STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031003	A. BUILDING: _____ B. WING _____	R-C 10/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CARE	4002 SOUTH NC 41 WALLACE, NC 28466

(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 Duplin County Department of Social Services conducted a follow-up survey and complaint investigation on 10/11/17 - 10/13/17 and 10/16/17 - 10/17/17. The complaint investigations were initiated by the Duplin County Department of Social Services on 08/07/17, 08/22/17, and 08/24/17.	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 and interviews, the facility failed to assure the walls and floors were kept clean and in good repair for 3 common bathroom/shower rooms, 3 private resident bathrooms (201, 207, 210), 2 resident rooms (106, 108), the dayroom on 100 Hall, and the hallways on the 100 and 200 Halls. The findings are: Observation of the bathroom in resident room 207 on 10/11/17 at 10:34 a.m. revealed: -The toilet tissue holder was broken. -There were three small holes (smaller than the diameter of a dime) in the wall on the right side of the broken tissue holder. -The towel bar holder was missing; the hardware	D 074		

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D 074	Continued From page 1	D 074		

was still attached to the wall.
-The bathroom floor had multiple brown and gray colored stains of various sizes throughout the room.

Interview with a resident who resided in room 207 on 10/11/71 at 10:34 a.m. revealed she would like a toilet tissue holder that was not broken.

Observation of the common bathroom on the 200 Hall on 10/11/17 at 10:19 a.m. revealed:
-There was a light brown stain greater than 6 inches wide in size on the floor tile of the shower.
-The grout along the left wall near the floor had dark brown and black colored stains which extended into the corner of the wall.

Observation of the adjoining bathroom to resident room 201 on 10/12/17 at 3:08 p.m. revealed:
-The floor in the bathroom had dark brown stains in between the vinyl type floor squares near the toilet, and gray stains of varying sizes on the squares in front of the toilet.
-There was an 18 x 18 inch hole in the wall to the left of the toilet that was covered with a piece of white poster board type material and taped to the wall.

Observation of the bathroom in resident room 210 on 10/11/17 at 10:35 a.m. revealed:
-There was no toilet tissue holder on the wall.
-The wall beside the toilet had 12 inches by 12 inches of plaster repair that had not been sanded or painted.

Observation of the common bathroom on the 100 Hall on 10/11/17 at 11:50 a.m. revealed:
-Three of the walls had multiple light brown stains of various sizes.
-The grout around the toilet had dark brown and

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D 074	Continued From page 2	D 074		

black colored stains.
-The paint on the wall behind the toilet was chipping on 3 areas that were each 1 inch in diameter and 1 area that was 3 inches by 1 inch in diameter.

Observation of the dayroom on the 100 Hall on 10/11/17 at 10:18 a.m. revealed:
-The floor was covered with a dirty film with multiple black scuff marks.
-The floor at the threshold of the entrance ways to the dayroom had an area with a buildup of black stains that was approximately 6 inches in diameter.

Observation of the hallway at the main entrance on the 100 Hall on 10/11/17 at 10:29 a.m. revealed:
-The floor was covered with a dirty film and multiple black scuff marks.
-The floor had some light brown stained areas near the walls.

Observation of the hallway at the back entrance on the 100 Hall on 10/11/17 at 10:29 a.m. revealed:
-The floor had a very thick buildup of black stains with multiple black scuff marks all over the floor.
-The floor was sticky when walked on.
-There was a hole about 3 inches in diameter on the wall behind the door in the hallway that connected to the 100 Hall.

Observation of resident room 108 on 10/11/17 at 10:55 a.m. revealed:
-The floor in front of the bedside table had multiple cracks and pieces of missing tile.
-There were black scuff marks on the floor.
-The wall near the door had multiple small round fingerprint smudges.

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D 074	Continued From page 3 Interview with a resident in room 108 on 10/11/17 at 10:55 a.m. revealed the floor and wall had been that way "a long time" (over a year). Observation of resident room 106 on 10/11/17 at 11:14 a.m. revealed: -There was a buildup of dark stains on the floor and the floor was sticky. -There were multiple scratch marks with missing paint on the wall near the light switch. -There was a hole in the wall about 3 inches in diameter near the door. Interview with a resident in room 106 on 10/11/17 at 11:14 a.m. revealed: -The floor was always sticky and they never buff the floors. -The walls had been scratched for "a while". -The resident asked the painter who was in the facility yesterday (10/10/17) to paint the walls in her room. -The painter told her that he had to get permission to paint it. Observation of the common shower room on the 100 Hall beside room 104 on 10/11/17 at 11:44 a.m. revealed multiple areas of missing tile on the floor just outside of the bathroom door in the hallway. Observation of the hallway on the 200 Hall on 10/11/17 at 11:55 a.m. revealed the floor was covered with a dirty film with multiple black scuff marks. Interview with Maintenance staff on 10/11/17 at 10:08 a.m. revealed: -They had been working on getting the painting done in the facility.	D 074		

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D 074	Continued From page 4 -They started painting around the end of June 2017. -They had painted the walls in the hallways, dining room, and dayroom near the front entrance. -They had not painted the residents' rooms yet. -They had not started on the floors but that was their next project after they finished the floors. -The floors had scuff marks and needed refinishing and waxing. -They would also replace any broken tiles. Interview with the medication aide/supervisor on 10/11/17 at 4:10 p.m. revealed the owners were planning to get the floors done after they finished painting the walls. Interview with the Administrator on 10/12/17 at 10:02 a.m. revealed: -The Manager contacted the painter after the last survey in June 2017. -The painter was delayed in coming to the facility because there were other jobs ahead of the facility. -The painter just started painting at the facility about a month ago. -The painter had painted the walls in the common areas but he still had to paint the residents' rooms. -She contacted a floor company about 2 weeks ago but she wanted to finish painting before she started on the floors. -She planned to have the floors stripped and waxed and to repair the broken tiles.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And	D 076		

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D 076	Continued From page 5 Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to have furniture in good repair, including chest of drawers, night stands/bedside tables, dressers, chairs, television cabinet, headboard, and sofas, in 8 residents' bedrooms, the dayroom on the 100 Hall, and the dayroom on the 200 Hall. The findings are: Observation of resident room 205 on 10/11/17 at 10:22 a.m. revealed the drawer to the nightstand was missing a handle and the finish was scratched. Interview with a resident in room 205 on 10/11/71 at 10:22 a.m. revealed: -She did not bring the furniture in her room. -The furniture belonged to the facility. -The furniture had been like that since she moved in (no date provided). Observation of resident room 207 on 10/11/17 at 10:34 a.m. revealed the finish on the nightstand was scratched. Observation of resident room 102 on 10/11/17 at 11:03 a.m. revealed: -There were two chairs in the room; one of the chairs had two tears in the upholstery greater than 3 inches long near the top cushion. -A resident was sitting in the chair with the torn upholstery.	D 076		

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D 076	Continued From page 6 Based on observations, record reviews, and interviews, the resident who resided in room 102 was not interviewable. Observation of resident room 103 on 10/11/17 at 11:58 a.m. revealed: -The bottom drawer of the dresser was uneven and did not close all the way. -The top of the dresser had scratches in the finish. -The mirrored vanity did not have a handle on the drawer and the finish had multiple scratches. Observation of the common day room on the 200 Hall on 10/11/17 at 9:25 a.m. and 2:14 p.m. revealed: -The side tables had multiple scratches in the finish; one was missing a handle on the bottom drawer and the top drawer handle was loose and hanging down. -Four of four chairs had stains of varying sizes and various colors. -The fabric of the blue recliner smelled like urine. Observation of resident room 201 on 10/12/17 at 3:08 p.m. revealed the dresser and nightstand had scratches on the finish. Observation of resident room 210 on 10/11/17 at 11:58 a.m. revealed: -The top of the night stand at the end of the bed at the back of the room had multiple scratches and chips in the finish. -The top and sides of a dresser on the left side of the room had multiple scratches and chips in the finish. -The headboard to the bed on the left side of the room had multiple scratches in the finish.	D 076		

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D 076	Continued From page 7 Observation of the dayroom on the 100 Hall on 10/11/17 at 10:18 a.m. revealed: -There was a pink upholstered love seat with multiple dark stains all over the back and seat. -There was a beige leather recliner with a rip in the seat about 6 inches long with white cotton material coming up through the ripped area. -There was approximately a 2 inch ripped area on the front left side of the same beige recliner with cotton material exposed. -There was a blue leather upholstered chair with a spring hanging down from the underside of the chair and the wooden legs were scratched. -There was a blue 3 section leather sofa that was heavily soiled with dark stains on the arms and head rest areas of the sofa. -There was a blue cloth recliner heavily soiled with dried white and brown stains on the arms, seat, and back of the chair. -The hand lever on the right side of the blue cloth recliner was broken off with a piece of metal sticking out about 1 and ½ inches on the side of the chair. -There were 2 blue leather straight back chairs with wooden legs that were scratched and missing stain, and one chair had cracks in the middle of the seat. -The wooden television cabinet had two cabinet doors with broken handles hanging down sideways. -There was a pink upholstered chair with multiple dark stains on the back and seat of the chair and wooden legs with scratches. -There was a green leather chair with scratches and missing stain on the wooden legs. Observation of resident room 108 on 10/11/17 at 10:55 a.m. revealed: -The bedside table drawer was loose and uneven and did not close properly.	D 076		

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D 076	Continued From page 8 -There were multiple scratches and missing stain on the bedside table. -There was a wooden cabinet with a missing knob on the door on the right. -There was a 4 drawer dresser with scratches and missing stain. Interview with a resident in room 108 on 10/11/17 at 10:55 a.m. revealed: -The furniture had been that way a long time. -The facility was supposed to get new furniture but she did not know when. Observation of resident room 106 on 10/11/17 at 11:14 a.m. revealed: -There were two bedside tables with multiple scratches and missing stain. -There was a 4 drawer dresser with scratches and missing stain. Interview with a resident in room 106 on 10/11/17 at 11:14 a.m. revealed the furniture had been that way for a while. Interview with the medication aide/supervisor on 10/11/17 at 4:10 p.m. revealed she was not sure if there were any plans to replace the furniture. Interview with the Administrator on 10/12/17 at 10:02 a.m. revealed: -Some furniture had been removed but more will have to be removed and replaced. -She would start getting the furniture replaced this week.	D 076		
D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And	D 077		

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D 077	Continued From page 9 Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to maintain an approved sanitation classification at all times in the facility with a North Carolina Division of Environmental Health Sanitation score of 85 or above at all times. The findings are: Review of the facility's most current Environmental Health Sanitation inspection for the facility dated 05/03/17 revealed: -The facility's sanitation score was 75. -Demerits were noted including the following: -Floor tiles were worn at the entry to bathrooms. -Walls needed painting throughout facility including hallways, dining, and resident rooms. -Some walls had holes, needed repair in resident rooms/restrooms. -Storage kept in the bathtub of one shower room. -Several resident restrooms had excessive storage including personal hygiene items.	D 077		

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D 077	Continued From page 10 -Hot water in several rooms exceeded 116 degrees Fahrenheit (F) on the 200 Hall. -Roaches and flies were present throughout the building. -Limit food in rooms to help prevent infestation. -A professional exterminator was needed on a routine basis to tackle such a problem. -The medication storage room was unorganized and messy. -A few personal chairs were worn/stained. -Some dressers/side tables were worn. -Couches in common rooms were dirty under the cushions. -Roaches were present in one resident refrigerator. -Shower tiles needed cleaning with some mildew present in shower stalls. -Shower curtains were dirty and needed cleaning. -Toilet paper dispensers needed repair in some rooms. -General comments: Hand hygiene does not appear to be occurring in a manner so as to protect residents. Employees should wash hands between servicing one room and the next and before handling medications, foods as well as afterwards. Employees cannot properly wash hands after changing/aiding in diapering as there are no paper towels or soap in many resident rooms. Glove use does not substitute for adequate handwashing to reduce the spread of infectious contaminates. A better hand hygiene program is needed. Observations during the survey from 10/11/17 - 10/13/17 and 10/16/17 - 10/17/17 revealed areas documented on the sanitation report dated 05/03/17 that had not been corrected included: -Floors throughout the facility needed cleaning and repairing. -Walls in residents' rooms and bathrooms	D 077		

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D 077	Continued From page 11 throughout the facility were in poor repair and needed painting. -Furniture in the dining room, dayrooms, and resident bedrooms was in poor repair and/or needed cleaning. -Live roaches were observed in the kitchen and resident living areas. -Light fixtures were not working properly in a common shower room and the kitchen. -Hot water temperatures were greater than 116 degrees F at 7 fixtures on the 100 and 200 Halls. -Some resident bedrooms and restrooms were cluttered and had excessive storage including personal hygiene items. -Shower tiles needed cleaning with some buildup present in shower stalls. -Toilet paper dispensers needed repair in some bathrooms. -Problems with hand hygiene were noted during the medication pass observed on 10/12/17. Refer to specific findings for the following: -Tag 074, 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings. -Tag 076, 10A NCAC 13F .0306(a)(3) Housekeeping and Furnishings. -Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings. -Tag 105, 10A NCAC 13F .0311(a) Other Requirements. -Tag 113, 10A NCAC 13F .0311(d) Other Requirements. -Tag 282, 10A NCAC 13F .0904(a)(1) Nutrition and Food Service. -Tag 388, 10A NCAC 13F .1007(c) Medication Administration. Interview with the medication aide/supervisor on 10/11/17 at 9:32 a.m. revealed: -The facility had not been re-inspected because	D 077		

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D 077	Continued From page 12 they were still painting. -The Administrator wanted the painting of the facility to be finished before she called the health inspector to come back to the facility. Interview with the Administrator on 10/12/17 at 10:02 a.m. revealed: -She was aware the facility's sanitation grade was 75. -She had not gotten around to calling the health inspector to come back and re-inspect the facility. -The health inspector usually came "pretty quick" when she called. The facility failed to correct and maintain a North Carolina Division of Environmental Health sanitation score of 85 or above at all times as evidenced by a sanitation score of 75 on the sanitation report dated 05/03/17. The facility had not corrected the problems identified by the health inspector, including the walls and floors throughout the facility had not been maintained in good repair or kept clean; residents' furniture was not kept in good repair; and water temperatures were greater than 116 degrees at two fixtures, resulting in one resident not washing her hands after toileting because she feared the water would burn her hands. The failure continued to be detrimental to the health, safety, and welfare of the residents, which constitutes an Unabated Type B Violation. Review of the facility's Plan of Protection dated 10/17/17 revealed: -Cited sanitation deficiencies from 05/03/17 have been corrected and Division of Environmental Services' office has been notified to come back for sanitation inspection to maintain a sanitation grade of 85 and above. -Treatment by exterminator company every 2	D 077		

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D 077	Continued From page 13 weeks until pest control is resolved and maintenance plan continued. -Building inside painted walls, holes in walls patched or in process. -In process of stripping/waxing floors. -On-going sanitation and maintenance of the building will be maintained to ensure a sanitation grade of 85 and above. -Administrator will do daily walk through to monitor facility sanitation issues.	D 077		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to assure the facility was clean, uncluttered and free of hazards in 3 resident rooms and a common shower room on the 100 Hall including issues with roaches in the facility.	D 079		

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D 079	Continued From page 14 The findings are: Observation of resident room 210 on 10/11/17 at 10:35 a.m. revealed: -There was a fly/insect catcher that was hanging over the resident's bed at the back of the room. -The fly/insect catcher was a 30 inch strip of sticky tape that was attached to the ceiling with a thumb tack that was halfway pushed into the ceiling. -There were 10 dead flies on the fly/insect catcher. -There was 1 roach trap behind the door that had 2 dead roaches in it. -There was 1 roach trap on the floor against the wall on the right side of the room that had 5 dead roaches in it. -There was a can of spray labeled "Flying Insect Killer" on the resident 's night stand at the end of his bed. Interview with a resident who resided in room 210 on 10/11/17 at 10:35 a.m. revealed: -"The staff put the fly catcher above my bed at the beginning of the summer." -He was not aware of the roach traps in the room. -His daughter brought him the insect spray at the beginning of the summer. -He sprayed the insect spray in his room if needed on flies or roaches. -He had not seen any flies or roaches in "several weeks". Interview with the medication aide/supervisor (MA/S) on 10/11/17 at 11:35 a.m. revealed: -She was not aware that there was a fly/insect catcher hanging above the bed in Room 210. -She was not aware of the roach traps in Room 210. -She would tell housekeeping to remove the fly	D 079		

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D 079	Continued From page 15	D 079		

catcher and roach traps.
-She had not seen any roaches or flies in Room 210.
-She "occasionally sees roaches at the staff desk."

Confidential interview with a resident revealed the resident saw a roach about a week ago.

Interview with a cook/medication aide on 10/11/17 at 8:20 a.m. revealed:
-She had not seen any roaches recently.
-The last time was 3 weeks ago.
-The exterminator's last treatment was one month ago.

Interview with a cook on 10/11/17 at 11:30am revealed:
-She had not seen any roaches.
-The cook thought the exterminator came every 2 weeks.

Interview with a family member on 10/12/17 at 12:22 p.m. revealed
-About 6 weeks ago, the family member saw roaches in a resident's dresser drawer; it was full of tiny roaches.
-About 6 weeks ago, a second resident had a lot of roaches in her room and the resident's family member bought insect spray.
-The family member spoke to the local health department about the roaches and was told the kitchen was sprayed for roaches about one month ago.

Interview with a personal care aide on 10/13/17 at 9:55am revealed:
-Staff were always having to "fight roaches."
-The exterminator sprayed twice a month, she thought.

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D 079	Continued From page 16 Observation of resident room 108 on 10/16/17 at 8:55am revealed there was a live roach crawling on the floor. Confidential interview with a second resident revealed: -There were roaches in the facility. -The exterminator had been coming to the facility but the resident was not sure how often. -The resident had roaches in the drawers of the bedside table a couple of weeks ago. -The resident asked the exterminator to spray their room a couple of weeks ago. Confidential interview with a third resident revealed: -The resident saw roaches in their room "once in a while". -The resident saw a roach that morning (10/11/17) near the bathroom and "mashed it with my foot". Confidential interview with a fourth resident revealed: -There was a big roach problem about a month ago. -The resident had seen roaches crawl across their bed. -Another resident gave them a can of roach spray and they had sprayed their rooms. -It was getting better. Observation of resident room 109 on 10/11/17 at 10:31 a.m. revealed: -The entry way to the resident's bathroom was cluttered with multiple racks of clothing hanging on the bathroom door. -The towel rack in the bathroom had multiple racks of clothing hanging on it.	D 079		

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D 079	Continued From page 17 -There was a bedside commode stored in the bathroom with clothes and empty clothes racks laying on top of it. -There was a white bookcase in the resident's bathroom filled with personal hygiene items and linens near the bathroom sink. -There was a bottle of bleach spray and bleach wipes on the top shelf of the bookcase in the bathroom. -There was limited space to access the sink with the bookcase and the bedside commode. Observation of the common shower room on the 100 Hall beside room 104 on 10/11/17 at 11:44 a.m. revealed: -There were scratch marks and yellow and brown stains on the toilet seat. -There was a Geri-chair tray stored in the shower stall on the right. -There was an incontinent brief laying on the back of the toilet. -The shower chair had some light brown stains on the side and the legs. -There were black stains in the grout of the tiled shower. -There was a white film of soap scum on the walls of the shower. -There were rust stains running down the wall below the metal hand bar. -There was a dead roach on the floor near the sink. Interview with the medication aide/supervisor on 10/11/17 at 4:10 p.m. revealed: -The housekeeper usually cleaned the showers every day. -Deep cleaning was done in about 2 to 3 rooms per day. -Families sometimes brought extra items that cluttered residents' rooms.	D 079		

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D 079	Continued From page 18 -The exterminator company came to the facility about once a month. -She saw a roach in the kitchen in the ice box yesterday (10/10/17). -She tried to get the roach out of the ice box but it got away. -She usually saw 10 or 12 roaches every day in the kitchen or dining room. -The roach problem had gotten better about 2 weeks ago. -Before that, you could flip a light on and roaches were everywhere. Interview with the Administrator on 10/12/17 at 10:02 a.m. revealed: -She thought the exterminator company came to the facility every 2 weeks and targeted treatment for the roaches. -She did not think they left invoices when they came but she would check. -There had been an improvement with the roaches but they were not gone. -She saw 1 or 2 roaches in the kitchen last week. Review of invoices from the exterminator company revealed: -05/09/17: The entry doors and dining/cafeteria were treated for roaches. -06/22/17: Pest control (roaches) for room 106 - 203, kitchen, dining room, janitor closet, and emergency closet. -07/25/17: The entry doors, dining/cafeteria, and bathrooms were treated for roaches. -08/08/17: The entry doors and dining/cafeteria were treated for roaches. -08/29/17: The entry doors and dining/cafeteria were treated for roaches. -09/12/17: The food preparation areas, entry doors, dining area, and a couple of resident rooms were treated for roaches.	D 079		

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D 079	Continued From page 19 -09/26/17: The kitchen, dining area, and a couple of resident rooms were treated for roaches. -There were no invoices for October 2017.	D 079		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure an adequate supply of towels, washcloths, and incontinence pads were available at all times to provide personal care for a current census of 20 residents. The findings are: Observation of the closet on the 100 hall identified by a medication aide (MA) as the facility's only linen closet on 10/11/17 at 4:04 p.m. revealed there were 4 washcloths, 18 bath towels, and 1 "chuck" incontinence pad. Observation of the laundry room on 10/11/17 at 4:12 p.m. revealed: -There was one washing machine and one clothes dryer. -The washing machine was in use; the dryer was not in use. -There was not any dirty laundry observed in the	D 080		

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D 080	Continued From page 20	D 080		

laundry room.
-There was a sticker posted on a cabinet door above the washing machine dated 08/10/17 with a handwritten note which read "Do not throw washcloths in trash! Rinse them out with your gloved hands and put in laundry! I have bought 36 cloths in the last 6 weeks, now where are they?"

Observation of the linen closet on 10/12/17 at 8:02 a.m. revealed there were 2 washcloths, 16 bath towels and no incontinence pads.

Interview with a personal care aide (PCA) on 10/12/17 at 8:06 a.m. revealed:
-There were times when there were no washcloths; a few weeks ago, she cut up a towel to use to bathe residents.
-The Manager and the first shift medication aide/supervisor (MA/S) were aware.
-The Manager had been out; the Administrator was filling in since the Manager was out.

Observation of the linen closet on 10/12/17 at 11:45 a.m. revealed there were 2 washcloths, 4 bath towels and no incontinence pads.

Interview with a second PCA on 10/12/17 at 11:46 a.m. revealed:
-There was "plenty" of linen for the residents to use.
-The residents got a clean towel and washcloth on their shower days.
-Staff on all shifts washed laundry as needed; the linen supply may get low because it was being laundered.

Interview with a MA/S on 10/12/17 at 11:50 a.m. revealed:
-Laundry was done when needed on all shifts

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D 080	Continued From page 21 -There was no laundry schedule. -There should be plenty of washcloths and towels for resident use. -A (named) staff member just put out 18 washcloths and 18 towels for resident use within the last "month or so." Observation of the linen closet on 10/12/17 at 2:45 p.m. revealed there was one washcloth, 6 bath towels and one incontinence pad. Interview with a third PCA on 10/12/17 at 6:45 p.m. revealed: -The facility did not supply disposable incontinence pads; they had a few non-disposable incontinence pads, but not enough. -The facility did not supply wipes, so staff had to use washcloths or buy their own to use for the residents. -Staff were always short on washcloths. -Two weeks ago, the first shift MA/S brought in two stacks of washcloths. -The PCA did not know where the washcloths went. Observation of the linen closet on 10/13/17 at 7:53 a.m. revealed there were 8 washcloths, 15 bath towels and one incontinence pad. Interview with a MA/S on 10/13/17 at 5:30 p.m. revealed: -The facility ran short once in a while on wash cloths. -Sometime last week, the MA/S noticed they were low on washcloths, but they had plenty of towels. Observation of the linen closet on 10/17/17 at 12:37 p.m. revealed there were no washcloths, 12 bath towels and 3 incontinence pads.	D 080		

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D 080	Continued From page 22 Observation of the PCA on 10/17/17 at 12:40 p.m. revealed the PCA was removing towels and washcloths from the dryer and folding the laundry in the laundry room. Interview with the PCA on 10/17/17 at 12:40 p.m. revealed there were enough washcloths and towels. Observation of a second PCA on 10/17/17 at 12:41 p.m. revealed the PCA was placing towels and washcloths in the linen closet. Observation of the linen closet on 10/17/17 at 12:45 p.m. revealed there were 3 washcloths, 19 bath towels and 3 incontinence pads. Confidential interview with a resident revealed: -The facility ran out of washcloths and towels "sometimes." -The other day, they had towels, but not wash cloths. -The resident had gotten her own washcloths, because she had to shower without a washcloth in the past. -Some residents did not have their own washcloths and towels. Confidential interview with a second resident revealed: -They ran out of washcloths "sometimes" and she did not have a wash cloth to wash her face in the morning. -She had not complained to anyone. -The Manager said she would get more washcloths a while ago. Telephone interview with a Home Health Nurse on 10/17/17 at 9:30 a.m. revealed there were	D 080		

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D 080	Continued From page 23 times when there were no towels or washcloths available for residents to use. Interview with the Administrator on 10/13/17 at 4:45 p.m. revealed -There were enough washcloths and towels for the residents. -She was aware of the rule that residents were to have towels and washcloths available at all times. -The Administrator would make sure they were available, and when low, would get more.	D 080		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to assure the electrical equipment was maintained in a safe and operating condition as evidenced by the light fixtures not working properly in two community shower rooms and the kitchen; a phone jack cover with a gap around it in a resident room; and an electrical outlet cover with a hole in a second resident room. The findings are:	D 105		

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D 105	Continued From page 24 Observation of resident room 207 on 10/11/17 at 10:34 a.m. revealed the telephone jack switch plate cover was too small and did not cover the hole in the wall, leaving a gap in the wall around it; there were no wires exposed. Interview with a resident who resided in room 207 on 10/11/17 at 10:34 a.m. revealed the phone jack had always been like that. Observation of the common bathroom on the 100 Hall on 10/11/17 at 11:55 a.m. revealed there was a missing cover on the overhead light fixture, leaving the bulbs exposed. Observation of resident room 210 on 10/11/17 at 10:35 a.m. revealed: -There was a hole in the electrical outlet cover on the left side wall of room. -The top left corner of the light switch in the bathroom was missing. Observation of the common bathroom on the 100 Hall across from room 104 on 10/11/17 at 11:50 a.m. revealed: -There was a missing cover on the overhead light fixture, leaving the bulbs exposed. -The cover to the light fixture was leaning against the wall over the bath tub. -The emergency pull cord next to the toilet used for emergencies was missing. Review of a re-inspection report for the facility's kitchen from Environmental Health Services dated 08/29/17 revealed: -Several light bulbs needed shielding in the kitchen. -Several lights were out in the kitchen. Observation of the common shower room on the	D 105		

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D 105	Continued From page 25 100 Hall beside room 104 on 10/11/17 at 11:44 a.m. revealed: -The fluorescent light on the ceiling did not have a cover or a bulb. -One of the two light bulbs over the sink was burned out. -It was dark in the bathroom due to 2 of 3 light bulbs not working. Interview with the second shift medication aide/supervisor (MA/S) on 10/11/17 at 4:10 p.m. revealed: -The common shower room on the 100 Hall beside room 104 was the bathroom that was used the most by residents. -The lights had been burned out in the common shower room for about a week. Interview with the first shift MA/S on 10/13/17 at 10:20 a.m. revealed: -She was not aware of the burned out lights in the common bathroom on the 100 Hall. -She did not know when the burned out lights would be replaced or repaired. Observation of the kitchen on 10/16/17 at 9:50 a.m. revealed: -The fluorescent light on the ceiling near the dry storage pantry was not working and there were several broken and missing pieces of the light cover. -The fluorescent light on the ceiling near the ice machine had only 1 of 4 bulbs working and it was flickering. -The fluorescent light on the ceiling near the refrigerator had only 2 of 4 bulbs working. --The fluorescent light on the ceiling near the 3 compartment sink had only 2 of 4 bulbs working. -The fluorescent light on the ceiling near the stove was not working.	D 105		

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D 105	Continued From page 26 Interview with the cook on 10/16/17 at 9:50 a.m. revealed: -The lights had been burned out for a while. -It was dark in the kitchen and they needed more light. Interview with Maintenance staff on 10/11/17 at 10:08 a.m. revealed: -They had been working on repairs for the facility. -They had replaced lighting in the facility since the last state survey in June 2017. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -She would have the whole lighting fixture in the kitchen replaced. -She would get the bulbs checked and replaced in the other areas as well.	D 105		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous Type B	D 113		

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D 113	Continued From page 27 Violation was not abated. Based on observations and interviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 7 of 13 water fixtures sampled in the residents' bathrooms and the common hall bathrooms on the 100 and 200 Halls of the facility, including 3 fixtures with steam observed. The findings are: Observation of the bathroom in resident room 202 on 10/11/17 at 10:15 a.m. revealed the water temperature at the sink was 120 degrees Fahrenheit (F) with visible steam. Interview with a resident who resided in room 202 on 10/11/17 at 10:15 a.m. revealed sometimes the water in the bathroom sink "gets very hot". Observation of the bathroom in resident room 210 on 10/11/17 at 10:35 a.m. revealed the water temperature at the sink was 120 degrees F with visible steam. Interview with a resident who resided in room 210 on 10/11/17 at 10:35 a.m. revealed the water in the bathroom sink was "very hot like I like it". Observation of the common bathroom on the 200 Hall on 10/11/17 at 10:20 a.m. revealed the water temperature at the sink was 120 degrees F with visible steam. Interview with a resident on 10/11/7 at 4:20 p.m. revealed: -The water in the (common) bathroom on the 200 hall was too hot to wash your hands.	D 113		

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D 113	Continued From page 28 -She could not wash her hands in there (common bathroom) after using the bathroom, because it was too hot. -She had told "everyone" but nobody cared. Interview with a family member on 10/12/17 at 12:22 p.m. revealed: -The water in the common bathroom on the 200 hall was "always way too hot." -She had mentioned it to staff several times, but "they won't fix it." Observation of the shared bathroom between resident rooms 205 and 206 on 10/11/17 at 10:22 a.m. revealed the water temperature at the sink was 119 degrees F. Interview with a resident who resided in room 205 on 10/11/17 at 10:22 a.m. revealed sometimes the water in the bathroom sink and shower was "too hot." Observation of the bathroom in resident room 207 on 10/11/17 at 10:34 a.m. revealed the water temperature at the sink was 120 degrees with visible steam. Interview with a resident who resided in room 207 on 10/11/17 at 10:34 a.m. revealed: -The water in the bathroom was "hot." -"That water will burn you." -The resident denied being burned by the hot water. Observation of the common bathroom at the end of the 100 Hall near the laundry room revealed: -The bathroom had a sink and a toilet. -The water temperature at the sink was 120 degrees Fahrenheit (F) with no steam observed.	D 113		

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D 113	Continued From page 29 Observation of resident room 109 on 10/11/17 at 10:29 a.m. revealed: -There was a toilet and a sink. -The water temperature at the sink was 120 degrees F with no steam observed. Interview with a resident residing in room 109 on 10/11/17 at 10:40 a.m. revealed: -The water temperature was not too hot or too cold for her. -She could adjust the water temperature. Interview with the Maintenance staff on 10/11/17 at 10:08 a.m. revealed: -The plumber had been to the facility "a while back" (could not give date). -The water temperatures should be right. -He was not aware of any problems with the water temperatures. -He did not check the water temperatures. Interview with the medication aide/supervisor (MA/S) on 10/11/17 at 10:15 a.m. revealed: -She did not check water temperatures at the facility. -She was not aware of anyone checking the hot water temperatures. Interview with the second shift MA/S on 10/11/17 at 4:10 p.m. revealed: -A family member reported the water temperatures were too hot but it had been a while (did not know timeframe). -A resident had complained about the water being too hot during the last state survey in June 2017. -She was not aware of any current problems with the water being too hot. -She was not aware of what the water temperature range should be. -She was not aware of a thermometer for staff to	D 113		

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D 113	Continued From page 30	D 113		

check water temperatures.
-She did not check water temperatures.
-She was not aware of anyone checking water temperatures unless it was done on first shift.
-She would post some caution signs in the bathrooms warning about the hot water temperatures.
-She would let the Administrator know about the hot water temperatures.

Interview with the Administrator on 10/12/17 at 10:02 a.m. revealed:
-The facility's Manager had been out on medical leave for about 2 months and was unavailable for interview.
-She called a plumber yesterday (10/11/17) to work on the hot water temperatures.
-The plumber turned down the thermostat on the hot water heater.
-She thought there was only one hot water heater at the facility but she was not sure.
-She had not checked any water temperatures at the facility.
-There was no water temperature log being kept at the facility to her knowledge.

Recheck of the water temperature in the common bathroom at the end of the 100 Hall on 10/12/17 at 3:20 p.m. revealed:
-The water temperature at the sink was 120 degrees F with no steam observed.
-There was a caution sign about the hot water posted in the bathroom.

Recheck of the water temperature resident room 109 on 10/12/17 at 3:22 p.m. revealed:
-The water temperature at the sink was 120 degrees F with no steam observed.
-There was a caution sign about the hot water posted in the bathroom.

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D 113	Continued From page 31 Recheck of water temperature in the shared bathroom between resident rooms 205 and 206 on 10/12/17 at 3:43 p.m. revealed: -The water temperature at the sink was 104 degrees F. -There was a caution sign about the hot water posted in the bathroom. Recheck of water temperature in resident room 207 on 10/12/17 at 3:39 p.m. revealed: -The water temperature at the sink was 102 degrees F. -There was a caution sign about the hot water posted in the bathroom. Recheck of water temperature in resident room 202 on 10/12/17 at 3:28 p.m. revealed: -The water temperature at the sink was 108 degrees F. -There was a caution sign about the hot water posted in the bathroom. Recheck of the water temperature of the common bathroom on the 200 Hall on 10/12/17 revealed: -The water temperature at the sink was 102 degrees F at 3:29 p.m. -The water temperature in the shower was 102 degrees F at 3:31 p.m. -There was a caution sign about the hot water posted in the bathroom. Interview with the Administrator on 10/13/17 at 10:50 a.m. revealed: -She realized yesterday (10/12/17) that the facility had 2 hot water heaters. -The Maintenance staff came yesterday (10/12/17) and turned down the second thermostat (for the 100 Hall).	D 113		

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D 113	Continued From page 32 Recheck of the water temperature in the common bathroom at the end of the 100 Hall on 10/13/17 at 1:50 p.m. revealed the water temperature at the sink was 112 degrees F. Interview with the Administrator on 10/16/17 at 9:00 a.m. revealed: -She had checked the water temperatures and they were running low since the thermostats were turned down on the hot water heaters. -She had called the Maintenance staff to come to the facility today, 10/16/17, to adjust the thermostats on the hot water heaters again. -She had started keeping a water temperature log. Review of the water temperature log provided by the Administrator revealed: -There was a column for a water temperature to be checked daily in one resident room on the 100 Hall, one resident room on the 200 Hall, one common bath on the 100 Hall, and one common bath on the 200 Hall. -Water temperatures were documented for 3 days, 10/14/17 - 10/16/17. -All water temperatures ranged from 102-110 degrees F with the exception resident room 201 on 10/15/17, when it was 90 degrees F. -The water temperature was noted to be adjusted on 10/16/17 and the hot water temperature in resident room 201 was 105 degrees F on 10/16/17. _____ The failure of the facility to assure hot water temperatures were maintained between 100 - 116 degrees F resulted in at least 3 bathroom fixtures used by residents being above 116 degrees F with steam observed. One resident would not wash her hands after toileting for fear of the hot water burning her hands. Residents and family	D 113		

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D 113	Continued From page 33 members had complained about the water being too hot. There was no system in place for the facility to monitor or check the hot water temperatures. The failure to maintain hot water temperatures between 100 - 116 degrees F continued to be detrimental to the health and safety of the residents and constitutes an Unabated Type B Violation. _____ Review of the facility's Plan of Protection dated 10/12/17 revealed: -Hot water heater control turned down and water temperature log implemented. -"Caution-Hot water is very hot" sign placed above faucet. -Thermometer will be purchased and water temperatures checked daily. -The Supervisor or designee will be responsible to check daily. -Any temperature out of range will be reported to Administrator in order to call maintenance. -Hot water temperature log will be maintained daily and water heater adjusted as indicated. -Logs will be monitored weekly by Administrator.	D 113		
D 127	10A NCAC 13F .0403(c) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (c) Medication aides and staff who directly supervise the administration of medications, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration.	D 127		

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D 127	Continued From page 34 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 1 of 4 medication aides sampled (A) completed six hours of continuing education annually related to medication administration and Staff A was observed during medication administration passes and 8 medication errors were identified. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 11/20/00 as a personal care aide (PCA), medication aide (MA) and supervisor. -There was no documentation of continuing education (CE) related to medication administration in Staff A's personnel record for 2016 or 2017. Observation of Staff A during the survey revealed: -Staff A worked as the MA on first shift on 10/11/17 - 10/13/17, 10/16/17, and 10/17/17. -Staff A was observed during the morning medication passes on 10/12/17 and 10/17/17 and 8 errors were identified during these medication passes. Interview with Staff A on 10/17/17 at 9:55 a.m. revealed: -She had been employed at the facility since 2000. -She was employed as a MA and Supervisor. -She had not had any CE training lately. -She thought she had CE in medications previously, but could not remember. Interviews with the Administrator on 10/16/17 at 8:40 a.m. and 9:00 a.m. revealed: -The facility's Manager was in charge of the personnel files.	D 127		

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D 127	Continued From page 35 -The Manager was responsible for making sure the medication aides (MA) had the required 6 hours of CE annually. -If the MAs had the required hours of CE, it would be in the plastic box with their personnel files. -The Manager had been on leave for about 2 months and was unavailable for interview. -She checked with the facility's Manager about the personnel files. -The Manager could not find any more information for the personnel files. -The Manager was responsible for the personnel files and making sure all staff met qualifications and requirements. -No one took over responsibility of the personnel files after the Manager went on medical leave. -There was no system to check behind the Manager or to monitor the personnel files.	D 127		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 5 staff sampled (C) was tested for Tuberculosis (TB) disease upon hire according to control measures for the	D 131		

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D 131	Continued From page 36 Commission for Health Services. The findings are: Review of Staff C's personnel record revealed: -There was no hire date documented in the record. -Staff C was rehired as a personal care aide. -There was documentation that Staff C had a negative tuberculosis (TB) skin test placed on 06/26/17 and read as negative on 6/28/17. -There was no documentation of additional TB skin tests for Staff C in the record. Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed: -She had worked at the facility in August 2016, left (could not recall date), and came back as a rehire twice. -She was last rehired on 09/01/17. -She was supposed to get a second TB skin test but she had not done it yet. Interviews with the Administrator on 10/16/17 at 8:40 a.m. and 5:30 p.m. revealed: -She was not aware that Staff C did not have a second TB skin test. -She checked with the facility's Manager about the personnel files. -The Manager could not find any more information for the personnel files. -The Manager was responsible for the personnel files and making sure all staff met qualifications and requirements. -The Manager had been on leave for about 2 months and was unavailable for interview. -No one took over responsibility of the personnel files after the Manager went on medical leave. -There was no system to check behind the Manager or to monitor the personnel files.	D 131		

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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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on interviews and record reviews, the facility failed to assure 3 of 5 staff sampled (B, C, E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry upon hire according to G.S. 131E-256. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired on 10/25/16 as a personal care aide (PCA). -There was documentation of a health care personnel registry (HCPR) check for Staff B dated 05/01/17 with no substantiated findings. -There was no documentation of a HCPR check prior to 05/01/17. Interview with Staff B on 10/17/17 at 5:20 p.m. revealed: -She was hired before August 2016, because she was working at the facility before her birthday, which was in August.	D 137		

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D 137	Continued From page 38 -She was hired as a PCA. -Her duties included administering medication, bathing, grooming, incontinent care and supervision of residents. -She started administering medication on 10/09/17. Based on interviews and record reviews, there were allegations of abuse and neglect related to Staff B. [Refer to findings under Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry.] Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 2. Review of Staff C's personnel record revealed: -There was no documentation of Staff C's hire date or position. -There was documentation of a health care personnel registry (HCPR) check for Staff C dated 07/20/17 with no substantiated findings. -There was no documentation of a HCPR check prior to 07/20/17. Interview with Staff C on 10/16/17 at 2:39 p.m. revealed: -Staff C was hired in August 2016 and rehired on 09/01/17. -She was a medication aide and personal care aide. Based on interviews and record reviews, there were allegations of drug diversion regarding Staff C. [Refer to findings under Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry.] Refer to interview with the Administrator on 10/16/17 at 8:40 a.m.	D 137		

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D 137	Continued From page 39 3. Review of Staff E's personnel record revealed: -Staff E was hired on 4/4/17 as a personal care aide (PCA), medication aide (MA) and supervisor. -There was documentation of an HCPR check on Staff E dated 5/1/17 with no substantiated findings. -There was no documentation of an HCPR check prior to 5/1/17. Interview with Staff E on 10/16/17 at 3:13 p.m. revealed: -She had been employed since March or April 2017. -She was a PCA, MA and Supervisor. -Her duties included administering medication, bathing, showering, dressing and feeding residents, incontinent care and getting residents out of bed. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. Interview with the Administrator on 10/16/17 at 8:40 a.m. revealed: -The HCPR checks should be done upon hire to assure there were no substantiated findings. -She checked with the facility's Manager about the personnel files. -The Manager could not find any more information for the personnel files. -The Manager was responsible for the personnel files and making sure all staff met qualifications and requirements. -The Manager had been out on medical leave for about 2 months and was unavailable for interview. -No one took over responsibility of the personnel files after the Manager went on medical leave. -There was no system to check behind the Manager or to monitor the personnel files.	D 137		

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D 137	Continued From page 40 The facility failed to assure no substantiated findings were listed on the North Carolina Health Care Personnel Registry upon hire for three staff. Staff B was alleged to have neglected three residents and Staff C was alleged to have diverted controlled substances. Both staff were reported to the Health Care Personnel Registry during the survey. The failure continued to be detrimental to the safety and welfare of the residents by not verifying staff had no substantiated findings listed on the registry for neglect and drug diversion allegations upon hire, and constitutes an Unabated Type B Violation. Review of the facility's Plan of Protection dated 10/16/17 revealed: -HCPR checks will be required and completed on all staff and documentation acquired on-line and placed in the personnel file on hire before beginning work. -The Administrator will audit charts immediately. -The Administrator will ensure no substantiated findings and all personnel files are complete with required documents before placing staff on schedule.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B	D 139		

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D 139	Continued From page 41 Violation was not abated. Based on interviews and record reviews, the facility failed to assure 5 of 5 staff sampled (A, B, C, D, E) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired as a medication aide (MA) and supervisor on 11/20/00. -There was a county criminal background check dated 5/24/00 in Staff A's personnel record. -There was no documentation of a state wide criminal background check being completed for Staff A upon hire. Interview with Staff A on 10/17/17 at 9:55 a.m. revealed: -She had been employed since 2000. -She thought she had a criminal background screening before being employed but it has been a long time ago. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 2. Review of Staff's B personnel record revealed: -Staff B was hired on 10/25/16 as a personal care aide (PCA). -There was documentation of a signed consent by Staff B on 6/4/17 for a criminal background check to be completed. -There was no documentation of a state wide criminal background check completed for Staff B upon hire. Interview with Staff B on 10/17/17 at 5:20 p.m. revealed:	D 139		

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D 139	Continued From page 42 -She was hired before August 2016, because she was working at the facility before her birthday, which was in August. -She was hired as a PCA, and was now a medication aide (MA). -Staff B remembered signing the paperwork for the criminal background check to be completed. -She did not know if the criminal background check was completed. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 3. Review of Staff C's personnel record revealed: -There was no documentation of Staff C's hire date. -Staff C was rehired at the facility as a personal aide (PCA), medication aide (MA) and supervisor. -There was no documentation of a signed consent for the criminal background check to be completed. -There was no documentation of a state wide criminal background check for Staff C upon hire. Interview with Staff C on 10/16/17 at 2:39 p.m. revealed: -She was first hired at the facility in August 2016 as a PCA, MA and Supervisor. -She had stopped working at the facility two times. -She got rehired on 09/01/17. -She completed the paperwork for the criminal background check to be done, but did not know if the criminal background check was completed. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 4. Review of Staff D's personnel record revealed: -There was no documentation of Staff D's hire	D 139		

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D 139	Continued From page 43	D 139		

date.
-Staff D was hired a personal care aide (PCA).
-There was documentation of a signed consent by Staff D on 5/1/17 for the criminal background check to be completed.
-There was no documentation that a state wide criminal background check had been completed for Staff D upon hire.

Interview with Staff D on 10/17/17 at 8:55 a.m. revealed:
-She started working at the facility in May 2017.
-She was hired as a PCA.
-She thought that a criminal background check was done, because she remembered signing the paperwork for the criminal background check to be completed.

Refer to interview with the Administrator on 10/16/17 at 8:40 a.m.

5. Review of Staff E's personnel record revealed:
-Staff E was hired on 4/4/17 as a medication aide and supervisor.
-There was documentation of a signed consent by Staff E on 4/2/17 for the criminal background check to be completed.
-There was no documentation of a state wide criminal background check being completed for Staff E upon hire.

Interview with Staff E on 10/16/17 at 3:13 p.m. revealed:
-She had been employed since March or April 2017.
-She was a MA and supervisor.
-She signed the release so the criminal background check could be completed.
-The Manager stated that she did the criminal background check.

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D 139	Continued From page 44 Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. Interview with the Administrator on 10/16/17 at 8:40 a.m. revealed: -The criminal background checks should have been done upon hire. -She checked with the facility's Manager about the personnel files. -The Manager could not find any more information for the personnel files. -The Manager was responsible for the personnel files and making sure all staff met qualifications and requirements. -The Manager had been out on medical leave for about 2 months and was unavailable for interview. -No one took over responsibility of the personnel files after the Manager went on medical leave. -There was no system to check behind the Manager or to monitor the personnel files. The failure of the facility to assure 5 of 5 staff sampled had a state-wide criminal background check upon hire resulted in the facility being unaware of any criminal background findings that could be detrimental to the welfare and safety of the residents. This continuing non-compliance constitutes an Unabated Type B Violation. Review of the facility's Plan of Protection dated 10/16/17 revealed: -Criminal background checks will be completed immediately on all personnel upon hire. -Personnel files without background checks will be completed immediately by Administrator. -The Administrator will review personnel files monthly to ensure all required documentation is present.	D 139		

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D 151	10A NCAC 13F .0501 (c) Personal Care Training And Competency 10A NCAC 13F .0501Personal Care Training And Competency (c) The Department shall exempt staff from the 80-hour training and competency evaluation program who are: (1) licensed health professionals; (2) listed on the Nurse Aide Registry; or (3) documented as having successfully completed a 40-45 hour or 75-80 hour training program or competency evaluation program approved by the Department since January 1, 1996 according to Rule .0502 of this Section. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 2 of 5 staff sampled (B, E) who provided personal care to residents, had successfully completed an 80-hour personal care training and competency evaluation program. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired on 10/25/16 as a personal care aide (PCA) . -Staff B was not listed on the Nurse Aide Registry. -There was no documentation of personal care training for Staff B. Interview with Staff B on 10/17/17 at 5:20 p.m. revealed: -She was hired before August 2016, because she was working at the facility before her birthday, which was in August. -She was hired as a PCA.	D 151		

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D 151	Continued From page 46 -Her duties included administering medication, bathing, grooming, incontinent care and supervision of residents. Refer to interview with the Administrator on 10/16/17 at 9:31 a.m. 2. Review of Staff E's personnel record revealed: -Staff E was hired on 4/4/17 as a personal care aide, medication aide and supervisor. -She was not listed on the Nurse Aide Registry. -There was no documentation of personal care training for Staff E. Interview with Staff E on 10/16/17 at 3:13 p.m. revealed: -Staff E was hired in March or April 2017 as a PCA, MA and Supervisor. -She had only taken two personal care classes. -Her duties included administering medication, bathing, showering, dressing and feeding residents, incontinent care and getting residents out of bed. Refer to interview with the Administrator on 10/16/17 at 9:31 a.m. Interview with the Administrator on 10/16/17 at 9:31 a.m. revealed: -She was the Administrator at the facility. -She was going to get the personnel records organized. -She questioned whether the staff still needed the personal care training hours since staff were already employed. -She would contact the pharmacy to see who other facilities used for personal care training. -She would look online and also contact the State office to find out who offered personal care training.	D 151		

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D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 5 medication aides (C, E) sampled received training by a licensed health professional on the care of	D 164		

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D 164	Continued From page 48 diabetic residents prior to administering insulin to residents. The findings are: 1. Review of Staff C's personnel record revealed: -There was no documentation of Staff C's hire date or position. -There was no documentation that diabetic training had been completed in Staff C's personnel record. Review of the facility's medication administration records and blood sugar logs revealed -Staff C administered insulin on 10/02/17, 10/03/17, and 10/07/17 - 10/09/17. -Staff C administered insulin on 09/01/17, 09/06/17, 09/07/17, 09/10/17 - 09/12/17, 09/15/17, 09/16/17, 09/19/17, 09/21/17 - 09/24/17, and 09/29/17. Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed: -She had worked at the facility in the past, left, and came back as a rehire twice. -She was last rehired on 09/01/17. -She started administering medications again around the end of September 2017 after she was rehired. -She administered medications including insulin. -She had no diabetes training that she could recall. -She thought she was scheduled for a class one time but she missed the class. Based on record reviews, Staff C documented administration of insulins for Resident #3 and Resident #16 including when there were errors and the insulins were not documented as being administered according to the orders. [Refer to	D 164		

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D 164	Continued From page 49 Tag D358 10A NCAC 13F .1004(a) Medication Administration.] Refer to interviews with the Administrator on 10/16/17 at 8:40 a.m. and 9:31 a.m. 2. Review of Staff E's personnel record revealed: -Staff E was hired on 4/4/17 as a personal care aide, medication aide and supervisor. -There was no documentation that diabetic training had been completed in Staff E's personnel record. Review of the facility's medication administration records and blood sugar logs revealed -Staff E administered insulin on 10/01/17, 10/02/17, and 10/04/17 - 10/12/17. -Staff E administered insulin on 09/09/17, 09/10/17, 09/12/17, 09/16/17 - 09/18/17, 09/21/17, 09/23/17, 09/27/17, and 09/28/17. Interview with Staff E on 10/16/17 at 3:13 p.m. revealed: -Staff E took the diabetic training about a month ago. -She was never given a certificate of completion. Based on record reviews, Staff E documented administration of insulins for Resident #3 and Resident #16 including when there were errors and the insulins were not documented as being administered according to the orders. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration.] Refer to interviews with the Administrator on 10/16/17 at 8:40 a.m. and 9:31 a.m. Interviews with the Administrator on 10/16/17 at 8:40 a.m. and 9:31 a.m. revealed:	D 164		

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D 164	Continued From page 50 -She checked with the facility's Manager about the personnel files. -The Manager could not find any more information for the personnel files. -The Manager was responsible for the personnel files and making sure all staff met qualifications and requirements. -The Manager had been on leave for about 2 months and was unavailable for interview. -No one took over responsibility of the personnel files after the Manager went on medical leave. -There was no system to check behind the Manager or to monitor the personnel files. -She had contacted the pharmacy and got certificates for staff that had taken the recent diabetic training offered at the facility. -She received a copy of the staff sign-up sheet. (Staff C and Staff E were not on the sheet.) The facility failed to assure 2 of 4 medication aides had received diabetic training prior to the administration of insulin, including documented and observed errors with long-acting and sliding scale insulin administration for at least two resident receiving insulin including one resident who had multiple blood sugars over 400 and as high as 600. This failure continued to be detrimental to the health, safety and welfare of the residents who were diabetics and received insulin and constitutes an Unabated Type B Violation. Review of the facility's Plan of Protection dated 10/16/17 revealed: -The pharmacy's nurse contacted to schedule diabetic training class. -All medication aides must attend. -The Administrator will monitor to ensure all medication aides have completed class and new hires will also be required to have this training	D 164		

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D 164	Continued From page 51 prior to administering insulin. -A diabetic training class will be scheduled annually and all medication aides are required to attend. -The Administrator will monitor personnel files monthly for required in-services.	D 164		
D 165	10A NCAC 13F .0506 Training On Physical Restraints 10A NCAC 13F .0506 Training On Physical Restraints (a) An adult care home shall assure that all staff responsible for caring for residents with medical symptoms that warrant restraints are trained on the use of alternatives to physical restraint use and on the care of residents who are physically restrained. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to provide physical restraint training for 5 of 5 staff sampled (A, B, C, D, E) who provided care to one resident restrained in a wheelchair with a gait belt. The findings are: A gait belt is a device used by caregivers to transfer residents with mobility issues from one position to another, from one location to another or while assisting residents to ambulate who have problems with balance. For example, a gait belt is	D 165		

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D 165	Continued From page 52 used to move a resident from a standing position to a wheelchair. Review of Resident #13's current FL-2 dated 03/20/17 revealed diagnoses included chest pain, atrial fibrillation, high INR (International Normalized Ratio, a test to monitor excessive bleeding or clotting), and peripheral vascular disease. Observation of Resident #13 on 10/11/17 at 11:50 a.m. revealed he was in the dining room in his wheelchair, restrained with a gait belt; the gait belt was around the reisdent's waist and secured to the back of the wheelchair. Observation of Resident #13 on 10/11/17 at 1:35 p.m. revealed: -The resident was sitting in a wheelchair in the dayroom on 100 Hall. -There was a gait belt around the resident's stomach that was hooked together on the back side of the wheelchair. Observation of Resident #13 on 10/11/17 at 4:02 p.m. revealed he was in the hallway in his wheelchair with his gait belt around his stomach and hooked together on the back of the wheelchair. Observation of Resident #13 on 10/12/17 at 12:22 p.m. revealed: -He was on the front porch with his family member. -He was restrained to his wheelchair with a gait belt around his stomach that was hooked on the back side of the wheelchair. Interview with Resident #13's family member on 10/12/17 at 12:22 p.m. revealed:	D 165		

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D 165	Continued From page 53 -Resident #13 wore the gait belt all of the time when he was in his wheelchair. -The staff member who got Resident #13 up and down applied and removed the gait belt as needed. -She denied complaints about how staff applied or removed the gait belt. Interview with a medication aide/supervisor (MA/S) on 10/17/17 at 12:00 p.m.: -Resident #13 wore the gait belt whenever he was in his wheelchair. -The staff member who got Resident #13 up or toileted him applied and removed his gait belt. -Resident #13's gait belt use was not documented. -She was trained "a while ago" on restraint use. -Facility staff had not had any recent training on the proper use of restraints. Interview with a personal care aide (PCA) on 10/17/17 at 5:20pm revealed: -She had never had any training on the application or use of Resident 13's restraint. -She applied and removed Resident #13's gait belt as needed. 1. Review of Staff A's personnel record revealed: -Staff A was hired on 11/20/00 as a nurse aide, medication aide (MA) and supervisor. -There was documentation on the Licensed Health Professional Support (LHPS) competency evaluation on 3/27/03 that Staff A was validated in vest, waist/belt restraint, pelvic, Geri chair with tabletop, lap pillow, wrist restraint and alternative care practices to restraint use. -She was validated by the Administrator, who was a nurse. -There was no documentation of restraint training in Staff A's personnel record.	D 165		

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D 165	Continued From page 54 Interview with Staff A on 10/17/17 at 9:55 a.m. revealed: -She had been employed since 2000 as a MA and supervisor. -She had not had any restraint training. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 10/25/16. -There was no job title or description.. -There was documentation on the Licensed Health Professional Support (LHPS) competency evaluation on 10/25/16 that Staff B was validated in vest, waist/belt restraint, pelvic, Geri chair with tabletop, lap pillow, wrist restraint and alternative care practices to restraint use. -There was no documentation of restraint training in Staff B's personnel record. Interview with Staff B on 10/12/17 at 7:50pm revealed: -She thought she had training on the use of restraints one month ago. -She was validated by the Administrator, who was a nurse. -She did not recall who taught the class. Interview with Staff B on 10/17/17 at 5:20 p.m. revealed. -Staff B was hired before August 2016, because she was working at the facility before her birthday, which was in August. -She was hired as a personal care aide, but was now a medication aide. -She had done restraint training in the past, but did not know where the documentation was. -She had not had any recent training.	D 165		

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D 165	Continued From page 55 Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 3. Review of Staff C's personnel record revealed: -There was no documentation of Staff C's hire date. -She was hired as a personal care aide, medication aide (MA) and supervisor. -There was documentation on the Licensed Health Professional Support (LHPS) competency evaluation on 6/27/17 that Staff C was validated in vest, waist/belt restraint, pelvic, Geri chair with tabletop, lap pillow, wrist restraint and alternative care practices to restraint use. -She was validated by the Administrator, who was a nurse. -There was no documentation of restraint training in Staff C's personnel record. Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed: -She had worked at the facility in the past, left, and came back as a rehire twice. -She was last rehired on 09/01/17. -She did not have restraint training. -They had one resident at the facility with "a belt" and there was an order for it. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 4. Review of Staff D's personnel record revealed: -There was no documentation of Staff D's hire date or job title. -There was documentation on the Licensed Health Professional Support (LHPS) competency evaluation on 5/1/17 that Staff D was validated in vest, waist/belt restraint, pelvic, Geri chair with tabletop, lap pillow, wrist restraint and alternative	D 165		

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care practices to restraint use.
-She was validated by the Administrator, who was a nurse.
-There was no documentation of restraint training in Staff D's personnel record.

Interview with Staff D on 10/17/17 at 8:55 a.m. revealed:
-She was hired in May 2017 as a personal care aide (PCA).
-She received restraint training when working at another facility.

A second interview with Staff D on 10/17/17 at 11:55am revealed she was trained "by herself" on proper use of the restraint belt.

Refer to interview with the Administrator on 10/16/17 at 8:40 a.m.

5. Review of Staff E's personnel record revealed:
-Staff E was hired on 4/4/17 as a medication aide (MA) and supervisor.
-There was documentation on the Licensed Health Professional Support (LHPS) competency evaluation on 4/4/17 that Staff E was validated in vest, waist/belt restraint, pelvic, Geri chair with tabletop, lap pillow, wrist restraint and alternative care practices to restraint use.
-She was validated by the Administrator, who was a nurse.
-There was no documentation of restraint training in Staff E's personnel record.

Interview with Staff E on 10/16/17 at 3:13 p.m. revealed:
-She was hired in March or April 2017 as a MA and supervisor.
-She had not had any restraint training.
Refer to interview with the Administrator on

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D 165	Continued From page 57 10/16/17 at 8:40 a.m. Interview with the Administrator on 10/16/17 at 8:40 a.m. revealed: -She checked with the facility's Manager about the personnel files. -The Manager could not find any more information for the personnel files. -The Manager was responsible for the personnel files and making sure all staff met qualifications and requirements. -The Manager had been on medical leave for about 2 months and was unavailable for interview. -No one took over responsibility of the personnel files after the Manager went on medical leave. -There was no system to check behind the Manager or to monitor the personnel files.	D 165		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.	D 176		

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D 176	Continued From page 58 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on observations, interviews, and record reviews, the Administrator failed to assure the overall management, operations, and policies and procedures of the facility were developed and implemented to maintain each residents' right to be free of serious harm, abuse, and neglect as evidenced by the Manager (Administrator-in-Charge) refusing to allow staff to contact 911 for a resident (#11), who was not feeling well and was confused; refusing to investigate allegations of abuse and report two staff to the Health Care Personnel Registry for resident abuse allegations received in August 2017; and the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, medication administration, resident rights, personal care and supervision, health care personnel registry, infection prevention requirements, housekeeping and furnishings, nutrition and food service, controlled substances, physical restraints, other staff qualifications, training and qualifications for medication aides, training on diabetic residents, screening for controlled substances and criminal background screening, all of which are the responsibility of the Administrator/Administrator-in-Charge. The findings are: Interview with the Administrator on 10/12/17 at 10:02 a.m. revealed: -The Manager (Administrator-in-Charge) had	D 176		

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been on leave for two months.
-She thought the Manager (Administrator-in-Charge) was coming back, but she would not be.
-'Things kind of mushroomed."

Interview with the medication aide/supervisor (MA/S) on 10/12/17 at 2:55 p.m. revealed:
-The Manager (Administrator-in-Charge), who was on leave, monitored medications and did the filing.
-On Monday (10/09/17) or Tuesday (10/10/17) of this week, the Manager (Administrator-in-Charge) texted her and told her that the MA/S and the Administrator would have to take over the Manager's duties.
-She and the Administrator had not started any monitoring systems since the Manager (Administrator-in-Charge) had been out (about 1 to 2 months).

Confidential interview with a staff revealed:
-"Nobody knew what to do".
-Staff were not to call anyone until talking to the Manager (Administrator-in-Charge).

Confidential interview with a second staff revealed:
-The staff had heard another staff say to call the Manager (Administrator-in-Charge) before calling 911 for emergencies.
-"It's not up to the Manager (Administrator-in-Charge), but they do what she says".
-The staff had no idea why staff would call the Manager first.
-There was an incident about 6 months ago where the staff called the Manager (Administrator-in-Charge) first and she told the staff not to send the resident out. The staff could

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not recall who the resident was.

Interview with a family member on 10/12/17 at 12:22 p.m. revealed:
-The Manager (Administrator-in-Charge)was a bully to the family member and staff.
-Staff "cowered" down to her.

Interviews with the Administrator on 10/13/17 at 10:30 a.m., 10:54 a.m. and 6:36 p.m., and on 10/16/17 at 9:45 a.m. revealed:
-The facility did not have a written policy for injuries of unknown origin and she was not aware of any specific process the facility used or followed for injuries of unknown origin.
-Her expectation for unexplained injuries was for the MA/S to send the resident to the hospital or notify the Primary Care Provider.
-The facility had no written policies on an emergency, on what to do if a resident refused to go to the hospital, or for changes in resident status to assure the physician was notified.
-The facility had not had a policy or system in place to assure staff called 911 or for documentation related to emergencies.
-There was not a written policy on sexual, verbal or physical abuse.

Noncompliance was identified in the following rule areas:

1. Based on observations, record reviews, and interviews, the facility failed to assure the acute and routine health care needs were met for 6 of 8 residents sampled (#1, #2, #3, #6, #10, #11) as related to failing to notify the primary care physician (PCP) of elevated blood sugars over 400 as ordered for a diabetic resident (#3) on 14 of 15 occasions; of unexplained injuries of skin tears and bruising for two residents (#1, #2); of

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inappropriate sexual behaviors from a resident (#6); of a resident's (#3) complaints of a prosthetic leg being uncomfortable and refusing to wear it; of a resident complaints of not feeling well, burning upon urination, decreased appetite and increased confusion prior to a hospitalization for diagnosis of sepsis (#11); of a resident (#10) with a change in status and complained of dizziness, exhibited sweating, altered mental status and refused to be sent to the hospital for emergent medical evaluation, who was later found deceased in his bed; failing to assure referral for home health services was completed for treatment of a sacral wound (#2); and failing to assure a resident (#1) was sent to the hospital for evaluation of a shoulder abscess and a head injury of unknown origin. [Refer to Tag D273, 10A NCAC 13F. 0902(b) Health Care (Unabated Type A1 Violation)].

2. Based on observations, record reviews, and interviews, the facility failed to assure three residents (#12, #14, #15) were protected from mental and sexual assault from Resident #6 who wandered into residents' rooms, stole a resident's food (#12), tried to get into bed with a resident (#15), and touched a resident in a sexual manner without consent (#14); failed to assure two residents (#6, #18) were free from physical abuse by two staff (Staff A and Staff D); failed to assure two residents (#6, #8) were free of neglect by ensuring the resident's (#6) personal care needs were met and was forced to sit at the nurse's desk by a staff (Staff B), and personal care was provided to a resident (#8), who was left lying on top of a heating pad and received burns and blisters to her back; and failed to ensure a resident (#12) was picked up from a local store after a reasonable amount of time. [Refer to Tag D338, 10A NCAC 13F. 0909 Resident Rights

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D 176	Continued From page 62 (Unabated Type A1 Violation)]. 3.Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 4 residents (#13, #16, #22) observed during the medication pass including errors with insulin and medications for heart / blood pressure, diabetes, prevention of blood clots, and a diuretic (#16); a medication for hypothyroidism (#22); and prevention of heart disease (#13, #22), and for 5 of 6 residents (#1, #2, #3, #4, #5) sampled including errors with insulin (#1, #3); narcotic pain medications (#3, #5); medications for infection (#1, #2, #4); and a medication for anxiety (#2). [Refer to Tag D358, 10A NCAC 13F. 1004(a) Medication Administration (Type A2 Violation)]. 4. Based on observations, interviews and a record reviews, the facility failed to provide adequate supervision to 1 of 5 sampled residents (#6), who was known to wander into residents' rooms, took food from a resident (#12), attempted to climb into bed with another resident (#15) and allegedly sexually assaulted another female resident (#14) without her consent. [Refer to Tag D270, 10A NCAC 13F. 0901(b) Personal Care and Supervision (Type A1 Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to report allegations of abuse, neglect and drug diversion to the North Carolina Health Care Personnel Registry (HCPR) and conduct investigations for 4 of 4 staff (A, B, C, D), and failed to investigate and report injuries of unknown origin for 2 of 2 residents (#1, #2) to the HCPR. [Refer to Tag D438, 10A NCAC 13F. 1205 Health Care Personnel Registry (Unabated Type A2 Violation)].	D 176		

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D 176	Continued From page 63 6. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 9 of 9 diabetic residents sampled (#1, #3, #7, #16, #17, #18, #19, #20, #21) with orders for blood sugar monitoring resulting in the shared use of glucometers. [Refer to Tag D932, G.S. 131D-4.4A(b)(1) Adult Care Home Infection Prevention Requirements (Unabated Type B Violation)]. 7. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records and failed to account for the use and administration of controlled substances for 2 of 2 sampled residents (#3, #17) including a resident (#3) who had some Oxycodone tablets tampered and replaced with an anti-nausea medication and a resident (#17) who had some Hydrocodone/Acetaminophen tablets tampered and replaced with a potassium supplement and a stool softener. [Refer to Tag D392, 10A NCAC 13F. 1008(a) Controlled Substances (Type B Violation)]. 8. Based on interviews and record reviews, the facility failed to assure 3 of 5 staff sampled (B, C, E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry upon hire according to G.S. 131E-256. [Refer to Tag D137, 10A NCAC 13F. 0407(a)(5) Other Staff Qualifications (Unabated Type B Violation)]. 9. Based on observations, interviews, and record reviews, the facility failed to implement orders from the primary care provider (PCP) for 4 of 4 residents sampled (#1, #2, 3, #4) who had orders	D 176		

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D 176	Continued From page 64 for weights and 2 of 2 residents sampled (#2, #3) with orders for blood pressure checks. [Refer to Tag D276, 10A NCAC 13F. 0902(c)(3)(4) Health Care (Type B Violation)]. 10. Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served to 3 of 3 residents sampled (#1, #2, #4) who had orders for thickened liquids (#2) and nutritional supplements (#1, #4). [Refer to Tag D310, 10A NCAC 13F. 0904(e)(4) Nutrition and Food Service (Type B Violation)]. 11. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 5 medication aides (C, E) sampled received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. [Refer to Tag D164, 10A NCAC 13F. 0505 Training On Care of Diabetic Residents (Unabated Type B Violation)]. 12. Based on observations, interviews, and record reviews, the facility failed to assure 3 of 4 staff sampled (B, C, E) who administered medications had completed the 5 hour and 10 hour or 15 hour state approved medication administration training courses as required; 1 of 4 sampled medication aides (C) had passed the written medication aide exam; and 2 of 4 medication aides sampled (B, C) had a clinical skills checklist completed prior to administering medications. [Refer to Tag D935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides, Training and Competency Requirements (Type B Violation)]. 13. Based on observations, interviews and record reviews, the facility failed to maintain an approved	D 176		

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sanitation classification at all times in the facility with a North Carolina Division of Environmental Health Sanitation score of 85 or above at all times. [Refer to Tag D077, 10A NCAC 13F. 0306(a)(4) Housekeeping and Furnishings (Unabated Type B Violation)].

14. Based on observations and interviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 7 of 13 water fixtures sampled in the residents' bathrooms and the common hall bathrooms on the 100 and 200 Halls of the facility, including 3 fixtures with steam observed. [Refer to Tag D113, 10A NCAC 13F. 0311(d) Other Requirements (Unabated Type B Violation)].

15. Based on interviews and record reviews, the facility failed to assure 5 of 5 staff sampled (A, B, C, D, E) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40. [Refer to Tag D139, 10A NCAC 13F. 0407(a)(7) Other Staff Qualifications (Unabated Type B Violation)].

16. Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was completed upon hire for 4 of 5 staff (B, C, D, E) sampled who were hired after 10/01/13. [Refer to Tag D992, G.S. 131D-45(a) Examination and Screening for the presences of controlled substances (Type B Violation)].

17. Based on observations, record reviews, and interviews, the facility failed to provide personal care in accordance with the assessed needs for 3 of 5 residents sampled (#3, #6, #15). [Refer to Tag D269, 10A NCAC 13F. 0901(a) Personal

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D 176	Continued From page 66 Care and Supervision (Type B Violation)]. 18. Based on observations, interviews and record reviews, the facility failed to assure 2 of 5 staff sampled (B, E) who provided personal care to residents, had successfully completed an 80-hour personal care training and competency evaluation program. [Refer to Tag D151, 10A NCAC 13F. 0501(c) Personal Care Training and Competency]. 19. Based on observations, interviews, and record reviews, the facility failed to assure staff documented the administration of medications immediately following the administration and observation of the resident actually taking the medications for 2 of 4 residents (#13, #22) observed during the morning medication passes on 10/12/17 and 10/17/17. [Refer to Tag D366, 10A NCAC 13F. 1004(i) Medication Administration]. 20. Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records (MARs) were accurate for 5 of 5 sampled residents (#1, #2, #3, #4, #17) including two residents with documentation on MARs that did not match controlled substance logs (#3, #17), two residents with inaccurate documentation for antibiotics (#1, #4), and one resident with inaccurate documentation for an antipsychotic and an antianxiety medication (#2). [Refer to Tag D367, 10A NCAC 13F. 1004(j) Medication Administration]. 21. Based on observations and interviews, the facility failed to assure infection control measures to prevent the development and transmission of disease or infection and prevent	D 176		

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D 176	Continued From page 67 cross-contamination were implemented by Staff A during the morning medication pass on 10/12/17. [Refer to Tag D371, 10A NCAC 13F. 1004(n) Medication Administration]. 22. Based on observations and interviews, the facility failed to assure two medication carts and the medication room were locked when the medication cart was not under the immediate or direct physical supervision of the medication aide. [Refer to Tag D378, 10A NCAC 13F. 1006(b) Medication Storage]. 23. Based on observations and interviews, the facility failed to destroy and/or return medications to the pharmacy within 90 days of their expiration or discontinuance by the physician. [Refer to Tag D388, 10A NCAC 13F .1007(c) Medication Storage]. 24. Based on observations, interviews, and record reviews, the facility failed to report suspected drug diversions of controlled substances to the pharmacy, local law enforcement, and the Health Care Personnel Registry for 2 of 2 sampled residents (#3, #17) who were prescribed Oxycodone (#3) and Hydrocodone/Acetaminophen (#17). [Refer to Tag D399, 10A NCAC 13F. 1008(h) Controlled Substances]. 25. Based on observations, record reviews and interviews, the facility failed to assure 1 of 4 medication aides sampled (A) completed six hours of continuing education annually related to medication administration and Staff A was observed during medication administration passes and 8 medication errors were identified. [Refer to Tag D127, 10A NCAC 13F. 0403(c) Qualifications of Medication Staff].	D 176		

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(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 176	Continued From page 68 26. Based on observations, record reviews, and interviews, the facility failed to ensure an order for a restraint was current and complete as required for 1 of 1 sampled residents with a gait belt used as a restraint in a wheelchair (Resident #13). [Refer to Tag D485, 10A NCAC 13F. 1501(d) Use of Physical Restraints and Alternatives]. 27. Based on observations, interviews, and record reviews, the facility failed to provide physical restraint training for 5 of 5 staff sampled (A, B, C, D, E) who provided care to one resident restrained in a wheelchair with a gait belt. [Refer to Tag D165, 10A NCAC 13F. 0506(a) Training on Physical Restraints]. 28. Based on record reviews and interviews, the facility failed to provide the provision of transportation for residents to medical appointments, the hospital, and shopping. [Refer to Tag D321, 10A NCAC 13F. 0906(a) Other Resident Care and Services]. 29. Based on observations and interviews, the facility failed to assure residents had access to a telephone to privately make and receive calls as evidenced by residents using the telephone at the nurses' desk without privacy. [Refer to Tag D324, 10A NCAC 13F. 0906(d) Other Resident Care and Services]. 30. Based on observations, interviews, and record reviews, the facility failed to assure the kitchen, dining and food storage areas were kept clean, orderly and free from contamination related to roaches in the kitchen and dining room. [Refer to Tag D282, 10A NCAC 13F. 0904(a)(1) Nutrition and Food Service].	D 176		

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D 176	Continued From page 69 31. Based on observations, interviews, and record reviews, the facility failed to serve 8 ounces of milk at least twice daily to the residents. [Refer to Tag D299, 10A NCAC 13F. 0904(d)(3)(A) Nutrition and Food Service]. 32. Based on observations and interviews, the facility failed to assure the walls and floors were kept clean and in good repair for 3 common bathroom/shower rooms, 3 private resident bathrooms (201, 207, 210), 2 resident rooms (106, 108), the dayroom on 100 Hall, and the hallways on the 100 and 200 Halls. [Refer to Tag D074, 10A NCAC 13F. 0306(a)(1) Housekeeping and Furnishings]. 33. Based on observations, interviews, and record review, the facility failed to have furniture in good repair, including chest of drawers, night stands/bedside tables, dressers, chairs, television cabinet, headboard, and sofas, in 8 residents' bedrooms, the dayroom on the 100 Hall, and the dayroom on the 200 Hall. [Refer to Tag D076, 10A NCAC 13F. 0306(a)(3) Housekeeping and Furnishings]. 34. Based on observations, record reviews, and interviews, the facility failed to assure the facility was clean, uncluttered and free of hazards in 3 resident rooms and a common shower room on the 100 Hall including issues with roaches in the facility. [Refer to Tag D079, 10A NCAC 13F. 0306(a)(5) Housekeeping and Furnishings]. 35. Based on observations and interviews, the facility failed to ensure an adequate supply of towels, washcloths, and incontinence pads were available at all times to provide personal care for a current census of 20 residents. [Refer to Tag D080, 10A NCAC 13F. 0306(a)(6) Housekeeping	D 176		

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D 176	Continued From page 70 and Furnishings]. 36. Based on observations, interviews, and record reviews, the facility failed to assure the electrical equipment was maintained in a safe and operating condition as evidenced by the light fixtures not working properly in two community shower rooms and the kitchen, a phone jack cover with a gap around it in a resident room and an electrical outlet cover with a hole in a second resident room. [Refer to Tag D105, 10A NCAC 13F. 0311(a) Other Requirements]. 37. Based on interviews and record reviews, the facility failed to assure 1 of 5 staff sampled (C) was tested for Tuberculosis (TB) disease upon hire according to control measures for the Commission for Health Services. [Refer to Tag D131, 10A NCAC 13F. 0406(a) Test for Tuberculosis]. 38. Based on record reviews and interviews, the facility failed to assure 4 of 22 residents sampled (#6, #9, #14, #19) had an annual FL-2 that was signed by their primary care provider (PCP). [Refer to Tag D235, 10A NCAC 13F. 0703(b)(c) Tuberculosis Test, Medical Examination and Immunizations]. 39. Based on observations, record review and interviews, the facility failed to assure a minimum of 14 hours of planned group activities were provided each week for the 20 residents currently residing in the facility. [Refer to Tag D317, 10A NCAC 13F. 0905(d) Activities Program]. 40. Based on observations, record reviews, and interviews, the facility failed to assure resident records were maintained in an orderly manner to include failure to file medication orders, contact	D 176		

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D 176	Continued From page 71 with residents' primary care provider (PCP), and hospital discharge orders for 3 of 3 residents sampled (#1, #2, #17). [Refer to Tag D433, 10A NCAC 13F. 1201(a) Resident Records]. 41. Based on interviews, the facility failed to develop and maintain policies and procedures related emergency procedures to include changes in resident condition. [Refer to Tag D448, 10A NCAC 13F. 1211(a) Written Policies and Procedures]. 42. Based on interviews and record reviews, the facility failed to provide training to 5 of 5 sampled staff (A, B, C, D, E) on the facility's policies and procedures including administration, ordering, disposition and storage of medications, use of physical restraints, accident and emergency procedures, supervision of wandering residents, and management of physical aggression or assault by a resident. [Refer to Tag D449, 10A NCAC 13F. 1211(b) Written Policies and Procedures]. The Administrator/Administrator-in-Charge failed to assure the management, operations, and policies of the facility were implemented to ensure the services necessary to maintain the residents' physical and mental health were provided as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes, which is the responsibility of the Administrator/Administrator-in-Charge. The failure of the Administrator to ensure residents were free of abuse and neglect by 3 staff resulted in Resident #18 being grabbed by Staff D, who dug her fingernails into the resident's arm causing a skin tear, Resident #6 being sprayed with a bleach solution by Staff A, and Resident #6, #15, and #3 being neglected by Staff B, who forced	D 176		

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D 176	Continued From page 72 Resident #6 to sit in a chair at the nurse's desk in an attempt to keep the resident from wetting his clothes, and delaying personal and incontinence care to Residents #15 and #3; to report the staff, who abused 2 residents and neglected 3 residents to the Health Care Personnel Registry and allow the staff to continue working in the facility placed the residents at risk for further abuse and neglect; to provide health care referral and follow-up for Resident #10, who refused to be transferred to the emergency room after experiencing dizziness and diaphoresis, and later died; to provide supervision of Resident #8, who had a heating pad left on her back which resulted in blisters and burns to the resident's back; to supervise Resident #6, who had a known history of wandering in other residents' rooms, resulting in the resident climbing in the beds of 2 female residents and sexually assaulting Residents #14 and #15; to administer medications as ordered, including insulins, heart and blood pressure medications, oral antidiabetic medications and antibiotics; to follow infection control guidelines by sharing glucometers between residents for blood sugar checks; and to assure criminal background checks were completed for 5 of 5 sampled staff upon hire. Interviews with the staff and Administrator revealed the Administrator-in-Charge had been on leave for 2 months and the Administrator was on-site at varying intervals and worked another full-time job, which resulted in serious neglect of the residents and physical harm to Residents #6, #8, #14, #15, #1 and #18 and death to Resident #10, which constitutes an Unabated Type A1 Violation. The facility's Plan of Protection dated 10/12/17 revealed: -Administrator will be available by phone and will be onsite for unforeseen occurrences.	D 176		

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D 176	Continued From page 73 -Administrator will be onsite each evening to check with staff and residents on the events of the day. -Supervisor will be in charge on all shifts to report problems/concerns and consult with Administrator to resolve any issues. -Supervisor will report to Director/Manager or Administrator, one of which will be available immediately, either onsite or by phone, to handle issues which may arise. -Administrator will be reviewing charts and overseeing medication administration, reviewing transportation schedule for appointments and reviewing documentation of notification to physician regarding resident condition.	D 176		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 4 of 22 residents sampled (#6, #9, #14, #19) had an annual FL-2 that was signed by their primary care provider (PCP).	D 235		

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D 235	Continued From page 74 The findings are: 1. Review of Resident #14's Resident Register revealed the resident was admitted to the facility on 11/26/13. Review of Resident #14's most current FL-2 dated 06/02/16 revealed diagnoses included coronary artery disease (CAD), hypertension, osteoarthritis, and Alzheimer's disease. Review of Resident #14 record revealed there was no FL-2 dated after 06/02/16. Review of a Medication Review for Resident #14 dated 08/31/17 revealed the Pharmacist documented Resident #14's FL-2 was due. Refer to interview with the medication aide/supervisor on 10/16/17 at 10:10 a.m. Refer to interviews with the Administrator on 10/16/17 at 8:40 a.m. and 10/17/17 at 11:45 a.m. 2. Review of Resident #9's Resident Register revealed the resident was admitted to the facility on 3/20/14. Review of Resident #9's current FL-2 dated 6/13/16 revealed diagnoses included dementia, osteoporosis, anxiety and gastroesophageal reflux disease. Review of Resident #9's record revealed there was not an FL-2 dated after 06/13/16. Refer to interview with the medication aide/supervisor on 10/16/17 at 10:10 a.m. Refer to interviews with the Administrator on	D 235		

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D 235	Continued From page 75 10/16/17 at 8:40 a.m. and 10/17/17 at 11:45 a.m. 3. Review of Resident #6's FL-2 dated 9/5/16 revealed: -Diagnoses included Congestive Heart Failure, Hypertension and Hyperlipidemia. -Resident #6 was ambulatory -Resident #6 was occasionally incontinent of bladder and bowel. Review of Resident #6's record revealed there was no FL-2 dated after 9/5/16. Refer to interview with the medication aide/supervisor on 10/16/17 at 10:10 a.m. Refer to interviews with the Administrator on 10/16/17 at 8:40 a.m. and 10/17/17 at 11:45 a.m. 4. Review of Resident #19's FL-2 dated 09/14/16 revealed: -Diagnoses included diabetes, hypertension, anxiety, obesity, hypothyroidism, mood disorders, insomnia, and osteoarthritis. -The resident was incontinent of bladder, ambulatory and required assistance with bathing. -The date of admission was listed as 08/14/15. Review of Resident #19's Resident Register revealed the date of admission was blank. Review of Resident #19's medical record revealed there was no FL-2 dated after 09/14/16. Refer to interview with the medication aide/supervisor on 10/16/17 at 10:10 a.m. Refer to interviews with the Administrator on 10/16/17 at 8:40 a.m. and 10/17/17 at 11:45 a.m.	D 235		

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D 235	Continued From page 76 Interview with the medication aide/supervisor on 10/16/17 at 10:10 a.m. revealed: -She was not aware some of the residents' FL-2 forms were not current. -She did not know why the FL-2 forms had not been done annually. -The facility's Manager usually did the FL-2 forms but she was out on medical leave. Interviews with the Administrator on 10/16/17 at 8:40 a.m. and 10/17/17 at 11:45 a.m. revealed: -She was not aware some of the residents' FL-2 forms were not current. -The FL-2 forms should be done annually. -The facility's Manager was responsible for getting the FL-2 forms completed. -The Manager had been on medical leave for about 2 months and was unavailable for interview. -No one took over responsibility of the residents' records after the Manager went on medical leave. -There was no system to check behind the Manager or to monitor the residents' records.	D 235		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION	D 269		

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D 269	Continued From page 77 Based on observations, record reviews, and interviews, the facility failed to provide personal care in accordance with the assessed needs for 3 of 5 residents sampled (#3, #6, #15). The findings are: Confidential staff interviews revealed: -Toileting/incontinent checks were completed by staff every two hours. -One month ago, when the Manager was still there, the facility was not stocked with the incontinent supplies needed for toileting residents. -A staff recalled there was only extra-large adult protective garments in stock and no wipes. -Staff did the best they could with what they had. -Most residents did not have wipes. -Wipes were not supplied for staff to use on residents; a staff bought their own wipes. -Staff had to wipe residents with toilet paper or paper towels if they did not have any washcloths. -There were times when the supply of adult protective garments was "really, really low"; "not long ago" was the last time the items were low. -There were "frequently" times when residents had to wear the wrong size adult protective garments and/or had to wear briefs when they wear supposed to wear pull ups (and vice versa). -There were times when residents had to wear other residents' adult protective garments. -The process used for keeping the items stocked was to notify the medication aide/supervisor (MA/S) when the items were running low, the MA/S contacted the Manager or Administrator to bring the items. -The facility did not supply disposable incontinent pads for resident use; there were a few non-disposable incontinent pads, but not enough.	D 269		

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D 269	Continued From page 78 -Prior to 10/15/17, there were only extra, extra-large (XXL) adult protective garments in stock; there were no smaller sized adult protective garments in stock. -Staff could not get in touch with the Administrator or Manager; the (named) MA/S did not know what to do about the supply of incontinent adult protective garments. -A resident's family member had some extra adult protective garments and went to get them and brought them back for the facility to use. -The Manager finally told staff to meet her family member outside of the facility to bring the adult protective garments. -A few days later, the facility ran out of adult protective garments again. -Staff had been cutting the XXL size adult protective garments and adult protective garments and tying them on the smaller female residents because they did not have small or medium size in stock; the Administrator and Manager were aware. -Since the Administrator started being at the facility, the supplies had been in stock. -A (named) staff donated 30 packages of adult protective garments to the facility on 10/15/17. Review of an entry dated 10/15/17 in the staff communication notebook revealed a (named) staff brought in 19 packs of disposable under pads (15 pads in each pack) and 30 packs of size medium adult protective garments (16 in each package) for facility use. Interview with a MA/S, a personal care aide (PCA) and a PCA/housekeeper on 10/13/17 at 7:55am revealed: -Eighteen of the twenty residents who resided in the facility wore adult protective garments (fifteen wore pull ups, three wore briefs).	D 269		

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D 269	Continued From page 79 -The facility was responsible for supplying adult protective garments to eleven residents, hospice supplied adult protective garments for one resident, and family members supplied adult protective garments for the remaining six residents. -The Manager and/or Administrator were responsible for making sure the items were in stock for the residents. -Staff notified the Manager and/or Administrator when the items were running low. Interview with a resident on 10/17/17 at 8:55am revealed: -The resident wore size extra-large adult protective garments. -The facility ran low on adult protective garments. -The resident liked to know there were enough pulls ups in case she had an accident. -She did not have any adult protective garments in her room at that time. Telephone interview with a Home Health Nurse on 10/17/17 at 9:30am revealed: -Wipes were not available for resident use like they should be. -One month ago, she had to go to her car to get wipes to use for a resident. Observation of the two closets identified by the Administrator where incontinent supplies were stored on 10/17/17 at 8:40am revealed: -In the first closet, there was one full, unopened bag of 40 count size medium pull ups, two opened bags of the same size medium pull ups with a total of 10 left in the two bags, and one opened bag of small/medium size briefs with a total of 36 left in the bag. -In the second closet, there were twenty unopened bags of size medium briefs (16 in each	D 269		

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bag), four additional open packages of the same size medium briefs that were almost full, and one package of XXL pull ups (a 12 count package) with only 4 remaining in the package.

Review of itemized receipts provided by the Administrator from a local department store revealed:
-There was receipt dated 10/02/17 at 10:41am for the purchase of one package of small briefs (40 count) and one package of large briefs (32 count).
-There was a second receipt dated 10/10/17 at 7:19pm which included the purchase of two packages of 36 count, pull ups, one package of 32 count briefs, and one package of 40 count small briefs.
-There was a third receipt dated 10/17/17 at 1:57pm for the purchase of one package of 32 count pull ups, one package of 36 count pull ups, and two packages of 40 count briefs.

Interview with the Administrator on 10/13/17 at 4:45pm revealed she did not have any additional receipts to provide related to the purchase of incontinent supplies such as wipes and adult protective garments.

1. Review of Resident #3's current FL-2 dated 03/07/17 revealed:
-Diagnoses included peripheral vascular disease, diabetes mellitus, and muscle weakness.
-The resident was non-ambulatory.
-The resident was incontinent of bowel and bladder.

Review of Resident #3's care plan dated 03/31/17 revealed:
-Resident #3 was non-ambulatory, required a wheelchair assistive device, and was a double

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amputee.
-The resident had limited strength in her upper extremities.
-The resident had daily incontinence of bowel and bladder.
-Resident #3 was totally dependent on staff for toileting; there was documentation the aides changed the resident's adult protective garments "q2h (every two hours) and prn (as needed)."
-The resident was totally dependent on staff for bathing and transferring; "bathed by aide and transferred to bed/chair and chair/bed by aide" was documented under the description of assistance needed.
-The resident required extensive assistance from staff with dressing; "dressed by aide" was documented under the description of assistance needed.

Interview with Resident #3 on 10/11/17 at10:22am revealed:
-She rang the call bell when she needed help from staff.
-She had called for help "about a week ago" on second shift because she was soiled; she needed help getting her adult protective garments changed, but nobody came to assist her.

Confidential interview with a resident revealed:
-Resident #3 had told the resident that she had to sit in soiled adult protective garments and her "butt got raw."
-Resident #3 would tell one staff that she was soiled, but the staff ignored the resident.

Confidential interview with a staff revealed Resident #3 had a red bottom, but it looked better last week.

Interview with a personal care aide (PCA) on

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D 269	Continued From page 82 10/12/17 at 6:45pm revealed: -Resident #3 had the beginning of skin breakdown on her buttocks. -The PCA first noticed it 3-4 days ago. -The resident complained she was hurting. Interview with a second PCA on 10/12/17 at 7:50pm revealed: -Resident #3 required assistance with toileting, was incontinent, was able to use her call bell, and could tell staff when she was wet. -Resident #3 had some "redness" on her bottom the previous weekend. -The PCA could not recall Resident #3 complaining of her call bell not being answered. -She was not aware of any instances when there had been delays in Resident #'s call bell being answered. Interview with a medication aide/supervisor on 10/13/17 at 9:00am revealed: -Resident #3 was incontinent and required assistance with all activities of daily living. -Resident #3 was on two hour toileting/incontinent checks. -A PCA told her "yesterday" (10/12/17) Resident #3 had a red bottom. -Staff put cream on the resident's bottom and there were no open sores on it. Observation of Resident #3 on 10/13/17 at 10:25am revealed: -Staff removed the resident's adult protective garments and wiped the resident's perineal area and buttocks with facial tissue. -There was a quarter-size red area on the resident's right buttocks; the skin was intact. -The skin on the left buttocks was pink in color and intact. -There was a 2 inch linear area where the skin	D 269		

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D 269	Continued From page 83 was red at the pressure point near the coccyx; the skin was intact. Interview with a PCA assisting Resident #3 on 10/13/17 at 10:25am revealed: -The staff did not have wipes to use unless the resident's family supplied them. -They had to use washcloths if residents had a bowel movements in order to clean the residents. -The facility ran out of wash cloths "sometimes." Interview with Resident #3 on 10/17/17 at 10:25am revealed: -She currently had a sore on her right hip and she thought the physician was aware of it. -She did not have any skin breakdown on her bottom to her knowledge. Refer to interview with a PCA on 10/12/17 at 8:06am. Refer to interview with a second PCA on 10/13/17 at 5:30pm. Refer to interview with a family member on 10/12/17 at 12:12pm. Refer to interview with a second family member on 10/12/17 at 3:45pm. Refer to the Interviews with the Administrator on 10/13/17 at 10:30am and 6:55pm. 2. Review of Resident #6's FL-2 dated 9/5/16 revealed: -Diagnoses included congestive heart failure (CHF), hypertension and hyperlipidemia. -Resident #6 was ambulatory -Resident #6 was occasionally incontinent in bladder and bowel.	D 269		

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D 269	Continued From page 84 Review of Resident #6's current Care Plan dated 6/8/15 revealed: -Resident #6 was assisted to the bathroom by staff; staff were to provide incontinent care every two hours as needed. -Resident #6 was assisted with dressing and needed prompting by staff for grooming and hygiene. Interview with a personal care aide (PCA) on 10/12/17 at 8:06am revealed Resident #6 would be soiled in less than one hour after being toileted. Confidential staff interview revealed: -Resident #6 was supposed to wear XL adult protective garments, but sometimes staff had to put a large one on him, because there were no XL adult protective garments in the facility. -The staff thought the resident would get red because the adult protective garments were too small for him. Confidential interview with a second staff revealed: -Staff made Resident #6 sit up on 2nd shift, most recent as last week. -The PCA had him sitting in the dining room, and she told him to sit up because he soiled the bed. Interview with a family member on 10/12/17 at 12:22pm revealed: -Staff made Resident #6 sit in a leather chair, because he would urinate in his bed. -He would be saturated with urine. -Staff do not toilet him like they should. Interview with a PCA/medication aide (MA) on 10/12/17 at 7:50pm revealed:	D 269		

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D 269	Continued From page 85 -"All he (Resident #6) does is sit and get in bed and eat." -All the resident wanted to do was sleep and eat. -Staff assisted Resident #6 with toileting. -She had to tell him to go to the restroom every couple hours or he would sit there and not go. -Staff had to get him up and change him when he wet himself. -She had never told him he could not go to bed because of incontinence. Interview with the Administrator on 10/12/17 at 10:30am revealed: -Resident #6 was made to sit in a chair at the desk because he was a "heavy wetter." -She did not interview the resident, but spoke briefly with all of the 3pm-11pm staff. Observation of the two closets identified by the Administrator where incontinent supplies were stored on 10/17/17 at 8:40am revealed there was one package of size XXL adult protective garments (a 12 count package) with only 4 remaining in the package. Interview with a PCA on 10/17/17 at 8:50am revealed Resident #6 and two other (named) residents wore size XXL adult protective garments. Refer to interview with a PCA on 10/12/17 at 8:06am. Refer to interview with a second PCA on 10/13/17 at 5:30pm. Refer to interview with a family member on 10/12/17 at 12:12pm. Refer to interview with a second family member	D 269		

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D 269	Continued From page 86 on 10/12/17 at 3:45pm. Refer to the Interviews with the Administrator on 10/13/17 at 10:30am and 6:55pm. 3. Review of Resident #15's current FL-2 dated 09/22/17 revealed: -Diagnoses included dementia and hypothyroidism. -The resident was semi-ambulatory and incontinent of bladder. -The resident was constantly disoriented and was "total care." Review of Resident #15's current assessment and care plan dated 08/26/16 revealed: -The resident was totally dependent on staff for toileting and had limited strength in her upper extremities. -The resident was incontinent of bladder daily and occasionally incontinent of bowel. -Staff were supposed to provide incontinent care for Resident #15 every 2 hours and as needed. Confidential interview with a resident revealed: -Resident #15 had to sit in a soiled adult protective garments; the last time it happened was last weekend. -A (named) staff came into Resident #15's rooms, and she told the staff she was soiled. -The (named) staff ignored her, signed the sheet hanging on the back of the door, and left. Observation of Resident #15 on 10/17/17 at 9:40 a.m. revealed: -Resident was assisted to the toilet by a medication aide (MA). -The resident was wearing an XXL adult protective garment provided by the facility. -The resident's pull-up was dry.	D 269		

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D 269	Continued From page 87 -The resident's buttocks were not reddened and did not have any signs of skin breakdown. Based on observations, record reviews, and interviews, Resident #15 was not interviewable. Observation of the two closets identified by the Administrator where incontinent supplies were stored on 10/17/17 at 8:40am revealed there was one package of size XXL adult protective garments (a 12 count package) with only remaining in the package. Interview with a personal care aide on 10/17/17 at 8:50am revealed Resident #15 and two other (named) residents wore a size XXL adult protective garments. Observation of Resident #15's room on 10/17/17 at 8:52am revealed there were no adult protective garments in her room. Confidential staff interview revealed: -Staff used another (named) resident's adult protective garments (supplied by his family) on Resident #15. -Resident #15 was supposed to wear pulls ups and could toilet herself, but she could not manage the briefs staff were putting on her. Refer to interview with a PCA on 10/12/17 at 8:06am. Refer to interview with a second PCA on 10/13/17 at 5:30pm. Refer to interview with a family member on 10/12/17 at 12:12pm. Refer to interview with a second family member	D 269		

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D 269	Continued From page 88 on 10/12/17 at 3:45pm. Refer to the Interviews with the Administrator on 10/13/17 at 10:30am and 6:55pm. Interview with a PCA on 10/12/17 at 8:06am revealed: -Residents were to be checked on and toileted every two hours. -The PCAs document incontinent care on the Personal Care log. -The PCA assigned to the hall was responsible for documenting on the log. Interview with a second PCA on 10/13/17 at 5:30pm revealed: -Residents were supposed to be checked every 2 hours, including toileting checks. -Staff should toilet the residents right then if they were soiled. Interview with a family member on 10/12/17 at 12:12pm revealed: -There were times when the family member came in and could smell feces from the hallway. -Staff would be sitting in the dining room, and the family member would tell them. -It had happened several times, but most recently as last week. Interview with a second family member on 10/12/17 at 3:45pm revealed: -The PCAs were not doing their job; they don't toilet the residents like they should. -Residents were made to sit in soiled adult protective garments and clothes. Interview with the Administrator on 10/13/17 at 10:30am revealed: -Medicaid was supposed to supply adult	D 269		

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protective garments for the residents, but the Manager said there had been a "mix up with a number" so the facility had not been getting the adult protective garments from Medicaid.
-The facility had been buying the items in order to provide them for resident use.
-She was not sure how long the mix up had been going on or if the Manager had done anything to correct the error in order to get Medicaid to provide the items for the residents.
-She purchased wipes for residents' use.
-She was told that morning (10/13/17) they were currently out of wipes
-Staff were to use washcloths if they ran out of wipes.
-Staff were supposed to notify her when the items were running short or out.
-She was not aware of staff using wipes or adult protective garments provided by family members of other residents; she did not know staff were using supplies on residents who were supposed to have the items supplied by Medicaid and/or the facility.
-She was not aware of the facility ever running out of adult protective garments.
-She was not aware of any resident having to wear the wrong size adult protective garments due to lack of the items being kept stocked for resident use.
-She was not aware of any resident having to wear briefs when they wear supposed to wear pull ups and vice versa due to lack of the correct items being in stock.
-She would make sure wipes, adult protective garments, and adult protective garments were kept in stock for residents' personal care needs.

A second interview with the Administrator on 10/13/17 at 6:55pm revealed she expected all staff to assist all residents with personal care as

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D 269	Continued From page 90 needed. _____ The facility failed to assure Resident #3, Resident #6, and Resident #15 received assistance with personal care in accordance with their assessed needs resulting in Resident #3 having redness to her perineal area after not being provided with incontinence care. The facility failed to assure disposable adult protective garments and wipes were maintained in stock to accommodate the assessed needs of multiple incontinent residents to include Residents #3, #6, and #15. The facility failed to maintain each residents' dignity as evidenced by multiple residents not having the correct size of adult protective garments; staff not having wipes to clean residents when providing incontinent care; and staff using items purchased by family members for specific residents on other residents. The facility's failure was detrimental to the health and welfare of the residents. This non-compliance constitutes a Type B Violation. _____ Review of the facility's Plan of Protection dated 10/13/17 revealed: -Incontinence supplies would be available at all times including wipes and adult protective garments. -Call bells would be answered in a timely manner. -Personal care would be documented on the personal care logs. -All staff who provided personal care would be re-inserviced by 10/ 16/17 on providing and documenting personal care; the in-service would be documented. -Residents would be monitored by observation and interview. -The supply closet for incontinence supplies would be monitored weekly. -The Administrator would be responsible for ordering the supplies.	D 269		

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D 269	Continued From page 91 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 1, 2017.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and a record reviews, the facility failed to provide adequate supervision to 1 of 5 sampled residents (#6), who was known to wander into residents' rooms, took food from a resident (#12), attempted to climb into bed with another resident (#15) and allegedly sexually assaulted another female resident (#14) without her consent. The findings are: Review of Resident #6's current FL-2 dated 9/5/16 revealed: -Diagnoses included Congestive Heart Failure, Hypertension and Hyperlipidemia. -Resident #6 was ambulatory -Resident #6 was occasionally incontinent of bladder and bowel. Review of Resident #6's most recent Care Plan	D 270		

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D 270	Continued From page 92 dated 6/8/15 revealed: -Resident #6 was assisted to the bathroom by staff; staff were to provide incontinent care every two hours as needed. -Resident #6 was assisted with dressing and needed prompting by staff for grooming and hygiene. Review of Resident #6's primary care provider (PCP) progress notes revealed that he had last been seen by his PCP on 8/16/17. 1. Review of Resident #14's current FL-2 dated 06/02/16 revealed: -Diagnoses included coronary artery disease (CAD), hypertension, osteoarthritis, and Alzheimer's disease. -Her orientation level was not documented. -The resident was non-ambulatory and had a Geri-chair. Observation of Resident #14 on 10/11/17 at 11:45am revealed: -She was in the dining room in her Geri-chair. -She was oriented to self and situation. Interview with Resident #14 on 10/11/17 at 11:45am revealed she received assistance from staff with bathing, dressing, and getting in her chair. Interview with the Administrator on 10/13/17 at 6:55pm revealed she had not been there enough to tell what Resident #14's orientation level was. Confidential interview with a third staff revealed: -Resident #6 went in other residents' rooms. -A resident (#14) said Resident #6 "tried to mess with her" sexually "in the past." -"I don't believe it."	D 270		

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D 270	Continued From page 93 -The staff was not sure if she reported it because "it was in the past." Confidential staff interview revealed: -"Two to three months ago, " Resident #14's family member said Resident #6 tried to get in bed with Resident #14. -"Nothing was done to stop him." -The staff had never observed Resident #6 in any other residents' bed. Interview with Resident #14 on 10/13/17 at 4:30 p.m. revealed: -Resident #6 tried to get in bed with her. -Resident #6 tried to rape her, but he did not because she fought him off. -She did not tell anyone about the incident because she did not want to get in trouble. -The incident happened about 3 months ago. -She had not seen Resident #6 today (10/13/17), but saw him yesterday. -She felt that she would be discharged from the facility if she told anyone. Second interview with Resident #14 on 10/13/17 at 5:52 p.m. revealed: -Resident #6 came and visited her room. -She was not a friend of the resident and did not want him in her room. -He attempted to "feel on her important parts" (private area). -It happened every night. -She told the "nurses" and they did not believe her; they said there was nothing to it. -Resident #6 normally sat at the end of the table in the dining room. (She pointed to the table in front of her indicating where the resident sat.) -She had not reported Resident #6 coming into her room to her family because she did not "talk that way to her family."	D 270		

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D 270	Continued From page 94 -When growing up Resident #14 was restricted from talking that way and did not talk that way now. -It was a matter of respect. -She was telling it now because she wanted to be protected. Interview with a personal care aide (PCA) on 10/13/17 at 6:50pm revealed Resident #14 was "with it" (oriented). Interview with a second PCA on 10/16/17 at 2:50pm revealed Resident #14 was oriented. Observation on in the dining room on 10/13/17at 6:02pm revealed: -Resident #14 was in the dining room. -Resident #6 walked into the dining room and Resident #14 said "He's the one." Refer to confidential staff interview. Refer to confidential Interview with a family member of a resident. Refer to Interview with a family member of a third resident on 10/13/17 at 10:10 a.m. Refer to Interview with Resident #6's family member on 10/13/17 at 12:522 p.m. Refer to Interview with Resident #6's guardian on 10/17/17 at 8:38 a.m. Refer to Interview with Resident #6 on 10/13/17 at 5:33 p.m. Refer to Interview with the PCP for Resident #6 on 10/16/17 at 4:08 p.m.	D 270		

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D 270	Continued From page 95 Refer to Interview with the Administrator on 10/12/17 at 9:55 a.m. Based on observations, interviews and record reviews, the facility failed to supervise Resident #6, who was known to wander, and was reported by Resident #14's family member to have attempted to get into the bed with Resident #14; Resident #14 also reported to staff that Resident #6 had attempted to touch her, but nothing was done to stop Resident #6 from coming into her room. 2. Review of Resident #15's current FL-2 dated 09/22/17 revealed: -Diagnoses included dementia and hypothyroidism. -The resident was semi-ambulatory. -The resident's orientation level was not documented. Review of Resident #15's current assessment and care plan dated 08/26/16 revealed the resident was sometimes disoriented. Interview with a personal care aide (PCA) on 10/13/17 at 6:50pm revealed Resident #15 was "sometimes disoriented." Interview with a second PCA on 10/12/17 at 7:49 p.m. revealed: -She felt that the resident needed "one on one care." -She felt that Resident #6 meant no harm toward staff or residents. -A resident informed her that Resident #6 had come into another resident's room during the night and tried to "mess with her sexually". -Resident #6 did not talk sexually. -The PCA did not know whether it had happened	D 270		

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D 270	Continued From page 96 or not. Confidential staff interview revealed: -Resident #6 went in to Resident #15's room. -The staff had never observed Resident #6 in any other residents' bed. Interview with a family member of a resident on 10/13/17 at 10:10 a.m. revealed: -A staff told her that Resident #6 went into a female resident's room and attempted to get in the bed with that resident. -The family member's biggest concern was that Resident #6 wandered. Interview with a second shift PCA on 10/12/17 at 6:46 p.m. revealed: -Resident #6 was very intelligent. -There was an incident when Resident #6 had gone to the bathroom, and went in Resident #15's room and pulled the door shut. -The PCA found Resident #6 kneeing over Resident #15, while Resident #15 was in the bed. -Resident #6 was standing midway over Resident #15's body and "kneeling over her." -She reported this to the medication aide/supervisor (MA/S); the MA/S did not do anything and just gave her a weird look. -Resident #6 had a bad habit of "feeling of himself" while walking down the hall. -All the female residents were afraid of Resident #6. -The PCA did not know if Resident #6's PCP was aware of his wandering, but the Administrator was aware that Resident #6 wandered. Interview with Resident #15's roommate on 10/12/17 at 6:25pm revealed: -Resident #6 came in her room and stole items so she had to "padlock" her closet door.	D 270		

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D 270	Continued From page 97 -She recalled Resident #6 being in her room maybe one month ago and also two weeks ago. -Two weeks ago, Resident #6 tried to get in bed with her roommate, Resident #15. -Resident #15 could not tell what was going on. -She "cussed him out" and he left. -She told the (named) staff that was on duty; the staff did not do anything. -"They (staff) all know" Resident #6 went into other residents' rooms and nothing had been done. Second interview with Resident #15's roommate on 10/13/17 at 5:35 p.m. revealed: -Resident #6 went in the resident's room and stole her cake off her dresser. -The second shift PCA saw Resident #6 with the cake and saw him attempting to "crawl" in the bed with the other resident in the room. -The PCA told her that Resident #6 was completely dressed. -The PCA made Resident #6 get out of the resident's room. -The resident had seen Resident #6 walking down the hall "masturbating," but this had been a long time ago. -The resident felt that Resident #6 knew what he was doing. -The resident told Resident #6's family member about the incident. Telephone interview with Resident #15's family member on 10/16/17 at 2:21pm revealed the family member denied any concerns related to Resident #15's care. Interview with the Administrator on 10/13/17 at 6:55pm revealed she had not been there long enough to tell what Resident #15's orientation level was.	D 270		

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D 270	Continued From page 98 Based on observations, record reviews, and interviews, Resident #15 was not interviewable. Based on observations, interviews and record reviews, the facility failed to supervise Resident #6, who was known to wander, and was reported by staff to have been observed kneeling over Resident #15 while she was lying in her bed. Resident #15 was unable to verbalize her needs and would not be able to communicate to staff if Resident #6 had attempted to assault her or get into her bed. Refer to confidential staff interview. Refer to confidential Interview with a family member of a resident. Refer to Interview with a family member of a third resident on 10/13/17 at 10:10 a.m. Refer to Interview with Resident #6's family member on 10/13/17 at 12:522 p.m. Refer to Interview with Resident #6's guardian on 10/17/17 at 8:38 a.m. Refer to Interview with Resident #6 on 10/13/17 at 5:33 p.m. Refer to Interview with the PCP for Resident #6 on 10/16/17 at 4:08 p.m. Refer to Interview with the Administrator on 10/12/17 at 9:55 a.m. 3. Review of Resident #12's current FL2 dated 4/6/17 revealed: -Diagnoses included Hypertension, Anemia,	D 270		

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D 270	Continued From page 99 Dementia, Depression and Hyperlipidemia -The resident was semi-ambulatory. -The resident was incontinent of bladder and bowel. Interview with Resident #12 on 10/13/17 at 8:45am revealed: -Resident #6 came into her room and took her snacks. -One to two weeks ago, Resident #6 was in her room at 1:30am "scaring me to death." -She was scared of Resident #6, but she was afraid to say too much because it would just make it hard on her. -"If I take my strong pain pill, I would not know if he got in bed with me or messed with me." Confidential staff interview revealed Resident #12 said that Resident #6 came into her room "often;" nothing had been done to stop him. Confidential interview with a second staff revealed: -Resident #6 went in Resident #12's room "all the time." -Resident #12 was "terrified" of Resident #6. Interview with a second shift personal care aide (PCA) on 10/12/17 at 6:46 p.m. revealed: -Resident #6 was very intelligent. -Resident #6 would steal all the food he could see. -The resident wandered in other residents' rooms all the time. -He stole snacks from Resident #12. Interview with a second PCA on 10/12/17 at 7:49 p.m. revealed: -She felt that the resident needed "one on one care."	D 270		

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D 270	Continued From page 100 -Resident #6 would steal food; the resident did not know it was wrong. -Resident #6 went in other residents' rooms looking for food. -She felt that Resident #6 meant no harm toward staff or residents. Confidential interview with a third staff revealed Resident #12 got scared when Resident #6 went into her room. Confidential interview with a family member of a resident revealed Resident #6 would go into other residents' rooms to take their food. Observation of Resident #12 on 10/13/17 at 8:45am revealed the resident alert and oriented, and began crying. Based on observations, interviews and record reviews, the facility failed to supervise Resident #6, who was known to wander into residents' rooms. Staff were aware that Resident #6 wandered into residents' rooms looking for food, and were also aware that he wandered into Resident #12's room frequently in search of food. Resident #12 was afraid of Resident #6, and nothing had been done to prevent Resident #6 from continuing to wander into other residents' rooms. Refer to confidential staff interview. Refer to confidential Interview with a family member of a resident. Refer to Interview with a family member of a third resident on 10/13/17 at 10:10 a.m. Refer to Interview with Resident #6's family	D 270		

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D 270	Continued From page 101 member on 10/13/17 at 12:522 p.m. Refer to Interview with Resident #6's guardian on 10/17/17 at 8:38 a.m. Refer to Interview with Resident #6 on 10/13/17 at 5:33 p.m. Refer to Interview with the PCP for Resident #6 on 10/16/17 at 4:08 p.m. Refer to Interview with the Administrator on 10/12/17 at 9:55 a.m. Confidential staff interview revealed: -Resident #6 was smart and knew right from wrong. -He would look back at staff and peek to see if they were looking before he went in or came out of a resident's room. -Staff tried to redirect him, but it did not work. -Staff had been told to watch him 24/7, and staff "tried their best." Confidential interview with a family member of a resident revealed: -She described Resident #6 and said he wandered into other residents' rooms. -She was informed by another resident's family member that Resident #6 went into a female resident's room who was not able to get out of bed and had his penis out. -She did not recall the female resident's name, but her room was located beside of his. -She received the information one month ago, but did not know when the incident had occurred. -"I am very concerned about him." -She did not want Resident #6 to go into her loved one's room and upset her.	D 270		

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D 270	Continued From page 102 Interview with a family member of a third resident on 10/13/17 at 10:10 a.m. -Resident #6 came in her family member's room, and wanted to see what the resident had in her refrigerator. -The family member reported the incident to the Administrator on the day that it occurred (unable to recall exact date). -The Administrator told the family member that she would have staff keep a closer watch on him. -The family member was informed by staff and other residents that Resident #6 went in other residents' rooms all the time looking for food. -The family member's biggest concern was that Resident #6 was a wanderer. Interview with Resident #6's family member on 10/13/17 at 12:52 p.m. revealed: -He had not seen any serious concerns at the facility. -Staff had told him that Resident #6 wandered. -Resident #6 had brain damage that occurred in 2007. -Resident #6 was enticed by food; if food was kept out for Resident #6 to see, he would take it. -Resident #6 was like a three or four year old child at times. -He was smart with a great IQ but his mind came and went. -Resident #6 was put in the facility so he could be observed 24 hours a day, 7 days a week. -The family member felt that Resident #6 needed increased supervision. Interview with Resident #6's guardian on 10/17/17 at 8:38 a.m. revealed: -Resident #6 was not competent enough to tell the guardian if the resident was being harmed. -Staff had not told the guardian about anything sexual related to Resident #6.	D 270		

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D 270	Continued From page 103 -The guardian felt the staff would have told her about any sexual behaviors regarding Resident #6. Interview with Resident #6 on 10/13/17 at 5:33 p.m. revealed: -He stayed in his room most of the time. -He normally sat in the dayroom until staff made him go to bed. -Resident #6 tried not to go in other residents' rooms. -If he went in other residents' rooms, it was to talk to them or watch television. Interview with the PCP for Resident #6 on 10/16/17 at 4:08 p.m. revealed: -Resident #6 had recently become her patient around July or August of 2017. -There had been no documentation for years that the resident wandered; there was no updated documentation about recent wandering. -The facility did not necessarily need to report to the PCP about the wandering if the resident could be easily redirected. -There was documentation in the resident's record from November 2016 about inappropriate sexual behavior. -There was no documentation as to what type of sexual behavior the resident was exhibiting. -There was documentation that the PCP at that time increased his psychiatric medication. -There was no documentation of any recent inappropriate sexual behavior. -Resident #6 did not receive mental health treatment. -The PCP was equipped to handle all of the resident's medical needs. -She saw Resident #6 at least once a month. Interview with the Administrator on 10/12/17 at	D 270		

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D 270	Continued From page 104 9:55 a.m. revealed: -There had been no reports from any staff about any inappropriate sexual acts by Resident #6. -She was aware that Resident #6 wandered, but the resident was only looking for snacks and drinks. -Resident #6 did not have a harmful bone in his body. -If things happened, it needed to be documented. The facility failed to supervise a resident, who was known to wander into other residents' rooms, resulting in the resident sexually assaulting two female residents, one of which was disoriented and unable to verbalize her needs. This failure resulted in serious physical harm and serious neglect of the residents, and constitutes a Type A1 Violation. Review of the facility's Plan of Protection dated 10/13/17 revealed: -Staff will monitor residents at least every two hours to ensure they are dry and not showing any adverse signs and symptoms which need to be addressed or reported. -The Administrator will ensure no use of heating pad unless specifically ordered by the physician, and if ordered, staff will supervise according to resident's needs. -Will monitor residents who wander every thirty minutes, including Resident #6. -In-service staff regarding monitoring and redirecting wandering residents. -Every two hour checks and interaction with residents to ensure no problems exist and they remain dry. -Documentation of every 30 minute checks for wandering residents. -The Administrator will check log on evening visits and observe staff who are monitoring residents.	D 270		

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D 270	Continued From page 105 -Monitor Resident #4, #12, #14, and #15 for patient safety. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2017.	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: FOLLOW-UP TO TYPE A1 VIOLATION. Based on these findings, the previous Type A1 Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to assure the acute and routine health care needs were met for 6 of 8 residents sampled (#1, #2, #3, #6, #10, #11) as related to failing to notify the primary care physician (PCP) of elevated blood sugars over 400 as ordered for a diabetic resident (#3) on 14 of 15 occasions; of unexplained injuries of skin tears and bruising for two residents (#1, #2); of inappropriate sexual behaviors from a resident (#6); of a resident's (#3) complaints of a prosthetic leg being uncomfortable and refusing to wear it; of a resident complaints of not feeling well, burning upon urination, decreased appetite and increased confusion prior to a hospitalization for diagnosis of sepsis (#11); of a resident (#10)	D 273		

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with a change in status and complained of dizziness, exhibited sweating, altered mental status and refused to be sent to the hospital for emergent medical evaluation, who was later found deceased in his bed; failing to assure referral for home health services was completed for treatment of a sacral wound (#2); and failing to assure a resident (#1) was sent to the hospital for evaluation of a shoulder abscess and a head injury of unknown origin.

The findings are:

1. Review of Resident #11's current FL-2 dated 10/05/16 revealed:
-Diagnoses included congestive heart failure (CHF), hypothyroidism, anxiety disorder, and hypertension.
-The resident's level of orientation was not documented.
-The resident was non-ambulatory, incontinent of bladder and bowel, and was total care.

Review of an Emergency Department (ED) Provider note (received from the local hospital) for Resident #11 dated 08/16/17 revealed:
-The resident was evaluated and discharged on 08/16/17 for diagnosis of urinary tract infection (UTI).
-She refused to come to the ED by emergency medical services (EMS) and was therefore transported to the ED by a family member.
-The resident presented to the ED after being disoriented two days and loss of appetite for one day.
-The resident had been treated "recently" for a UTI and delirium.
-She denied any urinary symptoms of UTI.

Interview with a medication aide (MA) on

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D 273	Continued From page 107 08/18/17 at 2:00pm revealed: -Resident #11 was not feeling well on Tuesday night (08/15/17). -Resident #11 was agitated the night before according to the notes. -The resident's tone and how she was talking was not right. -The family member wanted Resident #11 sent out to the hospital because the family member felt she had a urinary tract infection (UTI). -She had a UTI before and the resident was having the same symptoms. -The MA called 911. -The Manager told her that she was not supposed to call emergency management services (EMS) without going through her first. -The Manager told her to call EMS back and cancel the call. -The Manager would get a urine sample on Resident #11 on the next morning if she could remember. -The Manager stated she did not know who would pick the resident up from the hospital if she was sent out. -Resident #11's family member called to see which hospital Resident #11 was going to. -The MA informed the family member that Resident #11 was not going to the hospital. -The resident's family member called EMS about Resident #11 and that was how the resident got sent to the hospital. -The MA would call the Manager a lot of the times about a resident and would not get an answer, so she would not know what to do. Interview with Manager on 08/18/17 at 8:20am revealed: -It depended on what the complaint was, if a resident was sent to the hospital. -The emergency room was abused by a lot of	D 273		

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people.
-The facility was told by the emergency room (ER) staff that staff needed to learn to assess residents before sending them to the ER.
-If a resident always complained on the same thing, she would not send that resident out, but would consult with the primary care provider (PCP).

A second interview with the Manager on 08/22/17 at 10:15am revealed:
-She knew how Resident #11 acted when she had a UTI.
-She had it worked out with the PCP to send a urine sample to the PCP's office for testing.
-The first shift MA had not yet sent the urine specimen.
-The Manager had not refused to send Resident #11 to the hospital.
-Staff called Resident #11's family member and the family member took her to the hospital.

Interview with a Social Worker with the local Department of Social Services on 08/25/17 at 9:00am revealed:
-She had spoken with the family member of Resident #11.
-Resident #11 had been at the facility for a long time.
-The family member stated that he felt that Resident #11 should have been sent to the ER.
-The family member felt that Resident #11 had a UTI.
-The Manager would not send Resident #11 to the ER.
-The family member stated that he overrode the manager's decision and called EMS to transport Resident #11 to the ER.

Review of a second ED Provider note for

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Resident #11 (received from the local hospital) dated 09/26/16 revealed:
-Resident #11 was brought to the hospital ED by EMS after the facility reported she was unresponsive.
-Resident #11 presented to the ED with hypotension, but was awake, alert, and oriented.
-"This patient has a high probability of life-threatening deterioration in conditions, at the initial presentation or during the ED course related to: urinary tract infection ..., hypotension..., and sepsis due to urinary tract infection ..." (Sepsis is an infection of the blood that can cause low blood pressure, altered mental and respiratory status, kidney damage, and in some instances, death).

Review of a hospital Progress Note for Resident #11 dated 09/26/17 revealed:
-Resident #11 admitted 09/26/17 for "severe sepsis ...and hypotension on admission-identified source thus far as urinary tract infection ..."
-Resident #11 also had "acute renal failure superimposed on stage 3 chronic kidney disease."

Review of a hospital Discharge Summary for Resident #11 dated 09/29/17 revealed:
-The resident was admitted on 09/26/17 into the intensive care unit (ICU).
-During the hospitalization, Resident #11 was treated with intravenous (IV) fluids and IV antibiotics for diagnosis of "severe sepsis."
-Resident #11 was discharged on 09/29/17.

Confidential staff interview revealed:
-Resident #11 was usually oriented and often complained that she did not feel well.
-Resident #11 went out to the hospital sometime near the end of September 2017, had not

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returned to the facility.
-Prior to being sent out to the hospital in September 2017, Resident #11 was "congested" and had complained on and off for about one week that she "did not feel good" and it "burned when she went to the bathroom."
-Resident #11 did not see her doctor for her complaints.
-"They ignored her."
-"They should have got her checked out. They finally sent her out" (to the hospital), but she did not return to the facility and died in rehab a short time later (date of death unknown).

Confidential interview with a second staff revealed:
-Resident #11 was "total care" and required staff assistance with all activities of daily living.
-The staff was on duty a few days before Resident #11 was sent to the hospital on 09/26/17.
-The staff recalled that Resident #1 was "a little bit more confused" and complained she did not feel good.
-Resident #11 did not have any specific complaints, just that she did not feel good.
-The staff recalled Resident #11 had a poor appetite for two weeks before that.
-The staff reported Resident #11's complaints to the Medication Aide (MA) that day.
-The staff did not know if Resident #11's PCP was notified of her complaints; the MA was responsible for notifying the PCP.
-The staff did not recall changes in Resident #11's urinary habits such as odor or increase in frequency prior to the resident being sent to the hospital in September 2017.

Confidential interview with a third staff revealed:
-Resident #11 would say she did not feel good "a

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lot."
-The staff recalled the last time she saw Resident #11 in late September 2017, she complained she did not feel good and her "legs hurt real bad."
-The staff reported Resident #11's complaints to the MA; the MA said she had medication for that.
-Resident #11 went to the hospital sometime after that; she was told by another staff Resident #11 had a urinary tract infection and "sepsis."

Confidential interview with a fourth staff revealed:
-Prior to the resident going out to the hospital the last time (in September 2017), she would said "help, me, where am I," complained of her of pain in her buttocks, and would holler for staff constantly.

Review of the staff communication notebook revealed:
-On 09/21/17 on second shift, there was documentation Resident #11 "states she is sick on stomach and hurting all over."
-On 09/21/17 on third shift, there was documentation Resident #11 rested "good."
-On 09/22/17 on second shift, there was documentation Resident #11 had complaints of "pain and discomfort in both butt cheeks."
-There were no notes dated 09/26/17.
-There was an undated note on first and second shifts that Resident #11 was "still in hospital."
-On 09/27/17 on third shift, there was documentation Resident #11 was "still in hospital."
-There was no documentation dated after 09/27/17 in the staff communication notebook related to Resident #11.

Interview with a medication aide/supervisor (MA/S) on 10/12/17 at 3:30pm revealed:
-About one month ago, Resident #11 had a UTI,

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her son called 911 and she went to the hospital; she came back the same day with antibiotics.
-Resident #11 would "holler" for staff "non-stop."
-"That was her normal."
-She was off work two days when Resident #11 went back to the hospital on 09/26/17; she was septic.
-Resident #11 went to rehab after her September hospitalization and subsequently passed away.
-In the past when Resident #11 had a UTI, she would get confused.
-In September 2017, Resident #11 was not acting like she did when she had the UTI before (she was not confused).
-Resident #11 complained of not feeling good "a few days' before her September 2017 hospitalization, but it was nothing specific, she just did not feel well.
-When staff observed a change in a resident, the staff were supposed to call the primary care provider (PCP).
-The staff who observed the change was the one who was supposed to call the PCP.
-She did not think anyone notified Resident #11's PCP that she was not feeling well.

Interview with a second MA/S on 10/13/17 at 9:00am revealed:
-Resident #11 had not been feeling well for "about a week or so."
-She sent Resident #11 to the hospital on first shift on 09/26/17 because the resident was short of breath; the shortness of breath just started that day (09/26/17).
-Resident #11 also had a "gurgle in her throat" on 09/26/17.
-Resident #11 had not been eating for a "while" and staff had to feed her.
-There had not been any other changes in Resident #11 prior to 09/26/17.

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-Resident #11 "always said 'I don't feel good'."
-Her family was aware she did not feel well because she told them.
-Resident #11's PCP was not notified at all during the week she did not feel good before she went to the hospital on 09/26/17.
-The only physician notification was when she was sent to the hospital.
-Changes in resident's status or residents' complaints were not documented anywhere except the staff communication shift report notebook.

A second interview on 10/16/17 at 1:00pm with the MA/S who sent Resident #11 to the hospital revealed:
-There had not been any change in Resident #11's status until the day she was sent to the hospital (09/26/17).
-On 09/26/17, Resident #11 was in the dining room when she started gurgling and her respirations were not good.
-She called Resident #11's family member then she called 911.
-Resident #11 went to rehab (skilled nursing facility) after her hospital stay in September 2017.
-She was told Resident #11 got pneumonia and had a heart attack while at rehab and passed away.
-The process for a change in residents' status "depends on what's going on but the PCP was "usually" called by the MA.
-PCP notification was not always documented in the resident's record but it was supposed to be documented in the shift communication notebook.
-Nobody called Resident #11's PCP before her September 2017 hospitalization because "she did not have any complaints."

Review of Resident #11's record revealed:

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D 273	Continued From page 114 -There was no documentation of any recent ED visits for UTI, change in status, or her complaints of not feeling well. -There were no staff communication notes. -There was no documentation of Resident #11's PCP being notified of her complaints. -There were no faxes or physician orders related to Resident #11's complaints in September 2017 prior to her 09/26/17 hospitalization. -There was no documentation the resident was sent to the hospital ED by EMS on 09/26/17 for unresponsiveness. Telephone interview with Resident #11's family member on 10/17/17 at revealed: -In August 2017, Resident #11 went to the hospital for a UTI and was treated with antibiotics. -In September 2017, Resident #11 was sent back to the hospital again because she was disoriented and did not want to eat or drink anything. -When she got to the hospital on 09/26/17, she was septic. -The family had last visited Resident #11 on 09/24/17 between 2:00pm and 4:00pm and noticed she was disoriented and smelled like urine, she was "not herself," and did not want eat anything. -She was saying over and over again "I'm hurting." -The family talked to a (named) MA on 09/24/17 and was told she been like that all day and had not wanted to eat or drink for a few days. -In the past when the resident had a UTI, she would get confused; the family told the (named) staff this information on 09/24/16. -On 09/26/17, a (named) staff member contacted him to report her respirations were not good and her blood pressure was low; he told staff to send Resident #11 to the hospital ED.	D 273		

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D 273	Continued From page 115 -When the family got to the hospital, they were told Resident #11 was septic. -He did not think Resident #11's PCP was notified she was confused or had any complaints on 09/24/17. -The PCP should have been notified. Attempted telephone interview with Resident #11's PCP on 10/16/17 at 10:15am and 10/17/17 at 10:58am was unsuccessful. Interview with the Administrator on 10/16/17 at 9:45am revealed: -The expectation for a change in resident's status was to monitor the resident frequently, notify the PCP by telephone, and document the changes and notification. -The Medication Aides should be notifying the physician. -She was "unsure" if staff were following the expected procedure. -The facility currently did not have a system in place for changes in status to assure the physician was notified. -She would implement a policy as soon as possible and assure all staff were trained. -She did not have specific information regarding notification of Resident #11's PCP. Refer to interview with a Medication Aide/Supervisor on 10/12/17 at 3:30 p.m. Refer to interview with the Administrator on 10/16/17 at 9:45 a.m. 2. Review of Resident #1's current FL-2 dated 02/20/17 revealed diagnoses included senile dementia, uncontrolled Type II diabetes, hypertension, anemia, and depression.	D 273		

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D 273	Continued From page 116 Observation of Resident #1 on 10/11/17 at 11:03am revealed: -He was in his room sitting in a recliner. -He was neatly groomed and his clothing appeared clean. -He had a pink and red scaly rash on his nose and on the right side of his face /head above his ear and extended down below his ear and into his hairline. -He had a yellowish/light green colored bruise on the right front and right side of his head that was about 2.5 by 2.5 inches in size. -He had a skin tear on his right arm near the elbow that was oval shaped and measured approximately 1 by 1.5 inches in size. -He had two dime sized circular scabs on his right arm; one above the elbow and the second one on the underside of the forearm. -He had a linear scabbed area on the underside of his right forearm that measured approximately 2.5 inches long and was surrounded by redness. -He had a reddish colored bruised on his right arm near his wrist and a reddish bruise on his right hand. A. Interview with a personal care aide (PCA) on 10/11/17 at 11:05am revealed: -She was not sure, but she thought Resident #1 fell on 2nd shift about two weeks ago and got "just skin tears" on his right arm. -Resident #1 "picked at his skin sometimes." Interview with a second PCA on 10/11/17 at 4:10pm revealed: -She did not know how Resident #1 got the "bruises" on his arm. -The resident "always has some kind of bruise." Interview with a third PCA on 10/12/17 at 1:45pm revealed Resident #1's arms "always" had	D 273		

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D 273	Continued From page 117 scratches and bruises; the resident "runs into stuff." Interview with a fourth PCA on 10/12/17 at 6:45pm revealed: -Four or five days ago, Resident #1 fell in the dining room and "gashed open" his right elbow and it bled. -She did not know how he got the other arm injuries. Interview with a medication aide/supervisor (MA/S) on 10/11/17 at 11:12am revealed: -Resident #1 was never oriented, was a "brittle diabetic," and was a "very heavy care resident." -Resident #1 got bruised "often." -Resident #1 had a history of falls but had not fallen within the last three months. -She did not know how Resident #1 got the injuries on his right arm or how long they had been there; the injuries were probably from him hitting his arm against something. -She did not know if the PCP was aware of the arm injuries. -Resident #1's skin was checked on his shower days, which was Monday, Wednesday, and Friday. A second interview with the MA/S on 10/13/17 at 9:00am revealed: -The process for unexplained injuries was to notify the PCP and sometimes send pictures by phone. -If the resident was on hospice or home health (HH), the unknown injuries were reported to the nurse. -The hospice or HH nurse was supposed to call the PCP and also let the Manager know; the Manager would make a decision on what to do next.	D 273		

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D 273	Continued From page 118 -For skin tears, the process was to clean them with saline, put antibiotic cream on it, and put a dressing on it. Review of Resident #1's record to include Nursing/Progress notes and physician orders revealed: -There was no staff documentation related to the arm injuries. -There was no documentation made by staff that his current arm injuries were reported to the PCP, family, or HH. -There were no physician orders, notifications, or faxes related to the arm injuries. Review of the staff communication notebook revealed there was no documentation related to Resident #1's arm injuries. Review of the Interdisciplinary HH notes for Resident #1 revealed: -On 10/03/17: A HH visit was made for wound care. All wounds were healed except for a right heel wound. "Staff aware to contact [HH agency name] for questions or concerns." -On 10/11/17: A HH visit was made for wound care. All wounds were noted to be healed. Resident #1 had "scabbed abrasions" to his right forearm, Contact was made with the PCP office and staff were aware of the new findings. Staff were aware to contact the home health agency with questions on concerns. -The notes were signed by a Registered Nurse (RN). Review of an electronic HH visit note for Resident #1 dated 10/11/17 revealed: -Resident #1 was evaluated for wound assessment and treatment; all previous wounds were noted as healed.	D 273		

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-Resident #1 had scabbed abrasions to right forearm and elbow.
-The HH RN notified Resident #1's PCP and sent photos to the PCP upon request.
-The note was electronically signed by an RN.

Telephone interview with the HH RN on 10/17/17 at 9:30am revealed:
-She last saw Resident #1 on 10/11/17 and noted his arm injuries.
-The injuries on Resident #1's right arm were unexplained and she did not know how he got them.
-The facility was supposed to notify her of any new open areas in Resident #1's skin or any concerns.
-The facility had not notified her of Resident #1's arm injuries.

Based on observations, records review, and interviews, Resident #1 was not interviewable.

Telephone interview with a Nurse Practitioner (NP) at Resident #1's PCP office on 10/16/17 at 3:31pm revealed:
-The NP was aware of the injuries to his arm; it looked like he fell.
-The office wanted to be notified anytime the resident was injured.
-Nobody could tell her how Resident #1 got the arm injuries.

Interview with the Administrator on 10/13/17 at 10:30am revealed:
-The facility did not have a written policy for injuries of unknown origin and she was not aware of any specific process the facility used or followed for injuries of unknown origin.
-Her expectation for unexplained injuries was for the MA/S to send the resident to the hospital

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and/or notify the PCP.
-She did not know if staff were following her expectation.

B. Confidential staff interview revealed if a resident hit their head or was injured, they were supposed to be sent to the hospital emergency room (ER).

Interview with a personal care aide (PCA) on 10/11/17 at 11:05am revealed she did not know how Resident #1 got the bruise on his head; she just noticed it "today."

Interview with a second PCA on 10/11/17 at 4:10pm revealed she had been off for a while and when she returned to work on second shift on Monday (10/09/17), she noticed the bruise on Resident #1's head; she did not know what happened or how he got the bruise.
Interview with a third PCA on 10/12/17 at 1:45pm revealed:
-She first noticed the bruise on Resident #1's head on Sunday (10/08/17); she did not know how he got the bruise.
-She had not reported the bruise to anyone and the resident had not been sent to the hospital for the bruise/injury.

Interview with a fourth PCA on 10/12/17 at 7:50pm revealed:
-She did not know how Resident #1 got the bruise on his head; she thought he fell.
-She did not really know what to do when a resident had an unexplained injury because she was never trained, but she would report unexplained injuries to a medication aide/supervisor (MA/S).
-She did not really know what to do when a resident had a head injury or emergency; she was

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never trained.
-She would report it to a MA/S.
-The MA/S called 911 when needed, but she did not know the actual process.

Interview with a MA/S on 10/11/17 at 11:12am revealed:
-She had first noticed the yellow bruise on Resident #1's head on Monday (10/09/17); the bruise had not been there the last time she worked on Friday (10/06/17).
-She did not know how Resident #1 got the bruise on his head.
-Resident #1's primary care provider (PCP) had not been into the facility since the bruise was noticed and had not been notified about the bruise on his head.

Interview with a second MA/S on 10/12/17 at 3:30pm revealed:
-She had not seen the bruise on Resident #1's head.
-If he had a head injury, he should have been sent to the hospital.
-She did not think he was sent to the hospital for the head bruise; the last time she recalled Resident #1 going to the hospital was for low blood sugar.

A second interview with a MA/S on 10/13/17 at 9:00am revealed:
-Residents were supposed to be sent to the hospital if they had a head injury or suspected head injury.
-Resident #1 was not sent to the hospital for the bruise on his head because the bruise looked old.
-She thought Resident #1's HH RN called the doctor about the bruise on his head.

Interview with a third MA/S on 10/13/17 at 5:30pm

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revealed:
-The process for a head injury was to send the resident to the hospital.
-The resident may have a "concussion."
-She did not know anything about the bruise on Resident #1's head.

Review of Resident #1's record to include Nursing/Progress notes and physician orders revealed:
-There was no staff documentation by facility staff related to the bruise on his head
-There was no documentation made by staff related to the bruise being reported to the PCP, family, or home health (HH).
-There were no physician orders, notifications, or faxes related to the bruise.

Review of the staff communication notebook revealed there was no documentation related to the bruise on Resident #1's head.

Review of an electronic HH visit note for Resident #1 dated 10/11/17 revealed:
-Resident #1 was evaluated for wound assessment and treatment; all previous wounds were noted as healed.
-Resident #1 had a "bruise that is healing to right side of head."
-Staff told the HH RN Resident #1 "fell the other night, but no ER (emergency room) visit was made when he hit his head."
-The HH Registered Nurse (RN) notified Resident #1's PCP and sent pictures to the PCP by email, at the PCP's request.
-The note was electronically signed by a RN.

Telephone interview with the HH RN on 10/17/17 at 9:30am revealed:
-She last saw Resident #11 on 10/11/17 and

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observed the bruise on his head.
-Staff told her Resident #1 fell at the nurses' station; staff were unsure of the date of his fall.
-The facility had not notified her of Resident #1's head injury/bruise.

Based on observations, records reviews, and interviews, Resident #1 was not interviewable.

Telephone interview with Resident #1's family member on 10/13/17 at 7:06am revealed:
-The facility kept the family updated with Resident #1's status.
-The facility last contacted the family the previous week when he went to the hospital for low blood sugar.

Telephone interview with a Nurse Practitioner (NP) at Resident #1's PCP office on 10/16/17 at 3:31pm revealed:
-The office wanted to be notified anytime the resident was injured.
-Nobody could tell her how Resident #1 got the bruise on his head.
-The facility was expected to notify the PCP office of the bruise when it was found.
-The HH notified the PCP office about the bruise on Resident #1's head on 10/11/17.
-The facility had not notified the office of the bruise on his head.
-When asked if Resident #1 should have been sent to the ER for the bruise on his head, the NP said she expected the facility to follow their policy for emergencies or head injuries for the bruise.

Interview with the Administrator on 10/13/17 at 10:30am revealed:
-The procedure for a head injury or suspected head injury was to send the resident to the ER.
-All staff should know the procedure.

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D 273	Continued From page 124 -The facility did not have a written policy for injuries of unknown origin and she was not aware of any specific process the facility used or followed for injuries of unknown origin. -Her expectation for unexplained injuries was for the MA/S to send the resident to the hospital and/or notify the PCP. -She saw the bruise on Resident #1's head a few days ago. -She would have expected Resident #1 to have initially be sent to the ER for the bruise on his head. -Resident #1 was not sent to the ER. C. Interview with a personal care aide (PCA) on 10/16/17 at 3:00pm revealed: -A few months ago, Resident #1 had a "sore" on the back of his left shoulder. -The sore was little, but then it got big (maybe the size of a quarter). -The sore kept draining "blood" and what looked like "pus." -She kept a pad underneath the resident when he was in bed because it "kept draining." -The sore caused Resident #1 to grimace and say "ouch." -She told a (named) medication aide/Supervisor (MA/S) about the sore "several times" (unsure over what period of time); the MA/S said somebody would come take care of it. -It seemed like the sore was there a week or two. -She did not know if his PCP was aware of the sore. -She did not know if Resident #1 was sent to the hospital for the sore. Review of an electronic home health (HH) visit note for Resident #1 dated 08/07/17 revealed: -A scheduled HH visit was completed for wound care.	D 273		

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-Resident #1 was noted with two new skin wounds to the left mid back and the left upper shoulder.
-"Abscess noted to left upper shoulder ...staff instructed to have patient taken to the ED (emergency department) to have area treated."
-The PCP was made aware of the findings.
-Staff were "encouraged" to call the HH agency with any questions or concerns.
-The note was electronically signed by a Registered Nurse (RN).

Review of a second electronic HH visit note for Resident #1 dated 08/11/17 revealed:
-A scheduled HH visit was made for wound care.
-Resident #1 "continues to have abscess on left shoulder. Staff did not take patient to ER for I & D (incision and drainage) as recommended ..."
-A telephone call was made to the Manager (named) who stated she needed to look at the area and would contact Resident #1's PCP.

Review of a third electronic HH visit note for Resident #1 dated 08/14/17 revealed staff reported Resident #1 was currently at the ER for the abscess on his left shoulder.

Review of a hospital After Visit Summary for Resident #1 dated 08/14/17 revealed:
-Resident #1 was evaluated and treated for an abscess.
-The diagnosis was documented as "carbuncle." (A carbuncle is a severe boil/abscess under the skin, usually caused by a bacterial infection).
-Resident #1 was discharged with a prescription for oral antibiotics and a topical antibiotic ointment for the skin.

Telephone interview with the HH RN on 10/17/17 at 9:30am revealed:

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-She and another home health staff member were at the facility to see Resident #1 on 08/07/17 for wound care.
-Resident #1 had and abscess on his left shoulder that was draining yellowish purulent drainage.
-She told the (named) MA/S to send Resident #1 to the ER and the MA/S said she would.
-She notified the PCP of the abscess and the facility was going to send Resident #1 to the ER per her recommendation on 08/07/17.
-She went back for a scheduled visit on 08/11/17 and Resident #1 had not been to the ER about the abscess.
-On 08/11/17, the abscess had not really changed, but the resident still needed to go to the ER.
-She contacted the Manger on 08/11/17 about the abscess.
-The Manager said she would need to look at the abscess before sending the resident to the ER and she would call Resident #1's PCP.
-When she went for her next scheduled visit on 08/14/17, Resident #1 was at the hospital for the abscess.
-It was standard protocol for the HH agency to notify the PCP of changes in status and recommend sending a resident to the ER for evaluation when needed.
-The carbuncle was now healed.

Based on observations, records reviews, and interviews, Resident #1 was not interviewable.

Telephone interview with a Nurse Practitioner (NP) at Resident #1's PCP office on 10/16/17 at 3:31pm revealed:
-The home health agency notified the office about the carbuncle on Resident #1's shoulder on 08/07/17 and recommended it be lanced and

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drained.
-The NP did not have documentation of a delay in treatment for the carbuncle from 08/07/17-08/14/17.
-If the carbuncle was causing the resident problems or getting worse, the PCP office would want to be notified.
-The PCP office had not received any notifications from the facility about the carbuncle other than by the HH RN.

Interview with a MA/S on 10/13/17 at 9:00am revealed:
-She thought the HH nurse notified his PCP about Resident #1's carbuncle.
-The facility did not notify the PCP about the carbuncle.
-Resident #1 went to the hospital for the carbuncle; that was all she really knew about it.

Refer to interview with a MA/S on 10/12/17 at 3:30 p.m.

Refer to interview with the Administrator on 10/16/17 at 9:45 a.m.

3. Review of Resident #10's current FL-2 dated 9/1/17 revealed:
-Diagnoses included anemia, history of Non-ST Elevation myocardial infarction, bipolar affective disorder, traumatic Brain Injury, essential hypertension, and seizure disorder
-The resident was ambulatory.
-The resident was continent of bladder and bowel.

Review of an Accident/Incident Report dated 8/29/17 revealed:
-Resident #10 fell at around 8:20 p.m.
-The second shift medication aide (MA) was

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passing out medications, turned around and Resident #10 was lying on the floor with the back of his head bleeding.
-Pressure was applied to the back of Resident #10's head to stop the bleeding.
-Emergency Management Services (EMS) and the resident's family were contacted.

Review of Resident #10's hospital records revealed:
-Resident #10 was admitted on 8/29/17 with a diagnosis of a fall from ground level.
-Resident #10 was discharged on 9/1/17, and returned back to the facility.
-Resident #10'sfollow-up recommendations were to follow up with primary care provider (PCP) next week to check basic metabolic panel (a blood test that measures kidney function, electrolyte and fluid balance and glucose level), blood pressure with orthostatic, and hemoglobin and hematocrit (a test to measure the volume of red blood cells in the blood).

Interview with a first shift medication aide/supervisor (MA/S) on 9/14/17 at 8:20 a.m. revealed:
-Resident #10 had been in the hospital because of a fall.
-Resident #10 returned from the hospital on the evening of 9/1/17, after being in the hospital for a few days.
-The first shift personal care aide (PCA) came in on 9/2/17 at around 6:55 a.m. and went to speak to Resident #10.
-She started work around 6:40 a.m. but she had not yet had a chance to go to Resident #10's room.
-The PCA stopped at Resident #10's door, thought something was wrong with Resident #10, and called the MA/S to Resident #10's room.

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D 273	Continued From page 129 -She knew the resident was dead as soon as she saw the resident. -The cook/PCA contacted EMS. -She and the third shift PCA performed Cardio-Pulmonary Resuscitation (CPR) until EMS arrived. -She was unsure how long the resident had been dead. Interview with second shift PCA on 9/27/17 at 12:10 p.m. revealed: -She had been working at the facility for two months. -Resident #10 had sat outside the night before he died for a while with another resident. -Resident #10 came in from outside around 9:30 p.m., and when he got to the nurse's desk, he was sweating and not breathing right. -The second shift MA/S kept asking Resident #10 if he wanted to be transported to the hospital, but the resident kept refusing; the resident said he had just gotten out of the hospital and did not want to go back. -The PCA did not know if the MA/S contacted the resident's PCP. -The MA/S took Resident #10's vital signs and the resident's blood pressure was low, but it came back up; the PCA did not know where the MA documented the vital signs. -The PCA notified the MA/S of any issues with a resident, and the MA would contact the PCP and family member. -The MA/S were responsible for calling 911. -Resident #10 sat at the nurse's desk until around 10:45 p.m.; then, the MA/S walked the resident to his room. -The MA/S informed the third shift MA/S about Resident #10 and told her to keep a check on him. -The third shift MA/S did go and check on	D 273		

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D 273	Continued From page 130 Resident #10 before the PCA and the MA/S left the facility at 11:00 p.m. when their shift ended. -Resident #10 came out of his room, because the resident wanted to go back outside to smoke, but the staff wouldn't allow him to. -She left the facility at around 11:00 p.m. or a little after, and Resident #10 was still alive. Second interview with the first shift MA/S on 9/26/17 at 12:20 p.m. revealed: -Resident #10's call light was on when the MA/S arrived to work at around 6:40 a.m. but she did not go to the resident's room. -No other call lights were on but Resident #10's light. -The PCA came in to work at around 6:55 a.m. and went to Resident #10's room. -The PCA called the MA/S to Resident #10's room. -Resident #10 was laying on his back with his left arm and leg hanging off the bed. -Resident #10's call bell was hanging off the side of the bed like it had fallen off the bed. -The call lights used to buzz, but something happened, because the call lights have not buzzed in a couple of years. -The call lights could be seen from the nurse's desk from both halls. -Staff could see that the call lights were on even if they did not buzz. Interview with a first shift PCA on 9/26/17 at 12:10 p.m. revealed: -Resident #10 came back from the hospital the day before he died. -Resident #10's "call light was on when I got to work at around 7:00 a.m. I decided to go and check on the resident, because I had not seen the resident since the resident returned from the hospital."	D 273		

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-Resident #10's door was closed so the PCA knocked and called the resident's name and got no response.
-"I knew something was wrong with the resident as soon as I entered the room."
-The PCA called the MA/S to Resident #10's room.
-The MA/S and the third shift PCA took Resident #10 off the bed and started doing CPR.
-"I do not know how long Resident #1 had been dead."
-She noticed Resident #10's call light was on when she rounded the corner at the nurse's desk around 7:00 a.m.
-The third shift MA/S siad she did not know that Resident #10's call light was on.
A second interview with the first shift PCA on 9/27/17 at 11:45 a.m. revealed:
-"I knocked on resident's door, called the resident's name and got no answer. I opened the resident's door, and as soon as I saw Resident #10, I knew the resident was dead, because he was pale and not breathing."
-Resident #10's left foot and arm was hanging off the bed like he may have tried to get off the bed.
-The PCA immediately called the first shift MA/S to Resident #10's room.

Interview with a housekeeper on 9/14/17 at 11:46 a.m. revealed:
-Resident #10 had gone to the hospital on the Wednesday before he died.
-A family member came to the facility and informed the staff that the doctor was keeping him in the hospital because of his blood pressure.
-Resident #10 stayed in the hospital for three days.
-Resident #10 returned to the facility on the Friday evening before he died.
-She was told that Resident #10 died between the

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hours of 3:00 a.m. and 4:00 a.m.
-Resident #10 was found dead by a staff person on first shift.
-Staff were supposed to do two hour checks and incontinence care changes, so the housekeeper did not know why he was not found until first shift.

Interview with a resident on 9/26/17 at 3:05 p.m. revealed:
-Resident #10 was a good friend of the resident.
-Resident #10 came back to the facility from being in the hospital at around 3:30 p.m. the day before he died.
-Resident #10 and the resident sat outside and watched the lightening show in the sky until around 8:30 p.m. or 8:45 p.m. the night before he died.
-Resident #10 acted fine and talked about his family.
-The resident was told by staff that when Resident #10 got to the nurse's desk, Resident #10 started sweating, his coordination was gone, and he was not thinking right.
-Resident #10 was not sent back to the hospital.

Interview with the second shift MA/S on 9/28/17 at 3:45 p.m. revealed:
-Resident #10 arrived back at the facility from being in the hospital well after supper time.
-Resident #10 was happy; he went outside to smoke and stayed until his normal time, which was around 10:00 p.m.
-Resident #10 came inside and took his medications.
-Resident #10 became sweaty and unstable.
-She asked Resident #10 to sit down at the nurse's desk.
-She checked Resident #10's vital signs and his blood pressure was normal, but his oxygen level was low (93-94%).

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D 273	Continued From page 133 -The vital signs were written on a note pad that was at the desk at the time; she did not know where the pad was. -She did not contact the resident's PCP or family member. -Resident #10 did not want to go to the hospital. -She was ready to send him to the hospital, but he did not want to go. -The resident was able to communicate what he wanted; if he would not have been able to communicate, she would have sent him out. -Resident #10 said he would be alright after using his inhaler and getting his medications. -Resident #10 previously had these symptoms (being sweaty and unstable), but was all right after using his inhaler. -Resident #10 was a smoker and was on medication related to his breathing; Resident #10 was given his inhaler and he began to feel better. -Resident #10 went to his room. -Resident #10's symptoms were not ignored. -She informed the third shift MA/S about Resident #10's vital signs. -She made rounds before getting off work at 11:00 p.m., and Resident #10 was still alive. Interview with the third shift MA/S on 9/27/17 at 3:08 p.m. revealed: -The MA/S had been working at the facility for a couple of months on third shift. -She monitored the 200 hall at the facility. -She was responsible for making rounds to check on resident's every 1 ½ -2 hours to make sure residents were breathing, toileting residents if they were soiled, and changing bed linen if needed. -If a resident put on a call light, staff had to go and check on the resident. -She was working the night Resident #10 died. -He was in good spirits and did not complain.	D 273		

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-She talked with Resident #10 before he went to sleep.
-Resident #10 wanted to go outside around 11:30 p.m. or 12:15 a.m. to smoke a cigarette.
-She went outside with Resident #10, so he could smoke a cigarette.
-Resident #10 was not pale, clammy or complaining; he was talkative and happy.
-Resident #10 went to bed once he came back in from smoking.
-She checked on Resident #10 every two hours.
-She checked on residents by opening the residents' doors, but did not turn on the room light because she was able to see the resident from the hall light.
-She got up next to the resident's bed to make sure they were okay and still breathing, but she did not touch or bother the resident.
-She felt it would be rude to wake the residents if they were sleeping.
-She did not remember Resident #10's call light being on.
-When staff were walking up and down the halls checking on residents, they could not help but see when a resident's call light was on.
-She could look up and check to see if a resident's call light was on and switch position to monitor call lights on both halls when sitting at the nurse's desk.
-Someone was always supposed to be at the nurse's desk monitoring the call lights.
-On 9/2/17, she got off work at 7:01 a.m.

Interview with a PCA on 9/27/17 at 3:41 p.m. revealed:
-She only worked on third shift on the 100 hall at the facility.
-She did not go on the 200 hall of the facility unless the MA/S asked for help.
-Resident #10 was at the nurse's desk looking for

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D 273	Continued From page 135 the MA/S at 11:00 p.m. -She did not see Resident #10 anymore after that. -The residents were to be checked on every 1 ½ hours to make sure they were not wet and to help those that could walk to the bathroom. -The call lights were monitored while walking up and down the halls. -The PCA could see if the call lights were on while walking the halls or from the nurse's desk. Interview with the Administrator on 9/26/17 at 9:35 p.m. revealed: -The staff needed to do a closer check of the residents. -A staff meeting would be scheduled to address all the facility concerns. -A sign-up sheet would be put behind each resident's door to be signed by staff once a full room check had been completed. A second interview with Administrator on 10/13/17 at 10:54 a.m. revealed: -Resident #10 was in the hospital because of a fall. -The resident had just returned to the facility on the night that he died. -The third shift MA/S told her that she took a break with him and he was fine. -The dietary staff informed her that Resident #10 did not act like he was sick that evening when she spoke with the resident. -She was not aware that Resident #10 had complained. -She expected if a resident had any complaints that it be documented. -The facility had no written policies on an emergency. -The MA/S had been responsible for sending a resident to the hospital, if an emergency.	D 273		

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-The facility had no written policy on what to do if a resident refused to go to the hospital.
-She did not know of any resident that has refused to go to the hospital.
-If a resident refused medical care, it should be documented in the resident's record.
-She expected the PCP to be notified.

Refer to interview with a MA/S on 10/12/17 at 3:30 p.m.

Refer to interview with the Administrator on 10/16/17 at 9:45 a.m.

4. Review of Resident #6's current FL-2 dated 9/5/16 revealed:
-Diagnoses included congestive heart failure, hypertension and hyperlipidemia.
-Resident #6 was ambulatory
-Resident #6 was occasionally incontinent of bladder and bowel.

Review of Resident #6's current Care Plan dated 6/8/15 revealed:
-Resident #6 was assisted to the bathroom by staff; staff were to provide incontinenc care every two hours as needed.
-Resident #6 was assisted with dressing and needed prompting by staff for grooming and hygiene.

Review of Resident #6's primary care provider (PCP) progress notes revealed that he had last been seen by his PCP on 8/16/17.

Interview with a second shift personal care aide (PCA) on 10/12/17 at 6:46 p.m. revealed:
-Resident #6 would steal all the food he could see.
-The resident wandered in other residents' rooms

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D 273	Continued From page 137 all the time. -He stole snacks from another resident. -There was an incident when Resident #6 had gone to the bathroom, and went in Resident #4's room and pulled the door shut. -The PCA found Resident #6 kneeing over Resident #4's roommate, Resident #15, while she was in the bed. -Resident #6 was midway Resident #15's body kneeling over her. -She reported this to the medication aide/supervisor (MA/S). -Resident #6 had a bad habit of "feeling of himself" while walking down the hall. -All the female residents were afraid of Resident #6. -Resident #6 was very intelligent. -The PCA did not know if Resident #6's PCP was aware of his wandering, but the Administrator was aware that Resident #6 wandered. Interview with a second shift PCA on 10/12/17 at 7:49 p.m. revealed: -She felt that the resident needed increased supervision. -Resident #6 would steal food; the resident did not know it was wrong. -Resident #6 went in other residents' rooms looking for food. -She felt that Resident #6 meant no harm toward staff or residents. -A (named) resident told her Resident #6 had come into her room during the night and tried to "mess with her sexually". -She did not believe Resident #6 would do that. -She was not sure if the incident was reported to the Manager because it was in the past, Resident #6 did not talk sexually, and she did not know whether Resident #6 attempted to have sexual contact with the resident or not.	D 273		

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D 273	Continued From page 138 Interview with a first shift medication aide/supervisor (MA/S) on 10/13/17 at 9:01 revealed: -Resident #6's family member told them that they had to talk to Resident #6 like he was a child. -Resident #6 wandered. -Resident #6's PCP was aware that he wandered in residents' rooms looking for food. Interview with a family member on 10/13/17 at 10:10 a.m. revealed: -Resident #6 came in her family member's room, and wanted to see what the resident had in the refrigerator. -The family member reported the incident to the Administrator on the day that it occurred. -The Administrator told the family member that she would have staff keep a closer watch on him. -The family member heard from staff and other residents that Resident #6 went in other residents' rooms all the time looking food. -A staff told her that Resident #6 went into a female resident's room and attempted to get in the bed with that resident. -The family member's biggest concern was that Resident #6 wandered. Interview with Resident #6's family member on 10/13/17 at 12:52 p.m. revealed: -He had not seen any serious concerns at the facility. -Staff had told him that Resident #6 wandered. -Resident #6 had brain damage that occurred in 2007. -Resident #6 was enticed by food; if food was kept out for Resident #6 to see, he would take it. -Resident #6 was like a three or four year old child at times. -He was smart with a great IQ but his mind came	D 273		

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and went.
-Resident #6 was in the facility to receive increased supervision rather than being left at home.
-The family member felt that Resident #6 needed increased supervision.

Interview with Resident #6's guardian on 10/17/17 at 8:38 a.m. revealed:
-Resident #6 was not competent enough to tell the guardian if the resident was being harmed.
-Staff had not told the guardian about anything sexual relating to Resident #6.
-She was aware that Resident #6 wandered in residents' rooms looking food.
-Resident #6 was almost 500 pounds, at one time, and would eat all day, if allowed.
-The guardian felt the staff would have told her about any sexual behaviors regarding Resident #6.

Interview with Resident #6 on 10/13/17 at 5:33 p.m. revealed:
-He stayed in his room most of the time.
-He normally sat in the dayroom until staff made him go to bed.
-Resident #6 tried not to go in other residents' rooms.
-If he went in other residents' rooms, it was to talk to them or watch television.
-He had not taken any food from any residents or staff.

Interview with a resident on 10/13/17 at 4:30 p.m. revealed:
-Resident #6 tried to get in bed with her.
-He tried to rape her, but he did not because she fought him off.
-She did not tell anyone about the incident because she did not want to get in trouble.

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D 273	Continued From page 140 -The incident happened about 3 months ago. -She had not seen Resident #6 "today" but saw the resident yesterday. -She did not want it told because it would get her in trouble; she felt that she would be discharged from the facility if she told anyone. A second interview with a resident on 10/13/17 at 5:52 p.m. revealed: -Resident #6 came and visited her room. -She was not a friend of the resident and did not want the resident in her room. -He attempted to "feel on her important parts" (private area). -It happened every night. -She told the "nurses" and they did not believe her; they told her there was nothing to it. -Resident #6 normally sat at the end of the table in the dining room. (She pointed to the table in front of her indicating where the resident sat; Resident #6 came into the dining area and when he left, she stated "that is the one".) -She had not told anyone, including her family, the resident was coming into her room to her, because she did not talk that way to her family. -When growing up, she was restricted from talking that way and did not talk that way now. -"It was a matter of respect." -She was telling it now because she wanted to be protected. Interview with a second resident on 10/13/17 at 5:35 p.m. revealed: -Resident #6 "steals". -Resident #6 went in the resident's room and stole her cake off her dresser. -The second shift PCA saw Resident #6 with the cake and saw him attempting to "crawl" in the bed with the other resident in the room. -The PCA told her that Resident #6 was	D 273		

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completely dressed.
-The PCA made Resident #6 get out of the resident's room.
-The resident had seen Resident #6 walking down the hall "masturbating" but this had been a long time ago.
-Resident #6 "knows what he is doing;" he has plenty of sense.
-The resident told Resident #6's family member about the incident.
-The resident was not afraid of Resident #6.

Interview with the Resident #6's primary care provider (PCP) on 10/16/17 at 4:08 p.m. revealed:
-Resident #6 had recently become her patient around July or August of 2017.
-There had been no documentation for years that the resident wandered; there was no updated documentation about recent wandering.
-The facility did not necessarily need to report to the PCP about the wandering if the resident could be easily redirected.
-There was documentation in the resident's record from November 2016 about inappropriate sexual behavior.
-There was no specification as to what type of sexual behavior the resident was exhibiting.
-There was documentation that the PCP at that time increased his psychiatric medication.
-There was no documentation of any recent inappropriate sexual behavior.
-Resident #6 did not receive mental health treatment.
-The PCP was equipped to handle all of the resident's medical needs.
-She saw Resident #6 at least once a month.

Interview with the Administrator on 10/13/17 at 6:36 p.m. revealed:

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-There had been no reports from any staff about any inappropriate sexual acts by Resident #6.
-If things happened, they needed to be documented.
-Staff were supposed to report any incidents to her but she did not know if staff were aware to report the incidents.
-She was aware that Resident #6 wandered, but the resident was only looking for snacks and drinks.
-Resident #6 did not have a harmful bone in his body.

Refer to interview with a MA/S on 10/12/17 at 3:30 p.m.

Refer to interview with the Administrator on 10/16/17 at 9:45 a.m.

5. Review of Resident #2's current FL-2 dated 4/6/17 revealed:
-The diagnoses included Alzheimer's and Hypertension.
-The resident was non-ambulatory.
-The resident required a geriatric chair (Geri chair).
-The resident was incontinent of bladder and bowel.

A .Review of Resident #2's current Care Plan dated 4/6/17 revealed:
-The resident was always disoriented.
-The resident was totally dependent on the staff for eating, bathing, dressing and grooming.
-The resident was totally dependent on the staff for transfers to/from bed and chair.

Observation of Resident #2 on 10/12/17 at 8:10 a.m. revealed:
-The resident was in the dining room sitting in a

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D 273	Continued From page 143 Geri chair. -The resident was being fed by a Personal Care Aide (PCA). -The resident had a dressing on her right upper arm and a dressing on her left forearm with no writing on either of them to note when they had been applied. -The resident had a 2.0 by 0.25 inches in size scab below her right knee. -The resident had a 1.0 by 1.0 inches in size scab below her left knee. -The resident had multiple bruises on both arms and both legs. Based on observations, record reviews, and interviews, Resident #2 was not interviewable. Interview with a PCA on 10/12/17 at 8:15 a.m. revealed: -She did not know how Resident #2 got the skin tears or bruises. -She had been off work for a few days prior and does not recall that Resident #2 had the skin tears prior being off work. -She did not know if the physician had been notified. Observation of Resident #2 on 10/12/17 at 9:30 a.m. revealed: -The Medication Aide/Supervisor (MA/S) and a second PCA had removed the dressings on the resident's right upper arm and her left forearm. -The resident's right upper arm had two skin tears next to each other. -The first skin tear on the top right upper arm was 1.0 by 0.50 inches in size, pink in color and had blood tinged clear drainage. -The second skin tear was just under the first skin tear on the right upper arm, and was 0.50 by 0.50 inches in size, pink in color and had blood tinged	D 273		

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D 273	Continued From page 144 clear drainage. Interview with a second PCA on 10/12/17 at 9:35 a.m. revealed: -She did not know how Resident #2 got the skin tears or bruises. -She did not remember when the dressings were put on the resident's arms. -She did not know if the physician or family had been notified. Interview with MA/S on 10/12/17 at 9:40 a.m. revealed: -She did not know what caused the skin tears on Resident #2's arms. -There were no physician orders (or standing orders) for dressing changes. -She did not know if the physician was aware of the skin tears. -She would contact the physician immediately. Review of Resident #2's record revealed: -There was no documentation by the facility staff related to the injuries such as nursing or progress notes. -There was no documentation that the resident's current arm skin tears, scabs on both knees or bruises on arms and legs were reported to the PCP, family or hospice. Second interview with MA/S on 10/12/17 at 9:55 a.m. revealed: -She had just informed the physician's medical assistant of Resident #2's skin tears. -The physician's medical assistant informed her to call hospice for cleaning/dressing the skin tears. -The hospice RN would call the physician to obtain an order for cleaning/dressing the skin tears.	D 273		

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D 273	Continued From page 145 -The hospice RN told the MA/S to leave the dressings off the skin tears. -The hospice RN would arrive later that day to clean/dress the skin tears. Interview with the hospice RN on 10/12/17 at 12:07 p.m. revealed: -This was the first time she had seen Resident #2 since her discharge from hospice in June 2017. -She was waiting on a physician order to clean/dress the skin tears. -The hospice RN often performed dressing changes for skin tears on Resident #2 prior to her discharge from hospice in June 1017. Review of hospice physician order for Resident #2 dated 10/12/17 at 12:50 p.m. revealed a telephone order for "Skin tears, clean with soap and water and apply antibiotic ointment and cover with opsite (transparent adhesive film dressing). Leave in place for 5-7 days. Okay for facility staff to change in absence of hospice nurse." Observation of Resident #2 on 10/12/17 at 12:50 p.m. revealed the hospice RN cleansed and dressed the skin tears on both arms. Interview with MA/S on 10/13/17 at 9:10 a.m. revealed: -The process for injuries of unknown origin was to contact the physician and send pictures by phone if requested. -The process for skin tears was the Med Aide (MA) would clean with saline and put a dressing or band aid on it and document it. -The MA would write on the dressing the date when it was changed. -The MA should change the dressing each day. -The MA should give a verbal report at shift change about any resident with skin tears.	D 273		

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D 273	Continued From page 146 -There was no verbal report given to the MA/S for the current skin tears on Resident #2. -"The first time I knew of Resident #2's current skin tears was yesterday 10/12/17." Interview with Administrator on 10/13/17 at 10:55 a.m. revealed: -"I am not sure what to do with an injury of unknown origin." -"We do not have a written policy on injuries of unknown origin." -"The current process is the Supervisor makes a decision of whether or not to call EMS." -"If the Supervisor has a question they can call the Administrator." -"I am not sure if the staff have been formally trained on emergencies." -"I am not aware of any delays in delays in 911 care." Interview with the Physician on 10/13/17 at 2:15 p.m. revealed: -He was not aware of any skin tears on Resident #2. -The process he had communicated with the facility staff and his expectation was that they would write down any issues/requests pertaining to residents and fax it to their office, and follow-up with a phone call to the office alerting them. -He called the facility on 10/12/17 and spoke with the MA/S and asked if there were any issues he needed to be aware of. -The MA/S reported to the physician on 10/12/17 that there were no issues. -"I am very upset about the communication issues with the facility." Interview with family member on 10/17/17 at 8:50 a.m. revealed: -He was aware of the skin tears that are now	D 273		

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scabs on Resident #2's lower legs.
-He thought those older skin tears on her legs may have come from the Geri chair because she moves her legs constantly.
-He did not know how she got the current skin tears on each arm.
-"The skin tears have been on and off with her for the last one year."
-The staff previously called him and told him about skin tears and often apologize for "calling too much".

Interview with Administrator on 10/17/17 at 11:10 a.m. revealed:
-"I was first made aware of (Resident #2's) skin tears during this survey process."
-The normal process they would follow for skin tears is the MA/S would contact the physician and the home health/ hospice nurse for plan of care.

B. Review of physician orders for Resident #2 revealed:
-There was an order dated 9/6/17 for home health to evaluate and treat sacral ulcer.
-The order was in a folder with other residents' orders, notes, Medication Administration Records (MARs) laying at the staff desk.

Review of Resident #2's record revealed:
-The physician's order dated 9/6/17 for home health to evaluate and treat sacral ulcer was not filed in the resident's record.
-There was no documentation by the facility staff that a referral was made to home health such as nursing or progress notes.
-There was no documentation made by facility staff regarding a notation of a sacral ulcer.
-There was no documentation made by home health regarding a referral being received to evaluate and treat a sacral ulcer.

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D 273	Continued From page 148 -There was no documentation made by home health regarding evaluation and treatment of a sacral ulcer. Interview with a PCA on 10/13/17 at 11:30 a.m. revealed: -She was not aware of a physician's order for home health to evaluate and treat sacral ulcer for Resident #2. -She was not aware that Resident #2 had a sacral ulcer. -She bathes Resident #2 routinely and has not seen any skin breakdown on sacral area. Interview with MA/S on 10/13/17 at 11:40 a.m. revealed: -She was not aware of a physician's order for home health to evaluate and treat sacral ulcer for Resident #2. -She was not aware that Resident #2 had a sacral ulcer. Observation of Resident #2 on 10/13/17 at 12:40 revealed: -The hospice aide was bathing the resident in bed. -The resident's buttocks and sacral area had no signs of skin breakdown or redness. Interview with the hospice aide on 10/13/17 at 12:50 revealed she was not aware of any referral for Resident #2 regarding a sacral ulcer. Interview with the Physician on 10/13/17 at 2:15 p.m. revealed: -He was not aware that the order dated 9/6/17 for home health to evaluate and treat sacral ulcer was not completed. -His expectation was that all orders are carried out immediately after the order is written.	D 273		

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D 273	Continued From page 149 -"I am very upset about the communication issues with the facility." - He will be contacting the Administrator to follow up on his concerns. Interview with Resident #2's family member on 10/17/17 at 8:50 a.m. revealed: -He was not aware of Resident #2 having an order for home health referral for a sacral ulcer. -He was only aware of the skin tears. Interview with Administrator on 10/17/17 at 11:10 a.m. revealed: -She was not aware that Resident #2 had an order for home health referral for a sacral ulcer. -The normal process was the supervisor should have followed up on the order for the referral. -She was "not aware that the order was missed". Refer to interview with a Medication Aide/Supervisor on 10/12/17 at 3:30 p.m. Refer to interview with the Administrator on 10/16/17 at 9:45 a.m. 6. Review of Resident #3's current FL-2 dated 03/07/17 revealed diagnoses included diabetes mellitus, peripheral vascular disease, pneumonia, and muscle weakness. A. Review of Resident #3's current FL-2 dated 03/07/17 revealed: -There was an order for Novolog Flexpen inject per sliding scale 4 times a day: 200 - 250 = 2 units, 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units, and greater than (>) 400 = call physician. -There was an order for Levemir 60 units twice a day. (Levemir is long-acting insulin used to lower blood sugar.)	D 273		

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D 273	Continued From page 150 -There was an order for fingerstick blood sugars (FSBS) 4 times daily. Review of Resident #3's October 2017 medication administration record (MAR) revealed there was no documentation of any FSBS on the MAR. Review of Resident #3's October 2017 FSBS log revealed: -The resident's FSBS were to be checked 4 times a day. -The FSBS was 420 on 10/06/17 at 5:00 p.m. -The FSBS was 416 on 10/16/17 at 8:00 p.m. -There was no documentation the physician was contacted about the 2 FSBS over 400 as ordered. -The FSBS ranged from 50 - 420 from 10/01/17 - 10/13/17. Review of Resident #3's September 2017 FSBS log revealed: -The resident's FSBS was over 400 on 13 occasions from 09/01/17 - 09/30/17. -There was no documentation the physician was notified of 12 of the 13 FSBS readings over 400. -The FSBS was 432 on 09/08/17 at 11:30 a.m. and 511 on 09/11/17 at 8:00 p.m. but there was no documentation the physician was contacted. -The FSBS was 600 on 09/12/17 at 5:00 p.m. and the medication aide (MA) documented the physician was contacted. -The physician instructed the MA to administer insulin, recheck in 2 hours, and call the physician back at 7:00 p.m. with the results. -The FSBS was rechecked at 7:00 p.m. on 09/12/17 and the FSBS was 445. -There was no documentation the physician was contacted regarding the rechecked FSBS of 445 at 7:00 p.m. -The FSBS was 537 on 09/13/17 at 7:40 p.m.;	D 273		

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D 273	Continued From page 151 509 on 09/14/17 at 11:45 a.m.; 416 on 09/15/17 at 11:45 a.m.; 437 on 09/15/17 at 8:30 p.m.; 478 on 09/17/17 at 12:00 p.m.; 466 on 09/18/17 at 4:00 p.m.; 406 on 09/21/17 at 4:45 p.m.; 434 on 09/22/17 at 4:50 p.m.; and 484 on 09/23/17 at 8:00 p.m. -There was no documentation the physician was contacted on any of these occasions. -The FSBS ranged from 62 - 600 from 09/01/17 - 09/30/17. Interview with the medication aide (MA) on 10/13/17 at 9:07 a.m. revealed: -The MAs usually document insulin administration and FSBS on the FSBS log instead of the MARs. -The MAs were supposed to call the physician to find out how much SSI to administer if Resident #3's FSBS was over 400. -If they called the physician, it should be documented on the MAR or the FSBS log or they would have a fax from the physician in the resident's record. Interview with a second MA on 10/13/17 at 12:55 p.m. revealed: -She usually worked on second shift as a MA/supervisor. -The MAs were supposed to call the physician to find out how much SSI to administer to Resident #3 if her FSBS was over 400. -She had called the physician's office on 09/12/17 when the resident's FSBS was 600 and got a verbal order to administer 10 units of Novolog SSI. -She documented it on the back of the FSBS log. -She rechecked the FSBS on 09/12/17 at 7:00 p.m. -She thought she called the physician's office back after the recheck of 445 and there were no further orders.	D 273		

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D 273	Continued From page 152	D 273		

-She was not sure about calling the physician's office back since she did not document it.
-She usually documented on the MAR or FSBS log if she called the physician.
-If she had contacted the physician for other FSBS that were over 400, she would have documented it on the FSBS log.
-She did not recall contacting the physician on any other occasion.

Interview with Resident #3 on 10/17/17 at 10:25 a.m. revealed:
-She received insulin and FSBS checks about 3 or 4 times a day.
-She got SSI about 3 times a day and a different kind of insulin once or twice a day.
-Her FSBS ran so high sometimes she would have to get 60 units of insulin at night.
-She usually felt "nervous" when her FSBS was high.
-Her FSBS sometimes ran low and she would get "nervous and shaky".
-Her FSBS got so high in September 2017 that she had to go to the hospital.

Telephone interview with Resident #3's primary care provider (PCP) on 10/13/17 at 2:00 p.m. revealed:
-He was not aware Resident #3's FSBS had been running over 400.
-His office was contacted on one occasion in September 2017 about a high FSBS for Resident #3.
-If he had been contacted regarding the multiple FSBS over 400, he would have changed the resident's insulin dosage.
-The facility had his phone number and his assistant's phone number and they were available 24 hours a day 7 days a week.
-The facility could have called him anytime

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D 273	Continued From page 153 regarding the FSBS. B. Review of Resident #3's Assessment and Care Plan dated 03/31/17 revealed: -The resident was a double amputee, non-ambulatory, and used a wheelchair. -The resident had limited strength in upper extremities. -The resident was incontinent of bowel and bladder. -The resident was oriented and had adequate memory. -The resident was totally dependent for toileting, bathing, and transferring. -The resident required extensive assistance with dressing and limited assistance with grooming. -The resident was independent with eating and ambulation. Review of a physician's visit form dated 08/09/17 for Resident #3 revealed: -Resident #3 had bilateral below the knee amputations. -The resident would benefit from a prosthesis because of the bilateral amputations. -The prosthesis would be safer, increase mobility and help the resident avoid falls. Review of Resident #3's August 2017 medication administration record (MAR) revealed: -There was a handwritten entry starting 08/10/17 for right leg prosthesis to be on 2 hours, off for 2 hours, check for skin breakdown after removal. -It was scheduled to be on at 8:00 a.m., off at 10:00 a.m., on at 12:00 noon, off at 2:00 p.m., on at 4:00 p.m., off at 6:00 p.m., on at 8:00 p.m., and off at 10:00 p.m. -The prosthetic leg was documented as being on at 8:00 a.m. and off at 10:00 a.m. from 08/10/17 - 08/18/17, 0820/17 - 08/26/17, and 08/28/17 -	D 273		

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D 273	Continued From page 154 08/31/17. -The prosthetic leg was documented as being on at 12:00 p.m. and off at 2:00 p.m. from 08/10/17 - 08/18/17, 0820/17 - 08/26/17, and 08/28/17 - 08/31/17. -The prosthetic leg was not documented as being on at 4:00 p.m. or 8:00 p.m. from 08/10/17 - 08/31/17. -It was documented as refused at 4:00 p.m. and 8:00 p.m. from 08/10/17 - 08/12/17. -Documentation for 4:00 p.m. and 8:00 p.m. was blank from 08/13/17 - 08/31/17. Review of Resident #3's September 2017 and October 2017 MARs revealed no entry for the right prosthetic leg and no documentation it was being worn. Observations of Resident #3 from 10/11/17 - 10/13/17 and 10/16/17 - 10/17/17 revealed: -Resident #3 did not wear the prosthetic leg. -The prosthetic leg was in a chair next to the resident's bed.. Telephone interview with a medication aide (MA) on 10/16/17 at 2:40 p.m. revealed: -Resident #3 did not wear her prosthetic leg like she was supposed to wear it. -If staff helped Resident #3 put on the prosthesis, the resident would only wear it a short period of time and then pull it off. -The resident had not complained of pain from the prosthetic leg but that it was uncomfortable. -There was no skin breakdown on the resident's stumps. -She had not notified the physician that the resident was not wearing the prosthesis. -She did not know if anyone had notified the physician.	D 273		

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D 273	Continued From page 155 Interview with a medication aide (MA) on 10/17/17 at 9:01 a.m. revealed: -Both of Resident #3's legs had been amputated. -The resident only had one prosthetic leg and it was for her right leg. -Staff tried to get the resident to use the prosthetic leg but the resident complained about it hurting. -The resident already had physical therapy services to help her with the use of the leg. -She was not sure if the physician had been notified the resident was not wearing the prosthetic leg or complaining about it hurting. -There were no sores or opens areas on the resident's amputated leg stumps. Interview with Resident #3 on 10/17/17 at 10:25 a.m. revealed: -She had one prosthetic leg and physical therapy stopped coming because they said she was not making any progress with it. -Facility staff offered to help her with the prosthetic leg but some days she did not feel like wearing it. -She was supposed to wear the prosthetic leg on 2 hours and off 2 hours. -The prosthetic leg did not hurt but it "feels different and heavy". -The prosthetic leg was uncomfortable because it was heavy. -She did not have any skin breakdown on her leg stumps. Telephone interview with Resident #3's physician on 10/13/17 at 2:00 p.m. revealed: -He was not aware Resident #3 was refusing to wear her prosthetic leg. -No one from the facility had contacted him about the resident's refusal to wear the prosthesis. -The facility had his phone number and his	D 273		

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D 273	Continued From page 156 assistant's phone number and could reach him 24 hours a day 7 days a week. Refer to interview with a Medication Aide/Supervisor on 10/12/17 at 3:30 p.m. Refer to interview with the Administrator on 10/16/17 at 9:45 a.m. _____ Interview with a Medication Aide/Supervisor on 10/12/17 at 3:30 p.m. revealed: -When staff observed a change in a resident, the staff were supposed to call the PCP. -The staff who observed the change was the one who was supposed to call the PCP. Interview with the Administrator on 10/16/17 at 9:45 a.m. revealed: -The expectation for a change in resident's status was to monitor the resident frequently, notify the PCP by telephone, and document the changes and notification. -She was "unsure" if staff were following the expected procedure. -The facility currently did not have a system in place for changes in status to assure the physician was notified. -She would implement a policy as soon as possible and assure all staff were trained. -In an emergency, staff were supposed to call 911. -The facility had not had a policy or system in place to assure staff called 911 or for documentation related to emergencies. _____ The facility failed to coordinate and assure 6 of 8 residents sampled (#1, #2, #3, #6, #10, #11) received health care services necessary to maintain their mental and physical health and well-being; failed to notify the PCP of Resident	D 273		

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D 273	Continued From page 157 #3's fingerstick blood sugar results, ranging from 406 - 537 on fourteen occasions; a resident with a change in status, resulting in a delay in Resident #11 being evaluated for signs and symptoms of a urinary tract infection before being sent to the hospital for unresponsiveness, hypotension, altered respiratory status, and required in-patient hospitalization for intravenous antibiotic treatment for sepsis; and Resident #10's complaints of not feeling well, dizziness, change in mental status, and refusal of emergent medical treatment, resulting in the resident being found later that shift deceased in his bed. The facility's continued failure resulted in serious physical harm, death, and neglect, which constitutes an Unabated Type A1 Violation. _____ Review of the facility's Plan of Protection dated 10/13/17 revealed: -Any issues reported on survey will be reported to the physician or appropriate referral source. -Chart audit will be done by Administrator to ensure that all health care orders have been followed and health needs met. -Administrator will monitor by auditing random charts and observation with residents. -All communication with health care providers will be documented in resident records. -Facility will develop policy on emergency procedures regarding when to send residents out to hospital and staff will be in-serviced on new policy. -Administrator will review transportation log to ensure appointments are kept.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the	D 276		

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D 276	Continued From page 158 following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement orders from the primary care provider (PCP) for 4 of 4 residents sampled (#1, #2, 3, 4) who had orders for weights and 2 of 2 residents sampled (#2, #3) with orders for blood pressure checks. The findings are: 1. Review of Resident #2's current FL-2 dated 04/06/17 revealed: -Diagnoses included Alzheimer's and Hypertension. -There was an order for monthly weights. -There was an order for monthly blood pressure checks. Review of the 200 Hall Monthly Weights 2017 form on 10/12/17 at 12:00 p.m. revealed: -Resident #2's weight was documented as 112 pounds (lbs.) in March 2017. -Resident #2's weight was documented as 96 lbs. in April 2017. -Resident #2's weight was documented as 95 lbs. in May 2017. -Resident #2's weight was documented as 96 lbs. in June 2017.	D 276		

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D 276	Continued From page 159 -Resident #2's weight was not documented in July, August, September or October 2017. Review of the 100 Hall Monthly Weights 2017 form revealed Resident #2 was not listed on the form. Review of Resident #2's October 2017 medication administration records (MARs) revealed: -There was a computer generated entry to check weight every month. -There was no weight documented. -There was a computer generated entry to check blood pressure every month. -There was no blood pressure documented. Review of Resident #2's September 2017 MARs revealed: -There was a computer generated entry to check weight every month. -There was no weight documented. -There was a computer generated entry to check blood pressure every month. -There was no blood pressure documented. Review of Resident #2's August 2017 MARs revealed: -There was a computer generated entry to check weight every month. -There was no weight documented. -There was a computer generated entry to check blood pressure every month. -There was one blood pressure (122/68) documented on 08/08/17. Interview with a medication aide/supervisor (MA/S) on 10/12/17 at 12:05 p.m. revealed: -Resident #2 should have been weighed monthly. -Resident #2 "had most likely not been weighed	D 276		

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D 276	Continued From page 160 after June 2017 because she moved to the 100 Hall and her name was not transferred to the 100 Hall Monthly Weights 2017 form at that time". -She was not sure if Resident #2 had lost weight since June 2017. -Resident #2 should have had her blood pressure checked monthly. -She was not sure why Resident #2's blood pressure was not checked in September and October 2017. Telephone interview with Resident #2's Primary Care Provider on 10/13/17 at 2:15 p.m. revealed: -He had known Resident #2 for four years, and "she has gone downhill ever since". -He was not aware that the facility had not weighed Resident #2 since June 2017. -He expected Resident #2 to be weighed monthly as ordered. -He was not aware that the facility had not checked Resident #2's blood pressure since August 2017. -He expected Resident #2 to have blood pressure checks monthly as ordered. -He visited Resident #2 at the facility each month and expected all orders to be carried out immediately after the order was written. -He was going to contact the Administrator because he was concerned that physician orders were not being carried out as ordered. Based on interviews and record reviews, Resident #2 had not been weighed for 4 of the last 4 months as ordered and had not had blood pressure checks for 2 of the last 3 months as ordered. Refer to the schedule for blood pressure (BP) checks.	D 276		

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	HAL031003	A. BUILDING: _____ B. WING _____	R-C 10/17/2017

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GOLDEN CARE	4002 SOUTH NC 41 WALLACE, NC 28466

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D 276	Continued From page 161 Refer to the schedule for resident weight checks. Refer to interview with a first shift medication aide (MA) on 10/17/17 at 8:45 a.m. Refer to interview with a second shift personal care aide (PCA) on 10/17/17 at 9:08 a.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 2. Review of Resident #3's current FL-2 dated 03/07/17 revealed diagnoses included diabetes mellitus, peripheral vascular disease, pneumonia, and muscle weakness. Review of physician's orders dated 04/06/17 for Resident #3 revealed: -There was an order to check weights monthly. -There was an order to check blood pressure (BP) monthly. Review of the August 2017, September 2017, and October 2017 medication administration records (MARs) revealed: -There was an entry each month for the weight to be checked monthly. -There was an entry each month for the BP to be checked monthly. -The scheduled time for the weights and BPs to be checked was 7:00 a.m. - 3:00 p.m. (first shift). -There were no weights or BPs documented on the MARs from 08/01/17 - 10/13/17. Review of the facility's monthly weight book revealed: -Resident #3 weighed 110 pounds in April 2017. -Resident #3 weighed 116 pounds in June 2017. -There were no other weights documented for Resident #3.	D 276		

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D 276	Continued From page 162 Review of a physician's visit form dated 09/06/17 revealed the resident's BP was 100/63. Interview with a first shift medication aide (MA) on 10/17/17 at 8:45 a.m. revealed: -She did not know why the BPs and weights for Resident #3 had not been done. -It should be documented on the MARs. Interview with Resident #3 on 10/17/17 at 10:25 a.m. revealed: -The facility staff had not weighed her in a few months. -They facility staff "hardly ever" checked her BP. -She could not remember the last time her BP was checked by facility staff. Refer to the schedule for blood pressure checks. Refer to the schedule for resident weight checks. Refer to interview with a first shift medication aide (MA) on 10/17/17 at 8:45 a.m. Refer to interview with a second shift personal care aide (PCA) on 10/17/17 at 9:08 a.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 3. Review of Resident #1's current FL-2 dated 02/20/17 revealed: -Diagnoses included senile dementia, uncontrolled Type II diabetes, hypertension, anemia, and depression. -There was a physician's order for monthly weights. Review of the 100 Hall Monthly Weights 2017	D 276		

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D 276	Continued From page 163 form revealed: -Resident #1's weight was documented as 110 pounds (lbs.) in April and May 2017. -Resident #1's weight was not documented in June, July, or August 2017. -In September 2017, Resident #1's weight was documented as 100 lbs. -In October 2017, Resident #1's weight was documented as 104 lbs. . Review of Resident #1's August 2017 medication administration records (MARs) revealed: -There was a handwritten entry to check weight every month. -No weight was documented for Resident #1 in August 2017. Review of Resident #1's September 2017 MARs revealed: -There was a computer generated entry to check weight every month. -Resident #1's weight was documented as 100 pounds lbs. on 09/03/17. Review of a physician order for Resident #1 dated 10/02/17 revealed: -There was documentation of a seven pound weight loss over 6 weeks. -There was an order to check weight once weekly and record Review of Resident #1's October 2017 revealed: -There was a computer generated entry to check weigh every month. -There was no entry to check weight weekly. -Resident #1's weight was documented as 103 lbs. on 10/01/17. -There were no other weights documented. Interview with a medication aide/supervisor	D 276		

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D 276	Continued From page 164 (MA/S) on 10/12/17 at 11:56 a.m. revealed: -She did not think Resident #1 had lost any weight. -No residents were on weekly weight; all residents were weighed monthly. Interview with a personal care aide (PCA) on 10/12/17 at 7:50 p.m. revealed Resident #1 looked like he had lost weight over the last few months. Interview with a second MA/S on 10/13/17 at 5:30 p.m. revealed: -All residents were weighed monthly. -Resident #1 was always "skinny", but he had lost weight. -The last time she weighed Resident #1 was this month (October 2017) and he weighed 104 lbs. Telephone interview with Resident #1's family member on 10/13/17 at 7:06 a.m. revealed: -Resident #1 had lost weight. -The family member did not know how much weight he had lost or over what period of time, but the family had to purchase a smaller size sweat pants for the resident. -The family member did not know if or when Resident #1 was weighed. Telephone interview with a Nurse Practitioner (NP) at Resident #1's Primary Care Provider's office on 10/16/17 at 3:31 p.m. revealed: -Resident #1 had some weight loss, which was to be expected. -She expected Resident #1 to be weighed as ordered (weekly). Staff was asked to weight Resident #1 on 10/12/17 at 11:56 a.m.; however the weight was not provided and staff were not observed to weigh	D 276		

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D 276	Continued From page 165 the resident. Based on record reviews and interviews, Resident #1 was not weighed monthly, as ordered in July or August 2017 and was not weighed weekly for two weeks in October 2017. Based on observations, records reviews, and interviews, Resident #1 was not interviewable. Refer to the schedule for resident weight checks. Refer to interview with a first shift medication aide (MA) on 10/17/17 at 8:45 a.m. Refer to interview with a second shift personal care aide (PCA) on 10/17/17 at 9:08 a.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 4. Review of Resident #4's current FL-2 dated 06/05/17 revealed: -Diagnoses included traumatic brain injury, seizures, and bi-polar disorder. -Resident #4's weight was documented as 127 pounds (lbs.). Interview with Resident #4 on 10/11/17 at 4:20 p.m. revealed: -She had lost 21 lbs. since a recent hospitalization (unsure of the dates). -She had lost so much weight her top denture plate did not fit and she was going to be getting a new one. -All of her clothes were baggy because she had lost weight. -She was supposed to be weighed once a month. A second interview with Resident #4 on 10/13/17	D 276		

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D 276	Continued From page 166 at 4:50 p.m. revealed: -Every resident was supposed to be weighed once a month. -She was supposed to be weighed on the first Sunday of each month, but staff did not always weigh her. -The last time she was weighed was when the PCP was at the facility (unsure of date). -She did not recall her last weight. Review of a Provider Visit Form for Resident #4 dated 10/02/17 revealed: -There was documentation Resident #4 had a 4 lb. weight loss over two weeks. -Resident #4's weight was documented as 119 lbs. Review of Resident #4's physician orders revealed there was no orders for weight checks found. Interview with a medication aide/supervisor (MA/S) on 10/13/17 at 10:15 a.m. revealed: -Resident #4's orders for monthly weights should be in her record because all residents were weighed monthly. -She would look for the physician orders related to Resident #4's weights. -Resident #4 had some weight loss over the last couple of months. Interview with a second MA/S on 10/13/17 at 5:30 p.m. revealed: -All residents were weighed monthly. -She did not think Resident #4 had lost any weight. Review of the 100 Hall Monthly Weights 2017 form revealed: -Resident #4's weight was not documented in	D 276		

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D 276	Continued From page 167 August. -Resident #4's weight was documented as 117 lbs. in September 2017. -Resident #4's weight was documented as 122 lbs. in October 2017. Review of Resident #4's October 2017 medication administration records (MARs) revealed: -There was a computer generated entry to check weigh every month. -Resident #4's weight was not documented in October 2017. Review of Resident #4's September 2017 MARs revealed: -There was a computer generated entry to check weigh every month. -Resident #4's weight was documented as 117 lbs. on 09/03/17. Review of Resident #4's August 2017 MARs revealed: -There was a handwritten entry to check weigh every month. -No weight was documented for Resident #4 in August 2017. Telephone interview with a Nurse Practitioner (NP) at Resident #4's PCP office on 10/16/17 at 3:31 p.m. revealed: -She last evaluated Resident #4 on 10/02/17 and noted she had recent weight loss. -Resident #4 was supposed to be weighed monthly. -She expected Resident #4 to be weighed as ordered. A copy of Resident #4's physician order for weights was not provider by the end of the	D 276		

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D 276	Continued From page 168 survey. Based on record reviews and interviews, Resident #4 was ordered to be weighed monthly, per physician and facility procedure. There was no physician order found in Resident #4's record for monthly weights and staff were not able to locate the weight order. Resident #4's weight was not completed for August 2017. Refer to the schedule for resident weight checks. Refer to interview with a first shift medication aide (MA) on 10/17/17 at 8:45 a.m. Refer to interview with a second shift personal care aide (PCA) on 10/17/17 at 9:08 a.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. Review of a schedule for blood pressure (BP) checks posted at the nurses' station revealed: -BPs were to be taken on second shift at the beginning of the shift. -The BP schedule was broken down to 7 days a week with 3 room numbers listed under each day of the week except for Sundays. -There were two room numbers scheduled for Sundays. Review of a schedule for resident weights posted at the nurses' station revealed: -Second shift was to weigh residents on Sundays since there were no baths. -The weight schedule was broken down to 4 Sundays of the month with 5 room numbers each for the 1st, 3rd, and 4th Sundays of the month. -There were 4 room numbers scheduled for the 2nd Sundays of the month.	D 276		

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D 276	Continued From page 169 Interview with a first shift medication aide (MA) on 10/17/17 at 8:45 a.m. revealed: -Weights and vital signs should be documented on the MARs. -Second shift MAs and personal care aides (PCAs) were responsible for checking and documenting vital signs and weights. -There was an assignment sheet for staff indicating when the weights and vital signs should be checked. -She did not know why the weights and vital signs were not being done. Interview with a second shift PCA on 10/17/17 at 9:08 a.m. revealed: -The MAs and the PCAs usually did vital signs and weights on Sundays during second shift. -They usually documented the results on scratch pieces of paper. -She did not know where the scratch pieces of paper were kept. -She did not know when the vital signs or weights were last checked. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -Vital signs and weights should be documented on the MARs or the log books. -She was not aware vital signs and weights were not being done as ordered. -The MAs were supposed to do the vital signs and weights. -The vital signs and weights could be done on any shift. The facility failed to obtain weights as ordered for 4 of 4 residents sampled (#1, #2, #3, #4) including two residents with documented weight loss (#1, #4) and failed to obtain blood pressures	D 276		

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D 276	Continued From page 170 as ordered for 2 of 2 residents (#2, #3) including one resident with a diagnosis of hypertension. The facility's failure was detrimental to the health and welfare of the residents which constitutes a Type B Violation. _____ Review of the facility's plan of protection dated 10/17/17 revealed: -Charts will be audited immediately for health care orders, including weights and vital signs. -Staff on all shifts will be in-serviced. -Supervisor / medication aide will be responsible for implementation of orders, documentation of implementation on MARs, and follow-up. -Administrator to monitor orders daily. -Supervisor / medication aide will implement orders as soon as it comes in on all shifts. -Administrator will monitor orders and MARs daily to ensure compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 1, 2017.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the kitchen, dining and food storage areas were kept clean, orderly and free from contamination related to	D 282		

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D 282	Continued From page 171 roaches in the kitchen and dining room. The findings are: Review of a kitchen inspection report from Environmental Health Services dated 08/01/17 revealed: -The facillity's sanitation grade was 87.0 on 08/01/17. -Live adult roaches were observed on the prep tables and drawers. -Professional extermination needed every 2 weeks to help combat the severity of the problem. -It was documented that spraying was completed in June 2017, but there was no documentation from July 2017. -This documentation should be kept in a secure location for viewing. -A follow-up visit will be made to access extermination attempts. Review of a kitchen revisit report from Environmental Health Services dated 08/29/17 revealed: -A visit was made to verify correction of items noted on the last kitchen inspection. -An employee indicated an exterminator company sprayed earlier in the day and she thought they were spraying every 2 weeks. -However, documentation in the kitchen indicated the last time the exterminator company came was in June 2017. -A live juvenile roach was observed on the prep sink drainboards. -Several dead roaches were observed on a sticky pad that was not changed today with the exterminator company. -Make sure all sticky pads get changed to verify if current actions are working to eradicate the roach population.	D 282		

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D 282	Continued From page 172 the prep tables and drawers. Interview with the medication aide/supervisor (MA/S) on 10/11/17 at 4:10 p.m. revealed: -The exterminator company came to the facility about once a month. -She saw a roach in the kitchen in the ice box yesterday (10/10/17). -She tried to get the roach out of the ice box but it crawled further into the ice in the ice box and she could not get the roach. -She usually saw 10 or 12 roaches every day in the kitchen or dining room. -The roach problem had gotten better about 2 weeks ago. -Before that, you could flip a light on and the roaches were everywhere. Interview with a cook/MA on 10/11/17 at 8:20 a.m. revealed: -She had not seen any roaches recently; the last time was 3 weeks ago. -The exterminator's last treatment was one month ago. Observation of the kitchen on 10/16/17 at 9:50 a.m. revealed: -There was one roach crawling on the floor near the hand sink. -There was a roach crawling on the trash can near the hand sink. Interview with a cook on 10/16/17 at 9:50 a.m. revealed she still saw roaches in the kitchen but it was better. Interview with the Administrator on 10/12/17 at 10:02 a.m. revealed: -She thought the exterminator company came to the facility every 2 weeks and targeted treatment	D 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 282	Continued From page 173 for the roaches. -She did not think they left invoices when they came but she would check. -There had been an improvement with the roaches but they were not gone. -She saw 1 or 2 roaches in the kitchen last week. Review of invoices from the exterminator company revealed: -05/09/17: The entry doors and dining/cafeteria were treated for roaches. -06/22/17: Pest control (roaches) for room 106 - 203, kitchen, dining room, janitor closet, and emergency closet. -07/25/17: The entry doors, dining/cafeteria, and bathrooms were treated for roaches. -08/08/17: The entry doors and dining/cafeteria were treated for roaches. -08/29/17: The entry doors and dining/cafeteria were treated for roaches. -09/12/17: The food preparation areas, entry doors, dining area, and a couple of resident rooms were treated for roaches. -09/26/17: The kitchen, dining area, and a couple of resident rooms were treated for roaches. -There were no invoices for October 2017.	D 282		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking	D 299		

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D 299	Continued From page 174	D 299		

purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to serve 8 ounces of milk at least twice daily to the residents.

The findings are:

Review of the Resident Roster provided by the medication aide/supervisor on 10/11/17 revealed there were 20 residents currently residing in the facility.

Review of the "Cycle 1, Week 2" menu posted in the kitchen on 10/11/17 at 11:41 a.m. revealed:
-The posted menu did not include the current week for October 2017.
-Milk was listed to be served daily at breakfast, lunch and dinner; the serving size of milk was not documented on the menu.
-Based on the census, the facility required 3.75 gallons of milk daily.

Observation of the milk on hand on 10/11/17 at 11:41 a.m. revealed there were three full gallons of 2% reduced fat milk and one gallon of 2% reduced fat milk that had approximately ¼ of the milk remaining.

Observation of the lunch meal service on 10/11/17 at 12:00 p.m. revealed the residents were served beverages which included 4oz of milk.

Observation of the milk on hand on 10/12/17 at 8:19 a.m. revealed:
-There were three full gallons of 2% reduced fat

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milk and one gallon of 2% reduced fat milk that had approximately ¼ of the milk remaining.
- There were one gallon of 1% reduced fat milk that had approximately ¼ of the milk remaining.

Observation of the milk on hand on 10/13/17 at 8:34 a.m. revealed:
-There were four full gallons of whole milk.
-There was one gallon of 2% reduced fat milk that had approximately ¼ of the milk remaining.
-There was one gallon of 1% reduced fat milk that had approximately ¼ of the milk remaining.

Observation of the milk on hand on 10/17/17 at 8:25 a.m. revealed:
-There were six full gallons of 2% reduced fat milk and one gallon of 2% reduced fat milk that had approximately 2/3 of the milk remaining.
-There were two full gallons of 1% reduced fat milk.

Observation of the lunch meal service on 10/17/17 at 11:45 a.m. revealed residents were served beverages that included 6oz of milk.

Review of the posted menu in the kitchen for "Fall/Winter 2017-2018, Week 3" on 10/17/17 at 8:26 a.m. revealed:
-The posted menu included the current week for October 2017.
-Milk was listed to be served daily at breakfast, lunch and dinner; the serving size of milk was not documented on the menu.

Interview with a resident on 10/12/17 at 12:15 p.m. revealed the resident did not usually get milk at meals.

Interview with a second resident on 10/12/17 at 5:10 p.m. revealed:

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D 299	Continued From page 176 -"We never get milk." -The resident would like to have milk every day. -"I love it." Interview with a family member on 10/12/17 at 12:22 p.m. revealed: -The residents never had milk. -If it was served, it was only served at breakfast (with cereal). -The family member visited at least once daily and never saw milk being served at meals. Interview with a second family member on 10/12/17 at 3:45 p.m. revealed milk was not served at lunch or dinner. Confidential staff interviews revealed: -The first time the staff had ever seen milk served was that day (date withheld to maintain confidentiality). -The residents were "never" served milk. Interview with a Cook/Medication Aide (MA) on 10/11/17 at 8:20 a.m. revealed: -The Manager bought milk every other day. -They usually kept 4-5 gallons of milk on hand all the time. Interview with a second Cook on 10/13/17 at 8:30 a.m. revealed: -Milk was bought at a local store. -They kept 4-6 gallons on hand. -They served 6 ounce (oz.) of milk at each meal. -She did not know why residents would say they were not being served milk -If the Cook bought milk, she turned the receipt in to the Manager. -The only receipt she had was from 10/11/17. Review of an itemized receipt from a local	D 299		

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D 299	Continued From page 177 department store dated 10/11/17 revealed three gallons of milk were listed as purchased. Interview with the Administrator on 10/13/17 at 10:30 a.m. revealed: -The Manager bought milk from a local store for the facility. -The Administrator did not have any receipts for milk purchases. -They were supposed to have milk in stock. Based on observations, interviews, and review of the dietician approved menu, the facility failed to serve 8 ounces of milk at least twice daily to the residents and did not maintain enough milk on hand to serve 8 ounces of milk at least twice daily to a census of 20 residents.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served to 3 of 3 residents sampled (#1, #2, #4) who had orders for thickened liquids (#2) and nutritional supplements (#1, #4). The findings are:	D 310		

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D 310	Continued From page 178 1. Review of Resident #2's current FL-2 dated 04/06/17 revealed diagnoses included Alzheimer's and hypertension. Review of physician orders for Resident #2 dated 10/09/17 revealed an order for honey thickened liquids. Observation of the kitchen on 10/11/17 at 11:30 a.m. revealed: -There was a handwritten therapeutic diet list posted on the freezer door. -The therapeutic diet list did not list residents with orders for thickened liquids. Interview with a cook on 10/11/17 at 11:30 a.m. revealed: -Resident #2 was on honey thickened liquids. -She had been mixing and using thickener "for years." -She followed the directions on the thickener container to mix Resident #2's liquids. Review of the instruction on the thickener identified by the cook as belonging to Resident #2 revealed: (Thickener is a powder added to thin liquids to achieve nectar, honey, or pudding consistency for individuals with swallowing problems to prevent choking or aspiration of the liquids into the lungs). -For honey consistency water, mix 4 to 5 teaspoons of thickener to each 4 ounce glass of water. -For honey consistency nutrition supplement, mix "5-5.5" teaspoons of thickener to each 4 ounce glass of supplement. -For honey consistency milk, mix "5 to 5.5" teaspoons of thickener to each 4 ounce glass of milk.	D 310		

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D 310	Continued From page 179 -Let stand for 30 seconds to one minute to achieve desired consistency and serve. -When mixed with milk or nutritional supplement, stir briskly, let stand 5-10 minutes, stir and serve. -For best results, consume within 30 minutes of mixing. -There was no measuring device found inside the container of thickener. Observation of the lunch meal service on 10/11/17 at 12:00 p.m. revealed: -Resident #2 was in a Geri-chair in the dining room being fed by a staff member. -There was a 4oz glass of honey thickened water and a 4oz glass of honey thickened milk sitting at Resident #2's place setting. -The staff member was feeding Resident #2 a spoon of dark brown pudding thickened substance out of a 4oz glass. -Resident #2 did not exhibit any signs and symptoms of choking. Interview with Resident #2's hospice physician on 10/11/17 at 4:47 p.m. revealed: -Resident #2 had previously been on hospice, but she stabilized and was removed from hospice (he did not recall the dates right off hand). -Resident #2's family member requested she be re-evaluated for hospice because she was having swallowing difficulty and poor appetite. -He recalled it being mentioned at a care meeting that Resident #1 was on nutritional supplements and honey thickened liquids -Resident #2 would have been at risk for aspiration on any consistency of liquids due to her end stage dementia. -Resident #2 should not receive liquids thinner than honey consistency. Interview with a cook on 10/12/17 at 8:20 a.m.	D 310		

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revealed:
-She had already mixed Resident #2's beverages for breakfast.
-She put a teaspoon of thickener powder in the resident's water and orange juice.

Observation on 10/12/17 at 8:20 a.m. revealed the cook pointed to a regular teaspoon indicating that was what she had used to measure the thickener powder for Resident #2's water and orange juice.

Observation on 10/12/17 at 8:38 a.m. revealed:
-Resident #2 had 4oz of milk that was not thickened.
-Resident #2 had honey thickened water and orange juice served.

Staff was prompted on 10/12/17 at 8:38 a.m. not to serve the milk to Resident #2 because it was not honey thick consistency.

Interview with a medication aide/supervisor (MA/S) and cook on 10/12/17 at 8:39 a.m. revealed:
-Both acknowledged that Resident #2's milk was not honey thickened consistency.
-The MA/S had told the cook not to thicken Resident #2's milk.
-The MA/S said she told the cook not to thicken the milk because she thought it was a nutritional supplement and the supplement was already thickened.

Observation on 10/12/17 at 8:41 a.m. revealed:
-The cook began to demonstrate how she thickened Resident #2's liquids.
-She poured a nutritional supplement into a 4oz glass (without use of a measuring device).
-She picked up a regular teaspoon to measure

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the thickener powder.
-She was prompted to stop the process (because she was not using appropriate measuring devices, so as not to waste the nutritional supplement).

Interview with the cook on 10/12/17 at 8:45 a.m. revealed:
-She was trained a long time ago with a different type of thickener.
-She had not had any training on how to mix Resident #2's thickener.

Observation of the lunch meal service on 10/12/17 at 12:07 p.m. revealed:
-Resident #2 was in a Geri-chair in the dining room being fed by a hospice Registered Nurse (RN).
-There was a 4oz glass of honey thickened water and a 4oz glass of honey thickened tea sitting at Resident #2's place setting.
-The RN was feeding Resident #2 a spoon of dark brown pudding thickened substance out of a 4oz glass.
-Resident #2 did not exhibit any signs and symptoms of choking.

Interview with the hospice RN on 10/12/17 at 12:07 p.m. revealed:
-This was the first time she had seen Resident #2 since her discharge from hospice in June 2017.
-Resident #2 was appropriately responding to wanting more of her honey thickened beverage.
-Resident #2 did not exhibit any signs and symptoms of choking.

Telephone interview with Resident #2's PCP on 10/13/17 at 2:15 p.m. revealed:
-He was informed by a facility staff member on 10/9/17 that Resident #2 was having difficulty

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swallowing her food.
-On 10/9/17, he ordered honey thickened liquids.

Interview with a MA/S on 10/16/17 at 12:30 p.m. revealed Resident #2 was tolerating the honey thick liquids well.

Interview with the hospice RN on 10/16/17 at 12:35 p.m. revealed Resident #2 has had no issues with swallowing the honey thick liquids.

Interview with Resident #2's family member on 10/17/17 at 8:55 a.m. revealed:
-Prior to the resident's emergency room (ER) visit for coughing on 10/7/17, she was on a regular diet and had no problems swallowing that he was aware of.
-He was informed by the ER physician that "she may need to be considered for a liquid diet".

Review of hospital medical records for Resident #2's 10/7/17 ER visit did not show any physician order for diet.

Interview with the Administrator on 10/17/17 at 10:19 a.m. revealed she would make sure staff were trained to mix thickened liquids.

2. Review of Resident #1's current FL-2 dated 02/20/17 revealed diagnoses included senile dementia, uncontrolled Type II diabetes, hypertension, anemia, and depression.

Review of physician's orders for Resident #1 dated 02/21/17 revealed an order for a (named type/brand) nutritional supplement one carton every six hours while awake "no stop date."

Observation of the kitchen on 10/11/17 at 11:30 a.m. revealed:

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D 310	Continued From page 183 -There were none of the type/brand of nutritional supplements Resident #1 was ordered stocked in the refrigerator or freezer. -There was a handwritten therapeutic diet list posted on the freezer door. -The therapeutic diet list did not contain a list of residents with orders for dietary supplements. Observation of the lunch meal service on 10/11/17 from 11:30 a.m.-12:00 p.m. revealed Resident #1 was not served a nutritional supplement. Observation of the kitchen on 10/12/17 at 8:18 a.m. revealed the brand and type of nutritional supplement Resident #1 was ordered was not stocked in the refrigerator or freezer. Observation of the breakfast meal service on 10/12/17 from 8:00 a.m.-8:30 a.m. revealed: -Resident #1 was served orange and water for beverages. -Resident #1 was not served a nutritional supplement. Observation of the lunch meal service on 10/12/17 from 11:30 a.m. - 12:07 p.m. revealed: -Resident #1 was served water, tea, and 4oz milk for beverages. -Resident #1 was not served a nutritional supplement. Observation of the kitchen on 10/17/17 at 8:25 a.m. revealed the ordered brand of nutritional supplements for Resident #1 was not stocked in the refrigerator or freezer. Review of Resident #1's October 2017 medication administration records (MARs) revealed:	D 310		

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D 310	Continued From page 184 -There was a computer generated entry for the (named) brand of nutritional supplement one carton every 6 hours while awake with administration times of 8:00 a.m., 2:00 p.m., and 8:00 p.m. -The nutritional supplement was documented as given at 8:00 p.m. on 10/01/17 and 10/02/17. -The nutritional supplement was documented as given three times daily from 10/03/17-10/06/17. -The nutritional supplement was documented as given at 8:00 p.m. on 10/07/17 and 10/08/17. -The nutritional supplement was documented as given three times daily from 10/09/17-10/10/17. -The nutritional supplement was documented as given at 8:00 a.m. and 2:00 p.m. on 10/11/17 (it was not in stock). -The nutritional supplement was documented as given at 8:00 a.m. on 10/13/17 (it was not in stock). Interview with a medication aide/supervisor (MA/S) on 10/12/17 at 11:56 a.m. revealed Resident #1 was not on a nutritional supplement. Interview with a cook on 10/12/17 at 12:17 p.m. revealed: -She thought Resident #1 was on nutritional supplements three times a day unless the order changed. -They were out of Resident #4's brand/type of nutritional supplements right now. A second interview with the cook on 10/12/17 at 3:30 p.m. revealed: -She recalled taking the last of the brand/type of nutritional supplement Resident #1 was ordered out of the refrigerator on Tuesday (10/10/17); she gave the nutritional supplement to Resident #1. -She was told by a (named) MA/S to give Resident #1 a nutritional supplement three times	D 310		

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a day with meals but did not know if he had an order for the nutritional supplements.

Interview with a personal care aide (PCA) on 10/12/17 at 7:50 p.m. revealed:
-She thought Resident #1 was on a nutritional supplement at one time, but he had not been getting the supplement "recently" (over a month).
-Resident #1 looked like he had lost weight over the last few months.

Interview with a second cook on 10/13/17 at 8:30 a.m. revealed Resident #1 was the only resident on the specific brand of nutritional supplements.

Interview with a PCA on 10/16/17 at 3:00 p.m. revealed she had never observed Resident #1 being served a nutritional supplement at meals.

Telephone interview with Resident #1's family member on 10/13/17 at 7:06 a.m. revealed:
-Resident #1 had lost weight.
-The family member did not know how much weight he had lost or over what period of time, but the family had to purchase a smaller size sweat pants for the resident.
-The family member did not know if or when Resident #1 was weighed.
-Resident #1 was not on a nutritional supplement.

Review of a Provider Visit form for Resident #1 dated 10/02/17 revealed there was documentation of a seven pound weight loss in 6 weeks.

Telephone interview with a Nurse Practitioner (NP) at Resident #1's Primary Care Provider's office on 10/16/17 at 3:31 p.m. revealed:
-Resident #1 had some weight loss, which was to be expected.

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D 310	Continued From page 186 -She expected Resident #1 receive his (named brand/type) nutritional supplement as ordered. -She was not aware the facility was out of the (named brand/type) nutritional supplements or that Resident #1 had not been getting the nutritional supplements. -Her expectation on notification that the facility was out of nutritional supplements depended on how long the supplement had been out of stock. Staff was asked to weight Resident #1 on 10/12/17 at 11:56 a.m.; however the weight was not provided and staff were not observed to weigh the resident. A copy of the last three months of receipts from the vendor food orders was requested from the Administrator on 10/13/17 at 10:30 a.m.; however, the receipts were not provided. Observation of the kitchen on 10/17/17 at 8:15 a.m. revealed there was a handwritten diet list posted on the freezer which had Resident #1's name documented to receive nutritional supplements. Observation of the kitchen on 10/17/17 at 8:25 a.m. revealed the type/brand of nutritional supplements Resident #1 was ordered was not stocked in the refrigerator or freezer. Based on observations, records reviews, and interviews, Resident #1 was not interviewable. Refer to the interview with a cook on 10/12/17 at 11:30 a.m. Refer to the interview with a medication aide/supervisor (MA/S) on 10/12/17 at 12:15 p.m.	D 310		

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D 310	Continued From page 187 Refer to the second interview with a cook on 10/12/17 at 3:30 p.m. Refer to the interview with a second cook on 10/13/17 at 8:30 a.m. Refer to the interview with the Administrator on 10/13/17 at 10:30 a.m. Refer to the second interview with the Administrator on 10/17/17 at 10:19 a.m. 3. Review of Resident #4's current FL-2 dated 06/05/17 revealed diagnoses included traumatic brain injury, seizures, and bi-polar disorder. Review of a Provider Visit Form for Resident #4 dated 10/02/17 revealed: -There was documentation Resident #4 had a 4 lb. weight loss over two weeks. -Resident #4's weight was documented as 119 lbs. -There was an order for a (named type/brand) nutritional supplement with each meal. Interview with Resident #4 on 10/11/17 at 4:20 p.m. revealed: -She had lost 21 lbs. since a recent hospitalization (unsure of the dates). -She had lost so much weight her top denture plate did not fit and she was going to be getting a new one. -All of her clothes were baggy because she had lost weight. -She was supposed to be weighed once a month. Interview with Resident #4 on 10/13/17 at 4:50 p.m. revealed she had never received a (named) nutritional supplement.	D 310		

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D 310	Continued From page 188 Observation of the kitchen area on 10/11/17 at 11:30 a.m. revealed: -There were none of the type/brand of nutritional supplements Resident #4 was ordered stocked in the refrigerator or freezer. -There was a handwritten therapeutic diet list posted on the freezer door. -The therapeutic diet list did not list the residents with orders for nutritional supplements. Observation of the kitchen area on 10/12/17 at 8:18 a.m. revealed the type/brand of nutritional supplements Resident #4 was ordered was not stocked in the refrigerator or freezer. Observation of the supper meal service on 10/13/17 at 5:10 p.m. revealed: -Resident #4 was served milk, water, and tea as beverages. -She was not served a nutritional supplement. Observation of the breakfast meal service on 10/16/17 at 8:15 a.m. revealed: -Resident #4 was served milk, water, and orange juice as beverages. -She was not served a nutritional supplement. Review of Resident #4's October 2017 medication administration records (MARs) revealed: -There was not an entry for the nutritional supplements. -There was no documentation of Resident #4 receiving nutritional supplements on the October MAR. Interview with a medication aide/supervisor (MA/S) on 10/12/17 at 11:56 a.m. revealed Resident #4 was not on a (named) nutritional supplement	D 310		

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D 310	Continued From page 189 A second interview with the MA/S on 10/16/17 at 1:00 p.m. revealed: -She did not know Resident #4 had an order for the (named type/brand) nutritional supplements. -She would check on Resident #4's order for nutritional supplements. -She did not think Resident #4 had been getting nutritional supplements. -All she could say was they probably missed the order for Resident #4's nutritional supplements. Interview with a Personal Care Aide (PCA) on 10/16/17 at 3:00 p.m. revealed she had never observed Resident #4 being served any type of nutritional supplement at meals. A copy of the last three months of receipts from the vendor food orders was requested from the Administrator on 10/13/17 at 10:30 a.m.; however, the receipts were not provided. Telephone interview with a Nurse Practitioner (NP) at Resident #1's Primary Care Provider's office on 10/16/17 at 3:31 p.m. revealed: -She expected Resident #4 receive her (named) nutritional supplement as ordered. -She was not aware the facility was out of nutritional supplements or that Resident #4 had not been getting the nutritional supplements. -Her expectation on notification that the facility was out of nutritional supplements depended on how long the supplement had been out of stock. Observation of the kitchen area on 10/17/17 at 8:15 a.m. revealed there was a handwritten diet list posted on the freezer which had Resident #4's name documented to receive nutritional supplements.	D 310		

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D 310	Continued From page 190 Observation of the kitchen on 10/17/17 at 8:25 a.m. revealed the type/brand of nutritional supplements Resident #4 was ordered was not stocked in the refrigerator or freezer. Refer to the interview with a cook on 10/12/17 at 11:30 a.m. Refer to the interview with a medication aide/supervisor (MA/S) on 10/12/17 at 12:15 p.m. Refer to the second interview with a cook on 10/12/17 at 3:30 p.m. Refer to the interview with a second cook on 10/13/17 at 8:30 a.m. Refer to the interview with the Administrator on 10/13/17 at 10:30 a.m. Refer to the second interview with the Administrator on 10/17/17 at 10:19 a.m. _____ Interview with a cook on 10/12/17 at 11:30 a.m. revealed: -There were only two (named) residents who received a nutritional supplement (not Resident #1 or Resident #4). -There was no written list for staff on who was supposed to receive nutritional supplements; staff just knew who got them. Interview with a medication aide/supervisor (MA/S) on 10/12/17 at 12:15 p.m. revealed: -The (named brand/type) nutritional supplements were kept in the kitchen. -The cooks served the(named brand) nutritional supplements. -She did not know if the facility had any of the nutritional supplements Resident #1 and Resident	D 310		

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#4 were ordered in stock.
-The Manager ordered the (named brand/type) nutritional supplements.

A second interview with a cook on 10/12/17 at 3:30 p.m. revealed:
-The Manager usually ordered the nutritional supplements that Resident #1 and Resident #4 were ordered, but a different (named) staff ordered last time and may have forgotten to order the nutritional supplements.
-She did not recall the last time the facility had been out of the (named) nutritional supplements ordered for Resident #1 and Resident #4.

Interview with a second cook on 10/13/17 at 8:30 a.m. revealed:
-The Manager usually ordered the type/brand of nutritional supplements that Resident #1 and Resident #4 were ordered.
-She (the cook) ordered the (named brand/type) nutritional supplements the last time, but the Manager did not get them because she (the manager) did not think there were any residents who were supposed to get it.
-The MA/S was supposed to give the residents their nutritional supplements; if the MA/S forgot, she would give the nutritional supplements.
-There was no process in place to make sure residents got their nutritional supplements as ordered.
-She would make sure there was a process in placer to make sure residents got their nutritional supplements.

Interview with the Administrator on 10/13/17 at 10:30 a.m. revealed:
-Nutritional supplements were usually given at meals by whoever was working in the kitchen.
-Resident #1 and Resident #4's type/brand of

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nutritional supplements were ordered from a vendor; the Manager may have forgotten to order them.
-They did not usually run out of the (named) nutritional supplements.
-The (named) nutritional supplements were supposed to be kept in stock and given as ordered.
-She was not aware the facility was out of the type/brand of nutritional supplements Resident #1 and Resident #4 were ordered or they had missed receiving the nutritional supplements.
-She would think the dietary staff would let the MA/S know if they were out of the (named) nutritional supplements.
-The PCP would not be aware that the facility was out of the (named) nutritional supplements.

A second interview with the Administrator on 10/17/17 at 10:19 a.m. revealed:
-The specified brand/type of nutritional supplements should be routinely ordered from the vendor every two weeks by kitchen staff.
-They had called the vendor to try to get the (named) supplements delivered last week, but could not get them.
-She "assumed" the nutritional supplements would be back in stock "yesterday."
-The kitchen staff had been giving the nutritional supplements, but the procedure would be changed and the MA/S would give them now and document on the MARs.
-There would be a list kept with orders of who was supposed to get nutritional supplements.

The facility failed to assure nutritional supplements were kept in stock and served as ordered to two residents (#1, #4) with documented weight loss and failed to assure Resident #2, who had swallowing difficulty, was

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D 310	Continued From page 193 served honey thickened liquids, as ordered. The facility's failure was detrimental to the health and welfare of the residents which constitutes a Type B Violation. Review of the facility's Plan of Protection dated 10/12/17 revealed: -Facility will provide nutrition as ordered by the physician and ensure a supply is always available. -Staff will be in-serviced on how to mix thickener to correct thickeners ordered. -Diet list will be posted in the kitchen for supplements and thickeners. -Dietary Manager will be responsible for ordering supplements. -Administrator will audit charts for diet orders. -Dietary staff will inventory food supply to ensure there is always sufficient supply at all times. -Medication Aides will be responsible for giving supplements and documenting on MAR. -Food supply will be monitored weekly. -Administrator will conduct observation weekly of mixing thickener and review MAR for documentation weekly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 1, 2017.	D 310		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and	D 317		

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learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.

This Rule is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to assure a minimum of 14 hours of planned group activities were provided each week for the 20 residents currently residing in the facility.

The findings are:

Review of the activity calendar on 10/11/17, 10/12/17, 10/13/17, 10/16/17 and 10/17/17 revealed:
-There were no activities posted for October 2017.
-The activities posted showed only those for September 2017.

Observation on 10/11/17 from 9:15 a.m.-5:15 p.m. revealed there were no activities being conducted.

Observation on 10/12/17 from 8:00 a.m.-9:00 p.m. revealed:
-At 10:25 a.m., there was a bible study being facilitated by someone from the community.
-There were approximately 10 residents in attendance.
-There were no other activities observed.

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D 317	Continued From page 195 Observation on 10/13/17 from 7:45 a.m.-7:00 p.m. revealed there were no activities being conducted. Observation on 10/16/17 from 9:00 a.m.-5:45 p.m. revealed there were no activities being conducted. Observation on 10/17/17 from 8:15 a.m.-8:00 p.m. revealed there were no activities being conducted. Interview with a resident on 9/14/17 at 11:15 a.m. revealed: -Everything on the activity calendar was "a lie." -There were no activities at the facility, other than when the preacher came on Saturday; the preacher did not come every Saturday. Interview with a personal care aide (PCA) on 8/15/17 at 3:38 p.m. revealed she had never done activities with the residents. Interview with a second PCA on 10/17/17 at 5:20 p.m. revealed: -The activity calendar was "for show." -None of the activities posted were done. -It was luck if they even changed the calendar. -Residents had nothing to do but sit around; no activities were done with the residents. Interview with the medication aide/supervisor on 10/11/17 at 9:20 a.m. revealed: -"The aides on the floor" were responsible for doing the activities with the residents. -She and one other employee had taken the activities course in the past (no timeframe specified).	D 317		

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D 317	Continued From page 196 Confidential interview with a resident revealed: -The resident did not think the facility had activities other than church and preaching sometimes. -The resident did their own activities. Confidential interview with a second resident revealed: -They did not have enough activities at the facility. -They needed to have more activities at the facility. -They did not take the residents on outings. Interview with the Administrator on 10/13/17 at 10:50 a.m. revealed: -The Manager was responsible for doing everything at the facility including overseeing the activities. -The Manager had been out on medical leave for about 2 months and was unavailable for interview. -No one took over responsibilities of overseeing activities after the Manager went on medical leave.	D 317		
D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of	D 321		

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D 321	Continued From page 197 transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide the provision of transportation for residents to medical appointments, the hospital, and shopping. The findings are: Interview with Manager on 08/18/17 at 8:20 a.m. revealed: -She had no transport staff just to pick a resident up from the hospital. -The Manager was the transport person to pick a resident up if sent to the emergency room. Interview with a personal care aide (PCA) on 08/18/17 at 5:13 p.m. revealed: -She had been at the facility since October 2016. -A resident was sent out to the hospital if a family member could pick the resident up. -If the family member could not pick up the resident, the Manager would have to get out of bed and go pick up the resident. -That had been the reason why the Manager did not want to send residents to the hospital. Interview with the Manager on 08/22/17 at 10:15 a.mm revealed if family did not go with a resident when the resident was sent to the hospital, someone from the facility would pick the resident up. Confidential interview with a resident's family member revealed: -The family member lived close by, and visited	D 321		

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often.
-The family member had been told there was nobody to drive the facility van, so the family member took the resident to medical appointments.
-Staff used their personal cars to pick up residents from the hospital, but not since the Manager had been out.

Interview with a resident on 10/17/17 at 8:55 a.m. revealed:
-There was not enough staff to take residents to appointments.
-The Manager said there was no staff available to carry or transport residents to the doctor.

1. Interview with Resident #4 on 10/13/17 at 4:50 p.m. revealed:
-The Manager did not want to take her to appointments at a wound clinic because "it's so far away."
-A (named) Medication Aide/Supervisor (MA/S) told her the facility did not have enough staff to transport her to the wound clinic appointments.
-The Manager told the resident that she had to directly ask for her for transportation to the wound clinic.

Interview with a medication aide/supervisor (MA/S) on 10/12/17 at 1:40 p.m. revealed:
-The home health agency wanted Resident #4 to go to a physician in a nearby (named) city about her head wound, but the Manager wanted Resident #4 to go to a different physician in a different (named) city.
-"Somebody" (not facility staff) was taking Resident #4 to the appointments, but then the facility started transporting her to the appointments.
-The MA/S did not really know what happened,

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but "we didn't tell her we wouldn't take her"; Resident #4 was told to try to go to a specific physician.

Telephone interview with Resident #4's previous Social Worker (SW) on 10/16/17 at 4:48 p.m. revealed:
-The SW was concerned because Resident #4 had multiple medical appointments and the resident expressed concerns about lack of transportation to her appointments.
-Nobody at the facility could tell the SW how Resident #4 was transported to her medical appointments.
-The facility was not able to provide the SW with any documentation of any missed appointments.
-The SW took Resident #4 to multiple medical appointments for an infected head wound (in July 2017).
-The SW spoke with the Manager about her concern related to Resident #4's transportation to medical appointments.
-The Manager said Resident #4 had not missed any medical appointments and would not provide any other information related to transportation.

Review of an untitled document containing Resident #4's wound clinic visit history revealed Resident #4 missed an appointment on 10/02/17 at 10:00a.m.; the "reason cancelled" was documented as "transportation."

Telephone interview with a Registered Nurse (RN) at Resident #4's wound clinic office on 10/16/17 at 10:55 a.m. revealed:
-Resident #4 was scheduled for weekly wound clinic appointments for an open skull wound.
-Resident #4 missed an appointment scheduled for 10/02/17 due to lack of transportation; the appointment had been rescheduled.

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D 321	Continued From page 200 Interview with the Administrator on 10/12/17 at 4:00 p.m. revealed: -She did not know what happened regarding Resident #4's wound clinic transportation or appointments because she was not here then. -The Manager was not available for interview about the matter. Refer to the interview with the Manager on 8/24/17 at 10:15am. Refer to the interview with the Administrator on 10/17/17 at 10:10am. 2. Review of Resident #12's FL-2 dated 4/6/17 revealed: -Diagnoses included Hypertension, Anemia, Dementia, Depression and Hyperlipidemia -The resident was semi-ambulatory. -The resident had bladder and bowel continence. Interview with Resident #12 on 8/22/17 at 3:01 p.m. revealed: -Resident #12 had been at the facility for one year. -The doctor had stated that her "mind is sharp". -Resident #12 only took a heart pill and ibuprofen. -The Manager took her to the local store, and left her at the store for two hours. -She had to call the facility because she thought they had forgotten her. Interview with the Manager of the local store on 8/22/17 at 6:00 p.m. revealed: -On 07/24/17, Resident #12 was dropped off at the store. -She had not seen Resident #12 in a while at the store. -Resident #12 loved to come and shop at the	D 321		

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GOLDEN CARE	4002 SOUTH NC 41 WALLACE, NC 28466

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store.
-Resident #12 was told to sit outside on the bench once she had finished her shopping.
-It was 98 degrees outside on that day.
-She allowed Resident #12 to remain in the store outside of her office in a chair.
-She called the facility several times about someone picking up Resident #12.
-The resident remained at the store for 2 hours before being picked up.

Interview with the Manager on 8/24/17 at 10:15 a.m. revealed:
-Resident #12 did her own shopping at the local store.
-She took Resident #12 shopping at the store and dropped her off.
-It was sometime last month but she could not remember the date.
-Resident # 12 was competent to leave because she was capable of doing her own shopping and paying.
-Resident #12 shopped "forever" when she went to the store.
-She was across the street from the store at an appointment.
-The doctor's office was full so the Manager had to wait.
-The Manager of the store called to see if she had forgotten Resident #12.
-Resident #12 had only been at the store for one hour when she got the call.
-After she got the call, she picked Resident #12 up; it was about 15 minutes after she received the call from the store Manager.

Refer to the interview with the Manager on 8/24/17 at 10:15 a.m.

Refer to the interview with the Administrator on

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D 321	Continued From page 202 10/17/17 at 10:10 a.m. _____ Interview with the Manager on 8/24/17 at 10:15 a.m. revealed: -The facility had no specific transportation person; she was the transportation person. -The facility had one transportation van. Interview with the Administrator on 10/17/17 at 10:10 a.m. revealed: -If she could not transport a resident, the Housekeeper would; she would not pull an aide off the floor. -If it was after hours or if the Housekeeper was not there, she would transport residents to appointments or the hospital. -There was supposed to be transportation available when residents needed it.	D 321		
D 324	10A NCAC 13F .0906 (d) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (d) Telephone. (1) A telephone shall be available in a location providing privacy for residents to make and receive calls. (2) A pay station telephone is not acceptable for local calls; and (3) It is not the home's obligation to pay for a resident's toll calls This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents had access to a telephone to privately make and receive calls as	D 324		

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evidenced by residents using the telephone at the nurses' desk without privacy.

The findings are:

Observation on 10/13/17 at 10:19 a.m. revealed:
-A resident came to the nurses' station to use the telephone.
-There were 3 staff present at the nurses' station during the resident's telephone conversation.

Interview with the medication aide (MA) on 10/13/17 at 10:20 a.m. revealed:
-The phone at the nurses' station was the only phone the residents could use.
-If a resident asked for privacy, she would leave the nurses' station.

Interview with the first shift medication aide/supervisor on 10/13/17 at 8:55 a.m. revealed:
-Residents had access to a phone; the phone was kept at the nurse's desk.
-She would have to assist some residents.

Observation on 10/16/17 at 4:00 p.m. at the nurses' station revealed:
-A resident was standing next to the nurses' station talking on the phone (landline that the nurses use).
-There were staff and residents standing around the resident while he was talking.

Interview with a personal care aide (PCA) on 10/17/17 at 5:15 p.m. revealed:
-Residents use the phone at the nurses' station to make personal calls.
-"We try to not stand next to them when they are talking."
-"Sometimes I let them use my cell phone to

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D 324	Continued From page 204 make personal calls." Interview with a resident on 10/17/17 at 5:20 p.m. revealed: -The only phone they could use to make personal calls was at the nurses' station. -They could not use that phone to make long distance calls. -"I have no calls to make locally, only long distance, so I can't make any calls." -"No one has called me." Interview with another resident on 10/17/17 at 5:35 p.m. revealed: -"I have a cell phone, so I use that." -"Sometimes I use the phone at the desk, but people are standing around when I talk." Interview with the Administrator on 10/16/17 at 9:00 a.m. revealed: -They were supposed to get a new phone that would provide privacy for the residents after the survey in June 2017. -She had not had a chance to get that done. -The residents still currently had to use the phone at the nurses' station.	D 324		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by:	D 338		

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D 338	Continued From page 205 FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to assure three residents (#12, #14, #15) were protected from mental and sexual assault from Resident #6 who wandered into residents' rooms, stole a resident's food (#12), tried to get into bed with a resident (#15), and touched a resident in a sexual manner without consent (#14); failed to assure two residents (#6, #18) were free from physical abuse by two staff (Staff A and Staff D); failed to assure two residents (#6, #8) were free of neglect by ensuring the resident's (#6) personal care needs were met and was forced to sit at the nurse's desk by a staff (Staff B), and personal care was provided to a resident (#8), who was left lying on top of a heating pad and received burns and blisters to her back; and failed to ensure a resident (#12) was picked up from a local store after a reasonable amount of time. The findings are: 1. Review of Resident #8's FL-2 dated 7/8/16 revealed: -Diagnoses included hypertension, presbycusis and dementia. -Resident #8 was semi-ambulatory. -Resident #8 was continent of bladder and bowel. Resident #8's current Care Plan dated 9/11/15 revealed that the resident required assistance with incontinent care as needed daily and bathing by staff. Review of an Accident/Incident report dated	D 338		

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D 338	Continued From page 206 9/25/17 revealed that Resident #8 was found on 9/25/17 at 7:30 a.m. with blisters on the resident's back and the resident's back was red. Review of hospital records for Resident #8 dated 9/25/17 revealed: -Resident #8 arrived to the emergency room via EMS at 10:38 a.m. after the family member was contacted by the facility, at which she resides, and informed that Resident #8 had been left on a heating pad all night and that she was burned on her back. -The resident presented to the hospital with a thermal burn; she had a burn from the mid back area down to the mid buttock. -The resident had several blisters noted and some that had erupted. Interview with second shift medication aide/supervisor (MA/S) on 9/28/17 at 3:45 p.m. revealed: -She had been back working at the facility since 9/1/17. -Resident #8's family member came to the facility between 7:00 p.m.-8:00 p.m. -She was in the middle of passing out medications and was also on the telephone. -She remembered Resident #8's family member say that they had turned the heating pad on and requested that staff turn the heating pad off in two hours. -It slipped her mind to tell the second shift personal care aide (PCA) about the heating pad. -She did not know why the family member would turn the heating pad on and leave. -In the past, the family member had used the heating pad, but would turn it off before leaving the facility. -She did not realize that Resident #8 still had the heating pad.	D 338		

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-She and the second shift PCA did rounds together on the nights they worked.
-The PCA put Resident #8 in the bed around 9:00 p.m.
-She did not see the heating pad when she went into Resident #8's room.
-Rounds at the facility were made every two hours.

Interview with a first shift personal care aide (PCA) on 9/26/17 at 10:13 a.m. revealed:
-She went to Resident #8's room to get her up.
-A heating pad was underneath Resident #8.
-There was no cloth on top of the heating pad; the heating pad was directly on her skin and was on high.
-Resident #8 was lying on her right side.
-She had never known Resident #8 to use a heating pad.
-She was told that Resident #8's family member brought the heating pad in that evening.

Interview with the first shift MA/S on 9/26/17 at 8:40 a.m. revealed:
-The first shift PCA went to Resident #8's room to get resident up and dressed.
-The PCA noticed that Resident #8's back was red and blistered.
-A heating pad was laying on Resident #8's bed.
-Resident #8 had a heating pad in the past, but she thought it had been taken out of the facility.
-She did not know how long the heating pad had been under Resident #8.
-Resident #8 had to just lay there because the resident could not get up if she wanted to.
-All residents were supposed to be checked on every 1 to 2 hours.

Interview with a Social Worker (SW) from the local Department of Social Services on 9/29/17 at

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D 338	Continued From page 208 10:00 a.m. revealed: -She spoke with the second shift PCA on 9/25/17. -The PCA said that she checked on Resident #8 all the time. -The PCA reported that Resident #8's family member brought the heating pad to the facility the previous night. -The PCA laid Resident #8 down on the heating pad at around 9:00 p.m. for her back pain. -The PCA reported that she did not ask if Resident #8 was having back pain. Interview with second shift PCA on 9/29/17 at 10:55 a.m. revealed: -She did not know that Resident #8 had the heating pad. -She put Resident #8 to bed between 8:00 p.m.-9:00 p.m on the night of the incident (9/24/17). -She had nothing to do with heating pad and no one mentioned anything to her about a heating pad. -She did not see a heating pad. -She learned from Resident #8's family member the next day that the family member had spoken with the MA/S about the heating pad and the heating pad was brought in for warming Resident #8's hands. -She reported that the MA/S was the one that put the heating pad under Resident #8. -She learned from Resident #8's family member about what happened to the resident. -Resident #8 could turn, so the resident probably pulled the heating pad underneath herself. -Resident #8 was not a resident that will remain still. Interview with a third shift MA/S on 9/27/17 at 3:08 p.m. revealed: -She had been working at the facility for a couple	D 338		

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of months.
-She had never known Resident #8 to have a heating pad since she had been working at the facility.
-Resident #8 was soiled only one time during the night that night (9/24/17-9/25/17).
-The one time she was soiled, she was toileted by the third shift PCA, because the MA/S was in another resident's room.
-She walked in Resident #8's room every couple of hours to check on Resident #8.
-She did not document the checks because that was something the PCA knew to do.
-When she checked on Resident #8, she got up next to Resident #8's bed to make sure she was breathing; she did not touch or bother the resident.
-No one on second shift told her about the heating pad because she would have checked it.
-She did not see the heating pad when she checked on the resident.
-She lifted up the cover where the incontinent brief was and touched it to see if the resident was soiled, but she did not pull the cover off the resident because it would disturb her.

Interview with a third shift PCA on 9/29/17 at 11:25 a.m. revealed:
-She heard Resident #8 mumbling, on the night the incident occurred (9/24/17), so she went to check on the resident.
-The PCA was not working on the second hall but went to check on resident, because Resident #8 was normally quiet.
-She went into Resident #8's room between 12:00 a.m.-12:30 a.m on 9/25/17.
-Resident #8 was laying in the bed with her teeth still in and clothed.
-Resident #8 was soiled so she provided incontinent care to the resident.

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-Resident #8's body was warm but the resident kept two or three blankets on her bed.
-She removed the blankets and left one sheet on Resident #8.
-She knew the heating pad was there because she saw the black box lying beside the bed.
-There was a thin white blanket on top of the heating pad.
-She did not see what temperature the pad was set on.

Interview with the physical therapist on 10/4/17 at 2:59 p.m. revealed:
-Resident #8 was receiving physical therapy due to being non-ambulatory.
-She had been seen five times since 9/5/17 for physical therapy services for transferring and strengthening.
-She was receiving strengthening and learning to transfer.
-She was informed by the first shift Supervisor on 9/25/17 that staff went to get Resident #8 out of bed and found her back blistered and red.
-She was told that Resident #8 was found lying on a heating pad.
-The heating pad was lying on Resident #8's bed and it was on high.
-There were several blisters intact on Resident #8's back.
-Some of the blisters had busted, and some were curved-shaped like the heating pad.
-She contacted Resident's #8's family member, emergency management services (EMS) and attempted to reach the primary care provider (PCP).

Interview with Resident #8's family member on 9/26/17 at 2:20 p.m. revealed:
-The first shift MA/S on duty contacted her on 9/25/17 between 8:00 a.m. and 9:00 a.m. about

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coming to the facility regarding blisters on Resident #8's back.
-The family member went directly to the facility after receiving the call.
-The family member looked at Resident #8's back, and it was burned and red.
-Resident #8's physical therapist was at the facility and told her that Resident #8 needed to be taken to the hospital.
-EMS transported the resident to the hospital.
-The heating pad was brought into the facility by the family member to help keep Resident #8's hands warm.
-Resident #8 used the heating pad last winter to keep her hands warm.
-The family member informed the second shift MA/S that the family member had left the heating pad turned on so it could warm Resident #8's hands.
-The family member turned the heating pad on and left it hanging on the bed rails.
-The family member told the second shift MA/S to unplug the heating pad in 2 hours.
-The family member did not know why she said turn it off in two hours but she did.
-The family member was never told by staff that Resident #8 could not have the heating pad.
-The family member was unsure as to how the heating pad got on Resident #8's back.
-Resident #8 was stiff and unable to grip so there was no way Resident #8 could have moved the heating pad.
-Staff from the facility transported Resident #8 back to the facility.

Interview with the PCA/housekeeper on 9/26/17 at 2:41 p.m. revealed:
-She was asked to transport Resident #8 back to the facility from the hospital.
-That was when she learned that Resident #8 had

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gotten burned.
-Staff should have done the 2 hours checks like staff were supposed to do; then staff would have seen the heating pad.

Interview with the Administrator on 9/26/17 at 9:35 p.m. revealed:
-No heating pads should be at the facility.
-The staff needed to do a closer check of the residents.
-A staff meeting would be scheduled to address all the facility concerns.
-A sign-up sheet would be put behind each resident's door to be signed by staff once a full room check had been completed.
-Resident #8 had been moved to another facility.

Second interview with the Administrator on 10/16/17 at 9:45am revealed:
-The expectation for a change in resident's status was to monitor the resident frequently, notify the PCP by telephone, and document the changes and notification.
-She was "unsure" if staff were following the expected procedure.
-She would implement a policy as soon as possible and assure all staff were trained.
-In an emergency, staff were supposed to call 911.
-The facility had not had a policy or system in place to assure staff called 911 or for documentation related to emergencies.

2. Review of Resident #18's FL2 dated 5/4/17 revealed:
-Diagnoses included siabetes, hyperlipidemia, hypertension, chronic obstructive pulmonary disease (COPD), and mental retardation.
-The resident was semi-ambulatory

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D 338	Continued From page 213 Interview with Resident #18 on 8/22/17 at 4:40 p.m. revealed: -Resident #18 had been at the facility for 2 months. -The resident showed agency representative her right arm. -Another resident ran into her with the wheelchair. -The resident slapped the other resident on the arm. -She took off her belt to hit the other resident. -Staff D (personal care aide, PCA) grabbed her arm and Staff D's finger nails dug into the resident's arm and hand. -The incident happened on the morning of 8/22/17. Interview with Staff D on 10/17/17 at 8:55 a.m. revealed: -Resident #18 was fussing at another resident. -Resident #18 picked up a fork like she was going to stab the other resident. -The resident then took off her belt off to hit the other resident. -Staff D grabbed Resident #18's arm, and Resident 18's arm must have gotten bruised by her nails when she grabbed her arm. Interview with Resident #18's family member on 10/12/17 at 3:45pm revealed: -The incident between Resident #18 and another resident occurred, because the resident ran into Resident #18. -This happened at the end of July, beginning of August 2017. -A staff grabbed Resident #18, and dug her fingernails into Resident #18's arm. -"You could see the nail imprints in the resident's right forearm; the staff broke the skin and it bled. There were three areas on the arm." -The next day, the staff came up to the family	D 338		

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(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 338	Continued From page 214 member and said, "I am the one that dug my fingers into [name of Resident #18]. -The family member did not know the staff's name, but knew she worked different shifts. -The family member asked the staff, "Do you know that's abuse and you could go to jail?" -Another staff bandaged Resident #18's arm. -The family member did not know if the physician was notified. Interview with a medication aide/supervisor (MA/S) on 8/22/17 at 4:43 p.m. revealed: -Resident #18's family member told her that Staff D dug her nails into the resident's arm and hand. -The MA/S contacted the Manager after speaking with the family member. -The Manager was aware of the incident. -The Manager said that Staff D grabbed Resident #18 with too much force. -The Manger stated that Resident #18 started the incident. Interview with a medication aide (MA) on 10/13/17 at 10:25am revealed: -All she knew was Staff D was giving meds and heard the residents talking. -Staff D went to check on the residents, and the residents had "got into it." -Staff D grabbed Resident #18's arm and tore her skin. -Staff called the Manager, and the Manager looked at the resident's arm. -Staff called Resident #18's family member; the staff did not call her doctor. Interview with the Manager on 8/24/17 at 10:15 a.m. revealed: -She was made aware of the incident on the morning that it occurred. -Staff D did not intentionally hurt Resident #18.	D 338		

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D 338	Continued From page 215 -Staff D thought that Resident #18 was going to hurt the other resident. -Staff D was protecting the other resident. -Resident #18 had taken her belt off to hit the other resident. -The other resident bumped into Resident #18's walker with her wheelchair and it set Resident #18 off. -Resident #18 could get agitated but had never gotten aggressive. -She had spoken to Staff D about the incident, and Staff D said that she should have gone for the belt instead of Resident #18's arm. -She did not feel that Staff D needed to be reported to the Health Care Personnel Registry (HCPR), because she was protecting another resident. Interview with the Administrator on 10/12/17 at 10:30am revealed: -The Administrator had not gotten any reports from anyone related to allegations of abuse. -She expected staff to report any allegations of abuse to her when the Manager was out. Based on observations, interviews, and record reviews, the facility failed to assure Resident #18 was protected from abuse by Staff D, and failed to investigate or report the incident to HCPR. Staff D was allowed to continue to work at the facility, which exposed Resident #18 to further abuse as well as the other residents residing in the facility. 3. Review of Resident #6's current FL-2 dated 9/5/16 revealed: -Diagnoses included congestive heart failure (CHF), hypertension and hyperlipidemia. -Resident #6 was ambulatory. -Resident #6 was occasionally incontinent of	D 338		

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D 338	Continued From page 216 bladder and bowel. Review of Resident #6's most recent Care Plan dated 6/8/15 revealed: -Resident #6 was assisted to the bathroom by staff; staff were to provide incontinent care every two hours as needed. -Resident #6 was assisted with dressing and needed prompting by staff for grooming and hygiene. Interview with Resident #6's family member on 10/13/17 at 12:52 p.m. revealed: -He had not seen any serious concerns at the facility. -Staff had told him that Resident #6 wandered. -Resident #6 had brain damage that occurred in 2007. -Resident #6 was enticed by food; if food was kept out for Resident #6 to see, he would take it. -Resident #6 was like a three or four year old child at times. -He was smart with a great IQ but his mind came and went. -Resident #6 was put in the facility so he could be observed 24 hours a day, 7 days a week. Interview with Resident #6's guardian on 10/17/17 at 8:38 a.m. revealed Resident #6 was not competent enough to tell the guardian if the resident was being harmed. Interview with Resident #6 on 10/13/17 at 5:33 p.m. revealed most of the time, he stayed in his room until staff made him go to bed. A. Interview with a personal care aide (PCA) on 10/12/17 at 8:06am revealed: -Resident #6 would be wet in less than one hour after changing him.	D 338		

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D 338	Continued From page 217 -Residents were to be checked on and toileted every two hours. Interview with a second PCA on 10/12/17 at 11:35 a.m. revealed: -She was concerned about Resident #6 being made to sit up in a chair. -Staff B (medication aide/personal care aide) made Resident #6 sit up because he was a "heavy wetter" and Staff B did not want to have to change his bed linen. -The resident had been made to sit up until Staff B's shift had been completed at 11:00 p.m. -The resident was made to sit in front of the nurse's desk or in the dining room. -He had a right to go to bed when he wanted to. -Staff were at the facility to take care of the residents. Interview with a third PCA on 10/13/17 at 5:30 p.m. revealed: -Residents were supposed to be checked every 2 hours, including toileting checks. -Staff should change the residents right then if wet. Interview with the housekeeper/PCA on 10/12/17 at 8:57 a.m. revealed: -Resident #6 was like a child. -He had to be assisted with bathing, and needed to be prompted to go to the bathroom. -The family member wanted Resident #6 to be up and not in the bed all day. -The resident would wet himself. -He wore incontinent briefs all the time. -She never heard anything about second shift staff; she did not know how late Resident #6 was made to stay up. Interview with a first shift medication aide (MA) on	D 338		

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D 338	Continued From page 218 10/12/17 at 12:05 p.m. revealed: -She was informed by staff that Staff B would not allow Resident #6 to go to bed one evening last week. -The resident had not been allowed to go to bed because of "wetting the bed." -Staff B made Resident #6 sit in the dining room. -Staff B would make Resident #6 sit in the chair at the nurse's desk until she wanted him to go to bed. Interview with the housekeeper/MA on 10/12/17 at 12:30 p.m. revealed: -She was the cook on first and second shift, and also a MA and PCA. -She worked the previous Saturday, 10/7/17, and heard Staff holler at Resident #6 because he wanted to lay down after supper. -Staff B said, "Who is going to change Resident #6 when he pisses up the bed?" -She told Staff B that Staff B had to because it was her job. -Resident #6 had been made to sit up until 9:00 p.m. because Staff B would not let him go to bed, -Another PCA informed her that Staff B would put a chair at the nurse's desk and made Resident #6 sit until she wanted him to go to bed. -The Administrator had been made aware. Confidential interview with a second staff revealed Staff B made Resident #6 sit up on 2nd shift, most recent as last week; Staff B had him sitting in the dining room, and she told him to set up because "he wet the bed." Interview with a family member on 10/12/17 at 12:22pm revealed: -Staff made Resident #6 sit in a leather chair, because he would urinate in his bed. -He would be saturated with urine.	D 338		

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D 338	Continued From page 219 -Staff did not change him like they should. Interview with a second family member on 10/12/17 at 3:45pm revealed: -The PCAs were not doing their job; they don't change the residents like they should. -The residents were made to sit in wet briefs and clothes. Interview with a resident on 10/11/17 at 4:20 p.m. revealed: -Staff B won't help the residents. -Staff B stayed on the phone and watched television; she worked second shift now, and some third shift. -Residents asked for help and Staff B ignored them; "she would come in every two hours and sign the door." Interview with a second resident on 10/12/17 at 8:30 a.m. revealed: -Resident #6 had lived at the facility a long time. -Some staff treated Resident #6 nice, and some did not. -The resident thought Resident #6 was being treated better lately. -The resident had seen Resident #6 being made to sit in a chair in the hall. -The resident thought it was punishment for Resident #6 taking something since he would steal other residents' food Interview with Staff B on 10/12/17 at 3:12 p.m. revealed: -She was a PCA and had been for two years. -She had been working all three shifts at the facility. -Resident #6 loved to eat. -He asked the same questions over and over. -Resident #6 could not recall what day of the	D 338		

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week it was.
-He had to be told all the time to go to the bathroom.
-The resident wore incontinent briefs.
-The resident could be awake, but that did not mean he knew to go to the bathroom.
-Staff B had to "stay on" Resident #6 about stealing and going to the bathroom.
-The staff would move him from the dining hall after he finished eating, because he would steal other residents' food.
-When Resident #6 wet the bed, Staff B would ask him if he wanted to sit up a little longer once she made the bed.
-Resident #6 had been made to sit in a chair at the nurse's desk in order to keep an eye on him after he had gone in another resident's room.
-He had not sat at the desk that long during the times he had sat at the desk.

Interview with Staff B on 10/12/17 at 7:50pm revealed:
-"All he (Resident #6) does is sit and get in bed and eat."
-All the resident wanted to do was sleep and eat.
-Staff assisted Resident #6 with toileting.
-She had to tell him to go to the restroom every couple hours or he would sit there and not go.
-Staff had to get him up and change him when he wet himself.
-She had never told him he could not go to bed because of toileting.

Interview with the Administrator on 10/10/17 at 12:30 p.m. revealed:
-She had been made aware of staff making Resident #6 sit at the nurse's desk.
-She had been told that Staff B was making Resident #6 sit at the desk.
-She had spoken with Staff B and told her that

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D 338	Continued From page 221 Resident #6 had the right to lay down when he wanted to. Interview with the Administrator on 10/12/17 at 10:30am revealed: -Resident #6 was made to sit in a chair at the desk because he was a "heavy wetter;" somebody called the county before she could address the report (unable to recall which staff reported it to her). -She did not interview the resident, but spoke briefly with all of the 3pm-11pm staff. -She addressed the concerns with Staff B. -She had not started a formal investigation into the allegation, but had completed the groundwork. -She could not understand the rationale behind make Resident #6 sit up. B. Interview with a medication aide/supervisor (MA/S) on 8/7/17 at 9:30 a.m. revealed: -On 8/4/17, Resident #6 was sitting in the dining hall and asked for a piece of gum. -Resident #6 came to the nurse's desk to get the gum that was kept on the medication cart. -Resident #6's pants were wet in the front. -Resident #6 bent over the nurse's desk as if he wanted to reach behind the desk. -Staff A picked up a spray bottle and sprayed Resident #6 in the face. -There was a clear liquid in the bottle that the MA/S believed was a water and bleach mixture. -Staff A (MA/S) told Resident #6 to get his "nasty self" to his room and change his clothes. -The MA/S went to assist Resident #6. -Resident #6 asked the MA/S if she was going to hit him. -The MA/S did not report the incident to the Manger, because "the Manager was not going to do anything about the incident."	D 338		

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D 338	Continued From page 222 A second interview with the MA/PCA, who was working when Staff A sprayed the bleach at Resident #6, on 10/12/17 at 3:30pm revealed: -Staff A was "meaner than a snake". -On Friday, 8/4/17, the MA/PCA remembered a new girl was in training. -Staff A was up front and asked for her pay check, which was in the medication cart. -Resident #6 was in the dining room, sitting against the wall. -He asked for gum and the MA/PCA told him there was some on the medication cart. -He walked behind the nurse's desk. Staff A picked up a bottle of bleach water and sprayed him; his pants in the front got wet. -Staff scolded him, and said, "Look at you." -Staff A got loud with Resident #6. -He ducked and put his arm over his face. -"It's sad how Staff A treats him." Interview with a personal care aide (PCA) on 10/13/17 at 10:25am revealed Staff A sprayed Resident #6 in the face (don't recall date) with some kind of bleach solution. Interview with Staff A on 8/7/17 at 3:40 p.m. revealed: -Staff A would never do that to a resident. -She wished she knew "who the vicious person was that had told this lie." -Staff A had family members there that were "handicapped." -She would not want them to be mistreated if they had to be placed in a facility. -Residents should be treated like family. Interview with the Manager on 8/7/17 at 3:00 p.m. revealed: -She was not aware of any resident being	D 338		

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sprayed in the face.
-No incident had been reported to her.

Second interview with the Manager on 8/15/17 at 2:30 p.m. revealed:
-The staff needed to treat the residents like their own family, and if staff could not do that then staff needed to go and work somewhere else.
-There was no way that Staff A sprayed Resident #6 in the face.
-She had not heard anything about the spray bottle.
-No staff or the resident had reported anything to her about the spray bottle.
-She looked behind the medication desk and had not seen a spray bottle at the desk.
-The only spray bottles they had were disinfectant and air freshener that were kept in the janitor closet.
-The janitor closet was close to the nursing desk.
-Resident #6 had too have done something.

Third interview with the Manager on 8/22/17 at 10:15 a.m. revealed:
-She had no evidence of the spray bottle, but had been looking for it.
-She had not reported Staff A to the Health Care Personnel Registry (HCPR), because she did not believe Staff A had done that.
-She was not at the facility and did not see Staff A do it.
-No staff or resident reported the incident to her.
-She was not going to report to HCPR unless she knew who Staff A's accuser was.
-She did not know what to investigate.

C. Interview with a medication aide/supervisor (MA/S) on 9/12/17 at 4:15 p.m. revealed:
-They had donuts at the facility earlier in the week.

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D 338	Continued From page 224 -The donuts were at the nurse's desk. -Resident #6 saw the donuts and went behind the desk and got one. -Staff A (MA/S) came out of the kitchen, and saw Resident #6 with the donut. -She shoved Resident #6 in the back and pushed him down the hall. -Staff A told Resident #6 that the donut had poison in it and that Resident #6 would die. -Resident #6 was afraid to swallow the donut. -She had to assure Resident #6 that it was okay to eat the donut. -There was a physical therapist at the facility when the incident occurred. Second interview with the MA/S working at the time of the incident on 10/12/17 at 3:30pm revealed: -Staff A was "meaner than a snake". -There were donuts at the desk, and Resident #6 took a donut to eat. -Staff A told Resident #6 there was rat poison on them. Interview with a personal care aide (PCA) on 9/12/17 at 4:30 p.m. revealed: -She had only been at the facility for 3 months. -The residents were treated horrible, and she no longer wanted to work at the facility. -This week there were donuts behind the nurse's desk, and Resident #6 had gotten a donut. -Staff A came out of the kitchen and started shoving Resident #6 in the back. -Staff A told Resident #6 that there was poison in the donut and that he was going to die. -Resident #6 had started eating the donut. -Resident #6 looked like he was scared to finish eating the donut. Interview with a second PCA on 10/12/17 at	D 338		

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D 338	Continued From page 225 3:30pm revealed: -Staff A and another MA/PCA were at the desk when Resident #6 walked around and got a donut hole to eat. -Staff A jerked the donut out of Resident #6's hand and said, "That's rat poison. I guess you will die tonight." -The PCA told Resident #6 it was not rat poison. -Staff A talked hateful to Resident #6 all the time. Interview with Staff A on 9/14/17 at 8:20 a.m. revealed: -If Resident #6 would have wanted a donut, she would have given him one. -"Gosh, that never was said." -She knew where this was coming from and she was going to speak with a lawyer. -It was a bunch of lies. -If she would have done it, she would had taken the blame for it. -Staff A did not know why anyone would say that -She knew who she worked with during the day. -She would work on Saturday, and, then she would quit. Interview with the Manager on 9/14/17 at 8:30 a.m. revealed: -The Manager was "very angry." -She knew that there were donuts at the facility, because it was assisted living appreciation week. -She did not believe Staff A would have said that. -If she found out who told this, she would fire them on the spot. -The Manager was given the 24 hour and 5 day working forms to report to the Health Care Personnel Registry (HCPR). -She would not report Staff A to HCPR because Staff A would quit. Based on observations, interviews and record	D 338		

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reviews, the facility failed to protect Resident #6 from abuse and neglect from Staff A and B. Both staff were allowed to continue to work at the facility which exposed Resident #6 to further abuse and neglect from these staff as well as the othe residents residing in the facility.

4. Refer to Tag D270, 10A NCAC 13F. 0901(b) Personal Care and Supervision.

5. Review of Resident #12's FL-2 dated 4/6/17 revealed:
-Diagnoses included Hypertension, Anemia, Dementia, Depression and Hyperlipidemia
-The resident was semi-ambulatory.
-The resident had bladder and bowel continence.

Interview with Resident #12 on 8/22/17 at 3:01 p.m. revealed:
-Resident #12 had been at the facility for one year.
-The doctor had stated that her "mind is sharp".
-Resident #12 only took a heart pill and ibuprofen.
-The Manager took her to the local store, and left her at the store for two hours.
-She had to call the facility because she thought they had forgotten her.

Interview with the Manager of the local store on 8/22/17 at 6:00 p.m. revealed:
-On 07/24/17, Resident #12 was dropped off at the store.
-She had not seen Resident #12 in a while at the store.
-Resident #12 loved to come and shop at the store.
-Resident #12 was told to sit outside on the bench once she had finished her shopping.
-It was 98 degrees outside on that day.
-She allowed Resident #12 to remain in the store

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CARE	4002 SOUTH NC 41 WALLACE, NC 28466

(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 338	Continued From page 227	D 338		

outside of her office in a chair.
-She called the facility several times about someone picking up Resident #12.
-The resident remained at the store for 2 hours before being picked up.

Interview with the Manager on 8/24/17 at 10:15 a.m. revealed:
-Resident #12 did her own shopping at the local store.
-She took Resident #12 shopping at the store and dropped her off.
-It was sometime last month but she could not remember the date.
-Resident # 12 was competent to leave because she was capable of doing her own shopping and paying.
-Resident #12 shopped "forever" when she went to the store.
-She was across the street from the store at an appointment.
-The doctor's office was full so the Manager had to wait.
-The Manager of the store called to see if she had forgotten Resident #12.
-Resident #12 had only been at the store for one hour when she got the call.
-After she got the call, she picked Resident #12 up; it was about 15 minutes after she received the call from the store Manager.

_____

The facility failed to protect a resident from physical and verbal abuse by Staff A, who sprayed a bleach solution on the resident and talked rudely to this same resident and allowed Staff A to continue to work in the facility after allegations of abuse from another staff were reported to the Manager; a second resident from physical abuse from Staff D, who grabbed the resident's arm and dug her fingernails in the

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D 338	Continued From page 228 resident's arm which created a skin tear, by allowing Staff D to continue to work in the facility after allegations of abuse were reported to the Administrator; a resident from neglect by Staff B, who refused to provide incontinent care to the resident and forced the resident to sit at the nurse's station and would not change the resident's incontinent brief. Staff B was also allowed to continue to work in the facility after allegations of neglect were reported to the Administrator; and a resident from neglect by providing personal care, who was left lying on a heating pad and received thermal burns to her back. The facility's failure resulted in serious physical harm and serious neglect, which constitutes an Unabated Type A1 Violation. Review of the facility's Plan of Protection dated 10/12/17 revealed: -24 hour report to Health Care Registry followed by investigation and 5 day report. -Staff counseling/written warning or immediate termination. -Report Staff A, B, C, D to HCPR immediately and conduct investigations. -Any future allegations will be reported as required. -Administrator will in-service staff on Resident Rights immediately. -Supervisor to monitor and be aware of signs of abuse and neglect (rights) and report immediately to Manager/Administrator. -In-service to ensure staff of their responsibility to report. -Contact Ombudsman for in-service. -Administrator to do random observations and resident interviews with interactions with staff.	D 338		

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D 358	Continued From page 229	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 4 residents (#13, #16, #22) observed during the medication pass including errors with insulin and medications for heart / blood pressure, diabetes, prevention of blood clots, and a diuretic (#16); a medication for hypothyroidism (#22); and prevention of heart disease (#13, #22), and for 5 of 6 residents (#1, #2, #3, #4, #5) sampled including errors with insulin (#1, #3); narcotic pain medications (#3, #5); medications for infection (#1, #2, #4); and a medication for anxiety (#2). The findings are: 1. The medication error rate was 27% as evidenced by the observation of 8 errors out of 29 opportunities during the 7:30 a.m. / 8:00 a.m. medication passes on 10/12/17 and 10/17/17. A. Review of Resident #16's current FL-2 dated	D 358		

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D 358	Continued From page 230 06/10/17 revealed diagnoses included type II diabetes mellitus with chronic kidney disease - stage 3, hypertension, gram negative pneumonia, sepsis, and moderate protein malnutrition. a. Review of Resident #16's current FL-2 dated 06/10/17 revealed an order for Novolog Mix 70/30 insulin, 4 units twice daily. (Novolog Mix 70/30 is a mixture of a rapid-acting insulin and an intermediate-acting insulin used to lower blood sugar.) Review of a hospital discharge summary dated 06/13/17 for Resident #16 revealed: -The resident was admitted on 06/07/17 for pneumonia and acute respiratory insufficiency. -The resident was discharged on 06/13/17. -There was an order for Novolog Mix 70/30 insulin 4 units twice daily. Observation during the 8:00 a.m. medication pass on 10/12/17 revealed: -Resident #16 had a breakfast tray in his room on the table in front of him. -The resident had eaten all of his cereal and drank his milk. -The medication aide (MA) checked Resident #16's blood sugar and it was 123 at 8:11 a.m. -The MA administered 4 units of Novolin 70/30 insulin to Resident #16 at 8:13 a.m. after the resident had finished eating breakfast. (Novolin 70/30 insulin is a mixture of a short-acting insulin and an intermediate acting insulin. Novolin 70/30 insulin is not the same as Novolog Mix 70/30.) Review of Resident #16's October 2017 medication administration record (MAR) revealed: -There was a handwritten entry for "Insulin Nov 70/30" inject 4 units under skin every morning and inject 2 units every night for diabetes and it	D 358		

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D 358	Continued From page 231	D 358		

was scheduled for 8:00 a.m. and 8:00 p.m.
-The resident's FSBS ranged from 104 - 213 from 10/01/17 - 10/12/17.

Review of Resident #16's September 2017 MAR revealed:
-There was a handwritten entry for "Insulin Novolin 70/30" inject 4 units under skin every morning and inject 2 units every night for diabetes and it was scheduled for 8:00 a.m. only.
-The 8:00 a.m. dose of insulin was not documented as administered on 09/03/17 or 09/04/17 with no reasons for the omissions.
-There was no time noted for a night time dose of insulin but staff documented on 5 of 30 days on a second row below the 8:00 a.m. time.
-There was 25 days that no night time dose of insulin was documented as administered.
-The resident's FSBS ranged from 88 - 233 from 09/01/17 - 09/30/17.

Review of Resident #16's August 2017 MAR revealed:
-There was a handwritten entry for "Novolin 70/30" inject 4 units in the morning and inject 2 units in the evening and it was scheduled for 8:00 a.m. and 8:00 p.m.
-The 8:00 a.m. dose of insulin for 08/06/17 was not documented as administered with no reason for the omission.
-The 8:00 p.m. dose of insulin was not documented as administered on 08/01/17, 08/08/17, 08/09/17, 08/14/17, 08/17/17, 08/19/17, and 08/24/17 - 08/28/17.
-The resident's FSBS ranged from 81 - 224 from 08/01/17 - 08/31/17.

Observation of Resident #16's medications on 10/12/17 revealed:
-There was 1 opened vial of Novolin 70/30 insulin

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D 358	Continued From page 232 dispensed on 03/07/17 with no open date. -It could not be determined when the vial would have expired with no open date. (According to the manufacturer, Novolin 70/30 vials that have been opened can be kept at room temperature for up to 42 days.) -There was a second vial of Novolin 70/30 insulin dispensed on 07/27/17 that had not been opened. -Both vials were dispensed by the veteran's pharmacy with instructions for 4 units in the morning and 2 units at night. Interview with the MA on 10/12/17 at 12:40 p.m. revealed: -The facility policy was to administer insulin before a meal. -She usually administered Resident #16's insulin before he ate but she was running late that morning on 10/12/17. -The MAs were supposed to document the open date on all insulin. -She was not sure when Resident #16's insulin vial was first opened but it lasted a while because he only took a small amount. -She had not noticed the insulin order was for Novolog Mix 70/30. -Resident #16 always had Novolin 70/30 insulin to her knowledge. -Resident #16's medications came in the mail from a veteran's pharmacy. -She did not know if there had been any order changes for the resident. -She had handwritten the insulin information on the MARs. -She copied information from the prescription label when she transcribed it onto the MARs. -She was not sure why there were blanks on the MARs or why the night time dose was not scheduled and documented on the September 2017 MAR.	D 358		

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D 358	Continued From page 233 -She did not work second shift so she did not know if the resident received the evening dose of insulin in September 2017. -She would call Resident #16's primary care provider (PCP) and the veteran's pharmacy about the insulin. Interviews with the Administrator on 10/16/17 at 8:40 a.m. and 10/17/17 at 11:45 a.m. revealed: -The facility's Manager was responsible for getting the FL-2 forms completed. -The Manager had been out on medical leave for about 2 months and was unavailable for interview. -No one took over responsibility of the residents' FL-2 forms after the Manager went on medical leave. -There was no system to check behind the Manager or to monitor the residents' FL-2 forms. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -Staff should date the insulin when opened. -The facility's policy was to administer insulin before meals. -The MA on duty was responsible for clarifying medication orders. -If orders, MARs or labels did not match, the MA was supposed to stop and contact the physician to clarify the orders. Interview with Resident #16 on 10/17/17 at 2:20 p.m. revealed: -He usually got his medications after eat ate his meals. -He got his blood sugar checked in the evenings and it "runs good". -He was not sure how often he got insulin or what kind he was supposed to get. -His medication came from the veteran's	D 358		

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D 358	Continued From page 234	D 358		

pharmacy.

Interview with the MA on 10/12/17 at 2:50 p.m. revealed:
-She had spoken to a nurse at Resident #16's PCP office at the veteran's provider and they told her to call the pharmacy.
-The veteran's pharmacy would fax a list of Resident #16's medication orders.

Attempts to contact Resident #16's PCP and pharmacy on 10/17/17 at 10:52 a.m. were unsuccessful.

No further information regarding Resident #16's insulin was provided.

b. Review of Resident #16's current FL-2 dated 06/10/17 revealed an order for Lasix 40mg once daily. (Lasix is a diuretic used to treat swelling caused by fluid retention.)

Review of a hospital discharge summary dated 06/13/17 for Resident #16 revealed:
-The resident was admitted on 06/07/17 for pneumonia and acute respiratory insufficiency.
-The resident was discharged from the hospital on 06/13/17.
-The resident was started on Lasix due to some fluid overload.
-There was an order to start Lasix 40mg once daily.

Observation during the 8:00 a.m. medication pass on 10/12/17 revealed Resident #1 was administered one Lasix 20mg tablet at 8:10 a.m. instead of 40mg as ordered.

Review of Resident #16's October 2017 medication administration record (MAR) revealed

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D 358	Continued From page 235 there was an entry for Lasix 40mg 1 tablet daily and it was scheduled for 8:00 a.m. Review of Resident #16's September 2017 MAR revealed there was an entry for Lasix 40mg 1 tablet daily and it was documented as administered daily at 8:00 a.m. from 09/01/17 - 09/30/17. Review of Resident #16's August 2017 MAR revealed there was an entry for Lasix 40mg 1 tablet daily and it was documented as administered daily at 8:00 a.m. from 08/01/17 - 08/31/17. Review of Resident #16's July 2017 MAR revealed: -There was a computer printed entry for Lasix 40mg 1 tablet daily and it was scheduled at 8:00 a.m. -Lasix was documented as administered on 07/01/17 and from 07/17/17 - 07/30/17. -Lasix was not documented as administered from 07/02/17 - 07/16/17 and 07/31/17 with no reason noted. -There was a handwritten marked through 40mg and "20 changed mg" was written above the Lasix entry. -There was no date to indicate when the change was made for Lasix. Observation of Resident #16's medications on 10/12/17 revealed: -There was one bottle of Lasix 20mg tablets with 90 tablets dispensed on 09/08/17. -The instructions on the label were to take 1 tablet (20mg) daily for blood pressure and fluid control. -There were 102 Lasix 20mg tablets in the bottle.	D 358		

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D 358	Continued From page 236 Interview with the MA on 10/12/17 at 12:40 p.m. revealed: -Resident #16 used to have Lasix 40mg tablets. -She usually gave 2 of the Lasix 20mg tablets but she forgot this morning, 10/12/17, and only gave 1 tablet. -She did not know why there were 102 tablets in the bottle unless someone poured the previous supply into the new bottle. -Resident #16's medications came in the mail from a veteran's pharmacy. -She did not know if there had been any order changes for the resident. -She would call Resident #16's primary care provider (PCP) and the veteran's pharmacy about the Lasix. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -The MA on duty was responsible for clarifying medication orders. -If orders, MARs or labels did not match, the MA was supposed to stop and contact the physician to clarify the orders. Interview with Resident #16 on 10/17/17 at 2:20 p.m. revealed: -He was not sure about which medications he received. -His medication came from the veteran's pharmacy. -He did not have any swelling in his feet or legs. Interview with the MA on 10/12/17 at 2:50 p.m. revealed: -She had spoken to a nurse at Resident #16's PCP office at the veteran's provider and they told her to call the pharmacy. -The veteran's pharmacy would fax a list of Resident #16's medication orders.	D 358		

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D 358	Continued From page 237 Attempts to contact Resident #16's PCP and pharmacy on 10/17/17 at 10:52 a.m. were unsuccessful. No further information regarding Resident #16's Lasix was provided. c. Review of Resident #16's current FL-2 dated 06/10/17 revealed an order for Plavix 75mg once daily. (Plavix is used to prevent blood clots.) Review of a hospital discharge summary dated 06/13/17 for Resident #16 revealed: -The resident was admitted on 06/07/17 for pneumonia and acute respiratory insufficiency. -The resident was discharged on 06/13/17. -There was an order for Plavix 75mg once daily. Observation during the 8:00 a.m. medication pass on 10/12/17 revealed: -Resident #1 was not administered Plavix 75mg at 8:10 a.m. when he received his other morning medications. -The MA initialed the Plavix on the MAR as being administered. Review of Resident #16's October 2017 medication administration record (MAR) revealed: -There was an entry for Plavix 75mg 1 tablet daily and it was scheduled for 8:00 a.m. -Plavix was documented as administered from 10/01/17 - 10/12/17. Review of Resident #16's September 2017 MAR revealed there was an entry for Plavix 75mg 1 tablet daily and it was documented as administered daily at 8:00 a.m. from 09/01/17 - 09/30/17.	D 358		

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D 358	Continued From page 238 Review of Resident #16's August 2017 MAR revealed there was an entry for Plavix 75mg 1 tablet daily and it was blank with no Plavix documented as administered and no reason for the omissions for the entire month. Review of Resident #16's July 2017 MAR revealed: -There was an entry for Plavix 75mg 1 tablet daily and it was scheduled at 8:00 a.m. but none was documented as administered. -There was a handwritten note beside the entry for Plavix that it was discontinued but no date was documented and no initials. Observation of Resident #16's medications on 10/12/17 revealed there was no Plavix on hand for the resident. Interview with the MA on 10/12/17 at 12:40 p.m. revealed: -She gave the last dose of Plavix yesterday on 10/11/17. -She needed to order the Plavix because it had not been ordered to her knowledge. -They usually ordered medications when there was one week supply remaining on hand. -Resident #16's medications came in the mail from a veteran's pharmacy. -They did not use the back-up pharmacy for Resident #16 because his medications came from the veteran's pharmacy. -She did not know if there had been any order changes for the resident. -She would call Resident #16's primary care provider (PCP) and the veteran's pharmacy about the Plavix. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed:	D 358		

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D 358	Continued From page 239 -The MA on duty was responsible for clarifying discrepancies with medications. -If orders, MARs or labels did not match, the MA was supposed to stop and contact the physician to clarify the orders. -Medications should be ordered before they run out of the medications. Interview with Resident #16 on 10/17/17 at 2:20 p.m. revealed: -He was not sure about which medications he received. -His medication came from the veteran's pharmacy. -He did not think he was getting any blood thinners and he had never been on a blood thinner to his knowledge. Interview with the MA on 10/12/17 at 2:50 p.m. revealed: -She had spoken to a nurse at Resident #16's PCP office at the veteran's provider and they told her to call the pharmacy. -The veteran's pharmacy would fax a list of Resident #16's medication orders. Attempts to contact Resident #16's PCP and pharmacy on 10/17/17 at 10:52 a.m. were unsuccessful. No further information regarding Resident #16's Plavix was provided. d. Review of Resident #16's current FL-2 dated 06/10/17 revealed an order Diltiazem ER 180mg once daily. (Diltiazem is for heart / blood pressure.) Review of a hospital discharge summary dated 06/13/17 for Resident #16 revealed:	D 358		

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D 358	Continued From page 240 -The resident was admitted on 06/07/17 for pneumonia and acute respiratory insufficiency. -The resident was discharged on 06/13/17. -There was an order for Diltiazem ER 180mg once daily. Observation during the 8:00 a.m. medication pass on 10/12/17 revealed Resident #16 was administered Diltiazem ER 240mg at 8:10 a.m. instead of 180mg as ordered. Review of Resident #16's October 2017 medication administration record (MAR) revealed there was an entry for Diltiazem ER 180mg 1 capsule daily and it was scheduled for 8:00 a.m. Review of Resident #16's September 2017 MAR revealed there was an entry for Diltiazem ER 180mg 1 capsule daily and it was documented as administered daily at 8:00 a.m. from 09/01/17 - 09/30/17. Review of Resident #16's August 2017 MAR revealed there was an entry for Diltiazem ER 180mg 1 capsule daily and it was documented as administered daily at 8:00 a.m. from 08/01/17 - 08/31/17. Review of Resident #16's July 2017 MAR revealed: -There was an entry for Diltiazem ER 180mg 1 capsule daily and it was documented as administered on 07/01/17 and from 07/17/17 - 07/30/17. -Diltiazem ER was not documented as administered from 07/02/17 - 07/16/17 and 07/31/17 with no reason noted. Observation of Resident #16's medications on 10/12/17 revealed:	D 358		

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D 358	Continued From page 241 -There was one supply of Diltiazem 240mg with 90 capsules dispensed on 07/27/17 (a 3 month supply). -The instructions on the label were to take 1 capsule daily. -There were 14 Diltiazem 240mg capsules remaining. Interview with the MA on 10/12/17 at 12:40 p.m. revealed: -She had not noticed the dosage of Diltiazem on the MAR was 180mg and the dosage she administered an on hand was 240mg. -Resident #16's medications came in the mail from a veteran's pharmacy. -She did not know if there had been any order changes for the resident. -She would call Resident #16's primary care provider (PCP) and the veteran's pharmacy about the Diltiazem. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -The MA on duty was responsible for clarifying medication orders. -If orders, MARs or labels did not match, the MA was supposed to stop and contact the physician to clarify the orders. -The MAs were responsible for transcribing orders onto the MARs. -The MAs were supposed to read the MARs and make sure it matches the orders and the medications on hand. -The Manager was responsible for monitoring the MARs but she had been on medical leave for two months. -She was going to have to check the MARs. Interview with Resident #16 on 10/17/17 at 2:20 p.m. revealed:	D 358		

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D 358	Continued From page 242 -He was not sure about which medications he received. -His medication came from the veteran's pharmacy. Interview with the MA on 10/12/17 at 2:50 p.m. revealed: -She had spoken to a nurse at Resident #16's PCP office at the veteran's provider and they told her to call the pharmacy. -The veteran's pharmacy would fax a list of Resident #16's medication orders. Attempts to contact Resident #16's PCP and pharmacy on 10/17/17 at 10:52 a.m. were unsuccessful. No further information regarding Resident #16's Diltiazem was provided. e. Review of Resident #16's current FL-2 dated 06/10/17 revealed an order for Glipizide 5mg twice daily. (Glipizide lowers blood sugar.) Review of a hospital discharge summary dated 06/13/17 for Resident #16 revealed: -The resident was admitted on 06/07/17 for pneumonia and acute respiratory insufficiency. -The resident was discharged on 06/13/17. -There was an order for Glipizide ER 5mg twice daily. (Glipizide ER lowers blood sugar and is an extended-released medication. Glipizide ER is longer acting than immediate-released Glipizide.) Observation during the 8:00 a.m. medication pass on 10/12/17 revealed Resident #16 was administered Glipizide 5mg at 8:10 a.m. instead of Glipizide ER 5mg as ordered on 06/13/17. Review of Resident #16's October 2017	D 358		

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medication administration record (MAR) revealed:
-There was an entry for Glipizide 5mg 1 tablet twice a day 30 minutes before meals and it was scheduled for 8:00 a.m. and 5:00 p.m.
-The resident's FSBS ranged from 104 - 213 from 10/01/17 - 10/12/17.

Review of Resident #16's September 2017 MAR revealed:
-There was an entry for Glipizide 5mg 1 tablet twice a day 30 minutes before meals and it was documented as administered twice daily at 8:00 a.m. and 5:00 p.m. from 09/01/17 - 09/30/17.
-The resident's FSBS ranged from 88 - 233 from 09/01/17 - 09/30/17.

Review of Resident #16's August 2017 MAR revealed:
-There was an entry for Glipizide 5mg 1 tablet twice a day 30 minutes before meals and it was documented as administered twice daily at 8:00 a.m. and 5:00 p.m. from 08/01/17 - 08/31/17.
-The resident's FSBS ranged from 81 - 224 from 08/01/17 - 08/31/17.

Observation of Resident #16's medications on 10/12/17 revealed:
-There was one supply of immediate-released Glipizide 5mg tablets dispensed on 09/08/17.
-The instructions were to take 1 tablet twice a day 30 minutes before a meal for diabetes.
-There was no Glipizide 5mg ER tablets on hand for the resident.

Interview with the MA on 10/12/17 at 12:40 p.m. revealed:
-She had not noticed the order for Glipizide ER on the hospital discharge summary.
-She gave the Glipizide because that was the medication sent by the pharmacy.

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D 358	Continued From page 244 -Resident #16's medications came in the mail from a veteran's pharmacy. -She did not know if there had been any order changes for the resident. -She would call Resident #16's primary care provider (PCP) and the veteran's pharmacy about the Glipizide. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -The MA on duty was responsible for clarifying medication orders. -If orders, MARs or labels did not match, the MA was supposed to stop and contact the physician to clarify the orders. -The MAs were responsible for transcribing orders onto the MARs. -The MAs were supposed to read the MARs and make sure it matches the orders and the medications on hand. -The Manager was responsible for monitoring the MARs but she had been on medical leave for two months. -She was going to have to check the MARs. Interview with Resident #16 on 10/17/17 at 2:20 p.m. revealed: -He usually got his medications after eat ate his meals. -He got his blood sugar checked in the evenings and it "runs good". -He was not sure about which medications he received. -His medication came from the veteran's pharmacy. Interview with the MA on 10/12/17 at 2:50 p.m. revealed: -She had spoken to a nurse at Resident #16's PCP office at the veteran's provider and they told	D 358		

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her to call the pharmacy.
-The veteran's pharmacy would fax a list of Resident #16's medication orders.

Attempts to contact Resident #16's PCP and pharmacy on 10/17/17 at 10:52 a.m. were unsuccessful.

No further information regarding Resident #16's Glipizide was provided.

B. Review of Resident #13's current FL-2 dated 03/20/17 revealed:
-Diagnoses included atrial fibrillation, peripheral vascular disease, chest pain, and elevated INR (international normalized ration - for Coumadin monitoring).

a. Review of physician's orders for Resident #13 revealed there was an order dated 06/27/17 for Miralax 17gm once daily, mix in 8 ounces of juice or water and drink. (Miralax is a laxative used to treat constipation.)

Review of Resident #13's October 2017 medication administration record (MAR) revealed:
-Diagnoses printed on the MAR included confusion.
-There was an entry for Miralax, mix 1 capful (17gm) in 8 ounces of liquid and drink once daily at 8:00 a.m.

Interview with the medication aide (MA) on 10/12/17 at 7:44 a.m. revealed:
-She was preparing Resident #13's morning medications.
-She had already prepared and mixed Resident #13's Miralax in orange juice and put on the dining room table with the resident's breakfast.
-She mixed 1 capful (17gms) of Miralax powder in

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D 358	Continued From page 246 the orange juice. Observation of the MA on 10/12/17 at 7:44 a.m. revealed: -She was at the nurses' station preparing medications at the medication cart. -She could not see inside the dining room from her location. Observation of the medication pass on 10/12/17 at 7:46 a.m. revealed: -Resident #13 was sitting at a dining room table eating breakfast, feeding himself. -There were 2 other male residents sitting at the same table. -There was a cup of orange juice (about 6 ounces) sitting on the table beside the resident's plate. -The MA handed the resident the cup of orange juice to take his morning medications. -The resident drank about 2/3rds of the orange juice (with Miralax) and sat the cup back down. -The MA did not encourage the resident to finish drinking the orange juice with Miralax. -The MA left the dining room and went back to the medication cart at the nurses' station. -The MA initialed the Miralax as administered and stated, "he got that". Observation of the dining room on 10/12/17 at 8:17 a.m. revealed: -Resident #13 left the dining room. -There was approximately 15ml (1/2 ounce) of orange juice with Miralax left in the resident's cup on the table. Interview with the MA on 10/12/17 at 12:18 p.m. revealed: -She always mixed the Miralax in Resident #13's orange juice before breakfast and left it at the	D 358		

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dining room table with his breakfast meal.
-She thought other staff helped feed the resident and they would make sure he drank the orange juice.
-She had not asked other staff to watch the resident drink the orange juice.
-She had not told other staff there was medication in the resident's orange juice.
-She did no usually go back to see how much Miralax the resident drank because she thought he probably drank all of it.
-She was not aware Resident #13 did not drink all of the Miralax today, 10/12/17.
-She could not explain why she documented the Miralax was administered when she did not know how much he drank.

Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed:
-The MAs had been trained to actually watch the residents take their medications.
-The MAs should not leave the medications unattended.

Based on observations, interviews, and record reviews, Resident #13 was not interviewable.

Interview with Resident #13's family member on 10/12/17 at 12:12 p.m. revealed:
-The resident was supposed to get Miralax every day.
-She did not think he had been getting the medication daily because she helped toilet him and noticed he had been constipated on and off.
-The resident had been to the hospital in the past for impaction and she was concerned that he not get another impaction.

b. Review of Resident #13's current FL-2 dated 03/20/17 revealed there was an order for Aspirin

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D 358	Continued From page 248 81mg once daily. (Aspirin is used to prevent heart disease.) Review of Resident #13's October 2017 medication administration record (MAR) revealed: -There was an entry for Aspirin 81mg once daily at 8:00 a.m. -Aspirin was documented as administered from 10/01/17 - 10/12/17. Observation of the morning medication pass on 10/12/17 revealed: -Resident #13 was not administered Aspirin 81mg when she received her other scheduled morning medications at 7:46 a.m. -The MA documented the Aspirin as administered on the MAR. Interview with the medication aide (MA) on 10/12/17 at 12:18 p.m. -She usually administered Aspirin with the resident's other morning medications. -She overlooked the Aspirin that morning on 10/12/17 but should have administered it. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -The MAs had been trained to read the MARs. -The MAs should administer medications when they were scheduled to be administered. C. Review of Resident #22's current FL-2 dated 01/24/17 revealed: -Diagnoses included chronic diastolic heart failure, chronic kidney disease - stage 3, chronic obstructive pulmonary disease, essential hypertension, bilateral leg pain, pure hypercholesterolemia, Raynaud's phenomenon, neuropathy both feet, and Vitamin D deficiency. -There was an order for Levothyroxine 50mcg 1	D 358		

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tablet daily in the morning. (Levothyroxine is for hypothyroidism.)

Review of Resident #22's October 2017 medication administration record (MAR) revealed:
-There was and entry for Levothyroxine 50mcg Take 1 tablet every morning and it was scheduled to be administered at 7:30 a.m.
-Levothyroxine was documented as administered daily from 10/01/17 - 10/12/17.

Interview with the medication aide (MA) on 10/17/17 at 9:13 a.m. revealed:
-A few minutes ago, the housekeeper reported Resident #22 had dropped pills on the floor in the resident's room.
-The pills were picked up from the floor in the resident's room and put in a pill cup.
-Resident #22 would not take all of her morning pills at one time.
-Resident #22 liked to take the Levothyroxine first and then the other pills.
-Resident #22 ate breakfast in her room.
-The MAs would leave the morning medications in the resident's room so she could take the Levothyroxine before she ate breakfast.
-She would take the other pills when she ate breakfast.
-The resident did not have an order to self-administer.
-The MA was aware she was not supposed to leave the medications in the resident's room.
-The facility's Manager had told the MAs to do it that way before the Manager was out on medical leave.
-She usually checked the cup later in the mornings to see if it was empty.

Observation of the MA on 10/17/17 at 9:35 a.m. revealed she was standing at the medication cart

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holding the medication cup with 5 pills found on Resident #22's floor.

Interview with the MA on 10/17/17 at 9:35 a.m. revealed:
-She was not sure which pills were in the cup.
-They only found 5 pills on the floor.
-She was going to prepare and administer Resident #22's morning medications since the resident dropped them on the floor earlier.

Observation on 10/17/17 at 9:35 a.m. revealed:
-The 5 pills in the cup were identified by comparing the medications in cart.
-The 5 pills in the cup were Sotalol 80mg (for heart / blood pressure); Lasix 40mg (a diuretic), Vitamin D3 1000 units (a supplement); Diltiazem 30mg (for heart / blood pressure), and Levothyroxine 50mcg (for hypothyroidism).

Observation on 10/17/17 at 9:45 a.m. revealed Levothyroxine was not administered when the resident received her other morning medications.

Interview with Resident #22 on 10/17/17 at 9:46 a.m. revealed:
-Staff always left her morning medications in her room for her to take.
-She usually took the Levothyroxine tablet first then the others a little later.
-She dropped the cup of pills that morning (10/17/17) by accident.
-She thought she took the Levothyroxine that morning before she dropped the cup.

Interview with the MA on 10/17/17 at 10:15 a.m. revealed:
-She noticed earlier the Levothyroxine was one of the pills found on the floor.
-She was aware the resident did not get any

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Levothyroxine today, 10/17/17.
-The resident would not get any Levothyroxine today, 10/17/17 because the resident did not like to take Levothyroxine after breakfast.

Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed:
-The MAs had been trained to actually observe the residents take their medications.
-She was not aware the Manager had told staff to leave Resident #22's morning medications in the resident's room.

2. Review of Resident #3's current FL-2 dated 03/07/17 revealed diagnoses included diabetes mellitus, peripheral vascular disease, pneumonia, and muscle weakness.

A. Review of Resident #3's current FL-2 dated 03/07/17 revealed:
-There was an order for Novolog Flexpen inject per sliding scale 4 times a day: 200 - 250 = 2 units, 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units, and greater than (>) 400 = call physician. (Novolog is a rapid-acting insulin used to lower blood sugar.)
-There was an order for fingerstick blood sugars (FSBS) 4 times daily.

Review of Resident #3's October 2017 medication administration record (MAR) revealed:
-There was an entry for the Novolog Flexpen sliding scale that matched the order.
-There was no documentation of any FSBS or insulin administration for Novolog on the MAR.

Review of Resident #3's October 2017 FSBS log revealed:
-Novolog sliding scale insulin (SSI) was not administered as ordered on 7 occasions from

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D 358	Continued From page 252 10/01/17 - 10/13/17. -The FSBS was 256 on 10/03/17 at 8:00 p.m. and no SSI was documented as administered but 4 units were required. -The FSBS was 420 at 5:00 p.m. and 416 at 8:00 p.m. on 10/06/17 and 8 units were documented as administered but the order was to call the physician. -The FSBS was 208 on 10/07/17 at 8:30 p.m. and no SSI was documented as administered but 2 units were required. -The FSBS was 323 on 10/08/17 at 8:00 p.m. and no SSI was documented as administered but 6 units were required. -The FSBS was 344 on 10/09/17 at 4:45 p.m. and 2 units of SSI were documented but 6 units were required. -The FSBS was 253 on 10/09/17 at 8:30 p.m. and no SSI was documented as administered but 4 units were required. -The FSBS ranged from 50 - 420 from 10/01/17 - 10/13/17. Review of Resident #3's September 2017 FSBS log revealed: -Novolog sliding scale insulin (SSI) was not administered as ordered on 21 occasions from 09/01/17 - 09/30/17. -On 12 occasions, the FSBS ranged from 200 - 391 and would have required SSI from 2 to 8 units but none was documented as administered. -For example, the FSBS was 257 on 09/25/17 at 7:50 a.m. and 2 units of SSI were required but none was documented. (The next FSBS at 11:30 a.m. on 09/25/17 was 311.) -On 9 occasions, the FSBS was over 400 and staff documented they either administered 6 or 8 units of insulin but there was no documentation they contacted the physician to get an order. -For example, the FSBS was 537 on 09/13/17 at	D 358		

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(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 358	Continued From page 253 7:40 p.m. and 8 units was documented as administered but no contact with the physician to get an order was documented. -The FSBS on the log ranged from 62 - 600 from 09/01/17 - 09/30/17. Interview with the medication aide (MA) on 10/13/17 at 9:07 a.m. revealed: -The MAs usually document insulin administration and FSBS on the FSBS log instead of the MARs. -If SSI was administered, it would be documented on the FSBS log. -She did not know why some of Resident #3's SSI was not documented as administered when required. -The MAs were supposed to call the physician to find out how much SSI to administer if Resident #3's FSBS was over 400. -If they called the physician, it should be documented on the MAR or the FSBS log or they would have a fax from the physician. Interview with a second MA on 10/13/17 at 12:55 p.m. revealed: -She usually worked on second shift as a medication aide / supervisor. -The MAs were supposed to call the physician to find out how much SSI to administer to Resident #3 if her FSBS was over 400. -She had called the physician's office on 09/12/17 when the resident's FSBS was 600 and go a verbal order to administer 10 units of Novolog SSI. -She documented it on the back of the FSBS log. -If she had contacted the physician for other FSBS that were over 400, she would have documented it on the FSBS log. -She did not recall contacting the physician on any other occasion.	D 358		

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D 358	Continued From page 254 Telephone interview with Resident #3's primary care provider (PCP) on 10/13/17 at 2:00 p.m. revealed: -He was not aware Resident #3's FSBS had been running over 400. -His office was contacted on 1 occasion in September 2017 about a high FSBS for Resident #3. -The resident should be getting Novolog SSI and Levemir insulin as ordered. -He was not aware Resident #3 had missed any doses of insulin. Interview with Resident #3 on 10/17/17 at 10:25 a.m. revealed: -She received insulin and FSBS checks about 3 or 4 times a day. -She got SSI about 3 times a day and a different kind of insulin once or twice a day. -Her FSBS ran so high sometimes she would have to get 60 units of insulin at night. -She usually felt "nervous" when her FSBS was high. -Her FSBS sometimes ran low and she would get "nervous and shaky". -Her FSBS got so high in September 2017 that she had to go to the hospital. B. Review of Resident #3's current FL-2 dated 03/07/17 revealed: -There was an order for Levemir 60 units twice a day. (Levemir is long-acting insulin used to lower blood sugar.) -There was an order for fingerstick blood sugars (FSBS) 4 times daily. Review of Resident #3's October 2017 medication administration record (MAR) revealed: -There was an entry for the Levemir inject 60 units twice a day at 8:00 a.m. and 8:00 p.m.	D 358		

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D 358	Continued From page 255 -Levemir was not documented as administered at 8:00 a.m. on 10/07/17 and 10/08/17. -There was no reason for the omissions documented on the MAR. Review of Resident #3's October 2017 FSBS log revealed: -There was no Levemir documented as administered at 8:00 a.m. on 10/07/17 and 10/08/17. -Staff had drawn a line through the area used to document the type and amount of insulin on both occasions. -The FSBS ranged from 50 - 420 from 10/01/17 - 10/13/17. Review of Resident #3's September 2017 MAR revealed: -There was an entry for the Levemir inject 60 units twice a day at 8:00 a.m. and 8:00 p.m. -No Levemir was documented as administered from 09/01/17 - 09/30/17. -There was a handwritten note to "see flow sheet". Review of Resident #3's September 2017 FSBS log revealed: -Levemir insulin was not documented as administered on 30 of 60 occasions from 09/01/17 - 09/30/17. -The 8:00 a.m. dose was not documented as administered on 09/01/17 - 09/06/17, 09/08/17, 09/10/17 - 09/12/17, 09/16/17, 09/18/17, 09/19/17, 09/21/17 - 09/23/17, 09/27/17 - 09/30/17. -For example, the FSBS was 146 at 8:00 a.m. on 09/12/17 and no Levemir was documented as administered (the FSBS on 09/12/17 at 5:00 p.m. was 600). -The 8:00 p.m. dose was not documented as	D 358		

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administered on 09/01/17, 09/03/17 - 09/09/17, 09/12/17, and 09/17/17.
-On 4 occasions, staff documented 60 units of Novolog insulin was administered instead of 60 units of Levemir. (The resident used Novolog for sliding scale insulin.)
-For example, the FSBS was 325 on 09/21/17 at 8:00 p.m. and 60 units of Novolog were documented as administered (the next FSBS on 09/22/17 at 7:20 a.m. was 91).
-The FSBS was 391 on 09/19/17 at 8:00 p.m. and 66 units of Levemir were documented as administered instead of 60 units as ordered.
-The FSBS on the log ranged from 62 - 600 from 09/01/17 - 09/30/17.

Review of Resident #3's August 2017 MAR revealed:
-There was an entry for the Levemir inject 60 units twice a day at 8:00 a.m. and 8:00 p.m.
-Levemir was initialed at 8:00 p.m. from 08/02/17 - 08/05/17 but there was a handwritten line marking through the initials.
-There was no other Levemir doses initialed.
-There was a handwritten note to "see flow sheet".

Review of Resident #3's August 2017 FSBS log revealed:
-Levemir insulin was not documented as administered on 41 of 62 occasions from 08/01/17 - 08/31/17.
-The 8:00 a.m. dose was not documented as administered on 08/01/17 - 08/07/17, 08/09/17 - 08/13/17, 08/15/17 - 08/19/17, 08/21/17 - 08/26/17, 08/28/17 - 08/31/17.
-For example, the FSBS was 66 at 8:00 a.m. on 08/06/17 and no Levemir was documented as administered (the FSBS on 08/06/17 at 12:00 p.m. was 396).

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D 358	Continued From page 257 -The 8:00 p.m. dose was not documented as administered on 08/01/17, 08/12/17 - 08/15/17, 08/24/17 - 08/31/17. -The FSBS on the log ranged from 61 - 439 from 08/01/17 - 08/31/17. Review of pharmacy dispensing records for Resident #3 dated 04/17/17 - 10/17/17 revealed: -There were 12 Levemir Flexpens (36ml = 30 day supply) dispensed on 05/03/17. -There were 12 Levemir Flexpens (36ml = 30 day supply) dispensed on 06/28/17. -No Levemir was dispensed in 07/2017 or 08/2017. -There were 12 Levemir Flexpens (36ml = 30 day supply) dispensed on 09/15/17. Observation of Resident #3's medications on hand on 10/13/17 revealed: -There was one Levemir Flexpen in the top drawer of the medication cart dispensed on 09/15/17 with no open date documented (1 pen would be 2.5 day supply). -There were 6 unopened Levemir Flexpens in the medication refrigerator dispensed on 09/15/17 which was a 15 day supply. -If administered as ordered, the 12 Levemir Flexpens dispensed on 09/15/17 would last 30 days. -There should have been 1 Levemir Flexpen (2.5 day supply) remaining on 10/13/17 if the Levemir had been administered as ordered since 09/15/17. Interview with the medication aide (MA) on 10/13/17 at 9:07 a.m. revealed: -The MAs usually document insulin administration and FSBS on the FSBS log instead of the MARs. -If Levemir was administered, it would be documented on the FSBS log if it was not	D 358		

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documented on the MAR.
-She did not know why some of Resident #3's Levemir was not documented as administered when required.

Interview with a second MA on 10/13/17 at 12:55 p.m. revealed:
-She usually worked on second shift as a medication aide / supervisor.
-She did not know why Resident #3's Levemir was not documented as administered.
-It should be documented on the FSBS log if it was administered.

Telephone interview with Resident #3's primary care provider (PCP) on 10/13/17 at 2:00 p.m. revealed:
-He was not aware Resident #3's FSBS had been running over 400.
-His office was contacted on 1 occasion in September 2017 about a high FSBS for Resident #3.
-The resident should be getting Novolog SSI and Levemir insulin as ordered.
-He was not aware Resident #3 had missed any doses of insulin.

Interview with Resident #3 on 10/17/17 at 10:25 a.m. revealed:
-She received insulin and FSBS checks about 3 or 4 times a day.
-She got SSI about 3 times a day and a different kind of insulin (did not know the name) once or twice a day.
-Her FSBS ran so high sometimes she would have to get 60 units of insulin at night.
-She usually felt "nervous" when her FSBS was high.
-Her FSBS sometimes ran low and she would get "nervous and shaky".

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-Her FSBS got so high in September 2017 that she had to go to the hospital.

3. Review of Resident #1's current FL-2 dated 02/20/17 revealed diagnoses included senile dementia, uncontrolled Type II diabetes, hypertension, anemia, and depression.

A. Review of a hospital "After Visit Summary" for Resident #1 dated 08/14/17 revealed:
-Resident #1 was evaluated and treated for an abscess.
-The diagnosis was documented as "carbuncle." (A carbuncle is a severe boil/abscess under the skin, usually caused by a bacterial infection).
-Resident #1 was discharged with an order for Clindamycin 300mg four times daily for ten days. (Clindamycin is an antibiotic used to treat infection).

Review of Resident #1's medication administration record (MAR) for August 2017 revealed:
-There was a handwritten entry for Clindamycin 300mg four times a day with administration times of 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.
-Clindamycin was documented as administered on fourteen days (from 08/15/17 and 08/28/17).
-Clindamycin was first documented as being administered on 08/15/17 at 8:00 a.m.; the last dose was documented as administered on 08/28/17 at 8:00 a.m. (The order was for ten days; the final dose should have been given 10 days from 08/15/17, which was 08/24/17).
-On 08/15/17, the medication was documented as administered only twice, at 8:00 a.m. and 12:00 p.m.; the 4:00 p.m. and 8:00 p.m. doses were not documented as administered.
-On 08/17/17, the medication was documented as administered only three times, at 8:00 a.m.,

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D 358	Continued From page 260 12:00 p.m., and 4:00 p.m.; the fourth daily dose, scheduled for 8:00 p.m., was not documented as administered. -On 08/19/17, the medication was documented as administered three times, at 8:00 a.m., 12:00 p.m., and 8:00 p.m.; the dose scheduled for 4:00 p.m., was not documented as administered. -On 08/25/17 and 08/26/17, the medication was documented as administered three times a day at 8:00 a.m., 4:00 p.m., and 8:00 p.m. -On 08/27/17 and 08/28/17, the medication was documented as administered once a day at 8:00 a.m. -There was no documentation on the MAR related to any of the missed doses. Telephone interview with the Pharmacist from the facility's pharmacy provider on 10/16/17 at 2:30 p.m. revealed: -The pharmacy received the order dated 08/14/17 for Clindamycin 300mg on 08/14/17 and dispensed a total of 40 Clindamycin (a ten day supply) for Resident #1 on 08/14/17. -The pharmacy had not received any returns for Clindamycin from the facility for Resident #1. Observation of Resident #1's medications on hand on 10/12/17 at 11:15 a.m. revealed there was no Clindamycin on hand. Interview with a medication aide/supervisor (MA/S) on 10/13/17 at 10:15 a.m. revealed with the "holes" in the MARS, you would not know whether the medication was given or not. A second interview with a MA/S on 10/16/17 at 9:35 a.m. revealed she did not recall Resident #1 missing any antibiotics or refusing any medications.	D 358		

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D 358	Continued From page 261 Based on observations, record reviews, and interviews, Resident #1 was not interviewable. Review of Home Health (HH) Visit notes for Resident #1 revealed: -On 08/29/17 and 08/31/17, there was documentation by the HH Registered Nurse (RN) that the left shoulder caruncle wound was healing. -On 09/05/17 and 09/12/17, the HH RN documented the wound was healing and had no signs and symptoms of infection. -On 09/26/17, the HH RN documented the wound was healed. Telephone interview with a Nurse Practitioner (NP) at Resident #1's PCP office on 10/16/17 at 3:31 p.m. revealed medications were expected to be administered to Resident #1 as ordered. Interview with the Administrator on 10/16/17 at 9:35 a.m. revealed: -Staff were supposed to initial the MAR when medications were given. -No one would know if a resident got medications or not if the entry was not initialed. -If the MAR was not initialed, they did not get the medication. B. Review of Resident #1's physician orders dated 08/23/17 and 10/09/17 revealed an order for Toujeo inject 10 units subcutaneously every morning. (Toujeo is a long-acting insulin used to treat and control high blood sugar). Review of Resident #1's October 2017 medication administration record (MAR) revealed: -There was a computer generated entry for Toujeo 10 units subcutaneously every morning. "Prime pen with 3 units prior to each use-Do not	D 358		

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mix with other insulin-use within 42 days."
-Toujeo was documented as administered every day from 10/01/17-10/13/17.

Review of Resident #1's October 2017 FSBS log revealed:
-The resident's FSBS was checked 93 times from 10/01/17 - 10/16/17.
-The FSBS on the log ranged from 20 - "HI" (greater than 600 according to the manufacturer of the glucometer).

Review of the Toujeo "Highlights of Prescribing Information" from the manufacturer included in the package insert revealed opened (used) disposable prefilled Toujeo pens should be stored at room temperature and "must be discarded 42 days after being opened."

Observation of Resident #1's medications on hand on 10/12/17 at 11:22 a.m. revealed:
-There was an opened, disposable, prefilled Toujeo insulin pen with a pharmacy dispense date of 08/03/17.
-There was a sticker attached to the pen with handwritten documentation which read the Toujeo pen had been opened on 08/24/17 (42 days from 08/24/17 was 10/05/17).
-There were no other opened Toujeo insulin pens for Resident #1.

Interview with a medication aide/supervisor (MA/S) on 10/12/17 at 11:35 a.m. revealed:
-When insulin was opened, the medication aides put a sticker on it as documentation of the date it was opened.
-Insulin was kept for 28 days, then it was disposed of.
-Insulin was re-ordered before it ran out or expired so they medication was kept in stock.

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D 358	Continued From page 263 -Resident #1 had an unopened Toujeo pen that was not on the medication cart. -The Toujeo with the open date documented as 08/24/17 should had been disposed of before now because it was "expired." -The MA/S did not acknowledge the 42 day limit for use of the Toujeo or the notation printed on the MAR. Observation on 10/12/17 at 11:37 a.m. revealed: -The MA/S disposed of the Toujeo with the 08/24/17 open date in the sharps container. -The MA/S got a new Toujeo pen for Resident #1 out of the refrigerator. 4. Review of Resident #4's current FL-2 dated 06/05/17 revealed diagnoses included traumatic brain injury, seizures, and bi-polar disorder. Review of physician's orders for Resident #4 revealed; -There was an order dated 09/11/17 for Duricef 500mg twice daily, #20. (Duricef is an antibiotic used to treat bacterial infections). -There was an order dated 09/25/17 for Duricef 500mg twice daily, #30. Telephone interview with the Pharmacist from the facility's pharmacy provider on 10/16/17 at 2:30 p.m. revealed the pharmacy did not receive the prescription for Duricef dated 09/11/17 until 09/13/17 at 11:11 a.m.; twenty Duricef capsules (a ten day supply) were dispensed/delivered to the facility on 09/13/17. Review of Resident #4's September 2017 medication administration record (MAR) revealed: -For the 09/11/17 Duricef order, there was a handwritten entry for Cefadroxil (generic for Duricef) 500mg take one capsule twice daily for	D 358		

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D 358	Continued From page 264 "7" days with administration times of 8:00 a.m. and 5:00 p.m. -The first dose of Duricef was documented as given on twelve dates (from 09/13/17-09/24/17) with the first dose documented on 09/13/17 at 8:00 a.m. and the last dose documented as administered on 09/24/17 at 5:00 p.m. (The order was for only ten days). -Duricef was documented as administered twice daily from 09/13/17 - 09/23/17; on 09/24/17, Duricef was documented as administered at 5:00 p.m. -For the 09/25/17 Duricef order, there was a second handwritten entry for Cefadroxil 500mg take one capsule twice daily for "30" days with administration times of 8:00 a.m. and 5:30 p.m.; the first dose was documented as administered on 09/25/17 at 5:30 p.m. -There were 11 doses documented as administered in September from 09/25/17 - 09/30/17. Review of Resident #4's October 2017 MAR revealed: -There was an entry for Cefadroxil 500mg twice daily. -There were a total of 20 doses documented as administered from 10/01/17 - 10/13/17. -Cefadroxil was documented as administered only once daily on 6 dates: 10/01/17, 10/08/17, 10/09/17 and 10/11/17-10/13/17 (The order was for twice daily). Telephone interview with the Pharmacist from the facility's pharmacy provider on 10/16/17 at 2:30 p.m. revealed: -The pharmacy received the order for Duricef dated 09/25/17 on 09/25/17 at 1:48 p.m.; there was a note written by "somebody" at the facility included with the prescription asking the	D 358		

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pharmacy not to send the medication then.
-The pharmacy received the order for Duricef dated 09/25/17 a second time on 10/03/17 at 10:11 a.m., but without the note requesting the medication not to be sent; thirty Duricef were dispensed and delivered to the facility on 10/03/17 (a fifteen day supply).
-There had not been any Duricef returned to the pharmacy for Resident #4.

Review of Resident #4's medications on hand on the medication cart on 10/13/17 at 10:15 a.m. revealed:
-There was one card of Duricef on hand with a dispense date of 10/03/17.
-There was a total of 11 Duricef left on the card.

Interview with a medication aide/supervisor (MA/S) on 10/13/17 at 10:15 a.m. revealed with the "holes" in the MARS, you would not know whether the medication was given or not.

A second interview with the MA/S on 10/17/17 at 12:10 p.m. revealed:
-As far as she knew, Resident #4 had not missed any doses of antibiotics.
-Se did not recall Resident #4 ever refusing or having any left-over antibiotics.

Interview with a second MA/S on 10/13/17 at 5:30 p.m. revealed:
-Staff put their initials on the MAR after medications were given.
-If there was no initial, the medication was not given.
-If a medication was not given, the MA was supposed to write the reason on the back of the MAR.

Interview with Resident #4 on 10/13/17 at 4:50

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p.m. revealed:
-She had been on oral and intravenous (IV) antibiotics for her skull wound/infection.
-One of the oral antibiotics gave her diarrhea and did not help; she thought it was the same antibiotic she was currently taking (Duricef).
-She did not know if she had missed any doses of oral antibiotics.

Telephone interview with a Registered Nurse (RN) at Resident #4's wound clinic on 10/16/17 at 10:55 a.m. revealed:
-The physician had prescribed Resident #4 multiple oral and IV antibiotics for an infection and necrosis of the skull bone.
-Resident #4 was expected to take all antibiotics as ordered.
-If Resident #4 did not get the antibiotics as ordered, she would build up a resistance and require stronger antibiotics.
-Resident #4 was prescribed IV antibiotics for necrotic (dead) skull bone tissue; the need for IV antibiotics was not necessarily related to any missed oral antibiotics.

Interview with the Administrator on 10/16/17 at 9:35 a.m. revealed:
-If the MAR was not initialed, no one would know if a resident got the medications or not.
-If the MAR was not initialed, they did not get the medication.

5. Review of Resident #2's current FL-2 dated 04/06/17 revealed diagnoses included Alzheimer's and Hypertension.

A. Review of Emergency Department (ED) Provider note (received from local hospital) for Resident #2 dated 10/06/17 revealed:
-The resident was evaluated for complaint of

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coughing up blood.
-Chest x-ray was completed with no acute findings.
-The resident was discharged back to facility on 10/06/17.
-The resident's ED diagnosis was: Encounter for medical screening examination.

Review of the physician orders for Resident #2 revealed an order dated 10/06/17 for:
-Clarithromycin (Biaxin) (medication used to treat and prevent infections) 500 mg, take one tab by mouth two times a day for 10 days.
-Portable chest x-ray (Diagnosis: pneumonia).
-Hospice consult (Diagnosis: failure to thrive).

Review of an ED Provider note (received from local hospital) for a second visit for Resident #2 dated 10/07/17 revealed:
-The resident was evaluated for complaint of coughing up blood.
-The resident's family member reported that she had some cough and congestion and that her Primary Care Provider (PCP) had ordered a prescription for an antibiotic.
-The ED nurse documented (family member) reported "the facility nurse practitioner felt as if patient (resident) had pneumonia and reported to (family member) that patient (resident) would be started on antibiotic, (family member) was unsure if patient had received antibiotic today."
-The ED nurse documented (family member) reported "facility staff told him that they were sending patient (resident) to ED to be evaluated due to her breathing wasn't right."
-Resident's ED diagnoses were: Bronchitis and Cellulitis of right anterior lower leg.
-ED medications prescribed were: Cephalexin (Keflex) (medication used to treat infections caused by bacteria) 500mg oral capsule; take

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one cap by mouth four times a day for 7 days.
-Resident was discharged back to facility on 10/07/17.

Review of the physician orders for Resident #2 revealed an order dated 10/07/17 for Cephalexin (Keflex) 500 mg oral capsule, take one cap by mouth four times a day for 7 days.

Review of ED Provider note (received from local hospital) from a third hospital visit for Resident #2 dated 10/10/17 revealed:
-The resident was evaluated for altered mental status.
-Resident's ED diagnosis was: Encounter for medical screening examination.
-The Resident was discharged back to the facility on 10/10/17.

Review of Resident #2's October 2017 medication administration records (MARs) revealed:
-On 10/09/17 there was a handwritten order for Clarithromycin 500 mg, 1 tab by mouth twice daily for 10 days.
-On 10/09/17 there was a handwritten order for Cephalexin 500 mg, 1 capsule by mouth four times daily for 7 days.
-The first dose for Clarithromycin and for Cephalexin was administered on 10/9/17 at 8:00 p.m.

Based on observations, record reviews, and interviews, Resident #2 was not interviewable.

Interview with a medication aide/supervisor (MA/S) on 10/13/17 at 12:55 p.m. revealed:
-She did not know why the Cephalexin and the Clarithromycin were not given to Resident #2 until 10/09/17.

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D 358	Continued From page 269 -"Sometimes a staff member may put medication in the back room and not tell anyone that it had arrived." -She called the physician's office on 10/09/17 at 10:30 a.m. to verify that both antibiotics should be given. -She received confirmation from the physician's office to give both the Cephalexin and Clarithromycin as ordered. -She informed the pharmacy on 10/09/17 at approximately 10:35 a.m. that both Cephalexin and Clarithromycin should be given as ordered. -The normal procedure was to write the new medication on the MAR once it arrived to the facility, and then give as ordered. Interview with the Physician on 10/13/17 at 2:15 p.m. revealed: -He was not aware that Resident #2 did not receive the first dose of Cephalexin and the first dose of Clarithromycin until 10/09/17. -The normal process for new medication orders was that the facility would fax the order to the pharmacy immediately. -His expectation was that all orders are carried out immediately after the order is written. -He was concerned that "some infections could lead to sepsis within 24 hours if antibiotics are not started immediately". Interview with the Pharmacist at the facility's prescribing pharmacy on 10/16/17 at 9:45 a.m. revealed: -The order for Clarithromycin was received via fax from the facility on 10/07/17 at 7:57 p.m. -The main pharmacy dispensed the Clarithromycin on 10/09/17. -The order for Cephalexin was received via fax from the facility on 10/07/17 at 7:53 p.m. -The order for Cephalexin was sent from the main	D 358		

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D 358	Continued From page 270 pharmacy to the backup pharmacy on 10/09/17. -Cephalexin (4 capsules) were dispensed to the facility from the backup pharmacy on 10/09/17 at 11:51 a.m. -Cephalexin (6 capsules) were dispensed to the facility from the main pharmacy on 10/09/17 at 9:37 p.m. and the remaining capsules on 10/10/17 at 9:41 p.m. -The two prescriptions were received after hours on Saturday 10/07/17. -The pharmacy hours on Saturday (10/07/17) were 8:00 a.m.-12:00 p.m. -The process for pharmacy requests after hours was the facility needed to call their after hours service and let them know that a prescription was faxed and needed to be delivered to the backup pharmacy. -"If they were not called, they would not know that a prescription was faxed and sitting in que." -On 10/07/17 at 8:31 p.m. the backup pharmacy technician called the facility and spoke with the MA/S to get clarification if Resident #2 should be receiving both Clarithromycin and Cephalexin. -On 10/07/17 at 8:31 p.m. the MA/S was going to check with the physician and call the pharmacy back. -On 10/09/17 at 10:23 a.m. the pharmacy called the facility for follow-up. -On 10/09/17 at 10:35 a.m. the pharmacy received a call from the MA/S confirming that the physician wants Resident #2 to have both medications as ordered. Review of pharmacy dispensing records revealed the following: -Clarithromycin 500 mg capsules were dispensed for Resident #2 on 10/09/17. -Cephalexin 500 mg capsules were dispensed for Resident #2 on 10/07/17.	D 358		

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D 358	Continued From page 271 Interview with a family member on 10/17/17 at 8:50 a.m. revealed: -He was aware that the facility nurse practitioner prescribed an antibiotic for Resident #2 for possible bronchitis or pneumonia after her first ER visit on 10/06/17. -He was aware that the ED prescribed another antibiotic for Resident #2 for bronchitis and cellulitis. -He was not made aware that the antibiotics were delayed and that Resident #2 did not receive her first dose of either antibiotic until 10/09/17. Second interview with the MA/S on 10/17/17 at 10:00 a.m. revealed: -The process followed for pharmacy requests after hours was the facility would call the backup pharmacy and fax the prescription to them. -If the facility faxed the prescription to the main pharmacy then the facility would call them and speak with their after hours service and tell them the fax was sent. -The afterhours service would send the fax to the backup pharmacy to fill the prescription. -Once the new medication arrived to the facility, then the staff would write it on the MAR and give as ordered. Interview with the Administrator on 10/17/17 at 11:10 a.m. revealed: -She was not aware that Resident #2 had a delay in receiving the Cephalexin and the Clarithromycin. -The process for pharmacy requests after hours was the facility needed to call the pharmacy afterhours service and let them know that a prescription was faxed and needed to be delivered to the backup pharmacy. B. Review of the physician orders for Resident #2	D 358		

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revealed:
-There was an order dated 06/13/17 to give Lorazepam 0.5mg one tab three times a day.
-There was an order dated 08/09/17 to discontinue Ativan three times per day. Start Ativan 0.5 mg, take one tablet by mouth two times a day.
-There was an order dated 09/06/17 to give Lorazepam (Ativan) (medication used to treat the symptoms of anxiety) tab 0.5 mg, take one tablet by mouth three times a day.

Review of Resident #2's October 2017 MAR revealed:
-There was a computer-generated entry for Lorazepam 0.5mg take one tablet by mouth three times a day.
-There was a handwritten line drawn through the 4:00 p.m. dose.
-There were 2 doses of Lorazepam documented as administered daily from 10/01/17 - 10/9/17 and 10/11/17-10/15/17 and 1 dose documented as administered on 10/10/17 with no reason noted for the omitted dose.

Review of Resident #2's September 2017 MAR revealed:
-There was a computer-generated entry for Lorazepam 0.5mg take one tablet by mouth three times a day.
-There were 3 doses of Lorazepam documented as administered daily from 09/01/17 - 09/30/17.

Review of Resident #2's August 2017 MAR revealed:
-There was a computer-generated entry for Lorazepam 0.5mg take one tablet by mouth three times a day.
-On 08/09/17, there was a handwritten entry by the medication aide/supervisor (MA/S) for Ativan

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0.5mg; take one tablet by mouth two times a day.
-There were 3 doses of Lorazepam documented as administered daily from 08/01/17 - 08/05/17 and 08/07/17 - 08/08/17.
-There were 2 doses of Lorazepam documented as administered daily from 08/06/17, 08/09/17 - 08/13/17, 08/16/17 - 08/26/17, and 08/29/17 - 08/30/17.
-There was 1 dose of Lorazepam documented as administered daily from 08/14/17 - 08/15/17 and 08/27/17 -08/28/17.
-There were no doses of Lorazepam documented as administered on 08/31/17.

Based on observations, record reviews, and interviews, Resident #2 was not interviewable.

Interview with a MA/S on 10/13/17 at 1:55 p.m. revealed:
-She was not aware there was an order dated 09/06/17 to give Lorazepam 0.5 mg, take one tablet by mouth three times a day.
-She did not know who drew the handwritten line through the 4:00 p.m. dose on the September 2017 MAR.
-She was going to call the physician to clarify the correct order for the Lorazepam.

Interview with the Pharmacist from the facility's prescribing pharmacy on 10/16/17 at 9:45 a.m. revealed the 09/06/17 Ativan order for 0.5 mg, take one tablet by mouth three times a day was most current.

Review of pharmacy dispensing records revealed the following:
-Lorazepam 0.5mg tabs; 60 were dispensed for Resident #2 on 08/29/17.
-Lorazepam 0.5mg tabs; 90 were dispensed for Resident #2 on 09/13/17.

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D 358	Continued From page 274 Interview with the Administrator on 10/17/17 at 11:10 a.m. revealed: -She was not aware that the Ativan was not given according to physician's order. -The normal process for medication errors was to report it to the physician immediately. -The MA/S should have clarified the Ativan order with the physician and the pharmacy. 6. Review of Resident #5's FL-2 dated 03/22/17 in the closed record revealed: -Diagnoses included hypertension, chronic anticoagulation, chronic kidney disease, atrial fibrillation, sepsis, hypernatremia, and hypokalemia. -There was an order for Norco 5/325mg 1 tablet 3 times a day. (Norco is a narcotic pain reliever.) Review of a physician's order for Resident #5 dated 04/25/17 revealed an order to discontinue Norco 5/325mg. Review of Resident #5's April 2017 medication administration record (MAR) revealed: -There was an entry for Norco 5/325mg 1 tablet 3 times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -The last dose documented as administered was on 04/21/17 at 8:00 a.m. -The resident was noted to be in the hospital from 04/21/17 (2:00 p.m. dose) - 04/24/17. -Norco was documented as discontinued on 04/25/17. Review of Resident #5's May 2017 MAR revealed: -There was an entry for Norco 5/325mg 1 tablet 3 times a day at 8:00 a.m., 4:00 p.m., and 8:00 p.m.	D 358		

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D 358	Continued From page 275 -No Norco was documented as administered and there was handwritten documentation the order was "d/c" (discontinued). Review of the controlled substance (CS) log for Resident #5's Norco 5/325mg revealed: -The CS log started with administration on 04/06/17 at 8:00 a.m. -The last dose documented for April 2017 was 04/21/17 at 7:00 a.m. (prior to the order being discontinued on 04/21/17). -There were 2 doses documented after the order was discontinued on 04/25/17. -Two doses were documented as administered on 05/16/17 at 2:00 p.m. and 8:00 p.m. Interview with the medication aide (MA) on 10/17/17 at 12:52 p.m. revealed: -Resident #5 was a hospice resident who passed away a few months ago (not sure of date). -She remembered the resident's Norco being discontinued. -She was not aware the Norco was administered to the resident after it was discontinued. -The Norco should have been pulled out of the medication cart when it was discontinued. -She would check for any return records to the pharmacy. Review of a certificate of death for Resident #5 revealed: -The date of death was 05/27/17. -The causes of death listed was cardiac arrest, respiratory insufficiency, and end stage dementia. The facility failed to administer sliding scale insulin and long-acting insulin as ordered to Resident #3 who was diabetic and had multiple blood sugars over 400 and as high as 600. The facility failed to administer two courses of an oral	D 358		

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D 358	Continued From page 276 antibiotic as ordered to Resident #4 who had infection and necrosis of the skull bone. The facility failed to administer two antibiotics as ordered to Resident #2 who had 3 hospital visits and diagnoses included bronchitis and cellulitis of the right lower leg. The facility administered expired insulin to Resident #1 who had uncontrolled diabetes and had blood sugars ranging from 20 - "HI" (greater than 600). The facility failed to administer medications as order for 3 of 4 residents observed during medication passes with 27% medication error rate including errors with insulin, a diuretic, and medications for heart / blood pressure, diabetes, prevention of blood clots, hypothyroidism, and prevention of heart disease. The facility's failure to administer medications as ordered to the residents resulted in substantial risk of serious physical harm and neglect to the residents and constitutes a Type A2 Violation. Review of the facility's Plan of Protection dated 10/12/17 revealed: -Review with all Medication Aides regarding medication administration and maintaining medication accuracy. -Charts will be audited by Administrator and any medication errors reported to physician immediately. -Supervisor and Administrator will contact physician for medication clarifications. -In-service with Medication Aides and monitor each to ensure proper medication administration. -All orders will be filed immediately and organized in chart per Supervisor and Administrator. -Audits will include orders, MARs, and medications on hand. -Supervisor and Administrator will do random medication audits weekly. -Random medication pass observation by	D 358		

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D 358	Continued From page 277 Administrator monthly. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2017.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure staff documented the administration of medications immediately following the administration and observation of the resident actually taking the medications for 2 of 4 residents (#13, #22) observed during the morning medication passes on 10/12/17 and 10/17/17. The findings are: 1. Review of Resident #22's current FL-2 dated 01/24/17 revealed: -Diagnoses included chronic diastolic heart failure, chronic kidney disease - stage 3, chronic obstructive pulmonary disease, essential hypertension, bilateral leg pain, pure	D 366		

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hypercholesterolemia, Raynaud's phenomenon, neuropathy both feet, and Vitamin D deficiency.
-There was an order for Levothyroxine 50mcg 1 tablet daily in the morning. (Levothyroxine is for hypothyroidism.)
-There was an order for Lasix 40mg once daily in the morning. (Lasix is a diuretic.)
-There was an order for Sotalol 80mg once daily. (Sotalol is for heart / blood pressure.)
-There was an order for Diltiazem 30mg 3 times a day. (Diltiazem is for heart / blood pressure.)
-There was an order for Vitamin D3 1000 units 1 tablet daily in the morning. (Vitamin D is a supplement for Vitamin D deficiency.)

Review of physician's orders for Resident #22 revealed:
-There was an order dated 06/26/17 for Prednisone 5mg 1 tablet daily with breakfast. (Prednisone is a corticosteroid used to treat inflammation.)
-There was an order dated 08/15/17 to start Aspirin 81mg once daily. (Aspirin may be used to help prevent heart disease.)

Review of Resident #22's October 2017 medication administration record (MAR) revealed:
-There was an entry for Levothyroxine 50mcg 1 tablet every morning and it was scheduled to be administered at 7:30 a.m.
-There was an entry for Lasix 40mg 1 tablet every morning and it was scheduled to be administered at 7:30 a.m.
-There was an entry for Sotalol 80mg 1 tablet every day and it was scheduled to be administered at 7:30 a.m.
-There was an entry for Diltiazem 30mg 1 tablet 3 times a day it was scheduled to be administered at 8:00 a.m., 12:00 p.m., and 8:00 p.m.
-There was an entry for Vitamin D3 1000 units 1

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tablet every morning and it was scheduled to be administered at 7:30 a.m.
-There was an entry for Prednisone 5mg 1 tablet every other day and it was scheduled to be administered at 8:00 a.m.
-There was an entry for Aspirin 81mg 1 tablet every day and it was scheduled to be administered at 8:00 a.m.
-All seven of these medications were documented as administered in the morning on 10/17/17.

Observation on the 100 Hall and Resident #22's room on 10/17/17 at 8:45 a.m. revealed:
-Resident #22 called the Housekeeper (who was in the hall) into her room and told her she dropped her medicine.
-There were 5 pills on the resident's floor to the left of her recliner.
-The resident was holding an empty disposable soufflé cup in her hand.
-The Housekeeper swept up the pills and told Resident #22 she would tell the medication aide to get her some more medication.

Interview with the medication aide (MA) on 10/17/17 at 9:13 a.m. revealed:
-A few minutes ago, the housekeeper reported Resident #22 had dropped pills on the floor in the resident's room.
-The pills were picked up from the floor in the resident's room and put in a pill cup.
-Resident #22 would not take all of her morning pills at one time.
-Resident #22 liked to take the Levothyroxine first and then the other pills.
-Resident #22 ate breakfast in her room.
-The MAs would leave the morning medications in the resident's room so she could take the Levothyroxine before she ate breakfast.

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-She would take the other pills when she ate breakfast.
-The resident did not have an order to self-administer.
-The MA was aware she was not supposed to leave the medications in the resident's room.
-The Manager had told the MAs to do it that way.
-She usually checked the cup later in the mornings to see if it was empty.

Observation of the MA on 10/17/17 at 9:35 a.m. revealed she was standing at the medication cart holding the medication cup with 5 pills found on Resident #22's floor.

Interview with the MA on 10/17/17 at 9:35 a.m. revealed:
-She was not sure which pills were in the cup.
-They only found 5 pills on the floor.
-She was going to prepare and administer Resident #22's morning medications since the resident dropped them on the floor earlier.

Observation on 10/17/17 at 9:35 a.m. revealed:
-The 5 pills in the cup were identified by comparing the medications in cart.
-The 5 pills in the cup were Sotalol 80mg; Lasix 40mg, Vitamin D3 1000 units; Diltiazem 30mg, and Levothyroxine 50mcg.

Observation on 10/17/17 at 9:45 a.m. revealed:
-The MA administered Vitamin D3 1000 units, Lasix 40mg, Sotalol 80mg, Aspirin 81mg, Prednisone 5mg, and Diltiazem 30mg.
-Levothyroxine was not administered when the resident received her other morning medications.

Interview with Resident #22 on 10/17/17 at 9:46 a.m. revealed:
-Staff always left her morning medications in her

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room for her to take.
-She usually took the Levothyroxine tablet first then the others a little later.
-She dropped the cup of pills that morning (10/17/17) by accident.
-She thought she took the Levothyroxine that morning before she dropped the cup.

Interview with the MA on 10/17/17 at 10:15 a.m. revealed:
-They only found 5 pills on the floor.
-They did not find Aspirin or Prednisone on the floor.
-She was not sure if the resident had taken the Aspirin and Prednisone or if the pills were on the floor under furniture and they could not find them.
-Levothyroxine was one of the pills found on the floor.
-The resident would not get any Levothyroxine today, 10/17/17 because the resident did not like to take Levothyroxine after breakfast.

Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed:
-The MAs had been trained to actually observe the residents take their medications.
-She was not aware the facility's Manager had told staff to leave Resident #22's morning medications in the resident's room.
-The Manager was on medical leave and unavailable for interview.

2. Review of Resident #13's current FL-2 dated 03/20/17 revealed diagnoses included atrial fibrillation, peripheral vascular disease, chest pain, and elevated INR (international normalized ratio - for monitoring the blood thinner, Coumadin).

Review of physician's orders for Resident #13

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revealed there was an order dated 06/27/17 for Miralax 17gm once daily, mix in 8 ounces of juice or water and drink. (Miralax is a laxative used to treat constipation.)

Review of Resident #13's October 2017 medication administration record (MAR) revealed:
-Diagnoses printed on the MAR included confusion.
-There was an entry for Miralax, mix 1 capful (17gm) in 8 ounces of liquid and drink once daily at 8:00 a.m.

Interview with the medication aide (MA) on 10/12/17 at 7:44 a.m. revealed:
-She was preparing Resident #13's morning medications.
-She had already prepared and mixed Resident #13's Miralax in orange juice and put on the dining room table with the resident's breakfast.
-She mixed 1 capful (17gms) of Miralax powder in the orange juice.

Observation of the MA on 10/12/17 at 7:44 a.m. revealed:
-She was at the nurses' station preparing medications at the medication cart.
-She could not see inside the dining room from her location.

Observation of the medication pass on 10/12/17 at 7:46 a.m. revealed:
-Resident #13 was sitting at a dining room table eating breakfast, feeding himself.
-There were 2 other male residents sitting at the same table.
-There was a cup of orange juice (about 6 ounces) sitting on the table beside the resident's plate.
-The MA handed the resident the cup of orange

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juice to take his morning medications.
-The resident drank about 2/3rds of the orange juice (with Miralax) and sat the cup back down.
-The MA did not encourage the resident to finish drinking the orange juice with Miralax.
-The MA left the dining room and went back to the medication cart at the nurses' station.
-The MA initialed the Miralax as administered and stated, "he got that".
-The MA did not go back to the dining room to check on the resident.

Observation of the dining room on 10/12/17 at 8:17 a.m. revealed:
-Resident #13 left the dining room.
-There was approximately 15ml (1/2 ounce) of orange juice with Miralax left in the resident's cup on the table.

Interview with the MA on 10/12/17 at 12:18 p.m. revealed:
-She always mixed the Miralax in Resident #13's orange juice before breakfast and left it at the dining room table with his breakfast meal.
-She thought other staff helped feed the resident and they would make sure he drank the orange juice.
-She had not asked other staff to watch the resident drink the orange juice.
-She had not told other staff there was medication in the resident's orange juice.
-She did no usually go back to see how much Miralax the resident drank because she thought he probably drank all of it.
-She was not aware Resident #13 did not drink all of the Miralax today, 10/12/17.
-She could not explain why she documented the Miralax was administered when she did not know how much he drank.

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D 366	Continued From page 284 Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -The MAs had been trained to actually watch the residents take their medications. -The MAs should not leave the medications unattended. Based on observations, interviews, and record reviews, Resident #13 was not interviewable.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the	D 367		

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D 367	Continued From page 285 medication administration records (MARs) were accurate for 5 of 5 sampled residents (#1, #2, #3, #4, #17) including two residents with documentation on MARs that did not match controlled substance logs (#3, #17), two residents with inaccurate documentation for antibiotics (#1, #4), and one resident with inaccurate documentation for an antipsychotic and an antianxiety medication (#2). The findings are: 1. Review of Resident #3's current FL-2 dated 03/07/17 revealed diagnoses included diabetes mellitus, peripheral vascular disease, pneumonia, and muscle weakness. Review of Resident #3's physician's orders revealed: -There was an order dated 06/07/17 for Oxycodone 10mg 1 tablet 3 times a day. (Oxycodone is a narcotic analgesic used to treat moderate to severe pain). -There was an order dated 08/23/17 for Oxycodone 10mg 1 tablet twice a day. -There was an order dated 09/18/17 for Oxycodone 10mg 1 tablet twice a day. Review of the controlled substance (CS) log for Resident #3's Oxycodone tablets dispensed on 09/18/17 revealed: -The prescription label on the CS log matched the label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a day. -The medication aide signed that 60 Oxycodone tablets were received on 09/18/17. -The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at 4:00 p.m. and the last entry was on 10/11/17 at 8:00 p.m.	D 367		

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D 367	Continued From page 286 -The morning dose for 10/12/17 was not documented on the CS log. -Oxycodone was documented as administered 3 times a day on 09/21/17 - 09/24/17, 10/02/17, 10/03/17, 10/07/17, and 10/09/17 instead of twice a day. Review of Resident #3's September 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Oxycodone 10mg take 1 tablet 3 times a day at 8:00 a.m., 4:00 p.m., and 8:00 p.m. -There was no Oxycodone documented as administered beside the entry but staff documented the order was "rewritten". -There was a handwritten entry for Oxycodone 10mg take 1 tablet twice daily at 8:00 a.m. and 8:00 p.m. -Staff documented Oxycodone 10mg was administered twice a day from 09/01/17 - 09/30/17. -A total of 24 doses were documented as administered on the MAR from 09/19/17 - 09/30/17 but 28 doses were documented as administered on the CS log during this time period. -The MAR did not match the CS log. Review of Resident #3's October 2017 MAR revealed: -There was a computer printed entry for Oxycodone 10mg take 1 tablet twice a day at 8:00 a.m. and 8:00 p.m. -Oxycodone was documented as administered twice daily from 10/01/17 - 10/12/17 (8:00 a.m.) for a total of 21 tablets but 26 tablets were documented on the CS log during this time period. -The MAR did not match the CS log.	D 367		

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D 367	Continued From page 287 Observation of Resident #3's medication on hand on 10/12/17 revealed: -There was a card of Oxycodone 10mg tablets dispensed on 09/18/17. -There were 60 tablets dispensed and 5 pink, round tablets left in the bubble card. -Bubbles #1-5 still had tablets but bubble #3 was the only one with an unbroken seal. -Bubbles #1, 2, 4, and 5 had transparent tape over the broken seals holding the tablets in place. -The tablet in bubble #3 was Oxycodone 10mg. -The tablets in the other 4 bubbles were Promethazine 12.5mg tablets. -The empty bubbles for #11-15 and #20-21 had remnants of transparent tape peeling from the bubbles. -There was only 1 Oxycodone 10mg tablet in the bubble card. Interview with the medication aide on 10/12/17 at 6:48 p.m. revealed: -Last Thursday (10/05/17), she noticed a problem with Resident #3's Oxycodone. -She noticed the Oxycodone tablets were punched out of order on the bubble card and the amount on hand did not match the controlled substance (CS) log. -She did not know why the MAR documentation did not match the CS log. Interview with Resident #3 on 10/17/17 at 10:25 a.m. revealed: -She usually got her Oxycodone twice a day, in the morning and at night. -She sometimes had pain from her right leg amputation. -The pain medication helped but it made her sleepy. Refer to interview with the Administrator on	D 367		

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D 367	Continued From page 288 10/17/17 at 11:45 a.m. 2. Review of Resident #17's current FL-2 dated 09/25/17 revealed: -Diagnoses included diabetes mellitus with diabetic neuropathy, coronary artery disease, atherosclerotic heart disease, hyperlipidemia, iron deficiency, chronic obstructive pulmonary disease, constipation, insomnia, pain, rash, heartburn, urine retention, seasonal allergic rhinitis, wheezing, major depressive disorder, hypomagnesemia, gastroesophageal reflux disease, and pressure ulcer of right heel. Review of a physician's order dated 07/17/17 for Resident #17 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet every 4 hours as needed. (Hydrocodone/Acetaminophen is a controlled substance used to treat moderate to severe pain.) Review of Resident #17's controlled substance (CS) log for Hydrocodone/Acetaminophen revealed: -There was no prescription label on the CS log. -The information was handwritten at the top of the log with the resident's name, prescription number (dispensed on 07/17/17), name of the medication, and instructions to take 1 pill every 4 hours by mouth. -Staff signed that 29 tablets were received on 10/07/17. -The first entry documented on the log was on 10/07/17 at 8:00 p.m. and the last entry documented was on 10/11/17 at 9:00 p.m. with 22 tablets remaining. -A total of 7 tablets were documented as administered on the CS log.	D 367		

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D 367	Continued From page 289 Review of Resident #17's October 2017 medication administration records (MARs) revealed: -The MARs were handwritten and documentation for all medications started on 10/04/17. -There was no entry for Hydrocodone/Acetaminophen on the MAR and therefore none was documented as administered in October 2017. -The MAR did not reflect any of the 7 doses of Hydrocodone/Acetaminophen that were documented as administered on the CS log. -The MAR did not match the CS log. Observation of Resident #3's medication on hand on 10/12/17 revealed: -There were 2 cards of Hydrocodone/Acetaminophen 5/325mg tablets on hand. -Both cards were dispensed on 07/17/17 for a total of 75 tablets. -One card was dispensed with 60 tablets and the other card with 15 tablets. -The first card dispensed with 60 tablets had 8 tablets remaining in bubbles #1-7 and #11. -Bubbles #2, 3, 4, 5, and 7 were sealed with Hydrocodone/Acetaminophen 5/325mg tablets. -The seal was broken on bubbles #1, 6, and 11 and the pills taped in the bubbles were Docusate Sodium 100mg tablets. -The second card dispensed with 15 tablets had 14 tablets remaining in bubbles #1-14. -Bubbles #3-14 were sealed with Hydrocodone/Acetaminophen 5/325mg tablets. -Bubble #1 was taped with a Potassium Chloride 10mEq tablet inside. -Bubble #2 was taped with a Hydrocodone/Acetaminophen 5/325mg tablet inside. -Bubble #15 was empty but had tape stuck on it.	D 367		

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D 367	Continued From page 290 -There was a total of 18 Hydrocodone/Acetaminophen 5/325mg tablets on hand. Interview with a medication aide on 10/12/17 at 6:48 p.m. revealed: -She noticed a problem with Resident #17's Hydrocodone/Acetaminophen tablets yesterday (10/11/17). -She had not reported it to anyone. -She noticed the bubble card for the Hydrocodone/Acetaminophen tablets had tape on the back of the card and some of the pills in the card were not the same. -She had not noticed Hydrocodone/Acetaminophen was omitted from the October 2017 MAR. Interview with a second MA on 10/16/17 at 4:05 p.m. revealed: -She gave Hydrocodone/Acetaminophen to Resident #17. -She had not noticed the Hydrocodone/Acetaminophen was not on the MAR. -She documented it on the CS log. -She thought it may have been left off of the MAR since it was handwritten. -She did not know why Resident #17's October 2017 MAR was handwritten instead of printed by the pharmacy. -She could not locate any other October 2017 MARs for Resident #17. Interview with Resident #17 on 10/12/17 at 8:04 p.m. revealed: -His pain medication sometimes helped and sometimes it did not. -He did not know the name of his pain medication or if he got more than one kind.	D 367		

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(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 367	Continued From page 291 -He could get his pain medication every 4 to 6 hours if he needed it. -He usually got pain medication 3 or 4 times a day. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 3. Review of Resident #1's current FL-2 dated 02/20/17 revealed diagnoses included senile dementia, uncontrolled Type II diabetes, hypertension, anemia, and depression. Review of a hospital After Visit Summary for Resident #1 dated 08/14/17 revealed: -The diagnosis was documented as "carbuncle." (A carbuncle is a severe boil/abscess under the skin, usually caused by a bacterial infection). -Resident #1 was discharged with a prescription for Clindamycin 300mg four times daily for ten days. (Clindamycin is an antibiotic used to treat infection). Review of Resident #1's medication administration record (MAR) for August 2017 revealed: -There was a handwritten entry for Clindamycin 300mg four times a day with administration times of 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. -Clindamycin was first documented as being administered on 08/15/17 at 8:00 a.m. (The final dose should have been given 10 days from 08/15/17, which was 08/24/17). -On 08/15/17, the medication was documented as administered only twice, at 8:00 a.m. and 12:00 p.m.; the 4:00 p.m. and 8:00 p.m. doses were not documented as administered. -On 08/17/17, the medication was documented as administered only three times, at 8:00 a.m., 12:00 p.m., and 4:00 p.m.; the fourth daily dose,	D 367		

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scheduled for 8:00 p.m., was not documented as administered.
-On 08/19/17, the medication was documented as administered three times, at 8:00 a.m., 12:00 p.m., and 8:00 p.m.; the dose scheduled for 4:00 p.m., was not documented as administered.
-On 08/25/17 and 08/26/17, the medication was documented as administered three times a day (at 8:00 a.m., 4:00 p.m., and 8:00 p.m.).
-On 08/27/17 and 08/28/17, the medication was documented as administered once a day at 8:00 a.m.
-There was no documentation on the MAR related to any of the missed doses.
-There were a total of 42 doses documented as given between 08/15/17 and 08/28/17.

Telephone interview with the Pharmacist from the facility's pharmacy provider on 10/16/17 at 2:30 p.m. revealed:
-The pharmacy received the order dated 08/14/17 for Clindamycin 300mg on 08/14/17 and dispensed a total of 40 capsules of Clindamycin for Resident #1 on 08/14/17.
-The pharmacy had not received any returns for Clindamycin from the facility for Resident #1.

Interview with the Administrator on 10/16/17 at 9:35 a.m. revealed:
-Staff were supposed to initial the MAR when medications were given.
-She did not know why 42 doses of medication were documented as given when only 40 were dispensed by the pharmacy.

4. Review of Resident #4's current FL-2 dated 06/05/17 revealed diagnoses included traumatic brain injury, seizures, and bi-polar disorder.

Review of physician's orders for Resident #4

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D 367	Continued From page 293 revealed; -There was a prescription dated 08/07/17 for Duricef 500mg twice daily, #14. (Duricef is an antibiotic used to treat bacterial infections). -There was a second prescription dated 09/11/17 for Duricef 500mg twice daily, #20. -There was a third prescription dated 09/25/17 for Duricef 500mg twice daily, #30. Review of Resident #4's medication administration record (MAR) for August 2017 revealed there was no entry for the Duricef ordered 08/07/17 on the MAR. Review of Resident #4's September 2017 MAR revealed: -There was a handwritten entry for Cefadroxil (generic for Duricef) 500mg take one capsule twice daily for "7 days" with administration times of 8:00 a.m. and 5:00 p.m.. -For the 09/11/17 order, there were 23 doses of Duricef documented as administered with the first dose documented as administered on 09/13/17 at 8:00 a.m. and the last dose was documented as administered on 09/24/17 at 5:00 p.m.. There was no dose documented as having been administered on 09/24/17 at 8:00 a.m.. -There was a second handwritten entry for Cefadroxil 500mg take one capsule twice daily for "30" days (from the 09/25/17 order) with administration times of 8:00 a.m. and 5:30 p.m.; the first dose was documented as administered on 09/25/17 at 5:30 p.m. -For the 09/25/17 order, there were 11 doses documented as administered from 09/25/17-09/30/17. Review of Resident #4's October 2017 MAR revealed: -There was an entry for Cefadroxil 500mg twice	D 367		

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daily (from the 09/25/17 order).
-There were a total of 20 doses documented as administered from 10/01/17-10/13/17.

Telephone interview with the Pharmacist from the facility's pharmacy provider on 10/16/17 at 2:30 p.m. revealed:
-The pharmacy received the prescription dated 08/07/17 on 08/07/17 via fax at 3:22 p.m. and dispensed/delivered 14 capsules that same day to the facility.
-The pharmacy did not receive the prescription for Duricef dated 09/11/17 until 09/13/17 at 11:11 a.m.; twenty capsules were dispensed/delivered to the facility on 09/13/17.
-The pharmacy received the prescription for Duricef dated 09/25/17 on 09/25/17 at 1:48 p.m.; there was a note written by somebody at the facility included with the prescription asking the pharmacy not to send the medication then.
-The pharmacy received the prescription for Duricef dated 09/25/17 a second time on 10/03/17 at 10:11 a.m., but without the note requesting the medication not to be sent; 30 Duricef tablets were dispensed and delivered to the facility on 10/03/17.
-There had not been any Duricef returned to the pharmacy for Resident #4.

Observation of Resident #4's medications on hand on the medication cart on 10/13/17 at 10:15 a.m. revealed:
-There was one card of Duricef on hand with a dispense date of 10/03/17.
-There was a total of 11 Duricef left on the card.

Based on observations, interviews and record reviews, there were a total of 54 doses of Duricef documented as administered to Resident #4. There were 11 doses of Duricef on hand, for a

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total of 65 doses. The pharmacy dispensed a total of 64 Duricef for Resident #4 in August, September, and October 2017.

Interview with the Administrator on 10/16/17 at 9:35 a.m. revealed:
-Staff were supposed to initial the MAR when medications were given.
-She did not know why more doses of medication were documented than were actually dispensed by the pharmacy.

Refer to interview with the Administrator on 10/17/17 at 11:45 a.m.

5. Review of Resident #2's current FL-2 dated 4/6/17 revealed diagnoses included Alzheimer's and hypertension.

Based on observations, record reviews, and interviews, Resident #2 was not interviewable.

A. Review of the physician orders for Resident #2 revealed:
-There was an order dated 6/13/17 to give Lorazepam 0.5mg one tab three times a day.
-There was an order dated 8/9/17 to discontinue Ativan three times per day. Start Ativan tab 0.5 mg, take one tablet by mouth two times a day.
-There was an order dated 9/6/17 to give Lorazepam (Ativan) (medication used to treat the symptoms of anxiety) tab 0.5 mg, take one tablet by mouth three times a day.

Review of Resident #2's October 2017 medication administration record (MAR) revealed:
-There was a computer-generated entry for Lorazepam 0.5mg take one tablet by mouth three times a day.
-There was a handwritten line drawn through the

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D 367	Continued From page 296 4:00 p.m. dose. -There were 2 doses of Lorazepam documented as administered daily from 10/1-10/9/17 and 10/11-10/15/17 and 1 dose documented as administered on 10/10/17 with no reason noted for the omitted dose. Review of Resident #2's September 2017 MAR revealed: -There was a computer-generated entry for Lorazepam 0.5mg take one tablet by mouth three times a day. -There were 3 doses of Lorazepam documented as administered daily from 9/1-9/30/17 Review of Resident #2's August 2017 MAR revealed: -There was a computer-generated entry for Lorazepam tab 0.5mg take one tablet by mouth three times a day that was rewritten by the medication aide/supervisor (MA/S) on 8/9/17. -On 8/9/17, there was a handwritten entry by the MA/S for Ativan 0.5mg; take one tablet by mouth two times a day. -There were 3 doses of Lorazepam documented as administered daily from 8/1-8/5 and 8/7-8/8/17. -There were 2 doses of Lorazepam documented as administered daily from 8/6/17, 8/9-8/13/17, 8/16-8/26/17, and 8/29-8/30/17. -There was 1 dose of Lorazepam documented as administered daily from 8/14-8/15/17 and 8/27-8/28/17. -There were no doses of Lorazepam documented as administered on 8/31/17. Interview with a MA/S on 10/13/17 at 1:55 p.m. revealed: -She was not aware there was an order dated 9/6/17 to give Lorazepam tab 0.5 mg, take one tablet by mouth three times a day.	D 367		

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D 367	Continued From page 297 -She did not know who drew the handwritten line through the 4:00 p.m. dose on the September MAR. -She was going to call the physician to clarify the correct order for the Lorazepam. Interview with Pharmacist on 10/16/17 at 9:45 a.m. revealed: -The 9/6/17 Ativan order for 0.5 mg, take one tablet by mouth three times a day was most current. Review of pharmacy dispensing records revealed the following: -Lorazepam 0.5mg tabs; 60 were dispensed for Resident #2 on 8/29/17. -Lorazepam 0.5mg tabs; 90 were dispensed for Resident #2 on 9/13/17. Based on review of MARs for August-October 2017 the following errors in Ativan administration were revealed: -The August 2017 MAR shows 7 doses of Ativan were not documented as administered and there was no reason noted for the 8/6 (1 dose), 8/14 (1 dose), 8/15 (1 dose), 8/27 (1 dose), 8/28 (1 dose) and 8/31 (2 doses). -The September 2017 MAR shows for 9/1-9/5, there were 3 doses documented as administered each day and 2 doses should have been administered each day. -The October 2017 MAR shows for 10/1-10/9/17 (2 doses), 10/10/17 (1 dose) and 10/11-10/15/17 (2 doses) documented as administered each day and 3 doses should have been administered each day. Interview with the Administrator on 10/17/17 at 11:10 a.m. revealed: -She was not aware that the Ativan was not given	D 367		

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according to physician's order.
-Medication errors were to be reported to the physician immediately by the MA/S.
-The MA/S should have clarified the Ativan order with the physician and the pharmacy.

B. Review of the physician orders for Resident #2 revealed:
-An order dated 4/6/17 for Haloperidol (Haldol) (medication used to treat certain mental or mood disorders) 2 mg by mouth three times daily.

Review of Resident #2's October 2017 MAR revealed:
-There was a computer-generated entry for Haldol 2 mg tab take one tablet by mouth three times a day.
-There were 3 doses of Haldol documented as administered daily from 10/2-10/9/17 and 10/11-10/12/17.
-There were 2 doses of Haldol documented as administered on 10/1/17.
-There was 1 dose of Haldol documented as administered on 10/10/17.
-There were no doses of Haldol documented as administered on 10/13-10/15/17.

Review of Resident #2's September 2017 MAR revealed:
-There was a computer-generated entry for Haldol 2 mg tab take one tablet by mouth three times a day.
-There were 3 doses of Haldol documented as administered daily from 9/1-9/30/17.

Review of Resident #2's August 2017 MAR revealed:
-There was a computer-generated entry for Haldol 2 mg tab take one tablet by mouth three times a day.

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D 367	Continued From page 299 -There were 3 doses of Haldol documented as administered daily from 8/1-8/14/17 and 8/27/17. -There were 2 doses of Haldol documented as administered on 8/16-8/26/17 and 8/28-8/30/17. -There was 1 dose of Haldol documented as administered on 8/15/17. -There were no doses of Haldol documented as administered on 8/31/17. Based on review of MARs for August-October 2017 the following errors in Haldol administration were revealed: -The August 2017 MAR shows 19 doses of Haldol were not documented as administered and there was no reason noted for 8/16-8/26/17 (1 dose each day), 8/28-8/30/17 (1 dose each day), 8/15/17 (2 doses) and 8/31/17 (3 doses). -The October 2017 MAR shows 3 doses of Haldol were not documented as administered and there was no reason noted for 10/1/17 (1 dose) and 10/10/17 (2 doses). -The October 2017 MAR shows that 9 doses were not documented as administered on 10/13-10/15/17 (3 doses each day) for reason that medication was not in stock. Interview with a MA/S on 10/13/17 at 5:30 p.m. revealed: -The MAs initialed the MARs after administering the medications. -If there was no initial on the MAR, the medication was not administered. -If a medication was not administered, the reason was to be documented on the back of the MAR. Interview with MA/S on 10/16/17 at 2:40 revealed: -She knew on 10/13/17 at 8:00 a.m. that Resident #2's Haldol had "run out" and that she was going to reorder it. -"I just have not had a chance with everything	D 367		

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D 367	Continued From page 300 going on these last few days." -She will re-order the Haldol today (10/16/17). Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -The MAs were responsible for transcribing orders onto the MARs. -The MAs were supposed to read the MARs and make sure it matched the orders and the medications on hand. -The facility's Manager was responsible for monitoring the MARs but she had been on medical leave for two months and was still out. -She did not know why the MARs had so many omissions and "couldn't imagine what the problem was." -She was going to have to check the MARs.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure infection control measures to prevent the development and transmission of disease or infection and prevent cross-contamination were implemented by Staff A	D 371		

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D 371	Continued From page 301 during the morning medication pass on 10/12/17. The findings are: Observation of the morning medication pass on 10/12/17 revealed: -Staff A (medication aide) was preparing medications for Resident #2 and she crushed the medications in a pill crusher on the counter top at the nurses' station. -She was wearing gloves. -While she was crushing the medication, a roach crawled on the counter top around the bottom edge of the opened bowl of applesauce sitting on the countertop. -She knocked the roach on the floor with her gloved hand and killed it with her foot. -She continued to prepare Resident #2's medications by mixing some applesauce with the crushed pills. -She did not change gloves or wash her hands after killing the roach. -She used applesauce from the open container on the counter that the roach had been crawling around. -She administered the medications to the resident at 7:55 a.m. Interview with the medication aide (MA) on 10/12/17 at 7:56 a.m. revealed: -The exterminator sprayed about 2 weeks ago. -They still had some problems with roaches. Continued observation of the morning medication pass on 10/12/17 revealed: -Staff A removed her gloves after she administered Resident #2's medications at 7:55 a.m. -She did not wash or sanitize her hands. -She prepared and administered medications to	D 371		

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D 371	Continued From page 302 Resident #16 at 8:10 a.m. including insulin. -She used gloves when she checked Resident #16's blood sugar and administered his insulin at 8:13 a.m. -She did not wash or sanitize her hands after administering medications to Resident #16. Interview with the MA (Staff A) on 10/12/17 at 8:15 a.m. revealed: -She usually washed or sanitized her hands in between residents. -She must have forgotten to do it. -They always have sanitizer on the medication carts. Observation of both medication carts on 10/12/17 at 8:15 a.m. revealed there was hand sanitizer on top of both carts. Interview with the Administrator on 10/13/17 at 5:40 p.m. revealed: -They had infection control training for the medication aides after the survey in June 2017. -The MAs were supposed to either wash their hands or sanitize the between each resident. -Hand sanitizer was available on the medication carts.	D 371		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration	D 378		

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D 378	Continued From page 303 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure two medication carts and the medication room were locked when the medication cart was not under the immediate or direct physical supervision of the medication aide. The findings are: Observation on 10/12/17 from 8:23 a.m. - 8:25 a.m. revealed: -The medication aide/supervisor (MA/S) (Staff A) went behind the nurses' station to turn off a door alarm. -She then walked down the 100 Hall but left the 100 Hall medication cart unlocked. -The cart was not in her sight and no other staff was at the nurses' station. -She walked by the nurses' station at 8:25 a.m. and went into the dining room. -She could not see the nurses' station or the medication cart from the dining room. -She returned to the nurses' station again at 8:34 a.m. -She did not lock the medication cart and she walked back to the dining room within a few seconds. -The housekeeper walked near the nurses' station at 8:35 a.m. and back down the 100 Hall. -The MA/S returned to the nurses' station at 8:38 a.m. and locked the medication cart. Interview with the MA/S (Staff A) on 10/12/17 at 8:39 a.m. revealed: -She usually locked the medications when she was not at the nurses' station. -She forgot to lock it.	D 378		

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D 378	Continued From page 304 Observation on 10/12/17 from 11:50 a.m.-11:54 a.m. revealed: -The MA/S (Staff A) was at the medication cart which was parked behind the nurses' station desk. -The MA/S was preparing medications and administering them to various residents in the dining room. -At 11:50 a.m., the MA/S walked away from the medication cart into the dining room to administer medication to a resident and returned to the medication cart after administering the medication -The medication cart was left unlocked and unattended. -At 11:52 a.m., the MA/S left the medication cart a second time and went into the dining room to administer medication to another resident. -She did not lock the medication cart. -At 11:54 a.m., the MA/S returned to the medication cart and locked the cart. Observation on 10/13/17 from 10:34 a.m.-10:45 a.m. revealed: -The MA/S on duty (Staff A) was at the nurses' station and got a call on her personal cell phone. -The MA answered the call, walked away from the nurses' station and into the dining room. -She then walked outside of the dining room to a front porch area. -She could not see the nurses' station from the front porch. -The nurses' station was unattended. -Both medication carts (100 Hall and 200 Hall) were unlocked. -The door to the medication storage room was unlocked. -There were 4 plastic baskets of multiple bubble cards of medications for multiple residents on the counter of the nurses' station.	D 378		

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D 378	Continued From page 305 -There was 1 plastic basket with multiple bubble cards sitting on top of the 200 Hall cart. -There was a jar of medicated ointment sitting on top of the 100 Hall cart. -At 10:45 a.m., the MA/S walked by the nurses' station to the kitchen door to get a resident a cup of ice. -The resident stood beside the nurses' station while the MA/S went into the kitchen while the medications were still unlocked and unattended. -The MA/S returned to the nurses' station and handed the resident a cup of ice. Interview with the MA/S (Staff A) on 10/13/17 at 10:46 a.m. revealed: -She was going through the over-supply of medication to see what she needed to order. -The MAs have to order the medications because they did not get monthly cycle fills. -She forgot to lock up the medications when she got the phone call. -She usually locked the medications. Interview with the Administrator on 10/13/17 at 10:50 a.m. revealed: -The MAs knew they were supposed to keep the medications locked when not under their supervision. -She was not aware the MAs were not keeping the medication carts and the medication storage area unlocked and unattended.	D 378		
D 388	10A NCAC 13F .1007 (c) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (c) Medications, excluding controlled medications, shall be destroyed at the facility or returned to a pharmacy within 90 days of the	D 388		

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D 388	Continued From page 306 expiration or discontinuation of medication or following the death of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to destroy and/or return medications to the pharmacy within 90 days of their expiration or discontinuance by the physician. The findings are: Observation in the medication storage room on 10/12/17 at 3:00 p.m. revealed: -There were two Ziploc bags with prescription labels with IV (intravenous) antibiotics for Resident #4 in the refrigerator. -The Cefepime IV antibiotic was dispensed on 08/29/17 and expired on 09/05/17 and there were 2 left in the bag. -The Vancomycin IV antibiotic was dispensed on 08/29/17 and expired on 09/07/17 and there were 2 left in the bag. -There were two bottles of medicated topical antiseptic cleanser with expiration dates of 06/2015 and 10/2015. -There was a liquid antacid with expiration date of 04/2015. -There was a laxative with expiration date of 12/2016. -There was a bottle of medicated shampoo with expiration date of 12/2016. -There was a bottle of Aspirin 325mg with expiration date of 02/2017. -There was a jar of burn cream with expiration date of 02/2017. -There was an Albuterol inhaler for a deceased resident. -There was a steroid eye drop dispensed on	D 388		

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D 388	Continued From page 307 02/21/17 for a resident who no longer lived at the facility. -There was a bottle of powdered laxative dispensed on 05/09/17 for a resident who no longer lived at the facility. Interview with the medication aide (MA)/supervisor on 10/12/17 at 3:10 p.m. revealed: -The MAs were supposed to send medications back to the pharmacy when they expired. -The IV medications in the refrigerator had been brought in by a home health company for one of the residents. -The home health nurse would come to the facility to administer the IV medication. -The resident was no longer getting the IV medication. -She needed to call the home health agency to pick up the IV medication since it was expired and the resident was no longer using it. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -The medication aides (MAs) had been trained to date insulin when it was opened so they could determine the expiration date. -If medications were expired, they should be sent back to the pharmacy. -She had told the MAs to send the expired medications back to the pharmacy. -She was not aware there were still expired medications in the medication room. -The facility's Manager who had been on medical leave for 2 months would have been responsible to make sure the expired medications were returned. -She was going to clean out the medication room herself.	D 388		

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D 392	Continued From page 308	D 392		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records and failed to account for the use and administration of controlled substances for 2 of 2 sampled residents (#3, #17) including a resident (#3) who had some Oxycodone tablets tampered and replaced with an anti-nausea medication and a resident (#17) who had some Hydrocodone/Acetaminophen tablets tampered and replaced with a potassium supplement and a stool softener. The findings are: 1. Review of Resident #3's current FL-2 dated 03/07/17 revealed diagnoses included diabetes mellitus, peripheral vascular disease, pneumonia, and muscle weakness. Review of Resident #3's physician's orders revealed: -There was an order dated 06/07/17 for Oxycodone 10mg 1 tablet 3 times a day. -There was an order dated 08/23/17 for Oxycodone 10mg 1 tablet twice a day.	D 392		

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D 392	Continued From page 309 -There was an order dated 09/18/17 for Oxycodone 10mg 1 tablet twice a day. Interview with Staff E (medication aide) on 10/12/17 at 6:48 p.m. revealed: -Last Thursday (10/05/17), she noticed a problem with Resident #3's Oxycodone. -She noticed the Oxycodone tablets were punched out of order on the bubble card and the amount on hand did not match the controlled substance (CS) log. -She noticed the pills in the bubble card were the same size and color but had different imprint codes. -She asked a Nurse Practitioner (NP) who came to the facility on 10/05/17 about it and the NP said there were 2 different pills in the card. -The NP said it was Promethazine (for nausea) and Oxycodone in the bubble card. -The next day (10/06/17), Staff E noticed there was tape on the back of the bubble card. -She reported it to the Administrator "last weekend" (referring to weekend of 10/07/17 - 10/08/17). -The Administrator told Staff E to make sure she reported it to second shift staff. -Sometimes when she worked as the MA on second shift, she would let Staff C who was also a medication aide (MA) help her administer medications. -She would do the 100 Hall medication cart and Staff C would do the 200 Hall medication cart. -On 10/06/17 while she was working, Staff C asked her for the keys to the medication cart because Resident #16 wanted a prn (as needed) medication for tooth pain. -Staff C said she was going to get 2 Tylenol to give to the resident. -While Staff E was standing in the hall talking with a family member, she saw Staff C put a pill in her	D 392		

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pocket from a bubble card in the controlled substance drawer.
-She knew it was Resident #3's Oxycodone because she could see the pink tablets in the card and Resident #3's Oxycodone tablets were pink.
-When asked how she could see the small tablet from the hall, she stated she was standing near the nurses' station.
-She did not confront Staff C.
-She reported it to the Administrator on Saturday, 10/07/17.
-The Administrator said she was going to talk to Staff C.
-She did not report it to the pharmacy or the local law enforcement.
-She thought the Administrator would take care of it.
-Resident #3 had not complained the pain medication was not working.
-Staff E administered the pills from bubbles that were sealed not taped.

Attempts to contact the visiting Nurse Practitioner on 10/12/17 at 12:10 p.m. and 10/13/17 at 12:40 p.m. were unsuccessful.

Review of pharmacy dispensing records revealed 60 Oxycodone 10mg tablets were dispensed on 09/18/17.

Observation of Resident #3's medication on hand on 10/12/17 revealed:
-There was a card of Oxycodone 10mg tablets dispensed on 09/18/17.
-There were 60 tablets dispensed and 5 pink, round tablets left in the bubble card.
-Bubbles #1-5 still had tablets but bubble #3 was the only one with an unbroken seal.
-Bubbles #1, 2, 4, and 5 had transparent tape

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D 392	Continued From page 311 over the broken seals holding the tablets in place. -The tablet in bubble #3 was Oxycodone 10mg. -The tablets in the other 4 bubbles were Promethazine 12.5mg tablets. -The empty bubbles for #11-15 and #20-21 had remnants of transparent tape peeling from the bubbles. -There was only 1 Oxycodone 10mg tablet in the bubble card. Review of the controlled substance (CS) log for Resident #3's Oxycodone tablets dispensed on 09/18/17 revealed: -The prescription label on the CS log matched the label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a day. -Staff E signed that 60 Oxycodone tablets were received on 09/18/17. -The first entry on the CS log was 1 Oxycodone 10mg tablet was administered on 09/19/17 at 4:00 p.m. -The last entry on the CS log was 1 Oxycodone tablet was administered on 10/11/17 at 8:00 p.m. which left 6 tablets remaining on hand. -The morning dose for 10/12/17 was not documented on the CS log. -Oxycodone was documented as administered 3 times a day on 09/21/17 - 09/24/17, 10/02/17, 10/03/17, 10/07/17, and 10/09/17 instead of twice a day. -For each of those dates, first shift documented a morning dose and Staff C documented she administered an afternoon and evening dose (to equal 3 times a day). -On 10/09/17 at 11:00 p.m., Staff C noted the pill count was 9 instead of 10 and it was countersigned by Staff B. -Below that line, Staff C noted the pill was found in the cart and the count was 10 and Staff B countersigned it.	D 392		

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D 392	Continued From page 312 Interview with a Staff B on 10/12/17 at 7:30 p.m. revealed she and Staff C found one of Resident #3's Oxycodone in the medication drawer and taped it back in one of the bubbles during shift count. Review of Resident #3's September 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Oxycodone 10mg take 1 tablet 3 times a day at 8:00 a.m., 4:00 p.m., and 8:00 p.m. -There was no Oxycodone documented as administered beside the entry but staff documented the order was "rewritten". -There was a handwritten entry for Oxycodone 10mg take 1 tablet twice daily at 8:00 a.m. and 8:00 p.m. -Staff documented Oxycodone 10mg was administered twice a day from 09/01/17-09/30/17. -A total of 24 doses were documented as administered from 09/19/17-09/30/17 (but 28 tablets were documented on the CS log during this time period. Review of Resident #3's October 2017 MAR revealed: -There was a computer printed entry for Oxycodone 10mg take 1 tablet twice a day at 8:00 a.m. and 8:00 p.m. -Oxycodone was documented as administered twice daily from 10/01/17 - 10/12/17 (8:00 a.m.) for a total of 21 tablets (but 26 tablets were documented on the CS log during this time period. Observations, interviews, and record reviews for Resident #3 revealed: -Staff documented 45 tablets of Oxycodone were administered on the MARs but 54 tablets were	D 392		

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administered on the CS log from 09/19/17-10/12/17.
-The CS log indicated there should be 6 tablets on hand but there was only 1 Oxycodone 10mg tablet on hand and 4 other tablets in the card were Promethazine 12.5mg tablets.
-The CS log did not match the MARs and it did not accurately reflect the quantity of Oxycodone on hand.

Interview with the Administrator on 10/13/17 at 10:50 a.m. revealed:
-The bubble card for Resident #3's controlled medication had been put in the bottom of the medication cart today (10/13/17) and more had been ordered.
-She had not had a chance to review the CS logs for Resident #3.

Interview with a third shift MA on 10/13/17 at 5:30 p.m. revealed:
-"Pain pills" were counted at the end of each shift by the staff who were leaving and coming on shift.
-Two to three weeks ago, when counting with Staff E, she noticed tape on a resident's medication cards.
-She was not sure, but thought it was Resident #3's pain medication.
-She could not recall what the medication was with the tape on the card.
-She asked Staff E about it and she didn't know anything about it.
-There had not been any wrong counts lately.

Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed:
-Resident #3's controlled substance was taped on the back where some pills had fallen out of the bubble card.
-She had noticed some pills in Resident #3's

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bubble card did not look the same so she skipped those bubbles and punched from the sealed bubbles.
-She did not report it to anyone because the Administrator and the Manager knew because some MAs "report everything".
-Resident #3 complained about pain "a lot" even after she got her pain medication.

Interview with Resident #3 on 10/17/17 at 10:25 a.m. revealed:
-She usually got her Oxycodone twice a day, in the morning and at night.
-She sometimes had pain from her right leg amputation.
-The pain medication helped but it made her sleepy.

Telephone interview with Resident #3's primary care physician (PCP) on 10/13/17 at 2:00 p.m. revealed:
-He was not aware of any problems with Resident #3's Oxycodone.
-No one from the facility had reported any problems with the Oxycodone.
-He was concerned that Oxycodone tablets had been replaced with other medication.
-He would have wanted to know about this.
-No one from the facility had contacted him to get a new prescription for the Oxycodone.

Review of medications on hand for Resident #3 revealed a new supply of Oxycodone 10mg tablets were dispensed on 10/13/17.

Refer to telephone interview with the Administrator on 10/12/17 at 8:19 p.m.

Refer to interview with the medication aide (MA) on 10/13/17 at 1:40 p.m.

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D 392	Continued From page 315 Refer to telephone interview with Staff C on 10/16/17 at 2:40 p.m. 2. Review of Resident #17's current FL-2 dated 09/25/17 revealed: -Diagnoses included diabetes mellitus with diabetic neuropathy, coronary artery disease, atherosclerotic heart disease, hyperlipidemia, iron deficiency, chronic obstructive pulmonary disease, constipation, insomnia, pain, rash, heartburn, urine retention, seasonal allergic rhinitis, wheezing, major depressive disorder, hypomagnesemia, gastroesophageal reflux disease, and pressure ulcer of right heel. Review of a physician's order dated 07/17/17 for Resident #17 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet every 4 hours as needed. (Hydrocodone/Acetaminophen is a controlled substance used to treat moderate to severe pain.) Interview with Staff E (medication aide) on 10/12/17 at 6:48 p.m. revealed: -She noticed a problem with Resident #17's Hydrocodone/Acetaminophen tablets yesterday (10/11/17) -She noticed the bubble card for the Hydrocodone/Acetaminophen tablets had tape on the back of the card and some of the pills in the card were not the same. -She looked up the pills on the internet on her phone and there were Hydrocodone/Acetaminophen 5/325mg tablets, Potassium Chloride 10mEq tablets (potassium supplement), and Docusate Sodium 100mg (stool softener) tablets in the bubble card. -She had not reported it to any one at the facility.	D 392		

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D 392	Continued From page 316 -Resident #17 usually asked for a prn (as needed) pain pill (Hydrocodone/Acetaminophen) at night when he was ready to go to bed. -She administered him Hydrocodone/Acetaminophen bubbles that were sealed, not taped. -Resident #17 had complained that his pain medication did not work at times. -Resident #17 complained of his stomach hurting and he asked for two Imodium (for diarrhea) "the other night" (could not give specific date). -She administered two Imodium to the resident from a supply of medication he had from a recent stay at a rehabilitation facility. -She did not document it on the MAR. Interview with a second medication aide (MA) on 10/12/17 at 7:30 p.m. revealed: -Resident #17 asked her for two Imodium tablets on Monday, 10/09/17. -She did not administer any Imodium to the resident because he did not have an order. Review of pharmacy dispensing records revealed 75 Hydrocodone/Acetaminophen 5/325mg tablets were dispensed on 07/17/17. Observation of Resident #17's medication on hand on 10/12/17 revealed: -There were 2 cards of Hydrocodone/Acetaminophen 5/325mg tablets on hand. -Both cards were dispensed on 07/17/17 for a total of 75 tablets. -One card was dispensed with 60 tablets and the other card with 15 tablets. -The first card dispensed with 60 tablets had 8 tablets remaining in bubbles #1-7 and #11. -Bubbles #2, 3, 4, 5, and 7 were sealed with Hydrocodone/Acetaminophen 5/325mg tablets.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 317 -The seal was broken on bubbles #1, 6, and 11 and the pills taped in the bubbles were Docusate Sodium 100mg tablets. -The second card dispensed with 15 tablets had 14 tablets remaining in bubbles #1 - 14. -Bubbles #3-14 were sealed with Hydrocodone/Acetaminophen 5/325mg tablets. -Bubble #1 was taped with a Potassium Chloride 10mEq tablet inside. -Bubble #2 was taped with a Hydrocodone/Acetaminophen 5/325mg tablet inside. -Bubble #15 was empty but had tape stuck on it. -There was a total of 18 Hydrocodone/Acetaminophen 5/325mg tablets on hand. -There was a card of Docusate Sodium 100mg and Potassium Chloride 10mEq on hand in the medication cart for Resident #17 that had the same imprint codes as the Docusate and Potassium tablets observed in the Hydrocodone/Acetaminophen bubble cards. Review of Resident #17's controlled substance (CS) log for Hydrocodone/Acetaminophen revealed: -There was no prescription label on the CS log. -The information was handwritten at the top of the log with the resident's name, prescription number (dispensed on 07/17/17), name of the medication, and instructions to take 1 pill every 4 hours by mouth. -Staff C signed that 29 tablets were received on 10/07/17. -The first dose administered on the log was 10/07/17 at 8:00 p.m. -The last dose administered on the log was 10/11/17 at 9:00 p.m. with 22 tablets remaining. -A total of 7 tablets were documented as administered on the CS log.	D 392		

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D 392	Continued From page 318 Review of Resident #17's July 2017-September 2017 medication administration records (MARs) revealed: -There was a computer printed entry for Hydrocodone/Acetaminophen 1 tablet every 4 hours as needed on each MAR. -No prn (as needed) Hydrocodone/Acetaminophen were documented as administered from August 2017 - September 2017. Review of Resident #17's October 2017 MAR revealed: -The MARs were handwritten and documentation for all medications started on 10/04/17. -There was no entry for Hydrocodone/Acetaminophen written on the MAR and therefore none was documented as administered in October 2017. Interview with a medication aide (MA) on 10/16/17 at 4:05 p.m. revealed: -She gave Hydrocodone/Acetaminophen to Resident #17. -She had not noticed the Hydrocodone/Acetaminophen was not on the MAR. -She documented it on the CS log. -She thought it may have been left off of the MAR since it was handwritten. -She did not know why Resident #17's October 2017 MAR was handwritten instead of printed by the pharmacy. -She could not locate any other October 2017 MAR or CS logs for Resident #17. Observations, interviews, and record reviews for Resident #17 revealed: -The CS log available for review for the	D 392		

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D 392	Continued From page 319 Hydrocodone/Acetaminophen documented only 8 tablets of the 75 dispensed on 07/17/17. -Staff could not find any other CS logs for this medication to account for the other 67 tablets dispensed on 07/17/17. -No doses of prn Hydrocodone/Acetaminophen were documented as administered on the July 2017-October 2017 MARs. -The CS log on hand indicated there should be 22 tablets on hand. -There were 18 Hydrocodone/Acetaminophen tablets because 4 tablets on hand were different medications. Interview with the Administrator on 10/13/17 at 10:50 a.m. revealed: -The bubble cards for Resident #4's controlled medication had been put in the bottom of the medication cart and more had been ordered. -She had not had a chance to review the CS logs for Resident #17. Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed: -Resident #17 always complained about pain. -Resident #17's controlled substances were "messed up". -His bubble cards had tape on them. Interview with Resident #17 on 10/12/17 at 8:04 p.m. revealed: -His pain medication sometimes helped and sometimes it did not. -He did not know the name of his pain medication or if he got more than one kind. -He could get his pain medication every 4 to 6 hours if he needed it. -He usually got pain medication 3 or 4 times a day. -He denied any symptoms of stomach pain or	D 392		

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D 392	Continued From page 320 diarrhea. -He had not asked or received any Imodium to his knowledge. [It was documented on Resident #17's October 2017 MAR that he was receiving Tylenol 325mg 2 by mouth 3 times a day at 8:00 a.m., 2:00 p.m. and 8:00 p.m.] Interview with the Administrator on 10/16/17 at 9:00 a.m. revealed: -The CS logs should be filed in the resident's record. -The facility's Manager who was out on medical leave usually filed information in the records. -No one took over filing information since the Manager had been out sick. Review of medications on hand for Resident #17 revealed a new supply of Hydrocodone/Acetaminophen 5/325mg tablets were dispensed on 10/13/17. Refer to telephone interview with the Administrator on 10/12/17 at 8:19 p.m. Refer to interview with the medication aide (MA) on 10/13/17 at 1:40 p.m. Refer to telephone interview with Staff C on 10/16/17 at 2:40 p.m. _____ Telephone interview with the Administrator on 10/12/17 at 8:19 p.m. revealed: -Staff reported to her the "week before last" that some Hydrocodone tablets looked like they had been replaced in the cards with other medication. -She was not on-site at the facility when it was reported to her.	D 392		

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D 392	Continued From page 321 -She had not actually seen the bubble cards that had been tampered with. -She had not looked at the CS logs either. -Staff alleged that Staff C was taking the controlled substances. -She had not investigated the allegation. Interview with the medication aide (MA) on 10/13/17 at 1:40 p.m. revealed: -She noticed the back of the medication cards were taped on the controlled substances about 3 weeks ago. -She had noticed the documentation on the controlled substance logs were "off" because staff might document a pill was dropped on the floor. Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed: -The MAs count controlled substances with the oncoming MA at each shift change. -The MAs had noticed some of the pills in the controlled substance drawer would fall out. -The MAs had noticed blanks on the CS logs or MARs so it did not match. -She did not report it to anyone because the Administrator and the Manager knew because some MAs "report everything". _____ The facility failed to assure controlled substance logs accurately reflected the quantity of narcotic pain medications on hand for Resident #3 and Resident #17. Resident #3's Oxycodone tablets had been tampered with and at least 4 tablets replaced with an anti-nausea medication. Resident #17's Hydrocodone/Acetaminophen had been tampered with and 4 tablets replaced with a stools softener or a potassium supplement. There was no CS log to account for 67 Hydrocodone/Acetaminophen tablets for Resident #17. The facility's failure to maintain	D 392		

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D 392	Continued From page 322 accountability of controlled substances was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ Review of the facility's Plan of Protection dated 10/12/17 revealed: -24 hour report completed and alleged Medication Aide placed on unpaid leave pending results of investigation from Health Care Registry. -5 day report will be filed after facility investigation. -Physician will be notified of diversion of issue identified during survey. -Pharmacy and Sheriff notified today. -Will do complete controlled drug audit. -In-service for all Medication Aides on control drugs, counts and reports of discrepancies. -Administrator will do random control drug checks weekly for one month, then randomly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 1, 2017.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.	D 399		

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D 399	Continued From page 323 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to report suspected drug diversions of controlled substances to the pharmacy, local law enforcement, and the Health Care Personnel Registry for 2 of 2 sampled residents (#3, #17) who were prescribed Oxycodone (#3) and Hydrocodone/Acetaminophen (#17). The findings are: 1. Review of Resident #3's current FL-2 dated 03/07/17 revealed diagnoses included diabetes mellitus, peripheral vascular disease, pneumonia, and muscle weakness. Review of Resident #3's physician's orders revealed an order dated 09/18/17 for Oxycodone 10mg 1 tablet twice a day. Interview with Staff E (medication aide) on 10/12/17 at 6:48 p.m. revealed: -Last Thursday (10/05/17), she noticed a problem with Resident #3's Oxycodone. -She noticed the Oxycodone tablets were punched out of order on the bubble card and the amount on hand did not match the controlled substance (CS) log. -She noticed the pills in the bubble card were the same size and color but had different imprint codes. -The next day (10/06/17), Staff E noticed there was tape on the back of the bubble card. -She reported it to the Administrator "last weekend" (referring to weekend of 10/07/17-10/08/17). -On 10/06/17 while she was working, Staff C asked her for the keys to the medication cart because Resident #16 wanted a prn (as needed)	D 399		

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D 399	Continued From page 324 medication for tooth pain. -Staff C said she was going to get 2 Tylenol to give to the resident. -While Staff E was standing in the hall talking with a family member, she saw Staff C put a pill in her pocket from a bubble card in the controlled substance drawer. -She knew it was Resident #3's Oxycodone because she could see the pink tablets in the card and Resident #3's Oxycodone tablets were pink. -She did not confront Staff C. -She reported it to the Administrator on Saturday, 10/07/17. -The Administrator said she was going to talk to Staff C. -She did not report it to the pharmacy or the local law enforcement. -She thought the Administrator would take care of it. Observation of Resident #3's medication on hand on 10/12/17 revealed: -There was a card of Oxycodone 10mg tablets dispensed on 09/18/17. -There were 60 tablets dispensed and 5 pink, round tablets left in the bubble card. -Bubbles #1-5 still had tablets but bubble #3 was the only one with an unbroken seal. -Bubbles #1, 2, 4, and 5 had transparent tape over the broken seals holding the tablets in place. -The tablet in bubble #3 was Oxycodone 10mg. -The tablets in the other 4 bubbles were Promethazine 12.5mg tablets. -The empty bubbles for #11-15 and #20-21 had remnants of transparent tape peeling from the bubbles. -There was only 1 Oxycodone 10mg tablet in the bubble card.	D 399		

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D 399	Continued From page 325 Observations, interviews, and record reviews for Resident #3 revealed: -Staff documented 45 tablets of Oxycodone were administered on the MARs but 54 tablets were administered on the CS log from 09/19/17-10/12/17. -The CS log indicated there should be 6 tablets on hand but there was on 1 Oxycodone 1mg tablet on hand and 4 other tablets in the card were Promethazine 12.5mg tablets. -The CS log did not match the medication administration records and it did not accurately reflect the quantity of Oxycodone on hand. Interview with Resident #3 on 10/17/17 at 10:25 a.m. revealed: -She usually got her Oxycodone twice a day, in the morning and at night. -She sometimes had pain from her right leg amputation. -The pain medication helped but it made her sleepy. Refer to interview with the medication aide (MA) on 10/13/17 at 1:40 p.m. Refer to telephone interview with the Administrator on 10/12/17 at 8:19 p.m. Refer to interview with the Administrator on 10/13/17 at 10:50 a.m. Refer to telephone interview with Staff C on 10/16/17 at 2:40 p.m. Refer to interview with the Administrator on 10/13/17 at 5:37 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 10/17/17 at	D 399		

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D 399	Continued From page 326 2:00 p.m. Refer to interview with a staff of the local Sheriff's office on 10/17/17 at 12:04 p.m. 2. Review of Resident #17's current FL-2 dated 09/25/17 revealed diagnoses included diabetes mellitus with diabetic neuropathy, coronary artery disease, atherosclerotic heart disease, hyperlipidemia, iron deficiency, chronic obstructive pulmonary disease, constipation, insomnia, pain, rash, heartburn, urine retention, seasonal allergic rhinitis, wheezing, major depressive disorder, hypomagnesemia, gastroesophageal reflux disease, and pressure ulcer of right heel. Review of a physician's order dated 07/17/17 for Resident #17 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet every 4 hours as needed. (Hydrocodone/Acetaminophen is a controlled substance used to treat moderate to severe pain.) Interview with Staff E (medication aide) on 10/12/17 at 6:48 p.m. revealed: -She noticed a problem with Resident #17's Hydrocodone/Acetaminophen tablets yesterday (10/11/17) -She noticed the bubble card for the Hydrocodone/Acetaminophen tablets had tape on the back of the card and some of the pills in the card were not the same. -She looked up the pills on the internet on her phone and there were Hydrocodone/Acetaminophen 5/325mg tablets, Potassium Chloride 10mEq tablets (potassium supplement), and Docusate Sodium 100mg (stool softener) tablets in the bubble card.	D 399		

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D 399	Continued From page 327 -She had not reported it to any one at the facility. -Resident #17 usually asked for a prn (as needed) pain pill (Hydrocodone/Acetaminophen) at night when he was ready to go to bed. -She gave him Hydrocodone/Acetaminophen bubbles that were sealed, not taped. Telephone interview with the Administrator on 10/12/17 at 8:19 p.m. revealed: -Staff reported to her the "week before last" that some Hydrocodone tablets looked like they had been replaced in the cards with other medication. -The Hydrocodone tablets were for Resident #17. -She was not on-site at the facility when it was reported to her. -She had not actually seen the bubble cards that had been tampered with. Observation of Resident #17's medication on hand on 10/12/17 revealed: -There were 2 cards of Hydrocodone/Acetaminophen 5/325mg tablets on hand. -Both cards were dispensed on 07/17/17 for a total of 75 tablets. -One card was dispensed with 60 tablets and the other card with 15 tablets. -The first card dispensed with 60 tablets had 8 tablets remaining in bubbles #1 -7 and #11. -Bubbles #2, 3, 4, 5, and 7 were sealed with Hydrocodone/Acetaminophen 5/325mg tablets. -The seal was broken on bubbles #1, 6, and 11 and the pills taped in the bubbles were Docusate Sodium 100mg tablets. -The second card dispensed with 15 tablets had 14 tablets remaining in bubbles #1-14. -Bubbles #3-14 were sealed with Hydrocodone/Acetaminophen 5/325mg tablets. -Bubble #1 was taped with a Potassium Chloride 10mEq tablet inside.	D 399		

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D 399	Continued From page 328 -Bubble #2 was taped with a Hydrocodone/Acetaminophen 5/325mg tablet inside. -Bubble #15 was empty but had tape stuck on it. -There were a total of 18 Hydrocodone/Acetaminophen 5/325mg tablets on hand. -There was a card of Docusate Sodium 100mg and Potassium Chloride 10mEq on hand in the medication cart for Resident #17 that appeared to be the same tablets as identified in the Hydrocodone/Acetaminophen bubble cards. Observations, interviews, and record reviews for Resident #17 revealed: -The CS log available for review for the Hydrocodone/Acetaminophen documented only 8 tablets of the 75 dispensed on 07/17/17. -Staff could not find any other CS logs for this medication to account for the other 67 tablets dispensed on 07/17/17. -No doses of prn Hydrocodone/Acetaminophen were documented as administered the July 2017-October 2017 medication administration records (MARs). -The CS log on hand indicated there should be 22 tablets on hand. -There were 18 Hydrocodone/Acetaminophen tablets because 4 tablets on hand were different medications. Interview with Resident #17 on 10/12/17 at 8:04 p.m. revealed: -His pain medication sometimes helped and sometimes it did not. -He did not know the name of his pain medication or if he got more than one kind. -He could get his pain medication every 4 to 6 hours if he needed it. -He usually got pain medication 3 or 4 times a	D 399		

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D 399	Continued From page 329 day. -He denied any symptoms of stomach pain or diarrhea. -He had not asked or received any Imodium to his knowledge. Refer to interview with the medication aide (MA) on 10/13/17 at 1:40 p.m. Refer to telephone interview with the Administrator on 10/12/17 at 8:19 p.m. Refer to interview with the Administrator on 10/13/17 at 10:50 a.m. Refer to telephone interview with Staff C on 10/16/17 at 2:40 p.m. Refer to interview with the Administrator on 10/13/17 at 5:37 p.m. Refer to telephone interview with a pharmacist at the facility's primary pharmacy on 10/17/17 at 2:00 p.m. Refer to interview with a staff of the local Sheriff's office on 10/17/17 at 12:04 p.m. _____ Interview with the medication aide (MA) on 10/13/17 at 1:40 p.m. revealed: -She noticed the back of the medication cards were taped on the controlled substances about 3 weeks ago. -She told the Administrator at that time (3 weeks ago). -She had not observed anyone taking pills from the medication supply. -She had noticed the documentation on the controlled substance logs were "off" like staff	D 399		

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D 399	Continued From page 330	D 399		

might document a pill was dropped on the floor.
-She had not reported the concerns about the controlled substances to the pharmacy and she did not know if anyone had reported it.
-She did not know what the Administrator did about the issues after it was reported to the Administrator.

Telephone interview with the Administrator on 10/12/17 at 8:19 p.m. revealed:
-Staff alleged that Staff C was taking the controlled substances the "week before last".
-She had not investigated the allegation.
-She gave no explanation for not investigating the allegation.
-Staff did not report they had actually observed Staff C or anyone else take any pills.
-She had not reported it to the pharmacy, local law enforcement, or the Health Care Personnel Registry.

Interview with the Administrator on 10/13/17 at 10:50 a.m. revealed:
-Staff C came into work her shift on third shift last night (10/12/17).
-Staff C denied taking any pills.
-She was not going to put Staff C back on the schedule pending the outcome of her investigation.
-She was going to fill out the 24 hour report form for the HCPR.
-The first shift MA was going to call the pharmacy to report the problems with the controlled substances today (10/13/17).
-She had not called the local law enforcement yet.

Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed:
-She had not observed anyone take any pills from the facility.

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D 399	Continued From page 331 -There was hearsay that she was being accused of taking pills from the facility. -She denied taking any pills from the facility. -She last worked at the facility on last Wednesday or Thursday. -She was not currently scheduled to come back to work. Interview with the Administrator on 10/13/17 at 5:37 p.m. revealed: -The MA called the pharmacy today (10/13/17) to report the drug diversion. -She called the local sheriff's office today (10/13/17) and left a voice message for the sheriff about the drug diversion. Telephone interview with a pharmacist at the facility's primary pharmacy on 10/17/17 at 2:00 p.m. revealed: -A medication aide (MA) called the pharmacy and reported diversion of drug for Resident #3 and Resident #17 on 10/13/17 at 3:16 p.m. -He did the last drug reviews at the facility in August 2017 and he did not notice any problems with the controlled substances. -This was the first time this facility had reported any problems with drug diversion to the pharmacy. Interview with a staff of the local Sheriff's office on 10/17/17 at 12:04 p.m. revealed: -Nothing had been report by the facility related to drug diversion. -The last report received was from 2010.	D 399		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each	D 433		

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D 433	Continued From page 332 resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.	D 433		

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D 433	Continued From page 333	D 433		

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure resident records were maintained in an orderly manner to include failure to file medication orders, contact with residents' primary care provider (PCP), and hospital discharge orders for 3 of 3 residents sampled (#1, #2, #17).

The findings are:

1. Review of Resident #1's current FL-2 dated 02/20/17 revealed:
-Diagnoses included senile dementia, uncontrolled Type II diabetes, hypertension, anemia, and depression.
-There was an order to check finger stick blood sugar (FSBS) before meals and at bedtime.

Review of Resident #1's physician orders revealed:
-There was an order dated 06/05/17 to check FSBS at 7:00 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m..
-There was an order dated 07/10/17 to fax Resident #1's FSBS results to the primary care provider's (PCP) office every Wednesday.
-There was an order dated 08/23/17 to check FSBS daily at 7:00am, before meals and bedtime, two hours after lunch, and at 2:00 a.m. (six times daily).

Observation on 10/12/17 at 9:10 a.m. revealed:
-There were multiple stacks of various PCP orders, hospital discharge summaries, and medication administration records (MARs) laying on the desk at the nurses' station dating back to June 2017.

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D 433	Continued From page 334 -There was a hospital discharge summary for Resident #1 dated 08/14/17 in a folder stacked in a pile of other papers on the desk. -There were two binders identified by a medication aide/supervisor (MA/S) as the MAR books with a physician order dated 10/09/17 in one binder for Resident #1 with multiple orders to include discontinuing insulin before meals and providing a ½ peanut butter sandwich for the resident for bedtime snack nightly. Review of Resident #1's record revealed: -There was no documentation of his 08/14/17 hospital visit in the record to include the hospital discharge summary. -There was no documentation of staff communicating with Resident #1's PCP with the FSBS results every Wednesday on any date. -There was no copy of the physician order dated 10/09/17 in the record. Interview with the first shift MA/S on 10/12/17 at 9:10 a.m. revealed: -The orders for Resident #1 were in different places because the physician was watching his blood sugar closely. -That may have been why the 10/09/17 order was in the MAR book and not in the resident's record. -The items on the desk should have been filed. -The Manager usually filed the items in the residents' chart, but she was out sick. Telephone interview with a Resident #1's Home Health Registered Nurse on 10/17/17 at 9:30 a.m. revealed Resident #1's orders and other documentation was scattered everywhere. Refer to the interview with the first shift medication aide/supervisor (MA/S) on 10/12/17 at 2:40 p.m.	D 433		

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D 433	Continued From page 335 Refer to the interviews with the Administrator on 10/12/17 at 10:05 a.m., 10/16/17 at 2:56 p.m., and 10/17/17 at 12:40 p.m. 2. Review of Resident #17's current FL-2 dated 09/25/17 revealed: -Diagnoses included diabetes mellitus with diabetic neuropathy, coronary artery disease, atherosclerotic heart disease, hyperlipidemia, iron deficiency, chronic obstructive pulmonary disease, constipation, insomnia, pain, rash, heartburn, urine retention, seasonal allergic rhinitis, wheezing, major depressive disorder, hypomagnesemia, gastroesophageal reflux disease, and pressure ulcer of right heel. Review of a physician' order dated 07/17/17 for Resident #17 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet every 4 hours as needed. (Hydrocodone/Acetaminophen is a controlled substance used to treat moderate to severe pain.) Interview with a medication aide (MA) on 10/12/17 at 6:48 p.m. revealed: -She noticed a problem with Resident #17's Hydrocodone/Acetaminophen tablets yesterday (10/11/17). -She noticed the bubble card for the Hydrocodone/Acetaminophen tablets had tape on the back of the card and some of the pills in the card were not the same. Review of pharmacy dispensing records revealed 75 Hydrocodone/Acetaminophen 5/325mg tablets were dispensed on 07/17/17. Observations, interviews, and record reviews for	D 433		

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D 433	Continued From page 336 Resident #17 revealed: -The CS log available for review for the Hydrocodone/Acetaminophen documented only 8 tablets of the 75 dispensed on 07/17/17. -Staff could not find any other CS logs for this medication to account for the other 67 tablets dispensed on 07/17/17. -No doses of prn Hydrocodone/Acetaminophen were documented as administered the July 2017 -October 2017 MARs. -The CS log on hand indicated there should be 22 tablets on hand. -There were 18 Hydrocodone/Acetaminophen tablets because 4 tablets on hand were different medications. Interview with a second MA on 10/16/17 at 4:05 p.m. revealed she could not locate any other CS log for Resident #17's Hydrocodone/Acetaminophen. Interview with the Administrator on 10/16/17 at 9:00 a.m. revealed: -The CS logs should be filed in the resident's record. -The facility's Manager who was out on medical leave usually filed information in the records. -No one took over filing information since the Manager had been out sick. Refer to the interview with the first shift medication aide/supervisor (MA/S) on 10/12/17 at 2:40 p.m. Refer to the interviews with the Administrator on 10/12/17 at 10:05 a.m., 10/16/17 at 2:56 p.m., and 10/17/17 at 12:40 p.m. 3. Review of Resident #2's current FL-2 dated 4/6/17 revealed:	D 433		

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D 433	Continued From page 337 -The diagnoses included Alzheimer's and Hypertension. -The resident was non-ambulatory. -The resident required a geriatric chair (Geri chair). -The resident was incontinent of bladder and bowel. Review of physician order for Resident #2 revealed: -There was an order dated 9/6/17 for home health to evaluate and treat sacral ulcer. -The order was in a folder with other residents' orders, notes, medication administration records (MARs) laying on the staff desk. Review of Resident #2's record revealed: -The physician's order dated 9/6/17 for home health to evaluate and treat sacral ulcer was not filed in the resident's record. -There was no documentation by the facility staff that a referral was made to home health such as nursing or progress notes. -There was no documentation made by facility staff regarding a notation of a sacral ulcer. -There was no documentation made by home health regarding a referral being received to evaluate and treat a sacral ulcer. -There was no documentation made by home health regarding evaluation and treatment of a sacral ulcer. Refer to the interview with the first shift medication aide/supervisor (MA/S) on 10/12/17 at 2:40 p.m. Refer to the interviews with the Administrator on 10/12/17 at 10:05 a.m., 10/16/17 at 2:56 p.m., and 10/17/17 at 12:40 p.m.	D 433		

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D 433	Continued From page 338 Interview with the first shift (MA/S) on 10/12/17 at 2:40 p.m. revealed: -Hospital discharge orders and physician orders were "supposed to be looked at." -"The MAs got what they needed, and the orders would be filed." -The Manager usually filed the orders, but she had been sick for several months. -The MARs on the nurse's desk and folders for the physician and nurse practitioner had multiple orders in them to be filed. Interview with the Administrator on 10/12/17 at 10:05 a.m. revealed: -The Manager was responsible for resident records and filing. -Since the Manager had been out for two months, the filing had gotten behind. -In the Manager's absence, the Administrator and the first shift MA/S were responsible for maintaining the records on a daily basis. Interview with the Administrator on 10/16/17 at 2:56 p.m. revealed: -When there were physician orders or discharge visit notes, the MA's were to read them, get what was needed, and put them in the resident's record. -The Manager usually filed all the orders and paper work. -Not everything was filed "right now." -The Administrator was going to try to get it caught up. Interview with the Administrator on 10/17/17 at 12:40 p.m. revealed: -The records were scattered everywhere. -She was going to personally do record reviews and put the records in the medication room. -The MAs would be responsible for filing daily.	D 433		

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D 433	Continued From page 339 -She had to get a system for orders and filing.	D 433		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews and record reviews, the facility failed to report allegations of abuse, neglect and drug diversion to the North Carolina Health Care Personnel Registry (HCPR) and conduct investigations for 4 of 4 staff (A, B, C, D), and failed to investigate and report injuries of unknown origin for 2 of 2 residents (#1, #2) to the HCPR. The findings are: 1. Review of Staff C's personnel record revealed: -There was no documentation of Staff C's hire date. -She was hired as a personal care aide (PCA), medication aide (MA), and supervisor. Telephone interview with Staff C on 10/16/17 at	D 438		

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D 438	Continued From page 340 2:40 p.m. revealed: -She was first hired at the facility in August 2016. -She had left and came back as a rehire twice. -She was last rehired on 09/01/17. -She started administering medications again around the end of September 2017 after she was rehired. Interview with Staff E (medication aide) on 10/12/17 at 6:48 p.m. revealed: -Last Thursday (10/05/17), she noticed a problem with Resident #3's Oxycodone. -She noticed the Oxycodone tablets were punched out of order on the bubble card and the amount on hand did not match the controlled substance (CS) log. -She noticed the pills in the bubble card were the same size and color but had different imprint codes. -The next day (10/06/17), Staff E noticed there was tape on the back of the bubble card. -She reported it to the Administrator "last weekend" (referring to weekend of 10/07/17 - 10/08/17). -On 10/06/17, while she was working, Staff C asked her for the keys to the medication cart because Resident #16 wanted a prn (as needed) medication for tooth pain. -Staff C said she was going to get 2 Tylenol to give to the resident. -While Staff E was standing in the hall talking with a family member, she saw Staff C put a pill in her pocket from a bubble card in the controlled substance drawer. -She knew it was Resident #3's Oxycodone because she could see the pink tablets in the card and Resident #3's Oxycodone tablets were pink. -She did not confront Staff C. -She reported it to the Administrator on Saturday,	D 438		

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D 438	Continued From page 341 10/07/17. -The Administrator said she was going to talk to Staff C. -She did not report it to the pharmacy or the local law enforcement. -She thought the Administrator would take care of it. Observation of Resident #3's medication on hand on 10/12/17 revealed: -There was a card of Oxycodone 10mg tablets dispensed on 09/18/17. -There were 60 tablets dispensed and 5 pink, round tablets left in the bubble card. -Bubbles #1 - 5 still had tablets but bubble #3 was the only one with an unbroken seal. -Bubbles #1, 2, 4, and 5 had transparent tape over the broken seals holding the tablets in place. -The tablet in bubble #3 was Oxycodone 10mg. -The tablets in the other 4 bubbles were Promethazine 12.5mg tablets. -The empty bubbles for #11 - 15 and #20 - 21 had remnants of transparent tape peeling from the bubbles. -There was only 1 Oxycodone 10mg tablet in the bubble card. Interview with Staff E (medication aide) on 10/12/17 at 6:48 p.m. revealed: -She noticed a problem with Resident #17's Hydrocodone/Acetaminophen tablets yesterday (10/11/17) -She noticed the bubble card for the Hydrocodone/Acetaminophen tablets had tape on the back of the card and some of the pills in the card were not the same. -She looked up the pills on the internet on her phone and there were Hydrocodone/Acetaminophen 5/325mg tablets, Potassium Chloride 10mEq tablets (potassium	D 438		

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D 438	Continued From page 342	D 438		

supplement), and Docusate Sodium 100mg (stool softener) tablets in the bubble card.
-She had not reported it to any one at the facility.
-Resident #17 usually asked for a prn (as needed) pain pill (Hydrocodone/Acetaminophen) at night when he was ready to go to bed.
-She gave him Hydrocodone/Acetaminophen bubbles that were sealed, not taped.

Telephone interview with the Administrator on 10/12/17 at 8:19 p.m. revealed:
-Staff reported to her the "week before last" that some Hydrocodone tablets looked like they had been replaced in the cards with other medication.
-The Hydrocodone tablets were for Resident #17.
-She was not on-site at the facility when it was reported to her.
-She had not actually seen the bubble cards that had been tampered with.

Observation of Resident #17's medication on hand on 10/12/17 revealed:
-There were 2 cards of Hydrocodone/Acetaminophen 5/325mg tablets on hand.
-Both cards were dispensed on 07/17/17 for a total of 75 tablets.
-One card was dispensed with 60 tablets and the other card with 15 tablets.
-The first card dispensed with 60 tablets had 8 tablets remaining in bubbles #1 -7 and #11.
-Bubbles #2, 3, 4, 5, and 7 were sealed with Hydrocodone/Acetaminophen 5/325mg tablets.
-The seal was broken on bubbles #1, 6, and 11 and the pills taped in the bubbles were Docusate Sodium 100mg tablets.
The second card dispensed with 15 tablets had 14 tablets remaining in bubbles #1 - 14.
-Bubbles #3 - 14 were sealed with Hydrocodone/Acetaminophen 5/325mg tablets.

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D 438	Continued From page 343 -Bubble #1 was taped with a Potassium Chloride 10mEq tablet inside. -Bubble #2 was taped with a Hydrocodone/Acetaminophen 5/325mg tablet inside. -Bubble #15 was empty but had tape stuck on it. -There was a total of 18 Hydrocodone/Acetaminophen 5/325mg tablets on hand. -There was a card of Docusate Sodium 100mg and Potassium Chloride 10mEq on hand in the medication cart for Resident #17 that appeared to be the same tablets as identified in the Hydrocodone/Acetaminophen bubble cards. Interview with the medication aide (MA) on 10/13/17 at 1:40 p.m. revealed: -She noticed the back of the medication cards were taped on the controlled substances about 3 weeks ago. -She told the Administrator at that time (3 weeks ago). -She had not observed anyone taking pills from the medication supply. -She had noticed the documentation on the controlled substance logs were "off" like staff might document a pill was dropped on the floor. -She did not know what the Administrator did about the issues after it was reported to the Administrator. Telephone interview with the Administrator on 10/12/17 at 8:19 p.m. revealed: -Staff alleged that Staff C was taking the controlled substances the "week before last". -She had not investigated the allegations. -Staff did not report they had actually observed Staff C or anyone else take any pills. -She had not reported it to the Health Care Personnel Registry (HCPR).	D 438		

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D 438	Continued From page 344 Interview with the Administrator on 10/13/17 at 10:50 a.m. revealed: -Staff C came into work her shift on third shift last night (10/12/17). -Staff C denied taking any pills. -She was not going to put Staff C back on the schedule pending the outcome of her investigation. -She was going to fill out the 24 hour report form for the HCPR. Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed: -She had not observed anyone take any pills from the facility. -There was "hearsay" that she was being accused of taking pills from the facility. -She denied taking any pills from the facility. -She last worked at the facility on last Wednesday or Thursday. -She was not currently scheduled to come back to work and she did not know why. Interview with the Administrator on 10/16/17 at 1:12 p.m. revealed: -She was working on filling out the 24 hour report for HCPR for Staff C but she had not completed it yet. -She had not faxed the 24 hour report to the HCPR because it was incomplete. -She would fax it today (10/16/17). 2. Review of Resident #18's FL-2 revealed diagnoses included Diabetes, Arthritis Severe, Gait Instability, Hyperlipidemia, Hypertension, Chronic Obstructive Pulmonary Disease and Mental Retardation. Interview with Resident #18 on 08/22/17 at 4:40	D 438		

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D 438	Continued From page 345 p.m. revealed: -Another resident ran into her with the wheelchair. -The resident slapped the other resident on the arm. -She took off her belt to hit the other resident. -Staff D (personal care aide) grabbed her arm and Staff D's finger nails dug into the resident's arm and hand. -The incident happened on the morning of 08/22/17. Interview with Staff D on 10/17/17 at 8:55 a.m. revealed: -Resident #18 was fussing at another resident. -Resident #18 picked up a fork like she was going to stab the other resident. -Resident #18 then took off her belt off to hit the other resident. -Staff D grabbed Resident #18's arm, and Resident 18's arm must have gotten bruised by her nails when she grabbed her arm. Interview with Resident #18's family member on 10/12/17 at 3:45 p.m. revealed: -The incident between Resident #18 and another resident occurred, because the resident ran into Resident #18. -This happened at the end of July, beginning of August 2017. -A staff grabbed Resident #18, and dug her fingernails into Resident #18's arm. -"You could see the nail imprints in the resident's right forearm; the staff broke the skin and it bled. There were three areas on the arm." -The next day, the staff came up to the family member and said, "I am the one that dug my fingers into [name of Resident #18]. Interview with a medication aide/supervisor (MA/S) on 8/22/17 at 4:43 p.m. revealed:	D 438		

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D 438	Continued From page 346 -Resident #18's family member told her that Staff D dug her nails into the resident's arm and hand. -The MA/S contacted the Manager after speaking with the family member. -The Manager was aware of the incident. Interview with the Manager on 08/24/17 at 10:15 a.m. revealed: -She was made aware of the incident on the morning that it occurred. -Staff D did not intentionally hurt Resident #18. -Staff D thought that Resident #18 was going to hurt the other resident. -Staff D was protecting the other resident. -Resident #18 had taken her belt off to hit the other resident. -The resident bumped into Resident #18's walker with her wheelchair and it set Resident #18 off. -Resident #18 could get agitated but had never gotten aggressive. -She had spoken to Staff D about the incident, and Staff D said that she should have gone for the belt instead of Resident #18's arm. -She did not feel that Staff D needed to be reported to the Health Care Personnel Registry (HCPR) or that the incident needed to be investigated, because Staff D was protecting another resident. -She did not report Staff D to the HCPR. Interview with the Administrator on 10/12/17 at 10:30 a.m. revealed: -The Administrator had not gotten any reports from anyone related to allegations of abuse. -She expected staff to report any allegations of abuse to her when the Manager was out. 3. Review of Resident #6's FL-2 dated 09/05/16 revealed: -Diagnoses included Congestive Heart Failure,	D 438		

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Hypertension and Hyperlipidemia.
-Resident #6 was ambulatory
-Resident #6 was occasionally incontinent of bladder and bowel.

A. Interview with Resident #6 on 10/13/17 at 5:33 p.m. revealed most of the time he stayed in his room or sat in the dayroom until staff made him go to bed.

Confidential interview with a second staff revealed:
-Staff made Resident #6 sit up on 2nd shift, most recent as last week.
-The PCA [named] (Staff B) had him sitting in dining room, and she told him to sit up in the chair because "he wet the bed."

Interview with a family member on 10/12/17 at 12:22 p.m. revealed:
-Staff made Resident #6 sit in a leather chair, because he would urinate in his bed.
-He would be saturated with urine.
-Staff did not change him like they should.

Interview with a second family member on 10/12/17 at 3:45 p.m. revealed:
-The PCAs were not doing their job; they don't change the residents like they should.
-They were made to sit in wet briefs and clothes.

Interview with a resident on 10/11/17 at 4:20 p.m. revealed:
-Some staff would not help the residents, especially Staff B.
-Staff B stayed on the phone and watched television; she worked second shift now and worked some third shift.
-Residents asked for help and Staff B ignored them; "she would come in every two hours and

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D 438	Continued From page 348 sign the door." Interview with Staff B on 10/12/17 at 3:12 p.m. revealed: -The resident had to be told all the time to go to the restroom. -The resident wore incontinent briefs. -The resident could be awake, but that did not mean he knew to go to the bathroom. -The resident knew when he was wet. -Staff B had to "stay on" Resident #6 about stealing from other residents and going to the bathroom. -The staff would move him from the dining hall when he had finished eating because he would take the other residents' food. -When Resident #6 had wet the bed, she would get him up, and ask Resident #6 if he wanted to sit up for a little longer. -Resident #6 would sit at the nurse's desk, in the dining hall or in the day room. -Resident #6 had been made to sit at nursing desk in order to keep an eye on Resident #6 after he had gone in another resident's room. -The resident sat at the nurse's desk yesterday. -Resident #6 did not sit at the desk that long when he had sat at the desk. Second interview with Staff B on 10/12/17 at 7:50 p.m. revealed: -"All he (Resident #6) does is sit and get in bed and eat." -It was hard to get him to even go outside. -"He needed to be somewhere else, not in a home for old people." -Staff assisted with toileting. -She had to tell him to go to the restroom every couple hours or he would sit there and not go. -Staff had to get him up and change him when he wets himself.	D 438		

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D 438	Continued From page 349 -She had never told him he could not go to bed because of toileting. Interview with Administrator on 10/10/17 at 12:30 p.m. revealed: -She had been made aware of staff making Resident #6 sit at the nurse's desk. -She had been told that Staff B (personal care aide and medication aide/supervisor) was making him sit up. -She had spoken with Staff B and advised her that Resident #6 had the right to lay down when he wanted to. -She had already talked with Staff B so she did not understand why someone would have reported the matter. -The Administrator had knowledge of the 24 hour and 5 day working forms for reporting to the Health Care Personnel Registry (HCPR). Second interview with the Administrator on 10/12/17 at 9:55 a.m. revealed: -The Manager had been out on leave for two months. -She had been managing the facility since the Manager had been out sick. -She was told that a second shift PCA (Staff B) had been making Resident #6 sit at the nurse's desk in a chair because "he was a heavy wetter;" somebody called the county before she could address the report (unable to recall which staff reported it to her). -It had been a one-time incident; it was "the week before last, just a one-time thing." -She did not interview the resident, but spoke briefly with all of the 3pm-11pm staff; the alleged staff, Staff B, was not there. -She addressed the concerns with the Staff B. -She had not started a formal investigation into the allegations for making him sit up, but had	D 438		

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done the ground work.
-She had not gone into detail with Staff B about Resident #6 being made to sit up.
-She could not understand the rationale behind making Resident #6 sit up.
-Staff B would be written up and the write up would be placed in the personnel file.
-She would monitor the situation.
-She did not realize that she had to report to the HCPR if she had already handled the incident.
-She had not completed the 24 hour reporting.
-She now realized that she needed to report for the safety of the residents.
-She would speak with Staff B in more detail today and then would make the report to HCPR.

B. Interview with a MA/S on 08/07/17 at 9:30 a.m. revealed:
-On 8/4/17, Resident #6 was sitting in the dining hall and asked for a piece of gum.
-Resident #6 came to the nurse's desk to get the gum that was kept on the medication cart.
-Resident #6's pants were wet in the front.
-Resident #6 bent over the nurse's desk as if he wanted to reach behind the desk.
-Staff A picked up a spray bottle and sprayed Resident #6 in the face.
-There was a clear liquid in the bottle that the MA/S believed was a water and bleach mixture.
-Staff A told Resident #6 to get his "nasty self" to his room and change his clothes.
-The MA/S went to assist Resident #6.
-Resident #6 asked the MA/S if she was going to hit him.
-The MA/S did not report the incident to the Manager, because the Manager was not going to do anything about the incident.

A second interview with the MA/PCA, who was working when Staff A sprayed the bleach at

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D 438	Continued From page 351 Resident #6, on 10/12/17 at 3:30 p.m. revealed: -On Friday, 8/4/17, Staff A was up front and asked for her pay check, which was in the medication cart. -Resident #6 was in the dining room, sitting against the wall. -He asked for gum and the MA/PCA told him there was some on the medication cart. -He walked behind the nurse's desk. Staff A picked up a bottle of bleach water and sprayed him; his pants in the front got wet. -Staff A scolded him, and said, "Look at you." -Staff A got loud with Resident #6. -He ducked and put his arm over his face. -"It's sad how Staff A treats him." Interview with Staff A on 08/07/17 at 3:40 p.m. revealed: -Staff A would never do that to a resident. -She wished she knew "who the vicious person was that had told this lie." -Staff A had family members there were "handicapped." -She would not want them to be mistreated if they had to be placed in a facility. -Residents should be treated like family. Interview with Resident #6 on 08/07/17 at 5:20 p.m. revealed: -The resident was doing okay. -The resident was treated ok. -No one had sprayed him in his face as best he could remember. Interview with the Manager on 08/15/17 at 2:30 p.m. revealed: -There was no way that Staff A sprayed Resident #6 in the face. -No staff or the resident had reported anything to her about the spray bottle.	D 438		

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D 438	Continued From page 352 -"Resident #6 had to have done something." A second interview with the Manager on 08/22/17 at 10:15 a.m. revealed: -She had not reported Staff A to the Health Care Personnel Registry (HCPR), because she did not believe Staff A had done that. -She was not at the facility and did not see Staff A do it. -No staff or resident reported the incident to her. -She was not going to report to HCPR unless she knew who Staff A's accuser was. -She did not know what to investigate. -Staff A had done a lot for the facility. Interview with the Administrator on 10/12/17 at 10:30 a.m. revealed: -A staff was "let go" by the Manager for allegations of abuse (unable to recall date). -The Administrator had not gotten any reports from anyone related to allegations of abuse. -She expected staff to report any allegations of abuse to her when the Manager was out. C. Interview with a MA/S on 09/12/17 at 4:15 p.m. revealed: -They had donuts at the facility earlier in the week. -Resident #6 saw the donuts and went behind the desk and got one. -Staff A (MA/S) came out of the kitchen, and saw Resident #6 with the donut. -Staff A shoved Resident #6 in the back and pushed him down the hall. -Staff A told Resident #6 that the donut had poison in it and that Resident #6 would die. -Resident #6 was afraid to swallow the donut. -She had to assure Resident #6 that it was okay to eat the donut.	D 438		

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D 438	Continued From page 353 Interview with a PCA on 09/12/17 at 4:30 p.m. revealed: -This week (week of 9/10/17) there were donuts behind the nurse's desk, and Resident #6 had gotten a donut. -Staff A came out of the kitchen and started shoving Resident #6 in the back. -Staff A told Resident #6 there was poison in the donut and that he was going to die. -Resident #6 had started eating the donut. -Resident #6 looked like he was scared to finish eating the donut. Interview with a second PCA on 10/12/17 at 3:30 p.m. revealed: -Staff A and another MA/PCA were at the desk when Resident #6 walked around and got a donut hole to eat. -Staff A jerked the donut out of Resident #6's hand and said, "That's rat poison. I guess you will die tonight." -The PCA told Resident #6 it was not rat poison. Interview with Staff A on 09/14/17 at 8:20 a.m. revealed: -If Resident #6 would have wanted a donut, she would have given him one. -"Gosh, that never was said." -She knew where this was coming from and she was going to speak with a lawyer. -"It was a bunch of lies." -If she would have done it, she would had taken the blame for it. -Staff A did not know why anyone would say that. -She knew who she worked with during the day, so she knew who would have made up this story. -She would work on Saturday, and, then she would quit. Interview with the Manager on 09/14/17 at 8:30	D 438		

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a.m. revealed:
-The Manager was "very angry."
-She knew that there were donuts at the facility, because it was assisted living appreciation week.
-She did not believe that Staff A would have said that.
-If she found out who told this, she would fire them on the spot.
-She would not report Staff A to HCPR because Staff A would quit.

Interview with the Administrator on 10/12/17 at 10:30 a.m. revealed:
-The Administrator had not gotten any reports from anyone related to allegations of abuse.
-She expected staff to report any allegations of abuse to her when the Manager was out.

4. Review of Resident #1's current FL-2 dated 02/20/17 revealed diagnoses included senile dementia, uncontrolled Type II diabetes, hypertension, anemia, and depression.

Observation of Resident #1 on 10/11/17 at 11:03 a.m. revealed:
-He was in his room sitting in a recliner.
-He had a yellowish/light green colored bruise on the right front and right side of his head that was about 2.5 by 2.5 inches in size.
-He had a skin tear on his right arm near the elbow that was oval shaped and measured approximately 1 x 1.5 inches in size.
-He had two dime sized circular scabs on his right arm; one above the elbow and the second one on the underside of the forearm.
-He had a linear scabbed area on the underside of his right forearm that measured approximately 2.5 inches long and was surrounded by redness.
-He had a reddish colored bruised on his right arm near his wrist and a reddish bruise on his

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D 438	Continued From page 355 right hand. Interview with a personal care aide (PCA) on 10/11/17 at 11:05 a.m. revealed: -She was not sure, but she thought Resident #1 fell on 2nd shift about two weeks ago and got "just skin tears" on his right arm. -Resident #1 "picked at his skin sometimes." -She did not know how Resident #1 got the bruise on his head; she just noticed it "today." Interview with a second PCA on 10/11/17 at 4:10 p.m. revealed: -She had been off for a while and when she returned to work on second shift on Monday (10/09/17), she noticed the bruise on Resident #1's head; she did not know what happened or how he got the bruise. -She did not know how Resident #1 got the "bruises" on his arm; he "always has some kind of bruise." Interview with a third PCA on 10/12/17 at 1:45 p.m. revealed: -She first noticed the bruise on Resident #1's head on Sunday (10/08/17); she did not know how he got the bruise. -Resident #1's arms "always" had scratches and bruises; the resident "runs into stuff." Interview with the medication aide/supervisor (MA/S) on 10/11/17 at 11:12 a.m. revealed: -Resident #1 was never oriented and got bruised "often." -Resident #1 had a history of falls but had not fallen within the last three months. -She did not know how Resident #1 got the injuries on his right arm or how long they had been there; the injuries were probably from him hitting his arm against something.	D 438		

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D 438	Continued From page 356 -She did not know if the Primary Care Provider (PCP) was aware of the arm injuries. -She had first noticed the yellow bruise on his head on Monday (10/09/17); the bruise had not been there the last time she worked on Friday (10/06/17). -She did not know how Resident #1 got the bruise on his head. -Resident #1's skin was checked on his shower days, which was Monday, Wednesday, and Friday. Interview with a second MA/S on 10/13/17 at 9:00 a.m. revealed: -The process for unexplained injuries was to notify the PCP and sometimes send pictures by phone. -If the resident was on hospice or home health (HH), the unknown injuries were reported to the nurse. -The hospice or HH nurse was supposed to call the PCP and also let the Manager know; the Manager would make a decision on what to do next. Review of Resident #1's physician orders and progress/nursing notes revealed: -There was no staff documentation related to the injuries. -There were no physician orders, notifications, or faxes related to the injuries on the right arm and/or bruise on his head. Review of the staff communication notebook revealed there was no documentation related to Resident #1's right arm injuries or bruise on his head. Telephone interview with the HH Registered Nurse (RN) on 10/17/17 at 9:30 a.m. revealed:	D 438		

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D 438	Continued From page 357 -She last saw Resident #1 on 10/11/17 and observed the bruise on his head. -Staff told her Resident #1 fell at the nurses' station; staff were unsure of the date of his fall. -Staff had not noticed the red rash on Resident #1's face on 10/11/17. -The injuries on Resident #1's right arm were unexplained and she did not know how he got them. Based on observations, records reviews, and interviews, Resident #1 was not interviewable. Telephone interview with a Nurse Practitioner (NP) at Resident #1's PCP office on 10/16/17 at 3:31 p.m. revealed: -The HH RN notified the PCP office about the bruise on Resident #1's head on 10/11/17. -The NP was aware of the injuries to his arm; it looked like he fell. -Nobody could tell her how Resident #1 got the arm injuries or bruise on his head. Interview with the Administrator on 10/13/17 at 10:30 a.m. revealed: -The facility did not have a written policy for injuries of unknown origin and she was not aware of any specific process the facility used or followed for injuries of unknown origin. -Unexplained injuries were to be reported to the PCP or the MA/S was to send the resident to the hospital. -She did not know if staff were reporting to the PCP; she would talk to the staff about what she expected and what they were supposed to do. -She was not aware of the rule that unexplained injuries were supposed to be reported to health care personnel registry; the facility had not been reporting.	D 438		

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D 438	Continued From page 358 5. Review of Resident #2's current FL-2 dated 4/6/17 revealed: -The diagnoses included Alzheimer's and hypertension. -The resident was non-ambulatory. -The resident required a geriatric chair (Geri chair). -The resident was incontinent of bladder and bowel. Review of Resident #2's current Care Plan dated 4/6/17 revealed: -The resident was always disoriented. -The resident was totally dependent on the staff for eating, bathing, dressing and grooming. -The resident was totally dependent on the staff for transfers to/from bed and chair. Observation of Resident #2 on 10/12/17 at 8:10 a.m. revealed: -The resident was in the dining room sitting in a Geri chair. -The resident was being fed by a personal care aide (PCA). -The resident had a dressing on her right upper arm and a dressing on her left forearm. -The resident had a 2.0 by 0.25 inches in size scab below her right knee. -The resident had a 1.0 by 1.0 inches in size scab below her left knee. -The resident had multiple bruises on both arms and both legs. Based on observations, record reviews, and interviews, Resident #2 was not interviewable. Interview with a PCA on 10/12/17 at 8:15 a.m. revealed: -She did not know how Resident #2 got the skin tears or bruises.	D 438		

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D 438	Continued From page 359 -She had been off work for a few days prior and did not recall that Resident #2 had the skin tears prior being off work. -She did not know if the physician had been notified. Observation of Resident #2 on 10/12/17 at 9:30 a.m. revealed: -The medication aide/supervisor (MA/S) and a second PCA had removed the dressings on the resident's right upper arm and her left forearm. -The resident's right upper arm had two skin tears next to each other. -The first skin tear on the top right upper arm was 1.0 by 0.50 inches in size, pink in color and had blood tinged clear drainage. -The second skin tear was just under the first skin tear on the right upper arm, and was 0.50 by 0.50 inches in size, pink in color and had blood tinged clear drainage. Interview with a second PCA on 10/12/17 at 9:35 a.m. revealed: -She did not know how Resident #2 got the skin tears or bruises. -She did not remember when the dressings were put on the resident's arms. -She did not know if the physician or family had been notified by the MA/S. Interview with MA/S on 10/12/17 at 9:40 a.m. revealed: -She did not know what caused the skin tears on Resident #2's arms. -There were no physician orders (or standing orders) for dressing changes. -She did not know if the physician was aware of the skin tears. -She would contact the physician immediately.	D 438		

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D 438	Continued From page 360 Review of Resident #2's record revealed: -There was no documentation by the facility staff related to the injuries such as nursing or progress notes. -There was no documentation made by staff that her current arm skin tears, scabs on both knees or bruises on arms and legs were reported to the Primary Care Provider (PCP), family or hospice. Second interview with MA/S on 10/12/17 at 9:55 a.m. revealed: -She had just informed the physician's medical assistant of Resident #2's skin tears. -The physician's medical assistant informed her to call hospice for cleaning/dressing the skin tears. -The hospice Registered Nurse (RN) would call the physician to obtain an order for cleaning/dressing the skin tears. -The hospice RN told the MA/S to leave the dressings off the skin tears. -The hospice RN would arrive later that day to clean/dress the skin tears. Interview with the hospice RN on 10/12/17 at 12:07 p.m. revealed: -This was the first time she had seen Resident #2 since her discharge from hospice in June 2017. -She was waiting on a physician order to clean/dress the skin tears. - The hospice RN often performed dressing changes for skin tears on Resident #2 prior to her discharge from hospice in June 1017. Interview with MA/S on 10/13/17 at 9:10 a.m. revealed: -The process for injuries of unknown origin was to contact the physician and send pictures by phone if requested. -The process for skin tears was the MA would	D 438		

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D 438	Continued From page 361	D 438		

clean with saline and put a dressing or band aid on it and document it.
-The MA would write on the dressing the date when it was changed.
-The MA should change the dressing each day.
-The MA should give a verbal report at shift change about any resident with skin tears.
-Resident #2 had bandages on each arm that had no writing on them noting when they had been applied.
-There was no verbal report ever given to the MA/S for the current skin tears on Resident #2.
-"The first time I knew of Resident #2's current skin tears was yesterday 10/12/17."

Interview with Administrator on 10/13/17 at 10:55 a.m. revealed:
-"I am not sure what to do with an injury of unknown origin."
-"I was not aware that they are to be reported to the HCPR" (Health Care Personnel Registry).
-"We do not have a written policy on injuries of unknown origin."
-The current process was the Supervisor made a decision of whether or not to call EMS.
-If the Supervisor had a question they could call the Administrator.
-"I am not sure if the staff have been formally trained on emergencies."
-"I am not aware of any delays in 911 care."

Interview with the PCP on 10/13/17 at 2:15 p.m. revealed:
-He was not aware of any skin tears on Resident #2.
-His expectation was that the facility staff would write down any issues/requests pertaining to residents and fax it to their office, and follow-up with a phone call to the office alerting them.
-He called the facility on 10/12/17 and spoke with

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D 438	Continued From page 362 the MA/S and asked if there were any issues he needed to be aware of. -The MA/S reported to the physician on 10/12/17 that there were no issues. -"I am very upset about the communication issues with the facility." - He would be contacting the Administrator to follow up on his concerns. Interview with a family member on 10/17/17 at 8:50 a.m. revealed: -He was aware of the skin tears that are now scabs on Resident #2's lower legs. -He thought those older skin tears on her legs may have come from the Geri chair because she moved her legs constantly. -He did not know how she got the current skin tears on each arm. -"The skin tears have been on and off with her for the last one year." -The staff previously called him and told him about skin tears and often apologized for "calling too much". -"She's had bandages for a while." -He had not reported the skin tears to anyone after the staff had informed him. Interview with Administrator on 10/17/17 at 11:10 a.m. revealed: -She was first made aware of (Resident #2's) current skin tears during this survey process. -The normal process they would follow for skin tears was the MA/S would contact the physician and the home health/ hospice nurse for plan of care. _____ The facility failed to investigate allegations of abuse by Staff A and Staff D, allegations of neglect by Staff B, and allegations of drug diversion by Staff C, and report those allegations	D 438		

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D 438	Continued From page 363 to the Health Care Personnel Registry. This resulted in these staff continuing to work at the facility, which exposed residents to subsequent abuse, neglect and drug diversion. This continued failure resulted in substantial risk of serious physical, mental and verbal abuse, and serious neglect to the residents, which constitutes an Unabated Type A2 Violation. _____ Review of the facility's Plan of Protection dated 10/12/17 revealed: -Reports will be completed immediately (24 hours) to Health Care Personnel Registry and investigation will begin and 5 day Report will follow for Staff A, B, C, and D. -Any injury of unknown origin will be reported, including Resident #1 and #2. -Continued monitoring and ensuring reports are being filed with the registry on all incidences reported or observed. -In the future, all allegations of abuse, neglect, exploitation and drug diversion will be reported immediately as required per Administrator. -Facility staff will be in-serviced to report any allegations to the Administrator.	D 438		
D 448	10A NCAC 13F .1211 Written Policies And Procedures 10A NCAC 13F .1211Written Policies And Procedures (a) An adult care home shall develop written policies and procedures that comply with applicable rules of this Subchapter, on the following: (1) ordering, receiving, storage, discontinuation, disposition, administration, including self-administration, and monitoring the resident's	D 448		

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D 448	Continued From page 364 reaction to medications, as developed in consultation with a licensed health professional who is authorized to dispense or administer medications; (2) use of alternatives to physical restraints and the care of residents who are physically restrained, as developed in consultation with a registered nurse; (3) accident, fire safety and emergency procedures; (4) infection control; (5) refunds; (6) missing resident; (7) identification and supervision of wandering residents; (8) management of physical aggression or assault by a resident; (9) handling of resident grievances; (10) visitation in the facility by guests; and (11) smoking and alcohol use. This Rule is not met as evidenced by: Based on interviews, the facility failed to develop and maintain policies and procedures related emergency procedures to include changes in resident condition. The findings are: Interview with a personal care aide (PCA) on 10/12/17 at 7:50pm revealed: -She did not really know what to do when a resident had a head injury or emergency; she was never trained. -She would report it to a MA/S. -The MA/S called 911 when needed, but she did not know the actual process.	D 448		

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D 448	Continued From page 365 Interview with a medication aide/supervisor (MA/S) on 10/13/17 at 9:00am revealed changes in resident's status or residents' complaints were not documented anywhere except the staff communication shift report notebook. Interview with a second MA/S on 10/13/17 at 5:30pm revealed: -The process for a change in residents' status "depends on what's going on but the Primary Care Provider (PCP) was "usually" called by the MA. -PCP notification was not always documented in the resident's record but it was supposed to be documented in the shift communication notebook. Interview with a third MA/S on 10/12/17 at 3:30pm revealed: -When staff observed a change in a resident, the staff were supposed to call the PCP. -The staff who observed the change was the one who was supposed to call the PCP. Interviews with the Administrator on 10/13/17 at 10:30am, 10:54am and 6:36pm, and on 10/16/17 at 9:45am revealed: -The facility had no written policies on healthcare related emergencies or change in resident condition. -In an emergency, the MA/S had been responsible for sending a resident to the hospital. -In an emergency, staff were expected to call 911. -The facility had not had a policy or system in place to assure staff called 911 or for documentation related to emergencies. -She expected the PCP to be notified of changes in residents' condition and emergencies. -The expectation for a change in resident's status was to monitor the resident frequently, notify the	D 448		

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D 448	Continued From page 366 PCP by telephone, and document the changes and notification. -The Medication Aides should be notifying the physician. -She did not know if staff were following her expectations; she would talk to the staff about what she expected and what they were supposed to do. -The facility currently did not have a system in place for changes in status to assure the physician was notified. -She would implement a policy as soon as possible and assure all staff were trained. -She would create a policy book.	D 448		
D 449	10A NCAC 13F .1211 (b) Written Policies And Procedures 10A NCAC 13F .1211Written Policies And Procedures (b) In addition to other training and orientation requirements in this Subchapter, all staff shall be trained within 30 days of hire on the policies and procedures listed as Subparagraphs (3), (4), (6), (7), (8), (9), (10) and (11) in Paragraph (a) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide training to 5 of 5 sampled staff (A, B, C, D, E) on the facility's policies and procedures including administration, ordering, disposition and storage of medications, use of physical restraints, accident and emergency procedures, supervision of wandering residents, and management of physical aggression or	D 449		

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D 449	Continued From page 367 assault by a resident. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired as a Medication Aide (MA) and Supervisor on 11/20/00. -There was no documentation of training on facility policies or procedures in Staff A's personnel record. Interview with Staff A on 10/12/17 at 12:05 p.m. revealed: -Staff A had been at the facility since 2000. -Staff A was a MA/S. -Staff A had not had any training on the facility's policies and procedures. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 2. Review of Staff's B personnel record revealed: -Staff B was hired on 10/25/16 as a Personal Care Aide (PCA). -There was no documentation of training on facility policies or procedures in Staff B's personnel record. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 3. Review of Staff C's personnel record revealed: -There was no documentation of Staff C's hire date. -She was hired as a personal care aide (PCA), medication aide (MA) and supervisor. -There was no documentation of training on facility policies or procedures in Staff C's personnel record.	D 449		

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D 449	Continued From page 368 Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 4. Review of Staff D's personnel record revealed: -There was no documentation of Staff D's hire date. -Her job description revealed that she was hired as a Nurse Aide. -There was no documentation of training on facility policies or procedures in Staff D's personnel record. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. 5. Review of Staff E's personnel record revealed: -Staff E was hired on 4/4/17 as a Medication Aide (MA) and Supervisor. -There was no documentation of training on facility policies or procedures in Staff E's personnel record. Interview with Staff E on 10/17/17 at 3:13 p.m. revealed: -She was hired in March or April 2017. -She was a MA/S. -She had not had any training on facility policies and procedures. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. revealed: Interview with the Administrator on 10/16/17 at 8:40 a.m. revealed: -She checked with the facility's Manager about the personnel files. -The Manager could not find any more information for the personnel files. -The Manager was responsible for the personnel files and making sure all staff met qualifications	D 449		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CARE	4002 SOUTH NC 41 WALLACE, NC 28466

(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 449	Continued From page 369 and requirements. -The Manager had been out on medical leave for about 2 months and was unavailable for interview. -No one took over responsibility of the personnel files after the Manager went on medical leave. -There was no system to check behind the Manager or to monitor the personnel files. -The facility did not have written policies and procedures to her knowledge. -There were no policies and procedures for medications, emergencies, infection control, physical restraints, or supervision. -She needed to develop written policies and procedures so staff could be oriented and trained on them.	D 449		
D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months	D 485		

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D 485	Continued From page 370	D 485		

following the initial order.
(4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.
(5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record.
(6) The restraint order shall be kept in the resident's record.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION

The Type B Violation was abated.
Non-compliance continues.

Based on observations, record reviews, and interviews, the facility failed to ensure an order for a restraint was current and complete as required for 1 of 1 sampled residents with a gait belt used as a restraint in a wheelchair (Resident #13).

The findings are:

Review of Resident #13's current FL-2 dated 3/20/17 revealed:
-The diagnoses included chest pain, atrial fibrillation, high INR (International Normalized Ratio, a test to monitor excessive bleeding or clotting), and peripheral vascular disease.

Review of the Primary Care Provider's (PCP) order dated 2/12/2016 revealed:
-The order stated "wheelchair restraint".
-The order did not include the medical need for the restraint.

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D 485	Continued From page 371 -The order did not include the type of restraint to be used. -The order did not include the period of time the restraint was to be used. -The order did not include the time intervals the restraint was to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. -The restraint order was over two years old; it was to be updated by the resident's physician at least every three months following the initial order. Review of Resident #13's record revealed: -There was no assessment or care plan that addressed the use of the restraint. -There was no documentation for checks on the restraint, release of the restraint, or timing of the restraint use. Observation of Resident #13 on 10/11/17 at 11:50 a.m. revealed he was in the dining room in his wheelchair, restrained with a gait belt; the gait belt was around the resident's waist and secured to the back of the wheelchair. Observation of Resident #13 on 10/11/17 at 1:35 p.m. revealed: -The resident was sitting in a wheelchair in the dayroom on 100 Hall. -There was a gait belt around the resident's stomach that was hooked together on the back side of the wheelchair. Observation of Resident #13 on 10/11/17 at 4:02 p.m. revealed he was in the hallway in his wheelchair with his gait belt around his stomach and hooked together on the back of the wheelchair. Observation of Resident #13 on 10/12/17 at	D 485		

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D 485	Continued From page 372 12:22 p.m. revealed: -He was on the front porch with his family member. -He was restrained to his wheelchair with a gait belt around his stomach that was hooked on the back side of the wheelchair. Based on observations, record reviews, and interviews, Resident #13 was not interviewable. Interview with Resident #13's family member on 10/12/17 at 12:22 p.m. revealed: -Resident #13 wore the gait belt all of the time when he was in his wheelchair. -She requested the gait belt for Resident #13 to prevent him from falling and being injured. -The PCP was aware Resident #13 used the gait belt as a restraint. -She consented to the gait belt and had requested the order for the gait belt from the PCP. -The PCP order for the gait belt should be on file. -Staff who got Resident #13 up and down applied and removed the gait belt as needed. -She denied complaints about how staff applied or removed the gait belt. Interview with a personal care aide at 11:55 a.m. on 10/17/17 revealed: -Resident #13 wore the gait belt all day. -Staff put it on when he got up in the morning, and took it off at night when he went to bed. -It was used to keep Resident #13 from falling. Interview with a medication aide/supervisor (MA/S) on 10/17/17 at 12:00 p.m.: -Resident #13 wore the gait belt whenever he was in his wheelchair. -The staff member that got Resident #13 up or toileted him applied and removed his gait belt.	D 485		

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D 485	Continued From page 373 -Resident #13's gait belt use was not documented. -She was trained "a while ago" on restraint use at another facility. -Facility staff had not had any recent training on the proper use of restraints. Attempted telephone interview with Resident #13's PCP on 10/17/17 at 11:45 a.m. and 12:30 p.m. was unsuccessful. Interview with the Administrator on 10/16/17 at 5:55 p.m. revealed: -She was unaware that there was no updated physician order, assessment or care plan for the use of a restraint on Resident #13. -The normal process was that the Supervisor would insure the order, assessment and care plan are up-to-date. -There was no policy available for review. A gait belt is a device used by caregivers to transfer residents with mobility issues from one position to another, from one location to another or while assisting residents to ambulate who have problems with balance. For example, a gait belt is used to move a resident from a standing position to a wheelchair.	D 485		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by:	D911		

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D911	Continued From page 374 Based on observations, record reviews, and interviews, the facility failed to assure each resident was treated with dignity as related to personal care. The findings are: Based on observations, record reviews, and interviews, the facility failed to provide personal care in accordance with the assessed needs for 3 of 5 residents sampled (#3, #6, #15). [Refer to Tag D269, 10A NCAC 13F. 0901(a) Personal Care and Supervision (Type B Violation)].	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on 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 as related to health care, nutrition and food service, training on care of diabetic residents, adult care home medication aides training and competency, housekeeping and furnishings, other requirements, other staff qualifications, and examination and screening for controlled substances.	D912		

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D912	Continued From page 375 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to implement orders from the primary care provider (PCP) for 4 of 4 residents sampled (#1, #2, 3, 4) who had orders for weights and 2 of 2 residents sampled (#2, #3) with orders for blood pressure checks. [Refer to Tag D276, 10A NCAC 13F. 0902(c)(3)(4) Health Care (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served to 3 of 3 residents sampled (#1, #2, #4) who had orders for thickened liquids (#2) and nutritional supplements (#1, #4). [Refer to Tag D310, 10A NCAC 13F. 0904(e)(4) Nutrition and Food Service (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 5 medication aides (C, E) sampled received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. [Refer to Tag D164, 10A NCAC 13F. 0505 Training On Care of Diabetic Residents (Unabated Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to assure 3 of 4 staff sampled (B, C, E) who administered medications had completed the 5 hour and 10 hour or 15 hour state approved medication administration training courses as required; 1 of 4 sampled medication aides (C) had passed the written medication aide exam; and 2 of 4 medication aides sampled (B, C) had a clinical skills checklist completed prior to administering medications. [Refer to Tag D935, G.S. 131D-4.5B(b) Adult Care Home Medication	D912		

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D912	Continued From page 376 Aides, Training and Competency Requirements (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to maintain an approved sanitation classification at all times in the facility with a North Carolina Division of Environmental Health Sanitation score of 85 or above at all times. [Refer to Tag D077, 10A NCAC 13F. 0306(a)(4) Housekeeping and Furnishings (Unabated Type B Violation)]. 6. Based on observations and interviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 7 of 13 water fixtures sampled in the residents' bathrooms and the common hall bathrooms on the 100 and 200 Halls of the facility, including 3 fixtures with steam observed. [Refer to Tag D113, 10A NCAC 13F. 0311(d) Other Requirements (Unabated Type B Violation)]. 7. Based on interviews and record reviews, the facility failed to assure 5 of 5 staff sampled (A, B, C, D, E) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40. [Refer to Tag D139, 10A NCAC 13F. 0407(a)(7) Other Staff Qualifications (Unabated Type B Violation)]. 8. Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was completed upon hire for 4 of 5 staff (B, C, D, E) sampled who were hired after 10/01/13. [Refer to Tag D992, G.S. 131D-45(a) Examination and Screening for the Presence of Controlled Substances (Type B Violation)].	D912		

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D914	Continued From page 377	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents were free of abuse and neglect as related to management of facilities, health care, resident rights, medication administration, personal care and supervision, health care personnel registry, adult care home infection prevention requirements, controlled substances and other staff qualifications. The findings are: 1. Based on observations, interviews, and record reviews, the Administrator failed to assure the overall management, operations, and policies and procedures of the facility were developed and implemented to maintain each residents' right to be free of serious harm, abuse, and neglect as evidenced by the Manager (Administrator-in-Charge) refusing to allow staff to contact 911 for a resident (#11), who was not feeling well and was confused; refusing to investigate allegations of abuse and report two staff to the Health Care Personnel Registry for resident abuse allegations received in August 2017; and the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, medication administration, resident rights, personal care and supervision, health care personnel registry, infection prevention	D914		

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D914	Continued From page 378 requirements, housekeeping and furnishings, nutrition and food service, controlled substances, physical restraints, other staff qualifications, training and qualifications for medication aides, training on diabetic residents, screening for controlled substances and criminal background screening, all of which are the responsibility of the Administrator/Administrator-in-Charge. [Refer to Tag D176, 10A NCAC 13F. 0601(a) Management of Facilities (Unabated Type A1 Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to assure the acute and routine health care needs were met for 6 of 8 residents sampled (#1, #2, #3, #6, #10, #11) as related to failing to notify the primary care physician (PCP) of elevated blood sugars over 400 as ordered for a diabetic resident (#3) on 14 of 15 occasions; of unexplained injuries of skin tears and bruising for two residents (#1, #2); of inappropriate sexual behaviors from a resident (#6); of a resident's (#3) complaints of a prosthetic leg being uncomfortable and refusing to wear it; of a resident complaints of not feeling well, burning upon urination, decreased appetite and increased confusion prior to a hospitalization for diagnosis of sepsis (#11); of a resident (#10) with a change in status and complained of dizziness, exhibited sweating, altered mental status and refused to be sent to the hospital for emergent medical evaluation, who was later found deceased in his bed; failing to assure referral for home health services was completed for treatment of a sacral wound (#2); and failing to assure a resident (#1) was sent to the hospital for evaluation of a shoulder abscess and a head injury of unknown origin. [Refer to Tag D273, 10A NCAC 13F. 0902(b) Health Care (Unabated Type A1 Violation)].	D914		

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D914	Continued From page 379 3. Based on observations, record reviews, and interviews, the facility failed to assure three residents (#12, #14, #15) were protected from mental and sexual assault from Resident #6 who wandered into residents' rooms, stole a resident's food (#12), tried to get into bed with a resident (#15), and touched a resident in a sexual manner without consent (#14); failed to assure two residents (#6, #18) were free from physical abuse by two staff (Staff A and Staff D); failed to assure two residents (#6 and #8) were free of neglect by ensuring the resident's (#6) personal care needs were met and was forced to sit at the nurse's desk by a staff (Staff B), and personal care was provided to a resident (#8), who was left lying on top of a heating pad and received burns and blisters to her back; and failed to ensure a resident (#12) was picked up from a local store after a reasonable amount of time. [Refer to Tag D338, 10A NCAC 13F. 0909 Resident Rights (Unabated Type A1 Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 4 residents (#13, #16, #22) observed during the medication pass including errors with insulin and medications for heart / blood pressure, diabetes, prevention of blood clots, and a diuretic (#16); a medication for hypothyroidism (#22); and prevention of heart disease (#13, #22), and for 5 of 6 residents (#1, #2, #3, #4, #5) sampled including errors with insulin (#1, #3); narcotic pain medications (#3, #5); medications for infection (#1, #2, #4); and a medication for anxiety (#2). [Refer to Tag D358, 10A NCAC 13F. 1004(a) Medication Administration (Type A2 Violation)]. 5. Based on observations, interviews and a record reviews, the facility failed to provide	D914		

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D914	Continued From page 380	D914		

adequate supervision to 1 of 5 sampled residents (#6), who was known to wander into residents' rooms, took food from a resident (#12), attempted to climb into bed with another resident (#15) and allegedly sexually assaulted another female resident (#14) without her consent. [Refer to Tag D270, 10A NCAC 13F. 0901(b) Personal Care and Supervision (Type A1 Violation)].

6. Based on observations, interviews and record reviews, the facility failed to report allegations of abuse, neglect and drug diversion to the North Carolina Health Care Personnel Registry (HCPR) and conduct investigations for 4 of 4 staff (A, B, C, D), and failed to investigate and report injuries of unknown origin for 2 of 2 residents (#1, #2) to the HCPR. [Refer to Tag D438, 10A NCAC 13F. 1205 Health Care Personnel Registry (Unabated Type A2 Violation)].

7. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 9 of 9 diabetic residents sampled (#1, #3, #7, #16, #17, #18, #19, #20, #21) with orders for blood sugar monitoring resulting in the shared use of glucometers. [Refer to Tag D932, G.S. 131D-4.4A(b)(1) Adult Care Home Infection Prevention Requirements (Unabated Type B Violation)].

8. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records and failed to account for the use and administration of controlled substances for 2 of 2 sampled residents (#3, #17) including a resident (#3) who had some Oxycodone tablets

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D914	Continued From page 381 tampered and replaced with an anti-nausea medication and a resident (#17) who had some Hydrocodone/Acetaminophen tablets tampered and replaced with a potassium supplement and a stool softener. [Refer to Tag D392, 10A NCAC 13F. 1008(a) Controlled Substances (Type B Violation)]. 9. Based on interviews and record reviews, the facility failed to assure 3 of 5 staff sampled (B, C, E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry upon hire according to G.S. 131E-256. [Refer to Tag D137, 10A NCAC 13F. 0407(a)(5) Other Staff Qualifications (Unabated Type B Violation)].	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies.	D932		

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(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
D932	Continued From page 382 d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 9 of 9 diabetic residents sampled (#1, #3, #7, #16, #17, #18, #19, #20, #21) with orders for blood sugar monitoring resulting in the shared use of	D932		

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D932	Continued From page 383 glucometers. The findings are: Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the owner's manual for Brand A glucometer revealed: -The glucometer "is for one person use ONLY. DO NOT share your meter or lancing device with anyone". -"Do not use on multiple patients!" -All parts of the glucose monitoring system could carry blood-borne pathogens after use, even after cleaning and disinfecting. -Cleaning and disinfecting the meter destroys most, but not necessarily all, blood-borne pathogens. -Wash your hands thoroughly with soap and warm water before and after handling the meter, lancing device, lancets, or test strips as contact with blood presents an infection risk. -Clean and disinfect immediately after getting any blood on the meter or if meter is dirty. -Clean and disinfect the meter at least once a week. -If the meter is being operated by a second person who provides testing assistance, the meter and lancet device should be disinfected prior to use by the second person. -Clean and disinfect the meter with "ONLY PDI	D932		

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D932	Continued From page 384 Super Sani Cloth Wipes". Review of the owner's manual for Brand B glucometer revealed: -The glucometer is indicated for home or professional use in the management of patients with diabetes. -Healthcare professionals performing blood tests with this system on multiple users must always wear gloves and should follow the infection control policies and procedures approved by their facility. -The meter should be stored in its carrying case. -Clean the outside of the meter using a damp cloth and mild soap. -Acceptable cleaning solutions include: 70% isopropyl alcohol; a mixture of 1 part ammonia, 9 parts water; or a mixture of 1 part household bleach, 9 parts water. -There were no further instructions on how to disinfect the meter. Review of the owner's manual for Brand C glucometer revealed: -The blood glucose monitoring system "is for one person use ONLY. DO NOT share your meter or your lancing device with anyone". -"DO NOT use on more than one person." -All parts of the blood glucose monitoring system could carry blood-borne diseases after use, even after cleaning and disinfection. -Cleaning removes blood and soil, disinfecting removes infectious agents. -Clean the meter when visibly dirty. -Wipe the meter with a clean, lint-free cloth dampened with mild detergent/soap, 10% household bleach and water, or OSHA approved disinfectant. - Let Meter air dry thoroughly before using to test. -Do not use alcohol to clean the meter as it will	D932		

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D932	Continued From page 385	D932		

cause damage to the meter.
-No further instructions on how to disinfect the glucometer was provided.

Review of a letter dated 07/20/17 from the local county health services revealed:
-The county communicable disease coordinator made a visit to the facility regarding an infection control breach related to sharing of glucometers with multiple residents.
-The coordinator was informed the glucometer had already been replaced as soon as the problem was identified.
-Record review revealed the nine diabetic residents did not have Hepatitis B or C infection.
-Each resident had a designated monitor and testing supplies labeled with their names.
-The facility Manager had discussed the breach with the employee observed using the glucometer on multiple residents.
-The coordinator recommended staff be educated regarding glucose monitoring practices as soon as possible.
-They discussed changing to single-use lancets.
-Facility staff present could not verbalize the cleaning process for glucometers.
-No Super Sani Cloth Wipes were available but should be purchased immediately as glucometers should be cleaned after each use.

Review of a letter dated 08/07/17 from the local county health services revealed:
-The county communicable disease coordinator received a call regarding a complaint of improper glucose monitoring at the facility.
-It involved the use of a single glucometer for multiple residents.
-The same type of complaint was also received in July 2017.
-During the coordinator's visit to the facility, staff

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D932	Continued From page 386 were unable to provide proper cleaning protocol for glucometers and no Sani cloth wipes were available. -Directives given to the facility included: immediate in-service for all staff regarding safe glucose monitoring practices; dispose of all glucometers suspected to have been used by multiple residents and purchase new ones; purchase Super Sani Cloth Wipes as recommended by the manufacturer and provide in-service on cleaning of glucometers; replace pen lancet devices with single use lancet devices; update policies and procedures for glucose monitoring and provide copy to county health services. Interview with the Administrator on 10/13/17 revealed: -The facility did not have a written infection control policy and procedure. -The facility's policy was the medication aides were supposed to clean/disinfect the glucometers with Sani-wipe cloths after each use of the glucometers. Observations, interviews, and record reviews during the survey from 10/11/17 - 10/13/17 and 10/16/17 - 10/17/17 revealed: -There were 8 diabetic residents currently residing in the facility who required blood sugar monitoring and each resident had their own glucometer labeled with their name. -There was 1 glucometer in the medication cart for a resident who had been discharged from the facility in June 2017 but had current readings in the memory of the glucometer. -Nine of 9 sampled diabetics had readings in their glucometers that did not match their documented blood sugars.	D932		

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D932	Continued From page 387 1. Review of Resident #16's current FL-2 dated 06/10/17 revealed: -Diagnoses included type II diabetes mellitus with chronic kidney disease - stage 3, hypertension, gram negative pneumonia, sepsis, and moderate protein malnutrition. -There was no order for the fingerstick blood sugar (FSBS) to be checked. Observation of Resident #16's Brand B glucometer on 10/13/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #16's Brand B glucometer on 10/1317 revealed: -The date and time on the glucometer reflected the current date and time. -There were 12 readings in the memory of the glucometer and the dates ranged from 09/28/17 (7:02 a.m.) - 10/12/17 (8:27 p.m.). -The readings ranged from 103 - 291. -Eleven of the 12 FSBS readings were a.m. readings. -There was only 1 of 12 FSBS readings in the p.m. (10/12/17 at 8:27 p.m.) -There were no FSBS readings in the memory for 10/01/17, 10/02/17, or 10/06/17 - 10/08/17. -There were 3 FSBS readings for 10/12/17 at 6:59 a.m., 7:44 a.m., and 8:27 p.m. -The FSBS reading for 10/12/17 at 6:59 a.m. was 123 but the FSBS documented on the log was 124.	D932		

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D932	Continued From page 388 -The FSBS reading for 09/29/17 at 6:59 a.m. was 291 but the FSBS documented on the log was 162. Review of Resident #16's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked twice daily at 8:00 a.m. and 8:00 p.m. from 09/28/17 - 10/12/17. -The FSBS readings ranged from 103 - 215. -There were 18 of 30 documented FSBS on the log that were not in the memory of the glucometer from 09/28/17 - 10/12/17. -Two of the 12 FSBS readings in the glucometer did not match the FSBS documented on the FSBS log. Interview with Resident #16 on 10/17/17 at 2:20 p.m. revealed: -Staff usually checked his blood sugar in the evenings. -His blood sugar "runs good" and he was not having any problems with it. -Staff used a glucometer from the medication cart. -He did not know if he had his own glucometer in the medication cart. Refer to interview with a second shift medication aide (MA) on 10/12/17 at 7:50 p.m. Refer to interview with a first shift MA on 10/13/17 at 1:13 p.m. Refer to interview with the Administrator on 10/13/17 at 5:40 p.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m.	D932		

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D932	Continued From page 389 2. Review of Resident #1's current FL-2 dated 02/20/17 revealed diagnoses included type II diabetes mellitus - uncontrolled, senile dementia, hypertension, hyperlipidemia, anemia, and depression. Review of a physician's order dated 08/23/17 for Resident #1 revealed an order to check fingerstick blood sugars (FSBS) before meals, 2 hours after lunch, and at 2:00 a.m. (6 times a day). Observation of Resident #1's Brand C glucometer on 10/16/17 revealed: -The glucometer was stored in the top drawer of the 100 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #1's Brand C glucometer on 10/16/17 revealed: -The date on the glucometer reflected the current date of 10/16/17. -The time on the glucometer was 23 minutes beyond (2:37 p.m.) the current time of 2:14 p.m. -There were 63 readings in the memory of the glucometer dated 10/01/17 (2:25 a.m.) - 10/16/17 (11:37 a.m.) -The readings ranged from 20 - "HI" (greater than 600 according to the manufacturer). -There were no FSBS readings in the memory for 10/06/17 - 10/10/17. -Twelve of the FSBS readings in the memory did not match Resident #1's readings on the FSBS log.	D932		

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D932	Continued From page 390 Review of Resident #1's October 2017 FSBS log revealed: -The resident's FSBS was checked 93 times from 10/01/17 - 10/16/17 but only 63 FSBS readings were in the memory of Resident #1's glucometer for that time period. -The FSBS on the log ranged from 20 - "HI". -Twelve of the FSBS in the memory were not documented on the FSBS log. -For example, the resident's FSBS was documented as 272 on 1012/17 at 11:30 a.m. but this reading was not in the memory of the glucometer. -For example, the resident's FSBS was documented as 379 on 10/14/17 at 12:00 noon but this reading was not in the glucometer. -There were 36 documented FSBS reading on the FSBS log from 10/06/17 - 10/10/17 that were not in the memory of Resident #1's glucometer. Refer to interview with a second shift medication aide (MA) on 10/12/17 at 7:50 p.m. Refer to interview with a first shift MA on 10/13/17 at 1:13 p.m. Refer to interview with the Administrator on 10/13/17 at 5:40 p.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 3. Review of Resident #3's current FL-2 dated 03/07/17 revealed: -Diagnoses included diabetes mellitus, peripheral vascular disease, pneumonia, and muscle weakness. -There was an order for fingerstick blood sugars (FSBS) 4 times daily.	D932		

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D932	Continued From page 391 Observation of Resident #3's Brand A glucometer on 10/13/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #3's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 63 readings in the memory of the glucometer dated 09/25/17 (10:38 a.m.) - 10/13/17 (10:26 a.m.) -The readings ranged from 50 - 347. -Fifteen of the FSBS readings in the memory did not match Resident #3's readings on the FSBS log. Review of Resident #3's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time period. -The FSBS results on the log ranged from 50 - 420. -Eight documented FSBS on the log were not in the memory of Resident #3's glucometer. -For example, the resident's FSBS was documented as 344 on 10/09/17 at 4:45 p.m. but this reading was not in the memory of the glucometer. -The resident's FSBS was documented 4 times a	D932		

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D932	Continued From page 392 day on the log on 10/04/17, 10/07/17, 10/11/17, and 10/12/17 but there were 5 readings each of those days in the memory of the glucometer. Interview with Resident #3 on 10/17/17 at 10:25 a.m. revealed: -She received insulin and FSBS checks about 3 or 4 times a day. -Her FSBS ran so high sometimes she would have to get 60 units of insulin at night. -She usually felt "nervous" when her FSBS was high. -Her FSBS sometimes ran low and she would get "nervous and shaky". -She thought staff used different glucometers for the residents but she was not sure because the glucometers looked the same. Refer to interview with a second shift medication aide (MA) on 10/12/17 at 7:50 p.m. Refer to interview with a first shift MA on 10/13/17 at 1:13 p.m. Refer to interview with the Administrator on 10/13/17 at 5:40 p.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 4. Review of Resident #7's current FL-2 dated 10/04/17 revealed: -Diagnoses included type II diabetes mellitus with chronic kidney disease, Alzheimer's dementia, hypertension, hypothyroidism, hematuria, urinary tract infection, acute kidney injury, and acute encephalopathy. -There was no order for fingerstick blood sugars (FSBS).	D932		

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D932	Continued From page 393 Review of Resident #7' previous FL-2 dated 04/06/17 revealed an order to check FSBS 4 times a day. Observation of Resident #7's Brand A glucometer on 10/16/17 revealed: -The glucometer was stored in the top drawer of the 100 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #7's Brand A glucometer on 10/16/17 revealed: -The date on the glucometer reflected the current date of 10/16/17. -The time on the glucometer was 1 hour 4 minutes prior to (2:10 p.m.) the current time of 3:14 p.m.. -There were 48 readings in the memory of the glucometer dated 10/01/17 (6:18 a.m.) - 10/16/17 (5:48 a.m.) -The readings ranged from 79 - 568. -There were no readings in the memory for 10/02/17 - 10/03/17. -Eleven of the FSBS readings in the memory did not match Resident #7's readings on the FSBS log. Review of Resident #7's October 2017 FSBS log revealed: -The resident's FSBS was checked 47 times from 10/01/17 - 10/16/17 but there were 48 readings in the memory of Resident #7's glucometer for that time period. -The FSBS on the log ranged from 111 - 568.	D932		

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D932	Continued From page 394 -Eleven of the FSBS in the memory did not match documentation on the FSBS log. -There were 3 FSBS readings on the FSBS log that were not in the memory of the resident's glucometer -For example, the resident's FSBS was documented as 111 on 10/05/17 at 2:00 a.m. but this reading was not in the memory of the glucometer. Refer to interview with a second shift medication aide (MA) on 10/12/17 at 7:50 p.m. Refer to interview with a first shift MA on 10/13/17 at 1:13 p.m. Refer to interview with the Administrator on 10/13/17 at 5:40 p.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 5. Review of Resident #17's current FL-2 dated 09/25/17 revealed: -Diagnoses included diabetes mellitus with diabetic neuropathy, coronary artery disease, atherosclerotic heart disease, hyperlipidemia, iron deficiency, chronic obstructive pulmonary disease, constipation, insomnia, pain, rash, heartburn, urine retention, seasonal allergic rhinitis, wheezing, major depressive disorder, hypomagnesemia, gastroesophageal reflux disease, and pressure ulcer of right heel. -There was no order for fingerstick blood sugars (FSBS) to be checked. Review of a physician's order dated 07/20/17 for Resident #17 revealed an order to check FSBS 3 times a day before meals.	D932		

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D932	Continued From page 395 Observation of Resident #17's Brand A glucometer on 10/13/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #17's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 30 FSBS readings in the memory of the glucometer dated 10/05/17 (7:38 a.m.) - 10/13/17 (7:19 a.m.) -The FSBS readings in the memory ranged from 46 - 321. -Nine of the 30 FSBS readings in the memory did not match the resident's FSBS readings documented on the FSBS log. Review of Resident #17's October 2017 FSBS log revealed: -The resident's FSBS was checked 28 times from 10/05/17 - 10/13/17 but there were 30 readings in the memory of the resident's glucometer for that time period. -The FSBS readings on the log ranged from 66 - 321. -The resident's FSBS was documented as checked 4 times daily from 10/06/17 - 10/11/17 but the glucometer memory had 2 readings for 10/06/17, 3 for 10/07/17, 5 for 10/09/17, and 3 for 10/11/17. Refer to interview with a second shift medication	D932		

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D932	Continued From page 396 aide (MA) on 10/12/17 at 7:50 p.m. Refer to interview with a first shift MA on 10/13/17 at 1:13 p.m. Refer to interview with the Administrator on 10/13/17 at 5:40 p.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 6. Review of Resident #18's current FL-2 dated 05/04/17 revealed: -Diagnoses included diabetes, hypertension, and mental retardation. -There was no order to check fingerstick blood sugars (FSBS). Review of a physician's order dated 07/19/17 for Resident #18 revealed an order to check FSBS twice daily. Observation of Resident #18's Brand A glucometer on 10/16/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #18's Brand A glucometer on 10/16/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 25 FSBS readings in the memory of the glucometer dated 08/15/17 (7:00 a.m.) -	D932		

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D932	Continued From page 397 10/15/17 (8:54 a.m.) -The FSBS readings in the memory ranged from 51 - 298. -There were no FSBS readings in the memory for 08/25/17 - 10/14/17. -Twenty-three of the 25 FSBS readings in the memory did not match the resident's FSBS readings documented on the FSBS log. Review of Resident #18's August 2017 - October 2017 FSBS log revealed: -The resident's FSBS was checked 116 times from 08/15/17 - 10/15/17 but there were only 22 readings in the memory of the resident's glucometer for that time period. -The FSBS on the log ranged from 135 - 513. Refer to interview with a second shift medication aide (MA) on 10/12/17 at 7:50 p.m. Refer to interview with a first shift MA on 10/13/17 at 1:13 p.m. Refer to interview with the Administrator on 10/13/17 at 5:40 p.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 7. Review of Resident #19's current FL-2 dated 09/14/16 revealed: -Diagnoses included diabetes, hypertension, hypothyroidism, anxiety, obesity, mood disorders, insomnia, and osteoarthritis. -There was an order to check fingerstick blood sugars (FSBS) before breakfast. Review of the memory data for Resident #1's Brand A glucometer on 10/16/17 revealed: -The date on the glucometer reflected the current	D932		

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D932	Continued From page 398	D932		

date of 10/16/17.
-The time on the glucometer was 1 hour 4 minutes prior to (2:17 p.m.) the current time of 3:21 p.m..
-There were 22 FSBS readings in the memory of the glucometer dated 09/26/17 (5:51 a.m.) - 10/16/17 (6:11 a.m.)
-The FSBS readings in the memory ranged from 182 - 314.
-There were 2 FSBS readings in the memory for 09/30/17, 291 at 1:21 p.m. and 257 at 6:09 a.m.
-Three of the FSBS readings in the memory did not match Resident #19's readings on the FSBS log.

Review of Resident #19's September 2017 and October 2017 FSBS log revealed:
-The resident's FSBS was checked 20 times from 09/26/17-10/16/17 but there were 22 reading in the memory of Resident #19's glucometer for that time period.
-The FSBS on the log ranged from 182 - 314.
-There was no FSBS documented on the log for 10/08/17 but there was a FSBS reading of 214 on 10/08/17 in the memory of the glucometer.

Interview with Resident #19 on 10/11/17 at 10:55 a.m. revealed:
-She was borderline diabetic and staff checked her blood sugar once a day.
-Her blood sugar was usually in the 200s.
-She had her own glucometer when she lived at home.
-She thought staff used one glucometer for everybody at the facility.

Refer to interview with a second shift medication aide (MA) on 10/12/17 at 7:50 p.m.

Refer to interview with a first shift MA on 10/13/17

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D932	Continued From page 399 at 1:13 p.m. Refer to interview with the Administrator on 10/13/17 at 5:40 p.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 8. Review of Resident #20's current FL-2 dated 07/25/17 revealed: -Diagnoses included hypertension, hyperlipidemia, and peripheral vascular disease. -There was no order to check fingerstick blood sugars (FSBS). Observation of Resident #20's Brand A glucometer on 10/13/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #20's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 16 FSBS readings in the memory of the glucometer dated 09/26/17 (6:07 a.m.) - 10/11/17 (7:13 a.m.) -The FSBS readings in the memory ranged from 65 - 375. -There were no FSBS readings in the memory for 10/07/17, 10/12/17, or 10/13/17. -Two of the 16 FSBS readings in the memory did not match the resident's FSBS readings	D932		

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D932	Continued From page 400 documented on the FSBS log. Review of Resident #20's September 2017 and October 2017 FSBS log revealed: -The resident's FSBS was checked 17 times from 09/26/17 - 10/12/17 but there were only 16 readings in the memory of the resident's glucometer for that time period. -The FSBS on the log ranged from 65 - 172. -The FSBS was 92 on 10/07/17 at 8:00 a.m. but there was no reading for 10/07/17 in the memory of the glucometer. -The FSBS was 153 on 10/12/17 at 7:30 a.m. but there was no reading for 10/12/17 in the memory of the glucometer. Interview with Resident #20 on 10/16/17 revealed: -Staff checked her blood sugar in the mornings. -"It runs okay." -The facility had a glucometer they used to check her blood sugar. -She did not know if they used the same glucometer for other residents. Refer to interview with a second shift medication aide (MA) on 10/12/17 at 7:50 p.m. Refer to interview with a first shift MA on 10/13/17 at 1:13 p.m. Refer to interview with the Administrator on 10/13/17 at 5:40 p.m. Refer to interview with the Administrator on 10/17/17 at 11:45 a.m. 9. Review of Resident #21's FL-2 dated 04/06/17 in the closed record revealed: -Diagnoses included diabetes, congestive heart	D932		

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failure, hypertension, asthma, emphysema, atrial fibrillation, gastroesophageal reflux disease, degenerative joint disease, hypercholesterolemia, depression, anxiety, and coronary artery disease.
-There was no order to check fingerstick blood sugars (FSBS).

Review of Resident #21's closed record revealed the resident went to the hospital on 06/19/17 and did not return to the facility.

Observation of Resident #21's Brand A glucometer on 10/13/17 revealed:
-The glucometer was stored in the top drawer of the 200 hall medication cart.
-The glucometer was stored in a separate compartment and labeled with the resident's name.
-Each glucometer was stored in a separate compartment with dividers in the top drawer.
-There was a supply of single-use disposable lancets in the drawer.

Interview with the medication aide on 10/13/17 at 1:13 p.m. revealed:
-She did not know why Resident #21's glucometer was in the top drawer of the 200 hall medication cart.
-The resident no longer lived at the facility and her glucometer should not be stored in the medication cart.
-The resident went to the hospital and then to a rehabilitation facility about 2 to 3 months ago and was not coming back to this facility.

Review of the memory data for Resident #21's Brand A glucometer on 10/13/17 revealed:
-The date and time on the glucometer reflected the current date and time.
-There were 49 FSBS readings in the memory of

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D932	Continued From page 402	D932		

the glucometer dated 06/28/17 (1:00 a.m.) - 10/11/17 (6:06 p.m.)
-The FSBS readings in the memory ranged from 75 - 498.
-All 49 FSBS readings in the memory were obtained after the resident no longer lived at the facility.
-There was 1 FSBS reading in 06/2017.
-There were 16 FSBS readings in 07/2017.
-There were 6 FSBS readings in 08/2017.
-There were 4 FSBS readings in 09/2017.
-There were 22 FSBS readings in 10/2017.

Review of Resident #21's June 2017 FSBS log revealed the resident's last documented FSBS was 226 on 06/19/17 at 8:00 a.m.

Refer to interview with a second shift medication aide (MA) on 10/12/17 at 7:50 p.m.

Refer to interview with a first shift MA on 10/13/17 at 1:13 p.m.

Refer to interview with the Administrator on 10/13/17 at 5:40 p.m.

Refer to interview with the Administrator on 10/17/17 at 11:45 a.m.

Interview with a second shift medication aide (MA) on 10/12/17 at 7:50 p.m. revealed:
-About a month ago, they ran out of test strips for the Brand A glucometers.
-They were out of the test strips for at least 2 weeks.
-The facility Manager told the MAs to use the glucometer of a newly admitted resident who had a different glucometer and had a supply of test strips.
-The Manager told the MAs to use that

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glucometer for all of the residents until they could get more strips for Brand A glucometers.
-They shared that glucometer for at least 5 residents who had the Brand A glucometers during that time.
-They had an infection control class sometime after the survey in 06/2017 but prior to running out of strips in 08/2017.
-She denied sharing any glucometers between residents after the incident of not having strips in 08/2017.
-She was not aware of any glucometer sharing between residents currently at the facility.
-They did not have any policies and procedures for infection control.
-She did not recall being instructed on cleaning the glucometers.

Interview with a first shift MA on 10/13/17 at 1:13 p.m. revealed:
-Each diabetic resident had their own glucometer labeled in the medication carts.
-They recently got new glucometers for some of the residents but she could not recall the date when they received them.
-They were not supposed to share the glucometers between the residents.
-She denied sharing the glucometers between the residents.
-She was not aware of any MAs sharing the glucometers between the residents.
-She did not know why the FSBS readings in the memory of the glucometers did not match some of the readings on the residents' FSBS logs.

Interview with the Administrator on 10/13/17 at 5:40 p.m. revealed:
-They had infection control training for the medication aides after the survey in June 2017 and there were problems with staff sharing

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D932	Continued From page 404 glucometers between the residents. -They also got new glucometers for residents after the last survey (not sure of date). -The facility had not developed any written policies and procedures for infection control. -The Manager of the facility had been out on medical leave for about 2 months. -The Manager did not develop any written policies and procedures for infection control since the previous survey to her knowledge. -She was not aware the Manager had told the medication aides to share one resident's glucometer for other residents in 08/2017 when they ran out of strips. -She was not aware staff were currently sharing glucometers. -They were not supposed to share the glucometers. -Glucometers for discharged residents should not be stored in the medications carts. -She would contact the pharmacy today about getting new glucometers for the residents. -She would have an in-service with the medication aides about the glucometers. Interview with the Administrator on 10/17/17 at 11:45 a.m. revealed: -She had contacted a local pharmacy to get more glucometers for the residents. -The pharmacist was going to contact a representative from a glucometer company about getting more glucometers. -There was currently no timeline on when the glucometers would be obtained. _____ The facility shared glucometers between 9 of 9 diabetic residents in the facility receiving fingerstick blood sugar (FSBS) checks. Eight of 8 current residents had multiple FSBS readings recorded in the memory of their glucometers that	D932		

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D932	Continued From page 405 did not match FSBS readings documented on their FSBS logs. One of the residents left the facility in June 2017 but her glucometer was still being stored in the medication cart and had 49 FSBS readings recorded in the memory of the glucometer after the resident no longer lived at the facility with the most recent FSBS reading dated 10/11/17. The failure of the facility to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines was detrimental to the health and welfare of the residents due to possible exposure of blood borne pathogens by the continued sharing of glucometers, and constitutes an Unabated Type B Violation. Review of the facility's Plan of Protection dated 10/13/17 revealed: -In-service staff on glucometer use and cleaning after each use. -Notify physician and health department on breach of infection control. -Replace glucometers used for more than one resident. -In-service will be done beginning today with staff (Medication Aides) and continue until all have been in-serviced. -All glucometers will be disinfected immediately. -Administrator will monitor glucometers to ensure use for one resident only daily for one week, then weekly. -Will compare with blood sugar readings. -Infection control policy will be developed and implemented.	D932		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home	D935		

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D935	Continued From page 406 Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.	D935		

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

Based on observations, interviews, and record reviews, the facility failed to assure 3 of 4 staff sampled (B, C, E) who administered medications had completed the 5 hour and 10 hour or 15 hour state approved medication administration training courses as required; 1 of 4 sampled medication aides (C) had passed the written medication aide exam; and 2 of 4 medication aides sampled (B, C) had a clinical skills checklist completed prior to administering medications.

The findings are:

1. Review of Staff C's personnel record revealed:
-There was no documentation of Staff C's hire date.
-She was hired as a Personal Care Aide (PCA), Medication Aide (MA) and supervisor.
-There was documentation that Staff C had a medication clinical skills checklist completed 06/27/17.
-There was no documentation Staff C had passed the written medication aide exam.
-There was no documentation Staff C completed the 5, 10 or 15 hour medication aide training course.

Review of the residents' September 2017 and October 2017 medication administration records and blood sugar logs revealed:
-Staff C documented administration of medications including insulin on 10/02/17, 10/03/17, and 10/07/17 - 10/09/17.
-Staff C documented administration of

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medications including insulin on 09/01/17, 09/06/17, 09/07/17, 09/10/17 - 09/12/17, 09/15/17, 09/16/17, 09/19/17, 09/21/17 - 09/24/17, and 09/29/17.

Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed:
-She was hired in August 2016 as a MA and supervisor.
- She left and came back as a rehire twice.
-She was last rehired on 09/01/17.
-She started administering medications again around the end of September 2017 after she was rehired.
-She administered medications including insulin.
-She thought she took some type of medication exam over a year ago but she did not know if it was the state medication aide written exam.
-She did not recall taking the 5 hour, 10 hour, or 15 hour state approved medication aide courses.
-The Manager was supposed to go online and get confirmation that she was a MA.
-She could look for her paperwork, but it had been a long time, so did not remember where the paperwork was.

Refer to interview with the Administrator on 10/16/17 at 8:40 a.m.

Refer to interview with the Administrator on 10/17/17 at 2:00 p.m.

2. Review of Staff B's personnel record revealed:
-Staff B was hired on 10/25/16.
-There was no job title in the personnel record.
-There was no medication aide clinical skills checklist for Staff B.
-There was no documentation of Staff B passing the written medication aide exam.
-There was no documentation of Staff B

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D935	Continued From page 409	D935		

completing the 5 hour, 10 hour, or 15 hour state approved medication aide training courses.
-There was no medication aide verification form for Staff B.

Review of the residents' October 2017 medication administration records (MARs) revealed Staff B documented administration of medications on 10/14/17 and 10/15/17.

Interview with Staff B on 10/17/17 at 5:20 p.m. revealed.
-Staff B was hired before August 2016 as a personal care aide.
-She was now a medication aide (MA), and began administering medications on 10/09/17.
-She had MA training hours in the past but did not know where the documentation was.
-She had not had any recent training.

Review of documentation provided by the Administrator on 10/16/17 revealed:
-A medication aide clinical skills validation checklist was completed on Staff B on 10/15/17 by the Administrator, who was a Registered Nurse.
-There was a certificate that Staff B passed the written medication aide written exam on 11/10/04.

Refer to interview with the Administrator on 10/16/17 at 8:40 a.m.

Refer to interview with the Administrator on 10/17/17 at 2:00 p.m.

3. Review of Staff E's personnel record revealed:
-Staff E was hired on 04/04/17 as a medication aide (MA) and supervisor.
-There was documentation Staff E had completed a medication clinical skills checklist on 04/04/17.

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D935	Continued From page 410 -There was documentation Staff E passed the written medication aide exam on 01/23/08. -There was no documentation Staff E completed the 5, 10 or 15 hour medication aide training course. -There was no medication aide verification form for Staff E. Review of residents' September 2017 and October 2017 medication administration records and blood sugar logs revealed -Staff E documented administration of medications including insulin on 10/01/17, 10/02/17, and 10/04/17 - 10/12/17. -Staff E documented administration of medications including insulin on 09/09/17, 09/10/17, 09/12/17, 09/16/17 - 09/18/17, 09/21/17, 09/23/17, 09/27/17, and 09/28/17. Interview with Staff E on 10/16/17 at 3:13 p.m. revealed: -Staff E was hired in March or April 2017 as a MA and supervisor. -Staff E had previously taken the 5/10 hour or the 15 hour training at a previous facility, but never received a copy of her certificates; she thought she had the training in 2007. -The Manager had never requested copies of any training hours. -Staff E had not taken any MA training since being employed at the facility. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. Refer to interview with the Administrator on 10/17/17 at 2:00 p.m. Interview with the Administrator on 10/16/17 at 8:40 a.m. revealed:	D935		

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D935	Continued From page 411 -She checked with the facility's Manager about the personnel files. -The Manager could not find any more information for the personnel files. -The Manager was responsible for the personnel files and making sure all staff met qualifications and requirements. -The Manager had been on medical leave for about 2 months and was unavailable for interview. -No one took over responsibility of the personnel files since the Manager had not been available. -There was no system to check behind the Manager or to monitor the personnel files. Interview with the Administrator on 10/17/17 at 2:00 p.m. revealed: -She had been in contact with the pharmacy about training, but could not remember the date she was given for training. -She was told by the pharmacy that the training was offered on-line. -She would look at the on-line training, print off the training for the staff to review and the pharmacy staff would follow-up with the check off. The facility failed to assure 3 of 4 medication aides, who were administering medications, including insulin, to all residents in the facility, obtained the required training and qualifications for medication administration. The facility's failure to have qualified medication aides administering medications was detrimental to the health, safety and welfare of the residents, which constitutes a Type B Violation. Review of the facility's plan of protection dated 10/16/17 revealed: -Administrator will be responsible for medication aide qualifications.	D935		

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D935	Continued From page 412 -Medication aides must have required training and competency check offs before administering medications. -Pharmacy notified to schedule training class and competency check off to follow with 15 hour training. -Training will be completed online and hands on by registered nurse and each medication aide will be required to complete training by 10/27/17. -Medication aide class to be scheduled following completion of 15 hour class and annual training required thereafter. -Administrator will review files monthly for required training. -Medication aide qualifications will be completed immediately for Staff B, C, and E, as soon as RN can schedule class. -Documentation of medication aides passing written exam will be maintained on file. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 1, 2017.	D935		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device	D992		

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may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.

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

Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was completed upon hire for 4 of 5 staff (B, C, D, E) sampled who were hired after 10/01/13.

The findings are:

1. Review of Staff B's personnel record revealed:
-Staff B was hired on 10/25/16 as a personal care aide (PCA).
-There was documentation of a controlled substance screening in Staff B's personnel file

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D992	Continued From page 414 that was done on 05/09/16 by another place of employment. -There was no documentation of a controlled substance screening prior to hire. Interview with Staff B on 10/17/17 at 5:20 p.m. revealed: -She was hired before August 2016. -She started performing medication aide duties on 10/09/17. -She had not taken a drug screening and had never been asked to take one by the facility. Refer to interviews with the Administrator on 10/16/17 at 8:40 a.m. and 9:31 a.m. 2. Review of Staff C's personnel record revealed: -There was no documentation of Staff C's hire date. -Staff C was rehired. -She was hired as a personal care aide (PCA). -There was no documentation of a controlled substance screening prior to hire. Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed: -She was first hired at the facility in August 2016. -She had left and came back as a rehire twice. -She was last rehired on 09/01/17. -She started administering medications again around the end of September 2017 after she was rehired. -She used drug screening results from another place of employment to get rehired, but did not remember the date of the drug screening. -She had not been asked to submit to a drug screening. Based on interviews and record reviews, there were allegations of drug diversion against Staff C.	D992		

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D992	Continued From page 415 [Refer to findings under Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry.] Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. and 9:31 a.m. 3. Review of Staff D's personnel record revealed: -There was no documentation of Staff D's hire date. -Staff D was hired as a personal care aide (PCA). -There were results of a drug screening dated 04/04/17 that was obtained while she was taking classes at the local community college. -There was no documentation of a controlled substance screening prior to hire. Interview with Staff D on 10/17/17 at 8:55 a.m. revealed: -She started working at the facility in May 2017. -She was hired as a Personal Care Aide. -She had not had a drug screening since being employed at the facility. -She used a drug screening that she had taken while in the Nurse Aide course through the local community college to get employed. Interview with the Administrator on 10/16/17 at 9:31 a.m. revealed Staff D was hired on 05/01/17 as a personal care aide. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. and 9:31 a.m. 4. Review of Staff E's personnel record revealed: -Staff E was hired on 04/04/17. -She was hired as a Medication Aide (MA) and Supervisor. -There was documentation that a controlled substance screening had been completed on Staff E on 11/11/15 through her primary care	D992		

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D992	Continued From page 416 provider (PCP). -Staff E was positive for opiates. -There was no documentation from the PCP explaining the positive results from 11/11/15. -There was no documentation of a controlled substance screening prior to hire on 04/04/17. Interview with the Administrator on 10/16/17 at 8:40 a.m. revealed: -She was not aware Staff E had a positive controlled substance screening. -She thought the Manager may have overlooked it. -The Manager should have gotten documentation from Staff E's physician regarding the positive controlled substance screening prior to hiring Staff E. Interview with Staff E on 10/16/17 at 3:13 p.m. revealed: -She had been employed since March or April 2017. -She was a MA and Supervisor. -She was aware of the positive drug screening. -She "had the flu, if I can remember correctly and took medication with codeine". -She had not been asked to take a drug test upon hire to the facility but she was willing to do so. Refer to interview with the Administrator on 10/16/17 at 8:40 a.m. and 9:31 a.m. Interview with the Administrator on 10/16/17 at 8:40 a.m. revealed: -She checked with the facility's Manager about the personnel files. -The Manager could not find any more information for the personnel files. -The Manager was responsible for the personnel files and making sure all staff met qualifications	D992		

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D992	Continued From page 417 and requirements. -The Manager had been on medical leave for about 2 months and was unavailable for interview. -No one took over responsibility of the personnel files since the Manager was unavailable. -There was no system to check behind the Manager or to monitor the personnel files. -She was not aware that drug screenings had not been done upon hire. -She had a urine testing kit that she could start using immediately for drug screenings. The facility failed to perform urine screenings for controlled substances upon hire for 4 staff who provided direct care to residents; 3 of the 4 staff were medication aides and administered medications including controlled substances to residents. One of the medication aides had a positive drug screen with no documentation provided by a physician explaining the reasoning for the positive screening. There were allegations of drug diversion against a second medication aide who did not have a controlled substance screening prior to hire. This failure was detrimental to the safety and welfare of the residents, which constitutes a Type B Violation. Review of the facility's plan of protection dated 10/16/17 revealed: -Administrator will be responsible for screening for controlled substances. -Screening for controlled substances will be completed on all employees prior to hiring. -Any employee who does not have drug screening documentation in their file will have one done by 10/20/17. -Positive drug screening must have physician documentation as to why they are receiving controlled medication before beginning work	D992		

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D992	Continued From page 418 schedule. -Staff C will have urine test screening immediately. -Staff E's physician will be contacted immediately to get reason for positive drug screening. -Screening for controlled substances will be completed before hire and randomly as indicated. -Administrator will audit all personnel files for drug screening to ensure screens are negative. -Administrator will monitor files monthly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 1, 2017.	D992		