The staff member stated "I don't ball my fist up to nobody, what [am] I gonna ball my fist up for".

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D 346	10A NCAC 13F .1002(c) Medication Orders 10A NCAC 13F .1002 Medication Orders (c) The medication orders shall be complete and include the following: (1) medication name; (2) strength of medication; (3) dosage of medication to be administered; (4) oute of administration; (5) specific directions of use, including frequency of administration; and (6) if ordered on an as needed basis, a stated indication for use. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to clarify and ensure medication orders were complete for 1 of 5 residents sampled (#2) for DuoNeb nebulizer prescribed by the physician on an as needed basis that did not include an indication for use. The findings are: Review of Resident #2's current FL-2 dated 04/04/5 revealed: -Diagnoses included gastroesophageal reflux disease (GERD), lumbar stenosis, hypertension, arthritis, and diabetes mellitus. -Physician order for DuoNeb 2.5-0.5 mg./3 mL four times daily as needed. (DuoNeb is a combination of the drugs Albuterol and Ipratropium administered by nebulizer and used to treat and prevent wheezing, breathing difficulty, and coughing by relaxing and opening the air passages to the lungs to make breathing easier).	D 346		

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D 346	Continued From page 12 Review of Resident #2's record revealed: -No subsequent physician's orders for DuoNeb which superseded the order on the resident's FL-2 or provided indication for use. -No additional clarification by the prescribing provider of the as needed DuoNeb order stating the indication for use. Review of the Resident Registry revealed Resident #2 was admitted to the facility on 05/04/15. Interview with a Medication Aide/Nurse Aide (MA/NA) at 4:00 p.m. on 08/13/15 revealed: -Physician orders are found on the FL-2 and/or discharge summary. -Unclear or incomplete provider orders are clarified with the prescribing provider. -The Medication Aide (MA) or Executive Director (ED) are responsible for checking provider orders and obtaining clarification of orders when necessary. -The MA/NA recalled that Resident #2 had a physician order for nebulizer treatments PRN (as needed). Interview with Resident Care Coordinator (RCC) at 1:20 p.m. on 08/13/15 revealed: -The RCC was recently promoted from MA/NA to RCC and had been in the RCC position only a few days. -The facility had previously employed an Licensed Practical Nurse (LPN) in the position of Resident Care Director (RCD). -Physician orders are found on the FL-2. -It was facility procedure to compare the orders on the FL-2 form to the resident's medications on hand upon resident admission to the facility. -When discrepancies are found, the MA was responsible for clarifying the orders with the	D 346		

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prescribing provider.
-The MA was responsible for transcribing new and clarified provider orders to the resident's MARS and faxing a copy of the orders to the contracted pharmacy.
-The contracted pharmacy sends pre-printed MARS to the facility for each resident every month.
-When new MARS are received from the pharmacy, it was facility procedure to complete two monthly MAR checks by comparing the new MARs with the previous months MARs.
-The MA was responsible for completing the first MAR checks and the former RCD was responsible for completing the second monthly MAR checks.
-After the RCD left , two different MAs were responsible for completing the two monthly MAR checks.
-The RCC was not aware that Resident #2 had a physician order for PRN (as needed) nebulizer treatments.

Interview with a 1st shift MA/NA at 10:25 a.m. on 08/12/15 revealed:
-The MAs initial the resident's MARS beside each scheduled medication entry for the corresponding date and time to document the medication has been administered.
-The MAs initial the resident's MARS beside each PRN (as needed) medication entry for the corresponding date to document the medication was administered and documents the reason the PRN medication was administered on the reverse side of the MAR.

Review of Resident #2's June 2015 Medication Administration Records (MARS) revealed:
-Entry for DuoNeb solution with directions to give 1 nebulizer treatment 4 times a day as needed.

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D 346	Continued From page 14 -There were no staff initials beside the DuoNeb entry documenting the medication was administered to Resident #2 during the month of June 2015. -Each page of Resident #2's June MAR contained a box with the words "Completed Entries Checked." -The "Completed Entries Checked" box on each page of the MAR included documentation which included: the handwritten signature of the Resident Care Coordinator (RCC) beside the word "By"; "Med Tech" printed beside the word "Title" and "5/27/15" beside the word "Date." Review of Resident #2's July 2015 Medication Administration Records (MARS) revealed: -Entry for DuoNeb solution with directions to give one nebulizer treatment 4 times a day as needed. -There were staff initials beside the entry documenting DuoNeb was administered to Resident #2 on 07/07/15 and 07/31/15. -The reverse side of page 6 of the July MAR contained documentation dated 07/07/15 that DuoNeb was administered to Resident #2 for "wheezing." -The reverse side of the MAR contained documentation dated 07/31/15 that DuoNeb was administered to Resident #2 for "wheezing." -The MAR contained a box with the words "Completed Entries Checked." -The "Completed Entries Checked" box was blank and did not contain any additional documentation such as signature, title, and date. Review of Resident #2's August 2015 MAR revealed: -Entry for DuoNeb solution with directions to give 1 nebulizer treatment 4 times a day as needed. -There were staff initials on the MAR beside the DuoNeb entry documenting DuoNeb was	D 346		

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D 346	Continued From page 15 administered to Resident #2 on 08/13/15. -On the reverse side of the August MAR there was documentation dated 08/13/15 that DuoNeb was administered to Resident #2 for "coughing and shortness of breath." -Each page of Resident #2's August MAR contained a box with the words "Completed Entries Checked." -The "Completed Entries Checked" box on each page of the MAR included documentation which included: the handwritten signature of the Resident Care Coordinator (RCC) beside the word "By"; "Med Tech" printed beside the word "Title" and "08/01/15" beside the word "Date. Interview with the Pharmacist of the facility's contracted pharmacy at 8:51 a.m. on 08/17/15 revealed: -There was a physician order for DuoNeb treatments four times daily, as needed on Resident #2's FL-2 dated 04/08/15. -The FL-2 order did not include an indication for use of the DuoNeb medication. -The were no subsequent physician orders on file at the pharmacy which clarified the order by providing indication for use. -The pharmacy would contact Resident #2's primary physician by fax on 08/17/15 for clarification of an indication for use of the DuoNeb and notify the facility of indication for use. Interview with Resident #2's primary physician at 10:10 a.m. on 8/13/15 revealed: -Resident #2 had orders for DuoNeb treatments as needed when she transferred from her previous facility to her current facility and he had renewed the nebulizer treatments. -The physician had no knowledge that the DuoNeb order required clarification for indication for use.	D 346		

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D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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, record reviews, and interviews, the facility failed to administer prescription medications in accordance with orders by a licensed prescribing practitioner for 2 of 5 residents sampled (#1 and #2) for DuoNeb nebulizer treatments for Resident #2 resulting in coughing, wheezing, shortness of breath, and respiratory distress which required treatment for pneumonia and emergent treatment for diagnosis of atelectasis (atelectasis is a collapse of the small air sacs in the lungs), and Annusol suppositories for Resident #1.

The findings are:

1. Review of Resident #2's current FL-2 dated 04/08/15 revealed:
-Diagnoses included gastroesophageal reflux disease, lumbar stenosis, arthritis, hypertension, and diabetes mellitus.
-Physician order for DuoNeb 2.5-0.5 mg. /3 mL one treatment four times daily as needed.
(DuoNeb is a combination of the drugs Albuterol and Ipratropium administered by nebulizer to treat

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and prevent wheezing, breathing difficulty, and coughing by relaxing and opening the air passages to the lungs).

Review of the Resident Registry revealed Resident #2 was admitted to the facility on 05/04/14.

Review of Resident #2's record revealed there were no subsequent physician orders which clarified the indication for use of the as needed DuoNeb order on Resident #2's FL-2.

Review of the facility's "Daily Log" communication sheets revealed:
-Resident #2 complained of cough and congestion on 06/24/15.
-On 06/25/15 Resident #2 was noted to have a cough and was medicated per orders with as needed cough syrup.

Review of Resident #2's June 2015 Medication Administration Records (MARS) revealed:
-Entry for Ipratropium/Albuterol (DuoNeb) solution with directions to give 1 nebulizer treatment 4 times daily as needed.
-DuoNeb was not documented as administered in June 2015.
-Entry for Q-Tussin, take two teaspoons every 4 hours as needed for cough. (Q-Tussin is a medication used to control the symptoms of cough and congestion).
-Q-Tussin was documented as administered on 06/21/15 and 06/25/15 for coughing.

Interview with a 2nd shift Medication Aide (MA) at 4:00 p.m. on 08/13/15 revealed:
-Physician orders are found on the FL-2 and/or discharge summary.
-It was facility procedure to check the FL-2 form

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to ensure physician orders are initiated.
-Unclear or incomplete orders are clarified with the prescribing provider.
-The MA or Executive Director (ED) is responsible for checking physician orders and obtaining clarification of orders when necessary
-The MA recalled that Resident #2 had an order for PRN nebulizer treatments.
-The MA recalled Resident #2 did not have a nebulizer machine.
-The MA recalled Resident #2 coughing and administering cough syrup to Resident #2.

Interview with the Resident Care Coordinator (RCC) at 1:20 p.m. 08/13/15 revealed:
-The RCC was recently promoted and started the RCC position within the past week.
-The facility previously employed an LPN as Resident Care Director (RCD)
-It was facility procedure to check the FL-2 form for physician orders when a resident was admitted to the facility.
-Upon admission, a resident's medications on hand are compared with the orders on the FL-2.
-If a discrepancy is noted between the medications on hand and FL-2 form, the prescribing provider is contacted for order clarification.
-The MA on duty is responsible for getting clarification of physician orders.
-The MA on duty is responsible for transcribing new and/or clarified physician orders onto the MARS and faxing the orders to the contracted pharmacy.
-It was facility procedure to complete two checks of the monthly MARS before the MAR is used for administration of medications to residents.
-Discrepancies found during the monthly MAR checks are clarified with the prescribing provider.
-The staff member completing the MAR check is

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responsible for transcribing corrections of clarified orders to the new MARS.
-The RCC had never witnessed Resident #2 complain of shortness of breath
-The RCC recalled Resident #2 complaining of congestion and being administered cough syrup per physician's orders.
-The RCC notified Resident #2's Power of Attorney (POA) about Resident #2's complaints of congestions because "she was weak and couldn't cough it up."
-Resident was evaluated by her medical provider for her congestion and cough.
-The RCC did not know where or when Resident #2's nebulizer machine had been obtained.
-The facility orders medical equipment from a contracted medical equipment provider.
-It was facility procedure to ask the resident's family for permission to order the nebulizer machine from the facility's contracted medical equipment provider.
-The RCD was responsible for ordering any medical equipment needed by facility residents.

Review of the facility's "Daily Log" communication sheets revealed documentation dated 06/26/15 "come back from MD appointment with new orders and MD called back and did verbal order for Levaquin due to chest x-ray (possible pneumonia)."

Review of the "Family Practice Office/Clinic Note" obtained from Resident #2's primary care physician's (PCP) dated 06/26/15 and signed by Physician's Assistant (PA) revealed:
-Resident #2 was evaluated by the PA for complaint of cough and congestion.
-The "symptoms started 8 days ago."
-Resident #2 complained to the PA that she had wheezing and soreness in her chest from

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coughing.
-Resident had tried over the counter cough syrup with "little relief."
-Resident #2 was administered a DuoNeb nebulizer treatment in the medical office and her oxygen saturation improved from 93% to 96% after the DuoNeb.
-The PA ordered a chest x-ray which was initiated and the results were still pending.
-The "Family Practice Office/ Clinic Note" was counter signed by Resident #2's physician on 06/28/15.

Review of orders by the PA and dated 06/26/15 for Resident #2 revealed:
-Order for Albuterol CFC free 90 mcg inhalation aerosol 2 puffs inhalation four times daily, as needed for wheezing. (Albuterol is used to prevent and treat wheezing, shortness of breath, and coughing).
-Order for Guaifenesin 400 mg one every 4 hours as need for cough and congestion for 10 days. (Guaifenesin is used to control the symptoms of chest congestion).
-Order for Levaquin 500 mg daily for 10 days. (Levaquin is a medication used in the treatment of certain infections such as pneumonia, chronic bronchitis, urinary tract, kidney, and skin infections).

Review of Resident #2's June 2015 Medication Administration Records (MARS) revealed:
-A hand written entry for Albuterol CFC 90 mcg. Inhaler 2 puffs, 4 times daily, as needed for wheezing.
-Albuterol inhaler was documented as administered on 06/29/15 for wheezing.
-A handwritten entry for Guaifenesin 400 mg. take 1 every 4 hours as needed for cough/congestion for 10 days.

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-Guaifenesin was not documented as administered in June 2015.
-A handwritten entry for Levaquin 500 mg. daily for 10 days with a scheduled dosing time of 8:00 a.m.
-Levaquin was documented as administered from 06/27/15 through 06/30/15.

Review of Resident #2's July 2015 MARs revealed:
-Entry for Ipratropium/Albuterol (DuoNeb) solution with directions give 1 nebulizer treatment 4 times a day as needed.
-DuoNeb was not documented as administered from 07/01/15 - 07/06/15.
-Duplicate hand written entries for Albuterol CFC 90 mcg. Inhaler 2 puffs, 4 times daily, as needed for wheezing.
-Albuterol inhaler was not documented as administered to from 07/01/15 - 07/06/15.
-A handwritten entry for Guaifenesin 400 mg. take 1 every 4 hours as needed for cough/congestion for 10 days.
-Guaifenesin was not documented as administered from 07/01/15 - 07/06/15.
-Handwritten entry for Levaquin 500 mg. daily for 10 days with scheduled dosing time of 8:00 a.m.
-Levaquin was documented as administered from 07/01/15 - 07/06/15.

Review of the facility's "Daily Log" communication sheets revealed:
-On 07/06/15, Resident #2 was transported from facility to Emergency Room (ER) for "complaint of shortness of breath. Offered inhaler refused."
-On 07/07/15 Resident #2 had a follow up appointment with her physician. "Has nebulizer machine for breathing treatments. New order for Augmentin. Meds will arrive tonight."
On 07/08/15 "Resident was sent to ER this a.m."

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Review of discharge summary from the local hospital electronically signed by the treating physician and dated 07/06/15 revealed:
-Resident #2 was transported to the hospital by EMS for complaints of "dyspnea" and "cough."
-Resident required administration of oxygen at 3 liters per minute during transport from the facility to the hospital.
-"Per EMS, patient complained of shortness of breath for 2 days."
-Chief complaint was "respiratory distress."
-Diagnosis was atelectasis.

Interview with a 2nd shift Medication Aide (MA) at 4:00 p.m. on 08/13/15 revealed:
-The MA recalled coming to work during second shift and Resident #2 being out of the facility at a doctor appointment at "the end of June or maybe early July. "
-On that same day, the MA recalled speaking to the "nurse" at Resident #2's primary physician office.
-The MA recalled the nurse inquired if Resident #2 had been receiving the nebulizer treatments.
-The MA recalled the nurse asking if the facility had a nebulizer machine.
-The MA recalled Resident #2 returning from the physician's office that day with the nebulizer machine.

Telephone interview with the Licensed Practical Nurse (LPN) at Resident #2's primary physician's office at 4:51 p.m. on 08/13/15 revealed:
-The primary physician's office was first notified that Resident #2 did not have a nebulizer machine on 07/07/15
-The Physician's Assistant (PA) evaluated and diagnosed Resident #2 with pneumonia on 06/26/15.

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D 358	Continued From page 23 -The PA recommended Resident #2 be re-evaluated in one week. -The PA prescribed antibiotics for Resident #2 and the resident should have received breathing treatments as needed until re-evaluated in one week. -Resident #2 was evaluated for follow up by her primary physician on 07/07/15. -Resident #2 told the LPN she had been sent to the hospital the previous day for breathing problems. -The facility sent a copy of Resident #2's current MARS with her to the appointment on 07/07/15. -Resident #2's MARs contained orders for DuoNeb as needed. -The MARs did not contain documentation that the DuoNeb had been administered to Resident #2. -The LPN called the facility to inquire about the nebulizer treatments and was told by a MA that Resident #2 had not been receiving nebulizer treatments. -On that same date, the LPN spoke to the facility's Executive Director (ED) who informed her the facility did not have the equipment to administer nebulizer medications to Resident #2. -The ED said acquiring a nebulizer for Resident #2 "would be something he would have to look in to." -On 07/07/15, the physician's office supplied a nebulizer for Resident #2 to use at the facility. Review of the "Family Practice Office/Clinic Note" dated 07/07/15 and electronically signed by Resident #2's PCP revealed: -"Since our last visit, the patient has been treated with antibiotics for pneumonia." -"She went to the emergency room 2 days ago with continued shortness of breath." -"She had standing orders at her living facility for	D 358		

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nebulizer treatments however we just learned today that her facility did not actually have a nebulizer machine."
-"She has not been receiving any cough suppressants or nebulizers during her respiratory condition."
-"She continues to have some shortness of breath and wet sounding cough but is unable to produce sputum."
-Order for Augmentin 875-125 mg. every twelve hours for 10 days. (Augmentin is a combination of the medications amoxicillin and clavulanic acid used to treat certain infections caused by bacteria, including infections of the ears, lungs, skin, and urinary tract).

Review of physician's order dated 07/08/15 for Resident #2 revealed:
-Order for Albuterol 0.083% inhalation solution every 8 hours by nebulizer for 7 days. (Albuterol is a medication used in the prevention and treatment of wheezing, coughing, and shortness of breath).
-Order for Ipratropium 0.0125% inhalation solution by nebulizer with Albuterol every 8 hours for 7 days. (Ipratropium is a medication used to prevent wheezing, coughing, and chest tightness.)

Review of Resident #2's July 2015 MARs revealed:
-DuoNeb prn was documented as administered on 07/07/15 and 07/31/15 for wheezing.
-Handwritten entry for Albuterol 2.5 mg/3mL sol. 3 ml every 8 hours for 7 days with administration times scheduled at 8:00 a.m., 4:00 p.m., and 12:00 a.m. beginning 07/09/15.
-Albuterol nebulizer solution was not documented as administered on 07/09/15 and 07/10/15.
-Albuterol nebulizer solution was documented as

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administered from 07/11/15 - 07/16/15.
-Albuterol nebulizer solution was not documented as administered at the scheduled 12:00 a.m. dose on 07/12/15 and 07/13/15.
-Albuterol nebulizer solution was documented as "not available" and "not given " on 07/12/15.
-Handwritten entry for Ipratropium 125 mcg/mL nebulizer every 8 hours with Albuterol for 7 days with administration scheduled at 08:00 a.m., 4:00 p.m., and 12:00 a.m. beginning 07/09/15
-Ipratropium nebulizer solution was documented as administered from 07/11/15 - 07/16/15.
-Albuterol and Ipratropium were documented as "not available" and "not given" on 07/09/15, 07/10/15, and 07/12/15.
-Handwritten entry for Augmentin 875-125 mg one tablet every twelve hours for 10 days with scheduled dosing times of 08:00 a.m. and 08:00 p.m. and start date of 07/08/15.
-Augmentin was documented as administered from 07/08/15 - 07/17/15.

Attempt to contact the former ED by telephone for interview revealed the message left on 08/13/15 requesting a return telephone call was not returned.

Interview the Interim Executive Director (IED) at 1:04 p.m. on 08/13/15 revealed:
-The facility used a contracted provider for durable medical equipment (DME).
-The RCD was responsible for reviewing each resident's FL-2 for need of DME.
-The MAs were responsible for reviewing the FL-2 after the RCD quit.
-It was facility procedure to fax orders for DME to the contracted provider.
-The IED was not aware of where Resident #2's nebulizer machine was obtained or when it was acquired and she would call the contracted

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provider for further information.

Additional interview the IED at 4:40 p.m. on 08/13/15 revealed she could not ascertain where or when Resident #2's nebulizer machine had been obtained.

Interview with Resident #2's POA at 4:06 p.m. on 08/12/15 revealed her primary physician had addressed all medication concerns due to Resident #2's current health status and the fact that she had several recent falls.

Telephone interview with Resident #2's primary physician at 10:10 a.m. on 08/13/15 revealed:
-The physician evaluated Resident #2 at a follow up appointment "the first part of July " to the best of his recollection.
-He noted that Resident #2 had orders for as needed nebulizer treatments when she transferred from her previous facility to her current facility and had previously renewed the nebulizer treatments.
-Resident #2 complained of shortness of breath and was coughing and congested when evaluated in the physician's office.
-"It was audible with her just sitting in the chair. I did not need a stethoscope. She sounded wet."
-The facility had sent a copy of Resident #2's current MARS with her to the medical appointment.
-The physician assumed Resident #2 was receiving nebulizer medication as needed because the medication was ordered and listed on her current MARS.
-He was informed during the office visit by the LPN that Resident #2 was not getting breathing treatments because the facility did not have a nebulizer machine.
-The physician contacted the Executive Director

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D 358	Continued From page 27 (ED) of the facility (the ED resigned shortly thereafter) and requested the ED meet him at his office the same day that he evaluated Resident #2. -It was the facility's responsibility to notify his office that Resident #2 did not have a nebulizer machine, so one could have been provided for her. - It was his expectation that the facility provide the equipment and nebulizer treatments per orders. Review of the "Family Practice Office/Clinic Note" dated 08/03/15 and electronically signed by Resident #2's PCP revealed: -Resident was evaluated in the office for follow up from a fall. -"Patient presents today with chest congestion and left side pain." -Resident had upper airway congestion that resolved after a hard cough. -"Plan to have scheduled nebulizer treatments for the next week to help with bringing up her congestion." Review of physician's order dated 08/03/15 for Resident #2 revealed: -Signed physician order dated 08/03/15 for Albuterol 0.083% nebulizer solution every 8 hours for 7 days. -Signed physician order dated 08/03/15 for "Ipratropium solution to use with Albuterol solution for DuoNeb via nebulizer every 8 hours for 7 (seven) days." Review of Resident #2's August 2015 MARS revealed: -Handwritten entry for Albuterol neb 0.083% 1 ampule via nebulizer every 8 hours for 7 days with scheduled dosing times of 8:00 a.m., 4:00 p.m., and 12:00 a.m. beginning 08/03/15.	D 358		

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D 358	Continued From page 28 -Handwritten entry for Ipratropium 0.5 mg. solution with Albuterol solution via nebulizer every 8 hours for 7 days with scheduled dosing times of 8:00 a.m., 4:00 p.m., and 12:00 a.m. beginning 08/03/15. -There was documentation on the MAR that Albuterol was administered as scheduled to Resident #2 at 12:00 a.m. from 08/4/15 through 08/07/15. -There was no documentation on the MAR that Ipratropium was administered as scheduled at 08:00 a.m. from 08/04/15 through 08/06/15 and at 12:00 a.m. from 08/04/15 through 08/07/15. -Entry for Ipratropium/Albuterol (DuoNeb) with directions give 1 nebulizer treatment 4 times a day as needed. -There was documentation on the MAR that DuoNeb was administered to Resident #2 on 08/13/15 for "coughing and shortness of breath." Observation of Resident #2's medication on hand on 08/13/15 revealed: -Ipratropium solution 0.5 mg./3 mg. 3 mL inhalation one vial 4 times daily as needed with a dispense date of 04/17/14 with a quantity of 60 vials dispensed and 30 vials on hand. -Albuterol solution 2.5 mg./3 mL one vial by nebulizer every 8 hours for 7 days with a dispense date of 07/11/15 with 75 dispensed and 3 on hand. -Ipratropium solution 0.27 inhalation 1 treatment via nebulizer every 8 hours for 7 days with a dispense date of 08/03/15 and a quantity of 75 dispensed and 21 on hand. -Ipratropium solution/Albuterol DuoNeb use 1 vial via nebulizer every 8 hours for 7 days with a dispense date of 08/05/15 and 18 on hand. 2. Review of Resident #1's current FL-2 dated 06/18/2015 revealed: -A hospital generated FL-2 which included a new	D 358		

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diagnosis of lower gastro-intestinal bleeding.
-A hospital admission date of 06/17/2015.

Review of facility progress notes revealed Resident #1 was admitted to the facility on 06/23/2015.

Review of the hospital discharge medication list dated 06/23/2015 revealed:
-The hospital discharge medication list was dated and electronically signed by the physician on 06/23/2015.
-A physician order dated 06/23/2015 for Hydrocortisone Acetate (Anucort-HC Supp) (used to treat inflammation) 25mg one suppository rectally twice daily for 5 days.

Review of the June 2015 Medication Administration Records (MARS) revealed no transcription entry for Anucort HC suppository.

Review of the July 2015 Medication Administration Records (MARS) revealed no transcription entry for Anucort HC suppository.

Review of the August 2015 Medication Administration Records (MARS) revealed no transcription entry for Anucort HC suppository.

Interviews with three Medication Aides at the facility during the survey revealed:
-One MA was not sure who was responsible for transcribing orders to the MARs.
-A second MA used to transcribe orders to the MARs, but now the Resident Care Coordinator (RCC) did the transcribing of orders to the MARs.
-A third MA stated the MA on duty when the order came to the facility was responsible to transcribe the order to the MAR.

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Observation of Resident #1's medications on hand on 08/13/2015 at 6:30pm revealed a closed clear ziplock plastic bag with a printed pharmacy label for Anucort-HC Supp 25mg insert one supp rectally twice daily for 5 days dated 06/23/2015, quantity of 10 dispensed, quantity of 10 on hand.

Interview with the Medication Aide (MA) on 08/13/2015 at 6:30pm revealed:
-The MA had not administered the Anucort-HC suppositories to Resident #1.
-The MA did not know why the Anucort-HC suppositories had not been administered to Resident #1 as ordered.

Interview with the Interim Executive Director (IED) on 08/13/2015 at 6:45pm revealed:
-The IED did not know about the order for the Anucort-HC suppositories for Resident #1.
-The Resident Care Coordinator (RCD) was responsible for ensuring medications were transcribed to the medication administration records (MARS).
-The facility had not had a RCD since sometime in June 2015.
-In the absence of the RCD, the MA's were responsible for transcribing orders to the MARs and administering medications according to the physician orders.
-The IED did not know why the Anucort-HC suppositories had not been administered as ordered.

In a previous interview with Resident #1 on 08/11/2015 at 11:30am revealed:
-Resident #1 did not know the names for all medications ordered for the resident.
-The MA's administered the resident's medication to him.
-Resident #1 did not have any concerns about his

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D 358	Continued From page 31 medications. -Resident #1 was administered medication everyday by the MA's. ____________________ Review of the Plan of Protection submitted by the facility on 08/14/2015 revealed: -The Executive Director or designee would conduct an audit on all resident records to ensure all medications are being administered per physician orders. -A new order tracking system will be used on all new orders for new and existing residents to ensure all orders are processed and administered correctly. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2015.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to notify the county department of social services of incidents resulting in injury requiring medical treatment other than first aid and referral to local hospital for	D 451		

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emergency medical evaluation for 2 of 4 residents sampled (#2 & #3).

The findings are:

1. Review of Resident 3's current FL-2 dated 05/05/15 revealed diagnoses included Alzheimer's, depressive disorder, hypothyroidism, osteoarthritis, and thrombocytopenia.

Observation of Resident #3 on 08/11/15 at 10:50 a.m. revealed:
-Resident was seated in the common area of the Safe Haven unit of the facility.
-Resident was dressed for season and had on socks and shoes.
-Resident was holding a doll.
-Resident had a bruise which was yellow and purple in color on the left side of her face.
-The bruise surrounded the orbit of Resident 3's left eye and extended onto Resident #2's forehead and left cheek.
-The sclera of Resident #3's left eye was noted to be bright red in color on the right side of the pupil.
-Resident #3 did not respond verbally when spoken to.

Interview with the Resident Care Coordinator (RCC) on 08/11/15 at 10:55 a.m. revealed:
- Resident #3 "Fell off her bed and was sent to the ER."
- Resident #3 does not speak or respond verbally, but she does smile at times.

Review of Resident #3's record revealed:
-Discharge summary report from Emergency Department (ED) of local hospital dated 08/04/15 electronically signed by attending ED physician.
-The report revealed Resident #3 arrived at the ED at 7:25 a.m. on 08/04/15 and was discharged

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from the ED at 10:18 a.m. on 08/04/15.
-The diagnoses listed on the discharge summary included abrasion, contusion, and fall.

Interview with RCC on 08/11/5 at 3:55 p.m. revealed:
-If a resident had a fall resulting in head injury it was facility procedure to obtain the resident's vital signs and seek further medical evaluation by contacting Emergency Medical Services (EMS) immediately.
-It was facility procedure to also notify the resident's family, doctor, and the facility administrator when a resident is injured and transported out of the facility by EMS.
-It was facility procedure to complete an incident report and a fall report when a resident had a fall in which EMS is contacted.
-The person who witnesses the fall or the shift Medication Aide/Supervisor in Charge (MA/SIC) is responsible for completing the incident report and post fall report.
-It was procedure to fax the report to the county Department of Social Services (DSS) when a resident is transported from the facility to the hospital.
-The RCC had no other knowledge of Resident #3's fall, "She fell on 3rd shift."

Interview with a 2nd shift Medication Aide (MA) at 4:00 p.m. on 08/11/15 revealed:
-If a resident has a fall with a head injury such as a "knot or bleeding" additional medical evaluation is sought immediately by contacting EMS.
-The resident's family and physician, and the facility SIC are also notified of the fall and EMS transport.
-An incident report should be completed by the MA or SIC before the end of the shift.

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Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.

Interview with Resident #3's family member on 08/12/15 at 8:40 a.m. revealed:
-The family member was notified by facility staff that Resident #3 had fallen and was sent to the hospital at the time the fall occurred on 08/04/15.
-Family was not aware of any other incidents in which Resident #3 had fallen since admission to facility,
-At the family member's request, the Interim Executive Director (IED) had gone to the hospital to be with Resident #3.
-The family had not had any concerns regarding the safety and well-being of Resident #3 since her admission to the facility

Interview with the Adult Home Care Specialist for the county DSS on 08/12/15 at approximately 9:00 a.m. revealed that county DSS had not received notification from the facility of the incident on 08/04/15 in which Resident #3 fell and was sent to the hospital by EMS.

Observation at 10:33 a.m. on 08/12/15 revealed:
-The IED presented a handwritten statement written on yellow lined paper dated 08/04/15 and signed by a 3rd shift Medication Aid/Nurse Aide (MA/NA).
-The handwritten statement contained documentation that Resident #3 was found on the floor in her room with " blood and a large knot on her left side of her head (above her eyebrow)."
-The handwritten statement contained documentation that EMS was called and transported Resident #3 to the hospital "at or around 7:00 a.m."
-The handwritten statement was stapled to a two

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D 451	Continued From page 35 page document titled "Healthcare Incident/Accident Report." -The two page "Healthcare Incident/Accident Report" was blank and did not contain any written documentation. Interview with the IED at 11:39 a.m. on 08/12/15 revealed: -It was facility procedure to seek further medical evaluation by contacting EMS any time a resident had a fall that results in a head injury. -It was facility procedure to contact a resident's physician and family, and to notify the county DSS when a resident was transported by EMS to the hospital. -It was facility procedure to complete an Accident/incident Report at the time of occurrence. -The staff member witnessing or notified of an incident or the MA on duty for that shift is responsible for completing the Accident/Incident Report. -The MA is responsible for notifying the county DSS of the incident by faxing the Accident/Incident Report to DSS within 24 hours. -When reports are faxed to DSS, the fax verification sheet is expected to be stapled to the report. -When Resident #3 fell on 08/04/15, the 3rd shift MA/NA had stated that she could not find the Accident/Incident Report form so she had documented the incident by writing the statement on the yellow lined paper. -The IED had asked the MA/NA to complete the Accident/Incident report but it had not been done yet. -The Accident/Incident Report had not been faxed to the county DSS because the report had not yet been completed by the MA/NA. -The facility had a system in place to ensure	D 451		

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proper procedure was followed that included utilization of a fax log which contains a checklist of who to notify of accidents/incidents and documents that notifications are completed.
-The fax log had not been used since May 2015.
-The IED had just found the fax log on 08/11/15 and had made plans to implement utilization of the fax log immediately.

2. Review of Daily Log dated 07/26/15 11-7 shift revealed:
-Resident #2 "fell out of bed hit her head on the heat[er]."
-Resident #2 had a "scrape to the forehead and was light bleeding".

Review of Daily Log communication notes dated 07/27/15 3-11 shift revealed:
-Resident #2 complained of pain on left side.
-Resident #2 "has small abrasion to right 3rd toe. Pain to touch."
-Resident #2's family would like to see if the resident can get in to see the doctor "ASAP" (as soon as possible).
-Notice left for first shift to check with doctor's office.

Review of Daily Log communication notes dated 07/28/15 7-3 shift revealed:
-Resident #2 complained of pain.
-Resident #2 "was sent out due to fall. Resident returned around 11am."

Review of local hospital documents dated 07/28/15 for Resident #2 revealed:
-Resident #2 was transported via emergency medical services to the local hospital on 07/28/15.
-The report documented Resident #2 arrived at the local hospital at 9:00am and was discharged at 10:50am.

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-The primary complaint of Resident #2 was fall with onset of 2 days prior to arrival and contusion of chest.
-A chest xray was done on 07/28/15 which revealed remote left-sided fractures and no acute displaced fractures.

Review of an Incident/Accident Report dated 07/27/15 for Resident #2 revealed:
-Resident #2 had an unwitnessed fall in the resident's room on 07/27/15 at 3:15am.
-Resident was observed lying on floor next to the air conditioning unit.
-Type of injury noted was scratch/abrasion to forehead.
-Resident #2 complained of pain to left side.
-No first aid was administered.
-Resident #2 was not transferred to the hospital.

Review of facility incident/accident reports for the month of July 2015 revealed no documentation indicating the local County Department of Social Services was notified of the incident involving Resident #2 on 07/27/15.

Interview with Interim Executive Director on 8/12/15 at 11:37am revealed:
-The incident/accident reports are to be completed by the Medication Aide working the shift of occurrence.
- The Resident Care Director (RCD) ensures that all reports are completed in a timely manner.
-The Resident Care Director was no longer employed beginning the end of June 2015.
-If there is no Resident Care Director it is the responsibility of the Executive Director to ensure all needed forms are completed and sent out as required.
-If a resident falls the family, medical provider, Director of the facility, and local County

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THE CROSSINGS AT WAYSIDE	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 451	Continued From page 38 Department of Social Services are notified. Interview with the Adult Home Specialist Supervisor on 8/12/15 at 8:16am revealed: -She reviewed the incident/accident reports sent to the County Department of Social Services. -She did not receive an incident/accident report for Resident #2 dated 7/27/15 or referring to the incident/accident on 7/27/15. Interview with Resident #2's Primary Care Provider's nurse on 8/13/15 at 9:46am revealed the doctor was notified on 7/28/15 that Resident #2 fell and was sent to a local hospital. Interview with Medication Aide #1 on 8/13/15 at 3:58pm revealed: -She was called by another Medication Aide (Medication Aide #2) to assist in Resident #2's room after Resident #2 fell on 7/27/15 at about 3:15am -When Medication Aide #1 went into the room to assist, Resident #2 was in the bed with a cut across the forehead, "the length of a fingernail". -The cut was bleeding but stopped bleeding when Medication Aide #2 "wiped it with a cloth". Review of the facility's fall policy revealed the policy included all incidents will be reported to the appropriate agencies within the timeframe as required by state.	D 451		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights:	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047011	A. BUILDING: ____ B. WING ____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D911	Continued From page 39 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on interview, the facility failed to assure residents were treated with respect, consideration, and dignity by facility staff. The findings are: Based on observation and interviews, that facility failed to assure residents were treated with respect, consideration, and dignity as related to the manner in which staff speak to residents. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights].	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to referral and follow up, and medication administration. The findings are:	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047011	A. BUILDING: ______ B. WING ______	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 40 1. Based on record review and interviews the facility failed to assure referral and follow-up for 1 of 3 sampled residents with falls (Resident #2) by not sending the resident out for medical evaluation after an unwitnessed fall. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to administer prescription medications in accordance with orders by a licensed prescribing practitioner for 2 of 5 residents sampled (#1 and #2) for DuoNeb nebulizer treatments for Resident #2 resulting in coughing, wheezing, shortness of breath, and respiratory distress which required treatment for pneumonia and emergent treatment for diagnosis of atelectasis (atelectasis is a collapse of the small air sacs in the lungs), and Annusol suppositories for Resident #1. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D912		