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D 000	Initial Comments The Adult Care Licensure Section conduted an annual survey and complaint investigation on 10/15/15, 10/16/15, and 10/19/15 with an exit conference via telephone on 10/20/15.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Type B Violation Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 6 staff (Staff A, B, and C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G. S. 131E-256. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired as a Dietary Aide on 03/08/13. -His responsibilities were serving meals in the dining room. -There was no documentation of a HCPR check. Interview on 10/20/15 at 8:15 am with Staff A revealed: -He worked at the facility since March 2013. -He previously worked at a group home as a Medication Aide and Personal Care Aide.	D 137		

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-At this facility his duties were to serve meals in the Assisted Living dining room or transport the meal cart and serve meals in the Memory Care Unit dining room.
-He sometimes assisted with feeding residents in the Memory Care Unit, but not unless help was needed.
-He was unaware what a HCPR was and did not know if one had been completed upon his employment.

Interview on 10/16/15 at 5:20 pm with the Business Office Coordinator revealed:
-She was responsible for obtaining HCPR for staff.
-Staff A was hired as a Dietary Aide and worked in the kitchen and dining room.
-To her knowledge Staff A did not provide any direct care services to residents.
-She was unaware that HCPR checks had to be obtained for all staff.
-She will do a HCPR check on Staff A today.

An HCPR check was done on 10/16/15, and revealed no findings.

2. Review of Staff B's personnel record revealed:
-Staff B was hired as a Personal Care Aide (PCA) on 09/15/15.
-Her responsibilities were to assist resident with bathing/showering, dressing, transferring, ambulation, feeding and toileting.
-There was no documentation of a HCPR check.

Interview on 10/16/15 at 5:34 pm with Staff B revealed:
-She had worked for the company for over one year and wanted to transfer to this facility.
-She started working at this facility on 09/20/15.
-She mostly worked in the Memory Care Unit.

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-Her duties and responsibilities included assisting residents to the bathroom, on and off the toilet, helping with ambulation and transferring residents out of bed or from sitting positions.
-She helped with showering/bathing, feeding, brushing teeth and combing hair.
-To her knowledge, no paperwork had been done since she started working at the facility, because she transferred from a sister facility, and was not a new hire.

Interview on 10/16/15 at 5:21 pm with the Business Office Coordinator revealed:
-She was responsible for obtaining HCPR for staff.
-She had not done a HCPR check on Staff B.
-Staff B was not considered a new hire, but was transferred from a sister facility.
-She will do a HCPR check on Staff B today.

A HCPR check was done on 10/16/15, and revealed no findings.

3. Review of Staff C's personnel record revealed:
-Staff C was hired as a Housekeeper on 06/25/14.
-Her responsibilities included providing cleaning services throughout the facility and residents' rooms.
-There was no documentation of a HCPR check.

Staff C was unavailable for an interview.

Interview on 10/16/15 at 5:22 pm with the Business Office Coordinator revealed:
-She was responsible for obtaining HCPR for staff.
-She had not done a HCPR check on Staff C.
-Staff C was employed as a housekeeper and provided no health related services to the

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D 137	Continued From page 3 residents. -She was unaware that HCPR check needed to be completed for Staff C. -She will do a HCPR check on Staff B today. An HCPR check was done on 10/16/15, and revealed no findings. The facility provided the following Plan of Protection on 10/19/15. -Beginning immediately, all staff records will be reviewed to ensure HCPR check is completed. -The ED or designee will audit personal files routinely and upon hire of new staff to ensure ongoing compliance. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 4, 2015.	D 137		
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: A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for 2 of 2 sampled residents (Residents #4 and #6) with repeated falls which resulted in injury.	D 270		

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D 270	Continued From page 4 The findings are: A. Review of Resident #4's current FL-2 dated 09/09/15 revealed: -Diagnoses included Alzheimer's dementia, rheumatoid arthritis, and hypertension. -Level of Care documented was SCU (Special Care Unit). Review of Resident #4's care plan dated 02/09/15 revealed: -"No problems" with ambulation/locomotion. -"Uses walker if reminded" was documented under "Devices needed". -The resident required supervision for ambulation/locomotion. -No documentation regarding falls or increased supervision implemented to manage or reduce falls. Review of Resident #4's current care plan dated 05/19/15 revealed: -"No problems" with ambulation/locomotion. -No documentation under "Devices needed". -The resident required supervision for ambulation/locomotion. -No documentation regarding falls or increased supervision implemented to manage or reduce falls. Review of incident reports revealed: -Resident #4 had 14 falls from 01/06/15 to 08/29/15. -Ten of 14 falls were documented as unwitnessed or "found on floor". -Documented injuries included skin tears (01/06/15, 05/01/15, 08/03/15), complaints of right hip and knee pain (04/30/15), "small knot on head" (01/06/15), complaints of right elbow sore	D 270		

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(01/26/15), "head injury" (06/13/15), right knee pain (08/06/15), right arm pain (08/17/15), and "hit head on the left side" (08/29/15).

Review of staff notes revealed the fall on 08/17/15 resulted in a fracture of the right arm.

Further review of incident reports revealed:
-Four falls in January 2015: 01/06/15, 01/06/15, 01/06/15, 01/26/15.
-Two falls in April 2015: 04/21/15, 04/30/15.
-Two falls in May 2015: 05/01/15, 05/16/15.
-One fall in June 2015: 06/13/15.
-Four falls in August 2015: 08/03/15, 08/06/15, 08/17/15, 08/21/15, 08/29/15.

Interview on 10/16/15 at 10:00 am with the Resident Services Director (RSD) revealed:
-There had been numerous interventions tried for Resident #4 in an attempt to reduce her falls.
-Interventions tried included physical and occupational therapy, repair of glasses, body alarms, new shoes, treatment for a urinary tract infection, treatment for anxiety, and repeated placement on the "Butterfly Program" (falls management program).
-Staff repeatedly encouraged the use of the resident's walker, but she frequently did not remember to use the walker.
-The Butterfly Program required an increase in supervision from every two hours to hourly.
-There was no system for increasing supervision beyond the hourly checks when a resident continued to have falls while on the Butterfly Program.

Interviews on 10/15/15 at 4:00 pm and 10/16/15 at 11:55 am with the Administrator revealed:
-Residents were placed on the facility's falls management program, the Butterfly Program,

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when more than one fall occurred in a 30-day period.
-The resident remained on the Butterfly Program until there had been no falls in a 30-day period.
-While on the Butterfly Program, a representative from every facility department participated in a weekly review of residents on the program, evaluated interventions, and implemented new interventions as appropriate.
-Each department representative was responsible for communicating information to their respective department personnel to ensure that all facility staff participated in the monitoring of residents on the butterfly program.
-The intent of the Butterfly Program was to ensure all staff, clinical and nonclinical, were aware of residents with falls and interventions in place, so that residents would be monitored by all facility staff throughout the facility.
-The placement of a resident on the Butterfly Program required an increase in supervision from the standard 2-hour checks to hourly checks by Personal Care Aides.
-There was currently no system for determining if a resident required more supervision than the increase to hourly checks required by the Butterfly Program.
-There was currently no system for monitoring to ensure increased supervision of residents on the Butterfly Program was performed by staff.

Review of the Fall Prevention Check Lists completed on 01/07/15, 05/07/15, 08/07/15, and 08/29/15 revealed:
-Resident #4 was on the butterfly program on 01/07/15 and "graduated" from the program on 02/06/15.
-Resident #4 was placed on the butterfly program on 05/16/15 and "graduated" from the program on 07/13/15.

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-Resident #4 was placed on the butterfly program on 08/06/15 with no documentation of graduation date.

Review of the facility's monthly Personal Care Aide (PCA) logs for Resident #4 revealed:
-The monthly logs included instructions for how often residents were to be "checked".
-Staff documented 2-hour checks for Resident #4 from 01/01/15 through 04/30/15, during which time the resident experienced 6 falls with no documented increase in supervision.
-Staff documented hourly checks for Resident #4 from 05/01/15 through 06/30/15, during which time the resident experienced 3 falls. There was no documentation of increased supervision beyond the hourly checks in response to the resident's falls.
-Staff documented 2-hour checks for Resident #4 from 07/01/15 through 07/31/15.
-Staff documented "1-2 hour" checks for Resident #4 from 08/01/15 through 09/30/15, during which time the resident experienced 5 falls with no documentation of increased supervision beyond 1-2 hour checks in response to the resident's falls.
-Staff documented 2 hour checks for Resident #4 from 10/01/15 through 10/15/15.

Interview 10/15/15 at 3:17 pm with a Personal Care Aide (PCA) revealed:
-All residents were routinely checked every two hours as a standard.
-Residents on the Butterfly Program were supposed to be checked at least hourly.
-Supervisory checks were performed based on instructions on the PCA care logs and documented on the PCA care logs.

Interview on 10/15/15 at 3:30 pm with a

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medication aide (MA) revealed:
-Routine supervisory checks were conducted for all residents every 2 hours.
-Staff checked residents on the Butterfly Program hourly and every time staff passed by the resident's room, they "looked in" on the resident.

Interview on 10/15/15 at 3:45 pm with a second personal care aide revealed:
-Residents on the Butterfly Program were supposed to be checked hourly and documentation of rounds completed on the PCA flow record.

Interview on 10/16/15 at 11:30 am with Resident #4's Power of Attorney (POA) revealed:
-He was aware of Resident #4's multiple falls.
-He felt comfortable with the level of care and supervision provided by the facility.
-Staff had tried to "work with her (Resident #4)" to remember her walker, but she does not remember it.
-He did not feel that physical therapy was an effective intervention for Resident #4 because she had 3 falls while she was receiving physical therapy.
-He felt the facility was providing enough supervision because "no one can be there every minute".
-The resident had "been falling" since 2011 and was better off at the facility than at home.

Telephone interview on 10/20/15 at 12:05 pm with Resident #4's physician revealed:
-She was aware of the resident's repeated falls.
-An increase in supervision of the resident "would be great" but she did not know if it could be provided in an assisted living facility.
-The physician felt an increase in supervision would "most likely" decrease the number of

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D 270	Continued From page 9 Resident #4's falls. B. Review of Resident #6's current FL-2 dated 10/12/15 revealed diagnoses included fall at assisted living, congestive heart failure with pleural effusion, tachycardia, bradycardia, dementia, hypertension and osteoarthritis. Review of Resident #6's Resident Register revealed an admission date of 12/05/14. Review of Resident #6's Care Plan dated 10/15/14 revealed: -The resident was assessed for limited assistance with ambulation. -The resident was assessed for limited assistance with transfers with specific type of assistance noted as, "x 1 staff assist/support for safety, can bear weight" Review of the facility "Instructions for Quality Improvement Post Fall Investigation" form revealed: -"The following information is strictly provided to clarify terms related to supervision and interventions for QA Review of incidents of falls and accidents." -"Implementation of intervention, including adequate supervision, consistent with the resident's needs, goals and plan of care and recognized standards of practice, to reduce the risk of an accident." Observation of the hallway outside Resident #6's room on 10/15/15 at 2:20 pm revealed: -A loud beeping noise was coming from Resident #6's room with the door closed. -A chair alarm on the couch was beeping loudly and Resident #6 was not in the room or the	D 270		

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bathroom.
-All care staff were on the first floor and there were no staff present on the second floor to tend to the chair alarm or locate the resident.
-A private sitter for another resident was seeking assistance from facility staff to assist her resident to the restroom.
-A member of the housekeeping staff walked past and said she would get a staff member from downstairs to come upstairs to assist the resident and tend to the alarm in Resident #6's room as there was no one on that floor at this time.
-Resident #6 was unable to be located at this time by the staff available.

Interview with Resident #6 on 10/16/15 at 1:20 pm revealed:
-Resident #6 lying was in the bed and stated, "My back has never hurt like this before."
-The pain medication they were administering was not helping at all.
-Resident #6's back hurt because of the fall and did not hurt like this before his fall.
-Resident #6 had fallen before, but could not report how long it took staff to respond.
-The resident did not know what the call bell device was or what it was used for.

Review of Resident #6's staff notes revealed:
-On 9/28/15 at 3:45 am resident was showing signs of pain and complained of back pain and no fall noted.
-On 9/28/15 at 10:00 pm Resident #6 received an order for Tramadol 50mg (used for moderate pain) to be given twice daily as needed for pain and an order for an X-Ray of the Lumbar Spine.
-On 9/28/15 Resident #6's pain had increased and sitting at supper was very difficult.
-Resident #6 required increased assistance getting into the bed.

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D 270	Continued From page 11 Review of Resident #6's staff notes revealed: -There were 5 falls in September 2015 as follows: -On 9/29/15 at 4:30 am facility staff documented Resident #6 called for assistance and when staff arrived Resident #6 was sitting on the floor, needed help up and was "ok" and denied pain. -On 9/29/15 at 6:40 am facility staff notified RCD and left message to call facility. -On 9/29/15 facility staff documented Resident #6 "was found in room completely wet from urine, staff was assisting with getting out of bed when resident stated he was in too much pain". -On 9/29/15 facility staff documented at 8:30 am Resident #6 was sent to the local hospital because of severe pain as directed per RCD. -On 9/29/15 facility staff documented on second shift (3:00 pm-11:00 pm), Resident #6 returned from the emergency room with a "Fracture". -RCD documented on Incident Report Form dated 9/29/15 that Resident #6 sustained an L 5 compression fracture. -Fax cover sheet dated 9/29/15, addressed to adult home specialist from RCD stated, "Resdient diagnosed with compression fracture of L 5 at emergency room after sliding off bed on third shift last night." -On 9/30/15 facility staff documented at 2:00 am Resident #6 was "found on the floor at 1:07 am" by a Personal Care Aide (PCA) and was complaining of severe back pain and Resident #6 was sent to the local hospital. -On 9/30/15 facility staff documented on first shift (7:00 am-3:00 pm) Resident #6 was "found on the floor at 9:30 am by the Medication Aide." -On 9/30/15 facility staff documented he was trying to go to the bathroom and he was still complaining of severe back pain. -Medication Aide (MA) notified the Resident Care Coordinator (RCC) and the RCC said Resident	D 270		

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#6 was now on "The Butterfly Program" with one hour checks.

Review of staff notes revealed there were 2 documented falls for Resident #6 in October 2015 as follows:
-On 10/03/15 facility staff documented Resident #6 complained of back pain ,was unable to sit up straight and that it required three people to transfer Resident #6 to the wheelchair. Resident #6 was unable to shower due to pain.
-On 10/09/15 Resident #6 was observed on the floor, was assisted back to bed and encouraged to use call bell with bed alarm in place.
-10/10/15 at 6:40 am Resident #6 was found on the floor in the prone position at 5:40 am. "Resident stated he did not remember he was doing to fall. No new injury noted. Able to move arm and legs, alert and responsive. did state he had mid back pain. Resident had a fall two days ago." Resident #6 was sent to the hospital.

Review of Incident Reports for Resident #6 revealed:
-On 9/29/15 at 4:00 am, Resident #6 was found on the floor. At 9:00 am he was sent to the emergency room for evaluation.
-The final Outcome/Disposition was noted as Resident #6 had an L 5 compression fracture determined on X-ray.
-On 9/30/15 at 1:07 am, Resident #6 was found on the floor after an unwitnessed fall with head between the couch and the coffee table.
-The final Outcome/Disposition was noted as Resident #6 was put on "The Butterfly Program and times toileting".
-On 9/30/15 am, Resident #6 was found on the floor after an unwitnessed fall and resdient was trying to get up out of bed to go to the bathroom and fell.

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-The final Outcome/Disposition was noted as "staff encourages him to use his pendant/call bell prior to getting up and for any needs....placed on times toileting."
-On 10/09/15 (no time documented), Resident #6 was found on floor beside couch and the was not transported to hospital.
-The final Outcome/Disposition was noted as, "Resident continues to have acute pain with transfers and forgets to call for assistance before transfers. On Butterfly Program to increase supervision."
-No incident report was provided for the documented fall on 10/10/15 where Resident #6 was transported and admitted to the hospital.

Review of Resident #6's Post Fall Investigation completed 10/01/15 revealed:
-"The interventions were reviewed and updated as necessary in the resident's care plan and medical record."
-"Staff had been informed of necessary changes".
-"Staff had been trained and documented."

Review of Resident #6's record revealed:
-There was no updated Care Plan between 9/30/15 and 10/15/15 as the Post Fall Investigation indicated.
-The Nurse Aide log for 9/01/15-9/30/15 gave staff instructions to check Resident #6 every 2 hours.
-From 9/01/15 to 9/30/15 staff documented in the Personal Care Aide log on each shift that Resident #6 was checked every 2 hours for 70 times out of 90 opportunities.
-There was no increase in frequency for Resident #6 to be checked every hour after Resident #6 was placed on "The Butterfly Program" on 9/30/15.
-There was no documentation in Resident #6's

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record of any increase in monitoring or supervision.
-The PCA log for 10/01/15-10/15/15 provided staff instructions to check Resident #6 every 2 hours.
-From 10/01/15 to 10/15/15 staff documented on each shift that Resident #6 was checked every 2 hours for 31 times out of 45 opportunities.
-There was no increase in frequency for Resident #6 to be checked every hour after Resident #6 was placed on "The Butterfly Program" on 9/30/15.
-There was no documentation in Resident #6's record of any increase in monitoring or supervision.
-There was no increase in frequency for Resident #6 to be checked every hour after Resident #6 returned from the hospital on 10/12/15.

Interview on 10/16/15 at 2:49 pm with Resident #6's Responsible Party revealed:
-Resident #6 had no falls prior to these recent falls.
-He called Resident #6's physician and requested a change or increase in pain medication because Resdient #6 was still experiencing a lot of pain.
-The facility was doing "a fair job" in preventing falls, but there was room for improvement.
-The facility did place a butterfly on the door for increased monitoring.
-They were utilizing chair/bed alarms to prevent falls.

Attempted interview on 10/16/15 at 3:03 pm with Resident #6's physician was unsuccessful.

Interview on 10/16/15 at 6:03 am with a MA revealed:
-The Butterfly Program identified those in the facility that were falls risks.
-If a resident was on The Butterfly Program staff

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were to document in the communication book every hour after a fall for 24 hours and then every 2 hours for 24 hours.
-The MA named one resident that was on The Butterfly Program and it was not Resident #6.

Interview on 10/16/15 at 6:12 am with a Personal Care Aide (PCA) revealed:
-The Butterfly Program identified residents that were fall risks.
-If a resident was on the program the resident was to be closely monitored about every hour.
-There was no required documentation.
-Resident #6 was not named as being on The Butterfly Program.

Interview on 10/16/15 at 7:20 am with a second MA revealed:
-The Butterfly Program was for residents who suffered memory loss, dementia and confusion.
-If a resident was on The Butterfly Program staff was to monitor them every once in a while and report more to families, the nurse and the doctor.
-The was no documentation of this increased communication.
-Resident #6 was not listed as being on The Butterfly Program.

Interview on 10/16/15 at 10:20 am with the Resident Services Director (RSD) revealed the checks documented every two hours reflected documentation that the residents were being supervised hourly.

Interview on 10/16/15 at 9:55 am with the Administrator revealed:
-If a Resident had 2 falls in 30 days they were placed on The Butterfly Program.
-Anyone can place a resident on the program.
-If a resident was placed on The Butterfly

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D 270	Continued From page 16 Program they were checked every time any staff member walked passed the residents room. -He was unaware that there was no staff present on Resident #6's floor for an extended amount of time. -There was a lack of documentation in providing evidence of increased supervision. _____ On 10/16/15, the Administrator submitted a Plan of Protection which included: -Beginning immediately, all residents would be assessed to determine the level of supervision required to maintain safety . -Staff would provide supervision according to each resident's assessed needs. -The Executive Director or designee would monitor daily to ensure staff were providing supervision according to each resident's assessed needs. DATE OF CORRECTION FOR THE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 19, 2015.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, record review and interviews the facility failed to assure referral and	D 273		

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follow-up for 1 of 5 sampled residents with hypoxic respiratory failure, (Resident #2) by not sending the resident out for medical evaluation.

The findings are:

Observation and encounter with Resident #2 on 10/15/14 at 10:38 am revealed:
-The resident was alone in his room sitting in a recliner chair.
-The resident held his head down at periods of time as if it was heavy.
-There was a square table next to the chair.
-A Nebulizer machine was observed with a mouth piece tubing and medicine cup sitting on the table.
-The medicine cup appeared to be empty.
-The resident was awake.
-Upon entrance to Resident #2's room, the resident was making loud sounds inhaling air through his nose, with wheezing and audible rattle of loose phlegm that was heard three feet away from the resident.
-When inhaling, the resident took long deep breaths and appeared to be gasping for air.
-When the resident inhaled, the resident used all chest muscles and outline of his rib cage was easily seen, the resident's shoulders lifted up in height and he extended his neck with a deep curve in the middle of his neck.
-There were rattling sounds of loose phlegm coming from the resident's upper chest, esophagus, or throat area.
-When the resident exhaled, there was obvious expansion of his abdomen.
-When talking, the resident appeared to be short of breath and took rapid short breaths as if he was struggling for air.
-When asked how he was doing, the resident made frequent pauses between words to take

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breaths, even stopping to take a breath before finishing a word.
-The resident said "I have been short of breath all morning."
-He thought the facility staff were aware of his condition because they had been in his room earlier that day.
-The resident was unaware of the Nebulizer machine on the table and did not know what it was used for.
-The resident was not knowledgeable about his health care condition, and was unaware of medications, or treatments, if any, ordered.

At 10:43 am the surveyor alerted a Personal Care Aide (PCA) and told the PCA Resident #2 needed help and was having difficulty breathing.
-The PCA said she would get the Medication Aide (MA).
-At 10:45 am the PCA returned stating she was unable to locate the MA, and asked if the surveyor wanted her to get the Nurse.
-The PCA went to get the Nurse.
-The Nurse/Resident Services Director (RSD) entered the room and immediately started saying the resident had periods of sleep apnea, and was scheduled to see the physician next week.
-The RSD verbally said to the resident "you have an appointment next week?"
-The resident responded "I don't know."
-The nurse was unaware Resident #2 had difficulty breathing until the surveyor informed and asked to measure the resident's oxygen saturation.
-The resident's oxygen saturation was 95-96% on room air.
-The RSD left the room and returned with a stethoscope and listened to the resident's chest in the front and in the back.
-The Nurse documented the resident's lungs

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were clear.

Review of Resident #2's current FL2 (hospital discharge report) dated 06/09/15 revealed:
-Diagnoses included shortness of breath, acute respiratory failure, acute bronchitis, sinus tachycardia with history of chronic atrial fibrillation, congestive heart failure, cognitive impairment, dysrhythmia, dementia, verrucous papilloma, and irregular heart rate.
-The resdient was constantly not oriented to person and time.
-The resident required supervision with eating, limited assistance with ambulation; extensive assistance with toileting, transferring, dressing, and bathing.
-Medications to assist with breathing included Albuterol (Proventil) 90mcg 2 puffs every 6 hours as needed for wheezing; Albuterol nebulizer solution 2.5mg/0.083% every 6 hours for shortness of breath; and Mucinex 600mg take 1 tablet twice daily as needed for cough or loose phlegm.

Review of Resident #2's Personal Care Physician Authorization and Care Plan signed by the physician on 7/02/15 revealed:
-The resident's social/mental health history described the resident had diagnosis of dementia with behavior disturbance; macular degeneration and glaucoma; and enjoyed being around others.
-The resident needed limited assistance with bathing, dressing, and grooming.
-He needed supervision with eating, toileting, ambulation, and transferring.
-Other assistance needed was Nebulizer treatment as needed (PRN) for wheezing.

Review of nurses' notes revealed:
-09/29/15 at 2:05 pm the RSD noted - "med tech

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asked me to come and listen to resident. who was napping while in recliner. Initially notes audible wheeze & course Rhonchi, which turns to a snore for a few breaths & then cycles to a period of apnea that lasted approx. 15 seconds. No listed hx of sleep apnea." The physician was notified there was a concern the resident had apnea.

Review of a facsimile (fax) received from the physician 10/16/15 at 8:42 am revealed:
-The RSD wrote "V.O. for chest x-ray for SOB coughing, Rhonchi, & wheezing in all lobes. - may use mobile x-ray service."
-Fax was returned with the physician's signature.
-At 11:45 am Mobile x-ray was obtained. Results showed no acute disease.

Review of Resident #2's October 2015 Medication Administration Record (MAR) revealed:
-ProAir HFA, inhale 2 puffs into lungs every 6 hours as needed for wheezing or shortness of breath was printed on the MAR.
-Staff documented the administration of the medication once in October 2015, on the 15th.
-Staff documented on the back of the MAR the reason was "wheezing and shortness of breath," no effectiveness and time was documented on the MAR.
-Albuterol sulfate 2.5mg/3ML vial-Neb inhale 1 via Nebulizer every 6 hours as needed for wheezing or shortness of breath was printed on the MAR.
-Staff documented the administration of the medication once in October 2015, on the 15th at 7 am for time given and at 8 am for time noted.
-The reason noted was wheezing, no effectiveness was documented on the MAR.
-Mucinex 600mg 1 tablet twice daily as needed for cough or to loose phlegm was printed on the

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D 273	Continued From page 21 MAR. -Staff documented the administration of the medication on the front of the MAR was on October 14, 2015, but the failed to document on the back of the MAR, the reason, date, time, and effectiveness of the medication. Observation on 10/16/15 at 7:11 am of Resident #2's medications on hand at the facility revealed: -ProAir HFA, Albuterol sulfate 2.5mg/3ML vial-Neb, and Mucinex 600mg were available for administration. Observations by two surveyors on 10/16/15 from 6:54 am to 7:30 am of Resident #2 revealed: -The resident's door was closed, the resident was in the room alone, sitting in his recliner. -The resident was in his pajamas with bedroom slippers on his feet. -The Nebulizer machine was on the table beside the recliner with the same hose and medicine cup that was observed on Thursday, October 15, 2015. -Resident #2 was still in distress as observed yesterday. -Resident #2 was having an extremely difficult time breathing, and was breathing at an unusually rapid rate for someone sitting in a recliner. -Resident #2 was taking deep breaths with the abdomen being pulled deep into the chest, using all chest, shoulder and neck muscles to adequately ventilate. -He was able to answer close-ended questions with one and two word answers. -The resident was making loud rattling sounds with loose phlegm that was audibly louder than yesterday. -Wheezing upon inhalation and rhonchi upon inhalation and exhalation was evident without the aid of a stethoscope.	D 273		

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-Resident #2's skin was pale and he was weak.
-The resident gasped frequently when inhaling and stated, "I can't breathe".
-The surveyor notified the medication aide (MA) that Resident #2 was in distress.
-The MA was unaware the resident had as-needed medications to help wheezing and shortness of breath, until suggested by the surveyor.
-Medication Aide (MA) was very concerned about Resident #2, and was going to send Resident #2 out via ambulance, but was waiting until the Resident Services Director (RSD) assessed resident and approved of transport.
-RSD arrived, listened to his lung sounds with a stethoscope, and stated his lungs sounded much worse than they had yesterday (10/15/15).
-She was going to call Resident #2's family because his breathing and respiratory status declined significantly as compared with the day before.
-Resident #2's oxygen saturation was 93% as per pulse oximetry obtained by the RSD.
-RSD then brought a cup of coffee to Resident #2 because this would help "break up his congestion and help him to breathe".
-Resident #2 was unable to hold or drink his coffee.
-RSD stated that the family would not want to send him to the hospital but she was going to go call them anyway.
-MA arrived with Albuterol and administered medication via hand held nebulizer.
-Resident #2 could not hold the nebulizer and MA held the nebulizer for the entire treatment.
-Resident #2 took short, shallow breaths and coughed repeatedly during the treatment.
-The Albuterol treatment was somewhat effective and Resident #2's respirations decreased and the audible breath sounds had lessened but were still

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present.

Interview on 10/16/15 at 7:22 am with the first shift Medication Aide (MA) revealed:
-She had observed the resident's wheezing and having difficulty breathing.
-She was concerned and wanted to send the resident out to the hospital, but had to talk with the RSD first.
-The MA gave Resident #2 Mucinex at 7:15 am, but she would feel better sending the resident out to the hospital.
-Facility protocol was to notify the RSD to assess resident's before sending the resident out to the hospital.
-The MA was unaware Resident #2 had ProAir and Albuterol Nebs on the medication cart until informed by the surveyor.

At 7:25 am the RSD came to Resident #2's room and using a stethoscope listened to the resident's lungs.
-The RSD stated wheezing had worsened since yesterday and she was going to call the family to make a suggestion.
-The RSD was unaware that Resident #2 had Proventil and Nebs on the medication cart for wheezing and shortness of breath until informed by the surveyor.

Observation on 10/16/15 at 7:28 am of the MA administering Resident #2's Nebulizer treatment revealed:
-The MA changed the hose with mouth piece and medicine cup from the one previously observed.
-Observation count of Resident #2's respiration prior to obtaining the Nebulizer treatment was 28, after obtaining the treatment respirations dropped to 18.
-The resident still appeared to be in distress, and

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had a little improvement.

Second interview on 10/16/15 at 7:33 am with the first shift MA revealed:
-She gave Resident #2 Mucinex this morning, but had never given the resident a Nebulizer treatment prior to the one she was currently administering.
-It was normal for Resident #2 to sometimes be tired, short of breath, and take deep breaths.
-The MA saw Resident #2 yesterday morning to administer his medications, but did not observe any concerns that were not what she considered normal for the resident.
-She did not see the resident anymore before her shift ended.
-Later, when asked about why she initialed the administration of the nebulizer treatment on 10/15/15 on the MAR, but verbally stated she had never given a Nebulizer treatment before; the MA responded "I forgot."

Interview on 10/16/15 at 9:00 am with Resident #2's family member #1 revealed:
-The RSD at the facility called her this morning and told her the resident had some wheezing and cough.
-The RSD did not make it sound serious, but stated she would call the physician and then call the family member back.
-The family member said if the resident needed to go to the physician's office she would be the one to take the resident, so she was waiting to hear what she needed to do.

Interview on 10/16/15 at 4:45 pm with the second shift PCA revealed:
-She worked the second shift on 10/15/15 as PCA.
-She observed Resident #2 round 6:00 pm to

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7:00 pm and noticed the resident was breathing hard and raspy.
-She was very concerned and scared for the resident, so reported it to the MA on duty.
-She did not follow-up or see the resident anymore because she thought the MA would take care of the resident.
-Today she was surprised to see the resident in the same condition as yesterday.

Interview on 10/16/15 at 5:15 pm with the second shift MA revealed:
-She observed Resident #2 around 8:00 pm to give the resident his night time medications.
-The resident was sitting in a chair in the hallway (outside of this room).
-The resident had raspy deep breaths, and appeared to be tired, and was taking very deep breaths.
-She had not observed it, but thought the resident had been walking up and down the hallway, as this condition was normal when the resident walked.
-One day this week (unable to recall specific date) she gave the resident a Mucinex because he sounded congested and had a cough.

Second interview on 10/19/15 at 7:40 pm with the second shift MA revealed:
-At 6:00 pm on 10/16/15 she gave Resident #2 a Nebulizer breathing treatment.
-She told the resident to hold the hose in his mouth and she would come back and check on him.
-She felt it was okay to leave Resident #2 in the room alone to administer his medication.
-At 6:30 pm, the resident's family member came to her and said the resident looked bad.
-She told her about the X-ray and Nebulizer order change, then the family member said it must be

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congestive heart failure again.
-The MA stated Resident #2 usually appeared out breath.
-The MA gave the resident a Mucinex on 10/15/15, but prior to today she had never administered the PRN Nebulizer or Proventil.

Second interview on 10/19/15 at 9:55 am with Resident #2's family member revealed:
-On 10/16/15 around 9:10 to 9:15 am she called Resident #2's physician and asked to change the Nebulizer treatment from PRN to every 6 hours routine, requiring staff to give the medication.
-Resident #2 had dementia and was not aware of healthcare needs.
-The resident will not ask for PRNs when needed, so staff had to assess when a PRN was needed.
-Staff had not been administering PRNs and this was a continual problem that had been previously addressed several times with the Administrator.
-On 10/16/15, Resident #2 was admitted to the hospital with pneumonia in both lungs.
-The emergency department (ED) physician told the family member "they were lucky it was caught when it did, any longer Resident #2 would not have survived."

Interview on 10/19/15 at 11:15 am with the RSD revealed:
-Resident #2 had a history of snoring and taking deep breaths.
-On Thursday, October 15, 2015 when she entered the resident's room, she thought the resident was asleep.
-Although she had a conversation with the resident she did not observe anything that was not normal for the resident.
-She did listen to the resident's lungs on Thursday, October 15, 2015, and did not hear anything, but on Friday, October 16, 2015, she

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heard rattling of phlegm in both lungs.
-She did not send the resident out because family does not want the resident to go out.
-Later the mobile X-ray showed "no diseases."

Interview on 10/19/15 at 10:45 am with Personal Care Aid (PCA) that worked on 10/15/15 first shift revealed:
-She had observed Resident #2 being short of breath and having difficulty breathing when talking, but had never observed the resident struggling for air or having difficulty breathing when not walking.

Interview on 10/19/15 at 11:35 am a PCA that worked midnight shift revealed:
-She worked the night of 10/15/15 to the morning of 10/16/15, but did not enter Resident #2's room.
-She was unaware of the resident's condition or that the resident had difficulty breathing.
-She had observed that Resident #2 often was short of breath and had difficulty breathing when walking.
-She had also observed wheezing, but no major changes than usual.
-When the resident exerted himself there was always wheezing.

Interview on 10/19/15 at 11:58 am with a second PCA that worked midnight shift revealed:
-Resident #2 normally breathed heavy taking deep breaths to inhale air.
-She had not observed the resident since 10/14/15, but did not observe anything unusual.

Interview on 10/19/15 at 5:30 pm with Resident #2's family member revealed:
-She lived out of town and had not talked with another family member prior to visiting the facility.
-She arrived at the facility at 6:30 pm on Friday,

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D 273	Continued From page 28 October 16, 2015. -She observed that Resident #2 was in his room, alone. -The resident seemed lethargic and did not recognize family. -Although Resident #2 had dementia, he usually recognized family. -The resident had the Nebulizer hose in his mouth with steam coming from the opposite end. -The clear plastic cup appeared to be empty. -The resident was holding the hose to the Nebulizer machine in his mouth. -She could see the resident was weak, he was taking deep breaths using all upper body muscles, she could hear loose mucus rattling in the resident. -She went to the medication room to get the MA, and informed Resident #2 needed help and was "bad." -The MA informed he family member about the chest X-ray and Nebulizer order change. -The family member said something else was wrong then, maybe congestive heart failure again. -The resident needed to go out to the hospital. -The MA informed she would tell the RSD who was still in the building. -Family member got the RSD and asked her to listen to Resident #2 because he was "bad." -The RSD went to the room and stated the resident had gotten worse, and Nebulizer treatments were not working. -Family member #2 asked to call emergency responders to transport the resident to the hospital. -The RSD told the family member that based on the resident's current condition, he would not have made it through the weekend. -At the hospital in the emergency room the physician told Family Member #2 that Resident #2 was lucky, and if they had waited longer the	D 273		

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resident may not have made it.

Reviewing hospital records for Resident #2 on 10/19/15 revealed:
-Emergency Responders (ER) reported upon arrival Resident #2 had Rhonchi in lower lobes.
-ER gave Resident #2 three Nebulizer treatments at the facility and two Nebulizer treatments on the way to the hospital.
-The resident was evaluated in the Emergency Department (ED) with difficulty breathing, significant bronchospasm prophylaxis with dyspnea parietal.
-The resident's blood pressure was 138/64, pulse was 78, respiration was 16, and oxygen saturation was 93.
-Resident #2 was diagnosed with acute hyporic respiratory failure and respiratory distress.
-Resident #2 was admitted with chills, fever, cough productive of yellow sputum, and pneumonia.

Interview on 10/19/15 at 6:50 pm with the hospital nurse revealed:
-Resident #2 had pneumonia in both lungs.
-The pneumonia was pretty significant being in both lungs.
-Earlier identification and treatment of the pneumonia depending on when it was identified may not have worsened.
-Even a day earlier treatment could have relieved some of the resident's suffering inability to breathe.
-There was still possibly a concern regarding heart problems and the resident was still pretty weak.
-A full report could be obtained from medical records.

Interview on 10/20/15 at 8:05 am with the nurse

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at Resident #2's physician office revealed:
-Last Friday, October 16, 2015 they received a call from the RSD regarding Resident #2 having wheezing and some shortness of breath.
-The RSD did not make the resident's condition sound severe.
-The physician had no openings last Friday, so the RSD requested a mobile X-ray.
-The results were faxed back to the physician's office, with no acute disease.
-Resident #2's family member called and asked to change the Nebulizer treatment from PRN to routine every six hours.
-The order was faxed to the facility.
-The physician was unaware the resident was admitted to the hospital.
-The resident had an appointment at their office on Monday, October 19, 2015 regarding sleep apnea.
-The resident did not show-up, so she called family member, and was informed the resident was in the hospital.
-She looked in the hospital medical system and saw that Resident #2 was admitted for acute hyperopic respiratory failure secondary to pneumonia and acute diastolic heart problems.
-No one at the facility had informed the physician of the resident's condition.
-The physician had not been made aware that staff continually observed Resident #2's normal condition as being, tired, out of breath, and needing to take deep breath to inhale air.
-Resident #2 had a lot of healthcare illnesses with congestive heart failure, atrial fibrillation, history of respiratory failure and bronchitis.
-No it was not normal for Resident #2 to always be tired, have shortness of breath, and taking deep breaths to inhale air when breathing.
-The physician wanted to know those things, and no one at the facility had informed them that was

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the resident's condition.
-Due to the resident's medical history, it was important the resident got his PRN medications at the first sign of breathing difficulty.
-The family members had made them aware that sometimes the resident did not get his medications, and they had discussed this with the Administrator.

Interview on 10/20/15 at 12:58 pm with Resident #2's family member revealed:
-He usually visited Resident #2 every other week.
-He was at the facility on 10/14/15 and noticed the resident had some coughing with congestion.
-He told the MA on duty and asked her to give the resident's PRN Mucinex.
-"PRN judgement things tend to not get done at the facility, because it appears staff were too busy."
-This issue had been addressed previously with the Administrator, once prior to the current Resident Services Director (RSD) being hired, and once after the RSD was hired.
-Resident #2 had an appointment on 10/19/15 but it was for sleep apnea as informed by RSD.

_____

The facility provided the following Plan of Protection on 10/19/15:
-Beginning immediately, all residents will be assessed to ensure safety will be met for every resident to determine any health care concerns that require referral and follow-up will be met.
-The RSD/designee will assess all resident to assure health care needs are met.
-Designee will monitor on a daily bases that healthcare is provided according to resident assessed needs.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER

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D 273	Continued From page 32 19, 2015	D 273		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain an accurate and current listing of residents with physician ordered therapeutic diets for 3 of 5 sampled residents prescribed a therapeutic diet for the guidance of food service staff (Residents #1, #2 and #10). The findings are: On 10/15/15 at 11:05 am review of the therapeutic diet list posted in the kitchen revealed: -The list was updated 10/07/15. -The list included all the room numbers along with the residents' names and ordered diets. -Diets listed on the posting included General, Consistent Carbohydrate (CCHO), No Added Salt (NAS), Heart Healthy, Mechanical Soft and also specified who received thickened liquids and the consistency. -There were 70 residents and corresponding diets listed. -Comparison of the posted list with the facility's current census revealed there were 69 residents in the facility and 1 resident in the hospital.	D 309		

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A. Review of Resident #1's current FL2 dated 7/14/15 revealed:
-Diagnoses included: gastrointestinal bleed, congestive heart failure, anemia and iron deficiency, cerebral infarction, hypoglycemia, dehydration, dementia, hypertension, hypercholesterolemia, and gastroesophageal reflux.
-An order for a dysphagia 2, low sodium and heart healthy diet.

Review of Resident #1's physicians order revealed a diet order dated 6/23/15 for mechanical soft.

Review of the diet list dated 10/07/15 posted in the kitchen revealed Resident #1 was listed to have a mechanical soft diet.

Review of the diet book located in the kitchen revealed a diet order dated 6/23/15 for Resident #1 for a mechanical soft.

Observation of the lunch meal served to Resident #1 on 10/16/15 from 11:55 am to 12:40 pm revealed:
-The resident was served one 8 ounce glass of water and one 8 ounce glass of orange juice.
-The resident was served the mechanical soft therapeutic diet which was 1 piece of baked and ground chicken breast, 1/2 cup of green beans, 1/2 cup of mashed potatoes with gravy and one biscuit.
-He was also served 1/2 cup of mixed vegetables.
-The resident consumed 100% of the chicken, 100% of the green beans, 75% of the mashed potatoes with gravy, 50% of the biscuit and 100% of the mixed vegetables.

Review of the lunch menu to be served for a

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heart healthy diet for 10/16/15 revealed:
-The residents on this diet should be served baked chicken (ground for mechanical soft), 1/2 cup of boiled potatoes with no gravy, 1/2 cup of green beans and one biscuit.

Interview on 10/15/15 at 12:40 pm with Resident #1 revealed:
-He had no complaints about his meal and thought that lunch was good.
-He did not know what diet he was to be on and did not know what diet they brought him.

Refer to interview on 10/16/15 at 3:33 pm with the Dietary Manager.

Refer to interview on 10/16/15 at 4:35 pm with the Assistant Resident Care Coordinator.

Refer to interview on 10/16/15 at 4:15 pm am with the Administrator.

B. Review of Resident #2's current FL2 dated 06/09/15 revealed:
-Diagnoses included acute respiratory failure, shortness of breath, hyponatremia (low sodium level), sinus tachycardia with a history of chronic atrial fibrillation, cognitive impairment, hypotension and gastroesophageal reflux.
-An order for a heart healthy diet.

Review of Resident #2's physician order revealed a diet order dated 7/19/15 for no added salt.

Review of the diet list dated 10/07/15 posted in the kitchen revealed Resident #2 was listed to have a heart healthy diet.

Review of the diet book located in the kitchen revealed a heart healthy diet order dated 5/18/15.

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D 309	Continued From page 35 Observation of the lunch meal served to Resident #2 on 10/16/15 from 11:55 am to 12:40 pm revealed: -The resident was served one 8 ounce glass of water. -The resident was served the heart healthy therapeutic diet which was 1 piece of baked chicken breast, 1/2 cup of green beans, 1/2 cup of boiled potatoes without gravy and one biscuit. -The resident consumed 50% of the chicken, 100% of the green beans, 75% of the boiled potatoes, 100% of the biscuit. Review of the lunch menu to be served for a No added Salt for 10/16/15 revealed: -The residents on this diet should be served fried chicken, 1/2 cup of whipped potatoes, 1/2 cup of green beans and one biscuit. Interview on 10/15/15 at 12:35 pm with Resident #2 revealed: -He would rather have the fried chicken but this was "ok". -He did not ask for the fried chicken or anything else to drink. -He was not offered anything else to drink or a choice between the baked or fried chicken. Refer to interview on 10/16/15 at 3:33 pm with the Dietary Manager. Refer to interview on 10/16/15 at 4:35 pm with the ARCC. Refer to interview on 10/16/15 at 4:15 pm with the Administrator. C. Review of Resident #10's current FL2 dated 2/03/15 revealed:	D 309		

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D 309	Continued From page 36 -Diagnoses included dementia, congestive heart failure, urinary retention, benign prostatic hypertrophy, diabetes mellitus, edema, anemia, hypertriglycemia . -An order for no added salt, mechanical soft diet and nectar thickened liquids. Review of Resident #10's physicians order revealed a diet order dated 10/07/15 a mechanical soft diet. Nectar thickened liquids was not ordered on this diet order. Review of the diet list dated 10/07/15 posted in the kitchen revealed Resident #10 was listed to have a mechanical soft. Review of the diet book located in the kitchen revealed a mechanical soft diet 3/18/15. Observation of the lunch meal served to Resident #10 on 10/16/15 from 11:55 am to 12:40 pm revealed: -The resident was served one 8 ounce glass of nectar thickened water. -The resident was served the soft mechanical therapeutic diet which was 1 piece of baked chicken breast, 1/2 cup of green beans, 1/2 cup of boiled potatoes without gravy and one biscuit. -The resident consumed 50% of the thickened water, 20% of the chicken, 100% of the green beans, 75% of the mashed potatoes with gravy, 100% of the biscuit. Based on observation of Resident #10, record review and interviews with staff it was determined Resident #10 was not interviewable. Refer to interview on 10/16/15 at 3:33 pm with the Dietary Manager.	D 309		

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D 309	Continued From page 37 Refer to interview on 10/16/15 at 4:35 pm with the ARCC. Refer to interview on 10/16/15 at 4:15 pm with the Administrator. Interview on 10/16/15 at 3:33 pm with the Dietary Manager revealed: -He was provided the list of therapeutic diets by the Assistant Resident Care Coordinator (ARCC). -The ARCC updated the list and also supplied a copy of the therapeutic diet order from the physician. -The copies of the physician diet orders were kept in a notebook in the kitchen. -The diet orders were updated by the ARCC with new admissions, re-admissions and upon any change in therapeutic diet order. -He was not aware of any discrepancies in the diet list as compared with the current therapeutic diet orders. Interview on 10/16/15 at 4:35 pm with the ARCC revealed: -She updated the therapeutic diet list every time that there was a new admission or a change in diet. -If she was not present when the change occurred staff gave the dietary staff a copy of the updated diet and she updated the therapeutic diet list the next day. -Staff communicated the changes to her when she arrived to work the next day and she revised the diet list according to the new physician order. Interview on 10/16/15 at 4:15 pm am with the Administrator revealed: -It was the responsibility of the ARCC to update the therapeutic diet list. -If she was not present when an order was	D 309		

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D 309	Continued From page 38 changed, staff was to supply the kitchen with a copy of the diet order. -The diet list would be updated as soon as possible by the ARCC. -He was not aware the posted list for the Assisted Living side of the facility was dated 10/07/15 and was not accurate.	D 309		
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: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 3 of 5 residents (#7, #8, and #9) observed during the medication pass, including errors with vitamin supplements and an oral rinse. The findings are: The medication error rate was 11% as evidenced by the observation of 4 errors out of 34 opportunities during the 8:00 am medication pass on 10/16/15. A. Review of Resident #7's current FL-2 dated 9/16/14 revealed diagnoses included Alzheimer's	D 358		

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MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

(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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Dementia, osteoarthritis, and anxiety.

Review of Resident #7's Resident Register revealed an admission date of 08/21/12.

Review of Resident #7's physician' orders revealed an order dated 07/01/15 for chlorhexidine gluconate 12% oral rinse, rinse mouth with 15 milliliters (ml) twice daily (used to treat gum diseases). (Review of the manufacturer's label for the oral rinse revealed instructions to rinse mouth, spit out mouthwash-do not swallow. Do not eat, drink, or rinse mouth for at least 30 minutes after use).

Observation on 10/16/15 at 8:15 am of the medication pass revealed:
-Resident #7 was in the medication room.
-The Medication Aide (MA) prepared 15 mls of chlorhexidine gluconate 12% oral rinse in a plastic measure cup.
-The MA instructed Resident #7 to sip a little rinse and swish around.
-Resident #7 sipped a small amount (about 5 ml) and swallowed without any swishing, on 3 different attempts.
-The MA gave Resident #7 two ounces of water, stating "that should help with the taste" since the resident swallowed instead of spitting out.

Review of the October 2015 Medication Administration Record (MAR) for Resident #7 revealed chlorhexidine gluconate 12% oral rinse, rinse mouth with 15 mls twice daily was listed and scheduled for 8:00 am and 7:00 pm.

Interviews with the MA on 10/16/15 at 8:20 am and 1:35 pm revealed:
-She was aware Resident #7 was supposed to rinse and spit the oral rinse.

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D 358	Continued From page 40 -Some days the resident was able to rinse and spit the oral rinse, but other days the resident just sipped the oral rinse. -The former Special Care Coordinator (SCC) had told staff that the resident's physician was contacted about the resident occasionally swallowing the medication and the physician had approved administering the chlorhexidine gluconate 12% oral rinse even if the resident swallowed instead of spitting out. -She would look for documentation from the former SCC for the physician's notification. -Resident #9 would be eating breakfast in about 30 minutes. -She was not aware she should not give the resident water after the oral rinse. Interview with the Resident Services Director (RSD) on 10/16/15 at 3:30 pm revealed: -She and the Wellness Coordinator were responsible for monitoring medication administration and monitoring the MAs. -She was not aware Resident #7 was having difficulty with rinsing and spitting out chlorhexidine gluconate 12% oral rinse. -No MA had informed the RSD that Resident #9 was swallowing the oral rinse on some days. Based on record review and observation on 10/16/15, Resident #9 was determined not to be interviewable. Telephone interview on 10/19/15 at 10:04 am with Resident #7's Physician revealed: -He had been contacted by the facility SCC regarding Resident #7 not spitting out the chlorhexidine gluconate 12% oral rinse. -He recalled researching the ingestion of the oral rinse and found no documented cases for adverse side effects from occasionally swallowing	D 358		

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15 mls of the oral rinse.
-He was concerned that the resident had bad gum disease and was losing teeth.
-He thought the benefit of the rinse coming into contact with the gums and treating them out-weighed the risk of ingestion.
-He was not aware the facility staff were administering water after the oral rinse.

B. Review of Resident #8's current FL-2 dated 09/08/15 revealed:
-Diagnoses included dementia, and cerebral artery occlusion not otherwise specified, with infarct.
-An order for Folic Acid 1 mg (1000 mcg) daily (used to treat anemias).

Review of Resident #8's Resident Register revealed an admission date of 02/27/15.

Observation on 10/16/15 at 8:25 am of the medication pass revealed:
-Resident #8 was in the medication room.
-The Medication Aide (MA) prepared 9 oral medications, in a souffle cup, for administration.
-Included in the medications was one folic acid 400 mcg (physician order was for 1000 mcg) prepared from an over the counter stock bottle.
-The Resident took all the medications with 4 ounces of water.

Observation of the medication on hand for administration revealed a stock bottle of 250 Folic Acid 400 mcg with 62 tablets remaining. (The bottle was not labeled with the date received.)

Review of the October 2015 medication administration record (MAR) for Resident #8 revealed:
-Folic Acid 1 mg (1000 mcg) daily was listed on

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the preprinted MAR and scheduled for administration at 8:00 am daily.
-Daily administration was documented from 10/01/15 to 10/16/15.

Interview with the MA on 10/16/15 at 1:35 pm revealed:
-She routinely administered one folic acid 400 mcg daily when she administered Resident #8's medications.
-She was not aware Resident #8's folic acid was not the strength ordered on the current FL-2 dated 09/08/15.
-Resident #8 received his medications from a pharmacy other than the facility's contract pharmacy.
-Resident #8's family member provided the over the counter folic acid 400 mcg.
-She was not aware when the folic acid was received, but knew it had been at the facility for a least one month.
-Medications provided by family members were supposed to be reviewed for accuracy by the MA on duty when the medication was received, and by the Resident Services Director (RSD) or Special Care Coordinator (SCC) before being placed on the medication cart for administration.
-She did not double check the medication strength since it was on the medication cart already.
-She thought the night shift MAs performed cart audits, but was not sure how often.

Interview with the Wellness Coordinator on 10/16/15 at 3:30 pm revealed:
-She and the RSD were responsible for monitoring medication administration and monitoring the MAs.
-A family member provided the folic acid 400 mcg for Resident #8.

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D 358	Continued From page 43 -She was not aware the strength of folic acid provided by the family member was not the same strength of folic acid ordered on Resident #8's FL-2. -She was not aware that folic acid 1000 mcg could only be obtained from a pharmacy. -She would contact the family member and request the family member to obtain 1000 mcg folic acid from the resident's pharmacy provider. Based on record review and observation on 10/16/15, Resident #8 was determined not to be interviewable. C. Review of Resident #9's current FL-2 dated 02/12/15 revealed: -Diagnoses included acute systolic heart failure, chronic kidney disease, and anemia. -An order for Vitamin D3 (cholecalciferol) 1000 international units (IU) daily (used to supplement Vitamin D3 which helps with the absorption of calcium). -An order for glucosamine 500 mg daily (used to treat joint pain and arthritis). Review of Resident #9's Resident Register revealed an admission date of 09/24/14. Observation on 10/16/15 at 9:25 am of the medication pass revealed: -Resident #9 was sitting her room. -The Medication Aide (MA) for the Assisted Living Unit prepared 6 oral medications, in a souffle cup, for administration. -The MA stated she did not have 2 of the resident's scheduled medication, glucosamine 500 mg and Vitamin D3 1000 IU, to administer to Resident #9. -The MA entered Resident #9's room, informed the resident that 2 of her medications were not	D 358		

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available on the cart, and administered 6 oral medications.
-The resident took all the medications with 4 ounces of water.
-The MA documented administration of the 6 oral medications.
-The MA documented no Vitamin D3 1000 IU and glucosamine 500 mg was administered by placing her initials and circling the initials with documentation for " Not on Cart" on the back of the Medication Administration Record (MAR) for October 2015.

Observation of the medication on hand for administration on 10/16/15 at 9:23 am revealed:
-No Vitamin D3 1000 IU was available for administration to Resident #9.
-No glucosamine 500 mg was available for administration to Resident #9.

Review of the October 2015 MAR for Resident #9 revealed:
-Vitamin D3 1000 IU and glucosamine 500 mg were listed on the preprinted MAR and scheduled for administration at 8:00 am daily.
-Daily administration was documented from 10/01/15 to 10/15/15.

Interview with MA for the Assisted Living Unit on 10/16/15 at 9:40 am revealed:
-She worked the previous morning, 10/15/15, and Resident #9 had both of the medications to administer.
-She could not explain why the resident did not have either medication on the cart for administration.
-She looked in the other residents' medications stored on the medication cart, thinking the medications had been incorrectly returned in the wrong resident's medications, and could not find

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the medications for Resident #9.
-She would call the contract pharmacy or back-up pharmacy for delivery and administer later this morning (10/16/15).

Second interview on 10/16/15 at 11:30 am with the MA for the Assisted Living Unit revealed:
-She had not received Resident #9's Vitamin D3 1000 IU and glucosamine 500 mg from the pharmacy.
-She would contact Resident #9's physician provider for authorization to administer the once a day medications when received.

Interview on 10/16/15 at 12:00 pm with the facility contract Nurse Practitioner revealed:
-She was onsite today (10/16/15) for a routine visit to selected residents.
-She had not been contacted by a facility MA for authorization to administer Resident #9's Vitamin D3 1000 IU and glucosamine 500 mg later than the scheduled 8:00 am.
-Since the Vitamin D3 1000 IU and glucosamine 500 mg were once a day medication, the resident could receive the medications later in the day as far as she was concerned.

Telephone interview on 10/16/15 at 3:00 pm with the facility's contract pharmacy revealed dispensing records for Resident #9 as follows:
-Glucosamine 500 mg was dispensed for a month supply of 30 units on 06/16/15, 07/11/15, 08/10/15, and 09/13/15.
-Vitamin D3 1000 IU was dispensed for a month supply of 30 units on 06/14/15, 07/11/15, 08/10/15, and 09/13/15.
-The facility was not on an automatic cycle fill for residents' medication; medications were ordered by the facility.

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D 358	Continued From page 46 Interview on 10/16/15 at 2:50 pm with Resident #9 revealed: -She routinely received her morning medications together around 8:00 to 9:00 am. -She recalled the MA had told her she was not receiving 2 of her medications this morning. -She had not received the medications (glucosamine and Vitamin D3) yet. -She was not able to identify the names of all her medications. Interviews on 10/16/15 at 3:30 pm and 4:30 pm with the Wellness Coordinator revealed: -She and the Resident Services Director were responsible for medication administration and monitoring the MAs. -Resident #9 had not received her glucosamine 500 mg or Vitamin D 1000 IU medications today (10/16/15). -The morning MA for the Assisted Living Unit had left for the day.	D 358		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a care coordinator was on duty in the special care unit (SCU) at least eight hours a day, five days a week.	D 466		

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D 466	Continued From page 47 The findings are: Observations in the SCU at various times on 10/15/15 revealed: -There was one medication aide (MA) and two personal care aides (PCAs) on duty in the unit. -There was no care coordinator on duty in the unit. Interviews on 10/15/15 at various times with MAs and PCAs revealed: -There had not been a SCU coordinator for about 1 to 1 and 1/2 months. -The Administrator, the Resident Services Director (RSD), and the MAs had been fulfilling the duties of the care coordinator since the coordinator left. -One PCA stated the Administrator and the RSD usually walk through the unit to check on the unit and talk with the MA regarding any changes or new residents, and were usually there "about 10 minutes or so". -One MA stated the Administrator helped with new admissions and routinely walked through "pretty much every" day to see if the staff needed any help or had any issues, and was present in the unit "about 30 or 45 minutes". -One MA stated the RSD came through "occasionally a couple times a week" and was present in the unit from 10-30 minutes, and sometimes longer if she was updating careplans or Licensed Health Professional Support (LHPS) assessments. -A second PCA stated the Administrator and the Business Office Manager (BOM) routinely did a walk-through to check to see if the staff needed anything or had any concerns, and were in the unit at least 30 minutes and sometimes an hour if they were doing paperwork. -The Administrator and other management	D 466		

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members had also been present on weekends just to walk through and check on concerns.
-The RSD was "always available" for issues 24-7.

Interview on 10/15/15 at 3:01 pm with the RSD revealed:
-The previous SCU coordinator left around 09/08/15.
-The Administrator and the Life Enrichment Director filled in to complete the coordinator responsibilities related to activities.
-The Assistant RSD and the RSD filled in to complete the paperwork usually done by the coordinator.
-The management team was "in and out".
-There was always one MA and two PCAs on duty in the special care unit.
-No staff was currently assigned to fill in as coordinator in the unit for 8 hours a day, five days a week.

Interview on 10/15/15 at 4:15 pm with the Administrator revealed:
-There had not been a SCU coordinator for about a month.
-He used to be a SCU coordinator before he was an administrator, so he had been ensuring the care coordinator's duties were being completed, by himself or by other members of the management team.
-He did not realize a care coordinator needed to be on duty in the unit at least 8 hours a day, 5 days a week.
-No staff was currently assigned to fill in as coordinator in the unit for 8 hours a day, 5 days a week.
-The position of the care coordinator had been advertised but had not yet been filled.

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D912	Continued From page 49	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding supervision of residents, health care referral and follow up, and staff qualifications. The findings are: A. Based on record review and interviews the facility failed to assure referral and follow-up for 1 of 5 sampled residents with hyporic respiratory failure, (Resident #2) by sending the resident out for medical evaluation. [Refer to Tag 0273 10A NACA 13F .0902(b) Health Care (Type A1 Violation).] B. Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for 2 of 2 sampled residents (Residents #4 and #6) with repeated falls which resulted in injury. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] C. Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 6 staff (Staff A, B, and C) had no substantiated	D912		

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D912	Continued From page 50 findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G. S. 131E-256. [Refer to Tag 137 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation).]	D912		