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	HAL045001	A. BUILDING: _____ B. WING _____	R 02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL CARE CENTER-HENDERSONVILLE	1000 WEST ALLEN STREET HENDERSONVILLE, NC 28739

(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 Henderson County Department of Social Services conducted a follow-up survey and a complaint investigation on February 15-17, 2017 with a telephone exit on February 20, 2017. The complaint investigation was initiated by Henderson County Department of Social Services on January 17, 2017.	{D 000}		
{D 074}	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to have floor coverings kept clean in the common entrance area, living room, all 3 hallways, outside the main dining room, and in 2 of 2 common shower rooms. The findings are: Observations during the initial facility tour on 2/15/17 from 9:00 to 11:00am revealed: -The green carpeting on the entire length of the 100 hallway was worn thin and had multiple areas of discoloration. -The green carpeting on the entire length of the 200 hallway was worn thin and had multiple areas of stain. -There were areas of dark stain on the green and multicolored carpet on the 300 hall with a	{D 074}		

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{D 074}	Continued From page 1 bleached area approximately 12 inches by 11 inches in from of resident room #308. -The carpet under the water cooler on the 200 hall had very dark water stains with deep soiling an area approximately 2 feet by 1 foot. -The carpeting in the main entrance area outside the business office, medication rooms, and activity room was worn thin, had multiple areas of stain, and had multiple discolored gray areas of dirt. -The carpeting in the facility living room was worn thin with multiple areas of gray stains, especially around the activity table and in front of the chairs positioned around the room. -The hallway leading to the main dining room was worn thin and was discolored gray. -At the entrance to the main dining room the carpeting had heavily discolored brown areas. -There was a 2 ft. long by 1 ft. wide brown stain on the hallway in front of the dining room. -The carpet was discolored in the hallway in front of the kitchen door. -The carpet on the connecting hallway towards 300 hall in front of the exit doors had areas of gray stain. -The light colored grout of the white ceramic tiles of the floor in the first common shower room on the left coming from the entrance towards the main dining room had brown areas. -The light colored grout of the white ceramic tiles in the second common shower room on the left from the entrance towards the main dining room had brown areas. Review of the facility Sanitation Report dated 8/4/16 revealed: -Total score was 97.8. -1 demerit was deducted for floors clean, carpet clean, dry and odor free. -Under the comments section of the report	{D 074}		

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{D 074}	Continued From page 2 documented "Time to replace carpet in hallways. Carpet is worn and stained." Interview with the Executive Director on 2/16/17 at 10:50am revealed: -He was aware the carpet in the facility main hallways and living room was worn and stained. -He had contacted 3 carpet installers for a quote and only 1 had responded with a quote. -He did not share the quote information or the dates he had contacted the installers. -Currently the carpets were routinely vacuumed and cleaned with an extractor. Interview with Maintenance Supervisor on 2/17/17 at 11:19am: -He extracted the carpets in the main common area and living room/activity room every 2 weeks. -The carpets in the main hallways were cleaned monthly and the front area bimonthly. -The carpets were vacuumed daily. -The common shower room floors were pressure washed monthly. -He was informed by professional restoration cleaners the tiles in the shower rooms would require an epoxy coating after a deep cleaning in order to prevent discoloration of the grout. Confidential interviews with 8 residents and 2 family members revealed no complaints related to the condition of the carpet or shower floors.	{D 074}		
{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.	{D 273}		

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{D 273}	Continued From page 3 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 3 of 6 residents (Resident #1, #5 and #6) with a change in condition, a fall with injury, a pain medication not available, and an ammonia blood level not obtained as ordered. The findings are: A. Review of Resident #1's current FL2 dated 10/13/16 revealed: -Diagnoses included severe dementia. -Medications included Norco used for pain. -She was non-ambulatory with a wheelchair, constantly disorientated and a wanderer. -She was incontinent of urine and stool and required total care. Review of Resident #1's record revealed she was a full code. Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation and review dated 10/3/16 revealed: -Personal care tasks of "Care of residents who are physically restrained " and "Transferring non-ambulatory residents." -She had been a falls risk and had a wheelchair safety belt to be checked every 30 minutes and released every 2 hours and at mealtime. -She had no safety awareness. -She could no longer ambulate and required a 2 person assist for transfers. -She had been incontinent of bowel and bladder.	{D 273}		

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{D 273}	Continued From page 4 -Total dependence on staff for dressing, bathing, personal hygiene, transfers and toileting. -She required extensive assistance with feeding but still tried to feed herself. -Changes and follow-up noted her level of independence had declined and recommended more assistance with activities of daily living and feeding. Review of Resident #1's current Care Plan dated 12/20/16 revealed: -She had severe dementia. -She constantly laughed or yelled out inappropriately and did not speak. -She needed feeding assistance by the staff to insure she ate and drank as she no longer fed herself. -She had been disorientated, needed direction, required extensive assistance with eating and totally dependent on staff for toileting, locomotion using a wheelchair, bathing, dressing, grooming/personal hygiene and transferring. Review of the staff notes in Resident #1's record for January 2017 revealed: -On 1/31/17 at 5:00pm: A Personal Care Assistant (PCA) had attempted to transfer the resident from bed to wheelchair. -She could not support her weight and the resident "fell to the floor." No injury noted. -Vitals signs (VS) had been taken every 15 minutes post fall and noted by the Supervisor/MA to be "unremarkable aside from an O2 saturation of 84%" (the amount of oxygen in the blood. Normal range from 95% to 100%). -The post fall VS had not been documented. -No documentation the physician or Family Nurse Practitioner (FNP) had been notified of the fall or the low O2 saturation level. -"The shift would continue to monitor (the	{D 273}		

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{D 273}	Continued From page 5	{D 273}		

resident) and alert the next shift to monitor." No documentation this had been done.
-No 24 Hour Post Fall Checklist had been done.
-The resident had not been sent to the Emergency Room (ER) for evaluation.

Review of the facility's 24 Hour Post Fall Checklist revealed:
-"The checklist was to be kept in the 24 hour book until it's completion."
-"The Supervisor must make an entry in the nurses (staff) notes a minimum of every eight hours post fall for 24 hours."
-"The Supervisor was to initial "yes" or "no" for five questions at 8 hours, 16 hours and at 24 hours.
-The questions asked if there had been new or unusual complaints of pain or discomfort, outward rotation of the arms or legs, increased drowsiness, reluctance or trouble getting out of bed and was there a change in walking ability,
- "No" had been initialed for all questions at 8 hours, 16 hours and 24 hours post fall.

There was no 24 Hour Post Fall Checklist for Resident #1's fall on 1/31/17.

Review of an Incident and Accident Report for Resident #1 dated 1/31/17 revealed:
-At 5:00pm: PCA [name] had attempted to transfer the resident from bed to wheelchair, could not support her weight, and the resident had fallen to the floor.
-Supervisor noted no apparent injury and assisted PCA with lifting resident into a wheelchair.
-Her VS had been: P-80, T-96.4 degrees F and an O2 saturation of 84%.
-The physician and family had not been notified.
-A signature indicating the RCC was aware of the fall.

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{D 273}	Continued From page 6 Review of the facility's policy for transfers revealed, "If resident cannot stand, lift and pivot hips into chair, ALWAYS USE AN ASSISTANT WITH THIS." Review of the facility's falls policy revealed: -All residents would be assessed after a fall and the assessment recorded in the resident's record. -Assessment of the resident's condition would include: VS and neuro checks if an unwitnessed fall or head injury and wounds or contusions. (assessment of the level of consciousness, status of the pupils and facial symmetry) -The resident's physician would be notified of their current condition and any first aid rendered and the notification documented in the record. -The responsible party would be notified, staff were not to leave a voicemail but continue to call until the family had been reached and the notification documented in the record. -The staff were to report to the Executive Director (ED) any difficulty communicating with the resident's family. -The staff were to observe the resident closely and document any changes since the fall. -The staff were to notify the Resident Care Coordinator (RCC) of any changes so the physician could determine if there were need of further evaluation. Review of the staff notes in Resident #1's record for February 2017 revealed: -From 2/1/17 until 2/5/17 at 10:pm: No staff notes had been written. -On 2/5/17 at 10:00pm: A PCA had noticed the resident not breathing. -Emergency Medical Services (EMS) had been notified. -The staff had placed the resident on her back	{D 273}		

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{D 273}	Continued From page 7 and she started breathing. -When EMS arrived, the resident had started to respond, had been combative and confused. -On 2/6/17: The resident returned to the facility. -The ER nurse had informed the facility Supervisor they had not found anything wrong with the resident. -The Supervisor noted there would be "constant vigilance throughout the night and a 30 minute check sheet had been initiated." No documentation the "vigilance" or checks had been done. Confidential interview with a Medication Aide (MA) revealed: -On 2/5/17, Resident #1 had been found not breathing with blue tinged fingers. -She had been a full code. -She had been rolled on her back and started breathing but her eyes remained closed and she had been nonverbal. -When leaving the facility with EMS, she had been laughing, grunting and moving her arms. -Report from the hospital stated they had not found anything wrong with the resident. -Upon return, she appeared more quiet and her skin seemed more pale. -She leaned forward and required frequent positioning. -She had taken her medications and ate and drank well. Review of EMS records for Resident #1 dated 2/5/17 revealed: -At 10:10pm: They arrived at the facility, responding to a report of a full cardiac arrest with CPR being done. -The resident had been unresponsive, her skin pale with a bluish coloration and she had a pulse, CPR had not been performed, she started	{D 273}		

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{D 273}	Continued From page 8	{D 273}		

moaning and became combative, not wanting to be touched. The staff indicated that was her "normal" behavior.
-Her BP (blood pressure) had been 112/78 (Normal range: upper number between 90 and 120, and a lower number between 60 and 80).
-Her O2 saturation had been 70%.
-Her pulse had been 90 (Normal range: 60 to 100 beats per minute).
-Her temperature had been 95.2 degrees F (Normal range between 97 degrees to 99 degrees).

Review of hospital records for Resident #1 dated 2/5/17 revealed:
-At 10:29pm: She had arrived in the ER "awake, alert but combative."
-The physician noted her VS were normal.
-The physician had discussed with the resident's POA (Power of Attorney) various diagnostic tests and the resident's poor quality of life.
-The POA had felt testing would make the resident very uncomfortable.
-The physician told the POA, even with the testing done, and a diagnosis made, the resident would not have improved quality of life and without a diagnosis of further [medical] monitoring, the apparent life threatening process might return and result in her sudden death.
-The POA accepted that risk and agreed the resident would be more comfortable in familiar surroundings.
-At 12:19am: The resident had been discharged back to the facility.

Review of progress notes written on 2/7/17 by the Family Nurse Practitioner caring for Resident #1 revealed:
-She had seen the resident due to nausea and diarrhea and to follow-up on the ER visit on

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{D 273}	Continued From page 9 2/5/17. -Vital signs had been P-84, R-16 and BP-150/98. -Her assessment included a "life threatening event with no cause identified in the ER" and gastroenteritis (inflammation of the stomach and intestine)." -Her plan for the "life threatening event: Monitor and order labs since not done in the ER." -Her plan for the "gastroenteritis: Follow-up labs and utilize Imodium (for diarrhea) and Zofran (for nausea). Review of the staff notes in Resident #1's record revealed: -On 2/7/17: The resident had been seen by the FNP who ordered Imodium (for diarrhea) and Zofran (for nausea) , lab work and a urine specimen for analysis and culture with sensitivity. -On 2/7/17 at 9:40pm: A PCA had found the resident on the floor in her room. No injury noted. - VS were: BP (not taken due to resident not able to hold still), T-93.1 degrees F and an O2 sat of 88%. -A post fall checklist had been initiated. -The resident had been placed in bed on her side with pillows as a barrier and an unused mattress by her bed as a fall mat. "Will be on 30 minute checks." -No documentation the checks had been done. -No documentation the physician or FNP had been notified of the low O2 sat. and temperature. -No documention of a 24 Hour Post Fall Checklist. -The resident had not been sent to the ER for evaluation. -On 2/8/16: No staff notes had been written. -On 2/9/17: The resident had been "unusually lethargic (a lowered level of consciousness, with drowsiness, listlessness and indifference) prior to dinner and did not eat."	{D 273}		

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{D 273}	Continued From page 10 -When the Supervisor/Medication Aide (MA) attempted to give the resident her evening medications, she had been "unresponsive to touch/sound, respirations very rapid and shallow, extremities darker in color and cold, and without a pulse. -EMS had been notified (time of notification had not been documented) and transported her to the hospital. -On 2/10/17: A note documented the resident in "ICU (Intensive Care Unit at the hospital) and stable." Review of an Incident and Accident Report for Resident #1 dated 2/7/17 revealed: -At 9:40pm: (Unwitnessed fall) PCAs had found the resident laying on her right side a few feet from her bed. -The Supervisor noted no apparent injury and the resident had been put back in bed. -Pillows had been placed to prevent the resident from rolling and a spare mattress placed as a fall mat. -Thirty minute checks had been started. -Her VS were: P-53, T-93.1 degrees F and an O2 sat of 88%. -The physician had been notified of the fall but not of the low O2 saturation level. -The family had been called, but did not answer. -No signature indicating the RCC aware of the fall. Review of the 24 Hour Post Fall Checklist in Resident #1's record dated 2/7/17 revealed "No" had been initialed for all questions at 8 hours, 16 hours and 24 hours post fall. Review of EMS records for Resident #1 dated 2/9/17 revealed: -The facility had called 911 at 6:59pm.	{D 273}		

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{D 273}	Continued From page 11 -At 7:07pm: EMS arrived at the facility, responding to a report of SHOB (shortness of breath). -The resident had been found sitting in a wheelchair, unresponsive, with her head down. -Her skin had been cold to the touch, mottled with a bluish coloration and she did not have a pulse. -They had opened her airway, placed her on a stretcher and she remained unresponsive. -Her BP had been 70/50, T-96 degrees F, with an O2 saturation of 60%. -Staff had told EMS they had noticed the resident not "acting right" at 4:30pm and "decided to call 911 when she had a weak radial pulse." -The resident had bruising on her forehead of unknown cause and smelled strongly of urine. -They had arrived at the ER at 7:29pm. Review of hospital records for Resident #1 dated 2/9/17 revealed: -At 7:29pm: She had arrived in the ER, with "decreased mental status since 4:00pm today", lethargic, poorly responsive, had very dry mucous membranes, poor oral hygiene, and mottling of the lower extremities to trunk. -The facility had told the ER nurse the resident had no recent illnesses, falls or medication changes. -Lab tests included a BUN (Blood urea nitrogen), which indicated how well the kidneys and liver were working. Results: 99 (Normal range is 6-20). -A creatinine level, a test of kidney function. Results: 2.50. (Normal range is 0.50-1.20). -A blood sodium level greater than 180. (Normal range: 135-145). -She had been admitted to the ICU, diagnosed with severe sepsis (a life threatening complication of infection) due to acute kidney injury and severe hypernatremia, due to severe dehydration. -Additional tests during her hospitalization	{D 273}		

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identified a urinary tract infection, metabolic encephalopathy (temporary or permanent damage to the brain caused when the liver cannot remove toxins from the blood), hyperchloremia (her blood chloride level of 150 indicated dehydration. Normal range is 101-111), a small bowel ileus(inability of the intestine to contract normally and move waste out of the body), dysphagia (difficulty swallowing) with a "grim" prognosis, impacted stool in the rectum with disimpaction and a distended gallbladder with gallstones, "would likely not survive surgery."
-The attending physician noted bruising on the bridge of her nose, right temple and forehead, and both hips.
-The POA had told the physician he had not been notified of any falls at [the facility name].
-The resident remained non-verbal and unresponsive to voice/touch.
-On 2/13/17: The resident had been transferred to inpatient Hospice for end of life care.

Review of the facility's "Required Charting Guidelines" revealed charting, with follow-up, was required for:
-Incidents and/or accident with follow-up for at least 24 hours or as ordered and as needed.
-Acute episodes with follow-up as ordered or until symptoms subside.
-The administration of "as needed" medication(s) and/or treatment(s).
-A temperature or change in vital signs.
-Residents returning from the hospital for 7 days.
-Any unusual occurrence with follow-up each shift for 24 hours.

Interview on 2/16/17 at 4:00pm with Resident #1's POA revealed:
-On 2/5/17, the facility notified him the resident was not breathing, CPR had been initiated and

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{D 273}	Continued From page 13	{D 273}		

she had been sent to the ER.
-When he arrived at the ER, the resident appeared fine and the physician told him there was nothing wrong.
-He had asked if the resident could stay for observation, the physician told him there was no need, no reason and she had been discharged back to the facility.
-The next morning, she appeared tired and he did not stay to visit.
-On 2/7/17 and 2/8/17, a sign posted on the door of the facility discouraged visitors due to a stomach virus in the building and he had not visited.
-On 2/9/17, he had been notified by the facility, the resident had shallow breathing and had been sent to the ER "an hour ago."
-Upon his arrival at the ER, she had been unresponsive.
-The ER staff had showed him the resident's right eye lid and bridge of her nose appeared swollen with dark blue-black discoloration across the bridge of the nose, her right eye lid and onto her right cheek.
-There had also been blood on her hospital gown from a small laceration on the bridge of her nose that had been bleeding.
-Initial lab tests revealed a severe urinary tract infection and severe dehydration.
-She had been admitted to the ICU where she remained until discharge to hospice.
-He contacted the facility Resident Care Coordinator (RCC) and asked what had happened, where had the bruising come from.
-The RCC stated the resident had fallen out of bed.

Interview on 2/16/17 at 3:10pm with the RCC regarding Resident #1 revealed:
-She did not know why the PCA, on 1/31/17, did

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{D 273}	Continued From page 14 not follow policy and attempted to transfer the resident by herself, resulting in the resident being dropped on the floor. -She did not know why the staff had not provided the required documentation on the resident post fall. -She did not know why the physician had not been notified of the fall and of the low O2 sat level by the Supervisor on duty at the time. -She was unaware the family had not been notified of the fall. -On 2/5/17, during the last round, the staff found Resident #1 on her side, not breathing, her nails purple and her legs cold. -The resident had been placed on her back and started breathing and gurgling. -EMS had been called and the POA notified. -By the time EMS had started down the hall toward the ambulance, the resident had been laughing and "back to her normal self." -The ER did not find anything wrong and she returned to the facility. -She did not know why the staff had not provided the required documentation for 7 days after the resident returned from the hospital. -On 2/7/17, the FNP who cared for the resident, had ordered medication for the stomach virus and lab work since none had been done at the hospital. -She had not been notified of the fall at that time. -She did not know why the staff had not provided the required documentation on the resident post fall on 2/7/17. -She was not aware the physician had not been notified of the fall and of the low VS. -She did not know why the staff had written "No answer" after family notification on the incident/accident sheet instead of following the policy and continuing to call until the family had been reached.	{D 273}		

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{D 273}	Continued From page 15 -She was not aware of bruising on Resident #1 as described by the hospital. Interview on 2/16/17 at 4:55pm with a second MA revealed: -On 1/31/17, she had been the Supervisor when Resident #1 had been "dropped" by the PCA. -She did not know why the PCA had attempted to transfer the resident without asking for assistance. -She had assessed the resident and found no injury. -She did not know why she had not notified the physician or the family of the fall. -She had not notified the physician of the resident's low O2 saturation. -She was aware a 24 Hour Post Fall Checklist and an incident report had to be completed. -She was not aware of the facility's "Required Charting Guidelines. -On 2/7/17, she had been the Supervisor when Resident #1 had been found laying on the floor. -She had assessed the resident and found no injury. -She had notified the FNP of the fall. -She had not notified the FNP of the resident's low O2 sat, low pulse and low temperature. -She was aware a 24 Hour Post Fall Checklist and an incident report had to be completed -She was not aware of the Required Charting Guidelines. Interviews on 2/17/16 at 6:55am with a third MA and an RA revealed they had observed bruising on the right side of Resident #1's face, around her eye, when the resident had been taken to the ER on 2/9/17. Interview on 2/16/17 at 5:45pm with the ED revealed he had not been aware of bruising on	{D 273}		

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{D 273}	Continued From page 16 Resident #1's face prior to her being admitted to the hospital on 2/9/17. Interview on 2/17/17 at 3:41pm with the FNP who had cared for Resident #1 revealed: -She had not been notified of the resident's low O2 saturation level after the fall on 1/31/17. -She had followed up with the resident after her ER visit on 2/7/17 and ordered lab tests to check for dehydration and a urinary tract infection since none had been done at the hospital. -She could not recall bruising on the resident's face at that time. -She had not been notified of the resident's low O2 saturation level, body temperature or pulse after the fall on 2/7/17. -She would expect to be called if there were changes in the resident's vital signs. -She would expect the staff to monitor the resident and to call her should the resident's condition worsen. B. Review of Resident #6's FL2 dated 2/10/17 revealed: -Diagnoses included osteoporosis and schizophrenia. -Physician orders included morphine 30 mg every 6 hours and oxycodone 60 mg every 12 hours. Review of a hospital discharge record dated 11/16/16 revealed Resident #6 also had diagnosis of "chronic pain syndrome narcotic dependent." 1. Review of January 2017 Medication Administration Records (MAR) revealed: -The times for administration of morphine were entered for 5:00am, 11:00am, 5:00pm and 11:00pm. -No administration of morphine documented as administered for 4 days from 11:00pm on 1/6/17	{D 273}		

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{D 273}	Continued From page 17 through 11:00pm on 1/10/17 for a total of 12 doses. -The back of the MAR documented the morphine was not available. Review of the Controlled Drug Sheet for Resident #6's morphine revealed: -The last dose of a quantity of 60 morphine dispensed on 12/17/16 was documented as administered on 1/6/17 at 11:00pm. -The first dose of the quantity of 28 morphine dispensed on 1/10/17 was documented as administered 1/11/17 at 5:00am. Interview with the Resident Care Coordinator (RCC) on 2/17/17 at 4:00pm revealed: -Resident #6's physician would not fax scripts for controlled drugs so they had to go to his office to pick those up. -The Medication Aides (MAs) were supposed to order medications when the supply on the bubble pack reached the "blue" area which was usually about 7 days until the administration of the last dose. -The MAs were supposed to always call the pharmacy when they reordered controlled medications to determine if a hard script was required regardless if the medication label refill section read 0 or otherwise. -If the MAs called the pharmacy or physician for a refill for the morphine they documented in the 24 hour shift notes. -She was not aware if Resident #6 had complained of pain in January 2017 when the morphine had not been available. Review of the 24 hour shift notes dated 1/8/17 revealed one documentation that a medication aide, Staff A, "called and left a message at [physician name] office for hardscript for	{D 273}		

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{D 273}	Continued From page 18 morphine." Interview with Staff A, MA, on 2/17/17 at 2:45pm revealed: -She remembered calling "many times" to try to get the morphine refilled when Resident #6 ran out in January 2017, but not sure she had documented all the attempts. -Resident #6 did not complain about the pain during the time the morphine was not available. Telephone interview with the pharmacist on 2/20/17 at 10:46am revealed: -Their policy is to send the facility a list of controlled medications which require a hard script for the next refill and they sent one on 12/23/16 and again on 1/3/17 which had the morphine listed. -The facility did not return the 12/23/16 list which stated Resident #6 needed a refill. -The facility did send back the 1/3/17 list which showed Resident #6 needed a refill but she did not know what date it was returned. -The only documentation which showed on their computer system was that they received the hard script on 1/10/17 and dispensed the morphine on 1/10/17. -They dispensed 120 doses of morphine, a 30 day supply, on 11/22/16 and did not dispense any more until 1/10/17. Interview with the nurse at Resident #6's physician office on 2/20/17 at 11:03am revealed: -The physician was currently out of the office and not available. -She could not determine when facility staff or the pharmacy requested the morphine in January 2017. -The physician had a policy that hard scripts had to be picked up in the physician office.	{D 273}		

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{D 273}	Continued From page 19 Observations of Resident #6's medication on hand on 2/17/17 at 2:30pm revealed all medications were available for administration. Interview with Resident #6 on 2/17/17 at 3:30pm revealed she did not remember if she was in pain when she was out of morphine. Telephone interview with Resident #6's responsible person on 2/17/17 at 11:36am revealed there were no concerns related to her care at the facility. 2. Interview with Resident #6 on 2/15/17 at 10:14am revealed: -Her upper left thigh was hurting. -She fell "about 3 or 4 weeks ago." Review of Incident/Accident report dated 2/11/17 revealed: -Resident #6's roommate found her on the floor near the bed. -Resident #6 told the supervisor that she got tangled up in the bed covers. -Resident complained of pain in the right arm, right leg, and right side of forehead. Review of 24 Hour Shift Report notes dated 2/11/17 and signed by medication aide, Staff B, revealed: -Resident #6 complained of her right arm, right leg, and right side of her forehead but there was no description of assessment of skin or bruising. -Resident #6 was transported to local emergency room. Review of Emergency Room (ER) discharge notes dated 2/11/17 for Resident #6 revealed: -"Follow up with [Resident #6's primary care	{D 273}		

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physician]. Schedule an appointment as soon as possible for a visit in 2 days for recheck and further evaluation."
-No description of any bruising but diagnosis of "falls frequently."
-"CT Head Wo Contrast" (X-ray without contrast).
-"CT Cervical Spine Wo Contrast" (X-ray without contrast).
-No information related to X-ray results.

Observation of Resident #6 on 2/16/17 at 3:50pm with facility staff revealed:
-A swelling approximately 3 inches in diameter at the top of her left thigh.
-The swelling had a dark purple center surrounded by flesh toned skin.
-Dark purple-blue bruising was noted to the right of the swelling, down the inside of the leg to just above the left knee.
-An area of yellow discoloration and dark blue-purple bruising was noted above and to the left of the swelling, onto the back of the leg, below the curve of the left buttock.

Interview with Resident #6 on 2/16/17 at 3:50pm revealed:
-She told staff "it hurts" but could not remember which staff.
-She had pain in her left groin area especially when she walked.

Interview with the Resident Care Coordinator on 2/17/17 at 4:00pm revealed:
-She was not aware that Resident #6 had any bruising from the fall on 2/11/17.
-She was not in the facility on the day Resident #6 fell, but knew she went to the ER, was evaluated, and sent back to the facility.
-Their policy was for the medication aide to assess the resident within 24 hours after

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returning from the hospital.
-The medication aide on duty when Resident #6 returned from the ER was responsible for assuring any recommendations on the discharge instructions were implemented and should have assured the follow up appointment with the primary care physician was made.
-She was not aware of any follow-up recommended by the ER visit dated 2/11/17 and currently Resident #6 had no appointment scheduled with her primary care physician.

Review of shift notes dated 2/12/17 revealed a medication aide, Staff B, assessed Resident #6 and documented "Resident hasn't complained of pain from fall on 2/11/17...Resident showed a large bruise on left upper thigh. Resident continues to seem confused."

Telephone interview with medication aide, Staff B, on 2/20/17 at 1:18pm revealed:
-When Resident #6 fell on 2/11/17, she did not observe any bruising.
-When she assessed Resident #6's left leg on 2/12/17, she observed a bruise "smaller than a fist," on the inside of her left upper thigh.
-She saw no other bruising on Resident #6 on 2/12/17.

Telephone Inteview with Resident #6's responsible person on 2/17/17 at 11:36am revealed:
-The facility staff called to report the fall on 2/11/17.
-There were no concerns related to Resident #6's care at the facility.

C. Review of Resident #5's current FL2 dated 3/31/16 revealed:
-Diagnoses included liver cirrhosis and diabetes

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{D 273}	Continued From page 22 mellitus. -Physician order for lactulose 10gm/15ml give 30 ml three times daily (Used to treat or prevent complications of liver disease that works by decreasing the amount of ammonia in the blood). Review of subsequent physician orders for Resident #5 revealed the lactulose was increased to 40 ml three times daily on 9/6/16. Review of Resident #5's primary care physician orders dated 11/21/16 revealed a request for an ammonia level at next lab. Review of Resident #5's lab results dated 12/20/16 revealed no ammonia level. Review of the past ammonia levels documented in Resident #5's record revealed (Lab reference range 10-35): -66 on 8/16/16. -70 on 7/27/16. Interview with the Resident Care Coordinator on 2/16/17 at 10:40am revealed: -Blood draws are completed every Tuesday by staff who come to the facility. -Resident #5 did not have any blood draws for ammonia levels after 8/16/16. -She was not sure why the lab for the ammonia level was missed on the 12/20/16 lab draw but it should have been written on the order sheet which the technicians use as guidance. -The medication aide who filed the 11/21/16 primary care physician notes should have written the lab order and due date on the lab book, but she had failed to do so. -The primary care provider did see Resident #5 in December 2016 but did not address the ammonia lab.	{D 273}		

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{D 273}	Continued From page 23 -She would request the ammonia level be completed 2/17/17. Review of lab work completed on Resident #5 on 2/17/17 revealed the ammonia level was 28. The facility failed to assure referral and follow-up to meet the acute health care needs of Resident #1 who within a 10 day period of time, had fallen twice, been sent to the ER on 2 occasions due to life threatening events and admitted to the hospital ICU on the second visit. She was discharged to hospice for end of life care. Resident #6 did not receive routine pain medication prescribed for chronic pain for 4 days which could have led to breakthrough pain and withdrawal symptoms. Resident # 6 also sustained a fall with injury without continued assessment and follow-up as requested. A lab ordered for Resident #5 who was being treated for levels of ammonia in her body was delayed for over 1 and 1/2 months. The facility's failure to monitor the residents, report changes to the primary care provider per their policies and procedures, and implement timely follow-up was detrimental to the safety and the psychological and physical health of Residents #1, #5, and #6 constitutes a Type B Violation. A Plan of Protection was provided by the facility on 2/16/17 and included the following: -Every resident upon admission and/or an incident that sends resident to the hospital/ER, will receive a complete body check, from head to toe, upon arrival back to the facility. -All acute episodes need follow-up as ordered or until symptoms subside. -All shifts will chart on all residents returning from the hospital for seven days. -All medical referrals will be copied for the	{D 273}		

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{D 273}	Continued From page 24 Transporter and the RCC. -The Supervisor will document incidents in the 24 hour book. -Resident #5 to have an ammonia level drawn on 2/17/17. -Resident #6's physician and POA were notified of the injury. -Resident #6 was sent to the hospital for assessment of the injury. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 6, 2017.	{D 273}		
{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 assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 3 of 6 residents (Resident #1, #5	{D912}		

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{D912}	Continued From page 25 and #6) with a change in condition, a fall with injury and an ammonia blood level that was not done as ordered. [Refer to Tag 0273, 10A NCAC 13F .0902 (b) Health Care (Type B Violation)].	{D912}		