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{D 000}	Initial Comments The Adult Care Licensure Section and Gaston County Department of Social Services conducted a follow-up survey January 30, 2018 through February 2, 2018.	{D 000}		
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 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 assure implementation of orders for 2 of 3 sampled residents (Residents #1 and #3) with physician orders for continuous oxygen for shortness of breath related to heart disease, respiratory failure and chronic obstructive pulmonary disease (COPD) for Resident #1, and an order to elevate the resident's leg to reduce swelling in the lower extremities for Resident #3. The findings are: 1. Review of Resident #1's current FL2 dated 01/19/18 revealed: -Diagnoses included heart disease, respiratory failure, asthma, hypoxia, chronic obstructive	D 276		

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pulmonary disease (COPD), leukocyte disorder, and chronic renal failure.
-A physician's order for oxygen continuously at 2 liters.

Review of Resident #1 Care Plan signed by the physician on 01/05/18 revealed:
-Documentation Resident #1 was declining with her activities of daily living.
-The facility staff were to encourage the resident to allow them to assist more than she (Resident #3) was use to.
-The resident needed limited assistance with eating, toileting, ambulation and grooming.
-Resident #1 needed extensive assistance with bathing and sometimes dressing.
-At times the resident may need a wheelchair due to gout.

Review of a Emergency Medical Services (EMS) report dated 01/30/18 obtained from EMS office revealed:
-EMS got a call at 6:56 am regarding a person with breathing problems.
-"Upon arrival EMS responders found Resident #1 at the nurse station."
-"Resident #1 was not wearing oxygen."
-"Resident #1 told EMS that she had been feeling short of breath for the past two days."
-"Resident #1 stated to EMS responders she had no relief and wanted to be transported to the hospital to be assessed."
-Staff at the facility told EMS "Resident #1 was supposed to be on continuously oxygen (02) at 3-4 liters as needed."
-Staff reported to EMS "Resident #1 had not been compliant with wearing her nasal cannula."
-Resident #1 oxygen saturation level was 91% on room air as measured by EMS.
-EMS placed Resident #1 on oxygen 3 liters per

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minute, and oxygen level increased to 97%.
-"Resident #1 stated to EMS responder that oxygen placed on by the medic relieved her shortness of breath."

Review on 01/31/18 of the hospital emergency room summary report dated 01/30/18 obtained from the local hospital revealed:
-EMS reported to emergency room staff that upon arrival at the facility Resident #1 was short of breath and was not wearing oxygen.
-In the emergency room Resident #1's oxygen saturation level was 88% on room air.
-Resident #1 was admitted to the hospital with acute chronic systolic congestive heart failure, COPD with acute exacerbation, and shortness of breath.

Observation on 02/01/18 at 8:56 am of Resident #1's oxygen equipment at the facility revealed:
-12 portable stand alone tanks were in the utility closet.
-In the resident's room as a powder blue non-portable oxygen concentrator near the bed.
-The concentrator was set at 3 liters per minute.
-There was a four feet clear thin tubing with two small nozzles (nasal cannula) that extended from the concentrator.
-When turned on the concentrator it made audible humming sounds.
-On the opposite side of Resident #1's bed was a green metal portable oxygen tank.
-There was a 2-3 feet clear thin tubing with two small nozzles that extended from the tank.
-The tank was off with "O" showing on the black round handle, and when putting the two small nozzles near the skin no air was felt blowing from the nozzles.
-The black needle on the oxygen usage dial was positioned between "O" and refill.

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-The RCD used a key to turn the portable tank on, and she turned the black handle from 0 to 2.
-After waiting 60 seconds the black needle on the air usage dial was still positioned between "O" and refill, with light air felt in the nasal cannula.

Interview on 02/01/18 at 2:41 pm with Resident #1 (at the hospital) revealed:
-She had to wear oxygen continuously due to COPD and history of asthma.
-She had portable oxygen tanks and a non-portable oxygen concentrator in her room, that she used at bedtime.
-She used at least 3 portable oxygen tanks a day.
-When the RCD worked she turned on the portable tank for her.
-When the RCD was not on duty, she "fixed" (turned on) the portable oxygen tank herself.
-At bedtime she used the non-portable oxygen concentrator and turned it up to 3 liters, "that worked well for her at bedtime."
-Her oxygen was ordered at 2 liters, but recently she felt that she needed 3 liters.
-She told staff that she needed her oxygen increased to 3 liters, but did not recall which staff she told and could not recall the date.
-She was ordered Lasix for fluid retention, and sometimes when she woke up she had to rush to the bathroom, and forgot to put her oxygen on.
-The day prior to hospitalization (01/29/18) she did not wear her oxygen all day, because she did not feel good and did not have the strength to walk to her room to get the portable oxygen tank, and "fix it up".
-The same evening, prior to hospitalization (01/29/18) she told the second shift Medication Aide (MA) and the second shift Personal Care Aide (PCA) on duty that she was sick and short of breath.
-She had walked to the bathroom and coming

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back from the bathroom she felt sick and shortness of breath.
-She "flopped all over the hand railing in the hallway," because she did not feel good and was shortness of breath.
-She was "slumped" over the hand railing for 2-3 minutes before staff saw her.
-The MA, saw her "leaning over the railing" and stated "if you are shortness of breath, why is your oxygen not on?"
-The MA told her to put the oxygen on, but did not offer to get the oxygen for her.
-The MA said to her, "you know that you needed to be on oxygen every day," and the MA walked away.
-She felt sick and was shortness of breath and could not make it back to her room to get the oxygen.
-She went to the common sitting area because it was closer.
-She stayed in the common sitting area most of the day without using oxygen, because she did not feel like walking back to her room.
-She had a portable oxygen tank in her room and two unused portable oxygen tanks stored in the utility closet.
-She did not obtain the oxygen tank from her room because with "the shortness of breath that I had, I didn't feel like walking from the lobby (common sitting area), down the hallway to my room to fix one (oxygen tank) up."
-When she fixed up a oxygen tank, she used a key to turn the oxygen tank on for the air to flow out.
-On Monday (01/29/18), she did not have enough strength to turn the key for the air to flow out.
-There were staff and other residents sitting in the common living area where she was sitting.
-No staff asked her how she was feeling or offered to obtain the portable oxygen tank for her.

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-Being sick she could not think what to do.
-At bedtime, she decided to go to her room, she stopped frequently because she was short of breath, it took her close to 10 minutes or more to get back to her room.
-The day she went to the hospital (01/30/18), she got up at 6:45 am, her Lasix was working and she had to rush to the bathroom.
-She did not have time to turn the portable oxygen on.
-Coming back from bathroom she was "very badly, short of breath."
-She stopped in the hallway near the medication room, and "leaned over the hand railing."
-Staff were in the facility, but she did not see any staff in the hallway.
-The RCD approached her while she was in the hallway and asked her what was wrong.
-She told the RCD that she was short of breath and wanted to go to the hospital.
-She walked to medication room with the RCD and sat in a chair until EMS arrived.
-The RCD told the third shift PCA sit with her until EMS arrived.
-It was a total of 20 to 25 minutes from the time the RCD had seen her "leaned over the railing" until EMS arrived at the facility, and she did not have her oxygen on.
-No staff offered to bring the oxygen to her, checked her oxygen level, or checked any vital signs on her.
-EMS put the oxygen on the her, and it made her feel better.
-If staff observed her in the hallway without her oxygen on, they told her to go get her oxygen.

Interview on 02/02/18 at 12:13 pm with the RCD revealed:
-On 01/30/18 she came to work between 6:30 am and 6:45 am.

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-As she walked down the hallway she observed Resident #1 slumped over hand railing.
-She asked Resident #1 "what was going on."
-Resident #1 told her she was short of breath and wanted to go to the hospital.
-She asked Resident #1 if she wanted a breathing treatment, the resident stated "no, send me out."
-Resident #1 did not have her oxygen on, she put the oxygen back on resident and left the resident standing in the hallway near the medication room.
-The oxygen tank that Resident #1 was using the day she went to the hospital was the same tank that was currently Resident #1's room.
-She was unable to explain why EMS stated the resident was not wearing oxygen when they arrived.
-The facility had a pulse oximeter, but she did not check Resident #1's oxygen level because she did not have an order to check the resident's oxygen saturation.
-She did not check any of Resident #1's vital signs before EMS arrived.
-Resident #1 was ordered oxygen 2 liters continuous, and she continually had to remind the resident put her oxygen on.
-The RCD could not explain why the portable oxygen tank in Resident #1's room was reading "O" and refill, but stated "air was still coming out."
-No staff had reported to her that they observed Resident #1 short of breath and leaning on the railing in the hallway.
-If staff had observed Resident #1 in that position they should have assisted with obtaining the resident's oxygen and sent the resident out to the hospital.
-Also, if staff observed incidents with Resident #1 being short of breath they should have completed an incident report.
-She searched Resident #1's record and shift

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notes and did not find documentation where staff observed Resident #1 short of breath and/or leaning on the railing.

Interview on 01/30/18 at 4:10 pm with a resident revealed:
-This morning Resident #1 went to the hospital.
-Last night, Resident #1 was found "slumped" over in the hallway.
-Resident #1 was jittery all day, and did not wear her oxygen when she was in the building.
-Resident #1 had been walking around all day like she was in a daze.
-Resident #1 acted like she was in a lot of pain, and her lips were trembling.
-Resident #1 said she did not feel well.
-She did not tell staff, and was unaware if Resident #1 told staff she did not feel well.

Interview on 01/31/18 at 1:51 pm with Resident #1's roommate revealed:
-Resident #1 was short of breath the night before she went to the hospital (Monday, 01/29/18).
-On Monday, Resident #1 had gone all day without her oxygen on.
-Resident #1 told a staff person that she was short of breath, she was not sure of the staff person name, but thought it was the midnight staff.
-Resident #1 did not go to the hospital until the next morning.

Interview on 01/31/18 at 9:05 am with a third resident revealed:
-Resident #1 had asthma and could not be around cigarette smoke.
-Resident #1 would go outside sometimes without her oxygen, then later the resident would pass out.
-When Resident #1 passed out she informed staff

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and they would check Resident #1's blood pressure and blood sugar and they called the paramedics.
-On 01/29/18, she observed Resident #1 was shaking and drooling at the mouth.
-Resident #1 told her that she was short of breath, and Resident #1 was shaking and could not keep still.
-Resident #1 was shaking and drooling for at least three days.
-She thought Resident #1 told staff, but was not sure.
-In the morning on 01/30/18, Resident #1 was still shaking and had shortness of breath.
-Someone at the facility called the paramedics.
-She did not tell facility staff about Resident #1 shaking and drooling, but she was sure staff knew because Resident #1 was in the hallway where everyone could see her, and the facility also had cameras.

Interview on 01/31/18 at 4:18 pm with a fourth resident revealed:
-Resident #1 went out of the facility on Tuesday, January 30, 2018.
-The day prior to Resident #1 going to the hospital, she was leaning over the railing in the hallway, and her lips were trembling.

Interview on 02/01/18 at 9:00 am with a fifth resident revealed:
-Resident #1 went to the hospital on 01/30/18, because she was not feeling well.
-The day before Resident #1 went to the hospital, the resident told her she was weak, her mouth was shaking, and she was short of breath.
-On 01/30/17, the RCD saw Resident #1 in the hallway, short of breath and called the paramedics.
-After Resident #1 was taken to the hospital, the

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RCD came to her and asked why she did not tell her that Resident #1 was short of breath yesterday.
-She told the RCD that she thought staff knew Resident #1 was short of breath because everyone could see the resident in the hallway.

Interview on 02/02/18 at 10:02 am with a sixth resident revealed:
-The day before Resident #1 went to the hospital, she was "kind-of shaky."
-"Resident #1's lips were trembling real bad, and she was a little short of breath."
-He thought facility staff was aware of Resident #1's condition because they checked her oxygen every day using the little machine that goes on the end of finger.

Interview on 02/01/18 at 4:08 pm with the second shift Personal Care Aide (PCA) revealed:
-She worked on 01/29/18, the night before Resident #1 went to the hospital.
-After supper, Resident #1 was sitting in the common sitting area, and she approached Resident #1 about taking a shower.
-Resident #1 told her that she did not feel well.
-She did not inquire how or why the resident did not feel well.
-She had to frequently remind Resident #1 to put her oxygen on, but did not attempt to get the oxygen tank for Resident #1.
-Normally, if she told Resident #1 to get her oxygen, the resident would go to her room and get the oxygen.

Interview on 02/01/18 at 5:48 pm with the second shift Medication Aide (MA) revealed:
-She worked on 01/29/18 from 3:00 pm to 11:00 pm.
-When she came to work on 01/29/18 she

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observed Resident #1 in hallway, as if she was coming from the bathroom.
-Resident #1 did not have her oxygen on, and she noticed the resident was leaning over near the hand rail.
-She told Resident #1 to go put her oxygen on, and she thought the resident put the oxygen on.
-She did not ask Resident #1 how she was feeling, and she did not recall Resident #1 told her that she was short of breath.
-She saw Resident #1 again at 8:30 pm to give her medications and she was in bed using the non-portable concentrator.
-She checked the concentrator and it was on 2 liters.
-Staff was in Resident #1's room every 15 minutes to check on Resident #1's roommate, and observed Resident #1 was in bed sleeping with her oxygen on.

Interview on 01/31/18 4:08 pm with the third shift PCA revealed:
-She worked the third shift, her shift started at 11:00 pm on 01/29/18, and ended at 7:00 am the morning of 01/30/18.
-She recalled during her shift Resident #1 got out of bed at 2:45 am and walked down hallway to the common sitting area.
-She thought Resident #1 had her oxygen on, but was not sure.
-Resident #1 asked the time.
-She told Resident #1 the time, and after one minute Resident #1 returned to her room.
-Resident #1 did not complain of shortness of breath and to her did not appear short of breath.
-The next day, before her shift ended, the RCD told her to watch Resident #1 in the hallway while she was called EMS.
-She could not recall if Resident #1 had oxygen on or if the oxygen tank was in the hallway near

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the resident.
-When EMS arrived, she heard Resident #1 tell a paramedic that she had been short of breath for 2 days.
-She often had to re-direct Resident #1 to remind her to put the oxygen on.

Interview on 02/01/18 at 6:15 am with the third shift medication aide revealed:
-On 01/29/18 through 01/30/18, she worked as the medication aide on the third shift, from 11:00 pm to 7:00 am.
-Resident #1 did not complain to her about difficulty breathing.
-The facility had a device that checked the residents pulse and oxygen saturation level at the same time.
-Resident #1 had an order to check her pulse before administering one of her medications.
-She recorded the resident's pulse on the Medication Administration Record (MAR), but did not record the oxygen level because there was no order to record Resident #1's oxygen level.
-She checked Resident #1's pulse at 6:00 am the morning of 01/30/18, it was 97, but she did not recall what Resident #1's oxygen saturation was.
-The morning of 01/30/18, Resident #1 was laying in the bed sleeping with her oxygen on.
-She woke the resident up to take her medications, and did not recall the resident having difficulty breathing.

Interview on 02/01/18 at 6:25 am with another third shift Medication Aide (MA) revealed:
-She worked the midnight shift, 11:00 pm to 7:00 am.
-She sometimes had to remind Resident #1 to put her oxygen on, and the resident usually went back to her room to get the portable oxygen tank.
-She did not obtain the oxygen tank for Resident

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#1, the resident always went to her room to get the oxygen herself.

Interview on 02/02/18 at 9:50 am with the Physician Assistant (PA) revealed:
-She visited the facility every week, on Friday.
-The physician was in the the facility every Monday and Wednesday.
-There was no notification by the facility to her office according phone messages and computerized records regarding Resident #1 not feeling well or complained of shortness of breath on 01/29/18.
-There was no documentation that facility staff had informed Resident #1 was sometimes non-compliant with oxygen usage.
-She would want know any change in a resident's status, especially if a resident was complaining of shortness of breath.
-She expected facility staff to inform her anytime a resident's health had declined outside their baseline.
-She was did not know the facility had equipment to check Resident #1's oxygen saturation level, if they checked the resident's oxygen level she would want that documented to review when saw the resident.
-The facility staff never requested an order to record the resident's oxygen saturation level.

Interview on 02/02/18 at 3:29 pm with the physician revealed:
-He had seen Resident #1 on 01/22/18.
-Resident #1's oxygen saturation was 81%.
-The resident had a history of being hypoxic, so he wanted a chest X-ray (CXR).
-He forgot to write the order for the CXR.
-Facility staff had notified him that Resident #1 went to the hospital, but no one at the facility had called to inform the resident was shortness of

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breath on 01/29/18, or that Resident #1 was non-complaint with oxygen usage.

2. Review of Resident # 3's current FL2 dated 12/11/17 revealed:
-Diagnoses included edema, hypertension, dyspnea, anemia, chronic obstructive pulmonary disease (COPD), type 1 diabetes mellitus, cerebrovascular accident, and left ventricular hypertrophy.

Review of a physician visit summary report dated 10/31/17, in Resident #3's record revealed an order to "elevate leg while sitting."

Review of a physician visit summary report dated 11/28/17, in Resident #3's record revealed an order to "continue heel lift boot at all times and while in bed to offload the heel, and elevate the leg."

Review of physician's orders dated 12/19/17 from the wound center revealed:
-Continue using a heel lift boot at all times and while in bed to offload the heel.
-Elevate the legs in wheelchair.

Review of Resident #3's December 2017 and January 2018 electronic Medication Administration Record (eMAR) revealed:
-An entry to elevate Resident #3's legs when sitting up in a chair.
-An entry to elevate Resident #3's legs when sitting in the wheelchair (WC).
-Documentation staff implemented the order three times daily by initialing the eMAR.

Observations of Resident #3 from 01/30/18 through 02/02/18 are as follows:
-On 01/30/18 at 3:30 pm Resident #3 was in a

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wheelchair (WC) in the hallway, a staff was pushing the resident the common sitting area. The resident had a blue heel protector on his left foot. There was no mechanical leg lift attached to the WC to elevate the resident's leg. Both the resident's feet were on the floor.
-01/30/18 at 4:00 pm Resident #3 was in his WC in the common sitting area doing activities. The resident had a blue heel protector on his left foot. There was no mechanical leg lift attached to the WC to elevate the resident's leg. Both the resident's feet were on the floor.
-01/30/18 at 4:30 pm Resident #3 was in his WC in the common sitting area watching television. The resident had a blue heel protector on his left foot. There was no mechanical leg lift attached to the WC to elevate the resident's leg. Both the resident's feet were on the floor.
-01/30/18 at 5:00 pm Resident #3 was in his WC in the common sitting area watching television, his leg was not raised. The resident had a blue heel protector on his left foot. There was no mechanical leg lift attached to the WC to elevate the resident's leg. Both the resident's feet were on the floor.
-On 01/31/18 at 10:10 am Resident #3 was in his room sitting in the WC with his left foot on the foot rest. The blue heel protector boot was on. The foot was not elevated.
-On 01/31/18 12:12 pm Resident #3 was in the front common sitting area in his WC with his left foot on the rest of the WC. The blue heel protector boot was on.
-On 02/01/18 at 10:05 am Resident #3 was in the common area sitting in the WC. He was leaned to the left side with his head down. The left foot is on the foot rest of the WC. The blue heel protector boot was on. The foot was not elevated.
-On 02/02/18 at 4:55 pm with Resident #3 was sitting in wheelchair in common area. The left foot

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with the bootie on was on the floor, not on the wheelchair rest.

Observation on 02/01/18 at 11:35 am of Resident #3's left leg revealed:
-Sock on left leg was down around the calf.
-There was an in depth ring of ½ inch on Resident #3's left leg due to edema.
- The top of the left foot was puffy.
-The skin on the left foot and leg was dry and flaky.
-The wound on the left outer heel near ankle was healed with little crusty area in the center.

-Interview on 01/31/18 at 10:10 am and 02/01/18 at 4:40 pm with Resident #3 revealed:
-He did have a wound to his heel but it was healed.
-His legs were never elevated while sitting in his wheelchair.
-Staff did not take time to elevate his legs.
-When he was in bed his legs were elevated on a pillow.

Interview on 02/01/18 at 11:35 am with a personal care aide revealed:
-Resident #3 previously had a wound on his left heel but it had healed.
-The resident wore a bootie on the left foot at the request of Resident #3 and his family.
-The bootie was to prevent anymore wounds on the resident's heel.
-Resident #3 had to have his foot on the wheelchair foot rest with the bootie on.
-Resident #3's foot could not be on the floor, this was to reduce swelling.
-Resident #3 had a pillow on his bed to elevate the legs while in bed.
-She was not instructed by any staff to keep Resident #3's left foot on the wheelchair rest or

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elevated while in bed.
-She knew having the foot elevated reduced edema.
-Resident #3's legs were never elevated on the wheelchair leg extensions.
-She did not lift the resident's leg when he was sitting in his WC.
-She was did not know there was an order to lift the Resident's heel when he was in the WC or sitting up.

Interview on 02/01/18 at 6:15 pm with the Resident Care Director (RCD) revealed:
-Staff initialed the Medication Administration Record (MAR) referring to Resident #3 having his left foot on the wheelchair pedal or on a pillow in the bed.
-She thought having the bootie on his left foot and the left foot being on the wheelchair foot rest was considered elevated.
-Staff members never elevated Resident #3's legs higher than the foot rest.
-Resident #3's legs were always hanging down while sitting in the wheelchair.
-She could not recall the last visit Resident #3 had with the primary physician regarding edema to his left lower extremity.
-She went to the wound clinic with Resident #3 when he got the boot.
-The nurse said to keep the resident's foot from dragging the floor, so the wound did not open back up.
-The nurse did not put anything in writing, but she took the instructions to mean that elevating the resident's leg was putting his foot on the WC rest and off the floor.
-She had not contacted the physician at the wound clinic or Resident #1's primary care physician to clarify the meaning of elevating the resident's leg.

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D 276	Continued From page 17 Interview on 02/01/18 at 6:15 pm with the Administrator revealed: -Resident #3 wore the bootie daily on the left foot. -Staff put the resident's foot on mechanical extension foot rest on the WC. -Based on what the RCD told her, she considered elevating the Resident #1's leg meant "as long as the resident's foot was off the floor, it was elevated." -Resident #3's legs were never elevated higher than the foot rest when sitting in the wheelchair. -She did not think the swelling in Resident #3's leg was bad because she had seen the resident's leg when it swollen much worse. -The resident's WC was not capable of extending the leg to elevate it up in the air, off the floor. Interview on 02/01/18 at 4:30 pm with wound center staff revealed: -Resident #3 should have his legs elevated on the extended wheelchair leg. -The elevation would reduce swelling and prevent pressure on the heels. -Elevating the leg was to extend the leg up, so when the resident was sitting his leg up in the air. Interview on 02/02/18 at 9:37 am with the Physician Assistant (PA) revealed: -She had seen Resident #1 last week for urinary tract infection. -She had observed Resident #1 had the blue boot on because it very clear to see the boot. -She was did not know about the order to lift Resident #3's leg when in the WC and when sitting up. -The order came from the wound clinic because they treated the resident's wound and edema could possibly reopen the wound. -Until today, no one at the facility had clarified the	D 276		

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D 276	Continued From page 18 order to lift the resident's leg. -Today, staff said the resident's WC did not have means of raising the left rest, so she suggested to bring another in front of the resident's WC and elevate the leg. -Today, she also wrote an order to lay Resident #3 down every two hours and prop his leg up with pillows. -Today, observed some edema, but it was not too bad, however if he resident was sitting in an upright position all day, of course the edema would increase. -She would want to know if a resident's health was declining below what was considered baseline for that resident. Based on observation, interviews and record review the facility failed to implement health care orders as written by the residents primary care physician or other health care providers related to Resident #1's weakness, shortness of breath, and wearing oxygen; and Resident #3's increased swelling due his leg not being elevated. The facility's failure was detrimental to the health and safety of the residents and constitutes a unabated Type B Violation. The facility provided the following Plan of Protection: -Immediately, the facility notified the PCP and Resident #3 was assessed by the PCP and given new more specific orders. -Facility staff will be instructed to immediately contact the medical provider when Resident #1 show early signs of CHF or COPD and to follow the physician's orders. -The Administrator will schedule an in-service with a nurse (RN) to train all staff on what to look for (i.e. shortness of breath, swelling, weight gain, coughing, etc.) to ensure staff are knowledgeable	D 276		

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D 276	Continued From page 19 how to identify when a resident is in distress. -If staff identify any changes or concerns, it will be brought to the RCD and Administrator so an appointment can be made for the resident. -This will be done weekly for two months, then randomly thereafter. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 19, 2018.	D 276		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 3 sampled residents (Resident #2), with medication in his room, had a prescribing practitioner's order for the medication or to self-administer the medication. (Silvadene 1% cream an anti-bacterial cream to treat and prevent	D 375		

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D 375	Continued From page 20 infections in wounds and burns). The findings are: Review of Resident #2's current FL2 dated 12/11/17 revealed diagnoses included peripheral vascular disease (PVD), deep vein thrombosis (DVT), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), ventricular tachycardia, and hypertension. Review of Resident #2's record revealed: -A verbal physician order dated 09/06/17 and signed on 9/11/17 by the physician, clean left ankle wound with saline and apply Silvadene cream cover with dry dressing every pm. -An order for Home Health services for wound care start date 9/6/17. -An order dated 12/08/17 and signed by the physician on 12/11/17, discontinue cleaning of left ankle wound issue resolved. Observation on 1/31/18 at 10:50 am revealed: -Resident #2 was sitting in his wheelchair in his room, he removed a half used tube of cream from an unlocked top drawer on the night stand near his bed. -The cream had a pharmacy generated label, Silvadene 1% cream with the instructions to clean left ankle wound with saline, apply Silvadene cream, cover with dry dressing every evening, the label had a dispensed date of 09/06/17. -The resident removed a small unlabeled bottle of clear substance and a roll of paper towels from the night stand top drawer. -The resident removed dressing supplies, (non-stick secure adhesive dressing and paper tape) from the unlocked dresser top drawer located near the foot of his bed against the back wall of the room.	D 375		

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-Resident #2 took off his left shoe and sock.
-Resident #2's left leg was swollen and the sock left a circular indention around the entire calf approximately ½ inches into the skin of the bottom portion of the calf.
-Resident #2 removed a dressing to the left ankle.
-Resident #2 did not wash his hands or use hand sanitizer.
-Resident #2 had an ulcer to the outside area of the left ankle.
-The skin around the ulcer was a darker brown and this discoloration covered almost the entire ankle bony prominence.
-The dark area then turned to a dark red area about the size of a quarter.
-In the middle of the red area was a thick band of whitish/yellowish skin tissue that had separated from the open ulcer area.
-The ulcer opening had a whitish film over the area and an odor was present.
-There was a small amount of yellow drainage on the old dressing that Resident #2 removed from the left ankle ulcer.
-The extent of the ulcer could not be evaluated because of the old tissue.

Interview on 1/31/18 at 10:50 am with Resident #2 revealed:
-He had been applying Silvadene cream to his ulcer and wrapping it with gauze for 2 or 3 weeks.
-The ulcer had re-opened to the left ankle about 2 or 3 weeks ago.
-The ulcer to his left ankle had re-opened due to the increase in swelling to his legs, "the fluid has to come out somewhere."
-At one time both he and staff were completing dressing to the left ankle.
-Staff had left the Silvadene cream in his room, but Resident #2 would not say which staff had left

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it in the room.
-Staff had not made him aware the order for wound care using the Silvadene cream had been discontinued in December 2017.

Review of Resident #2's record revealed no order to self-administer the prescription medication Silvadene 1% cream or to complete wound care dressings.

Review of Resident #2's September 2017 electronic Medication Administration Record (eMAR) revealed:
-A pharmacy generated entry, clean left ankle wound with saline, apply Silvadene cream, cover with a dry dressing every evening scheduled for 8:00 pm.
-The wound care was documented as applied every evening from 9/7/17 through 9/30/17 the dressing was completed.

Review of Resident #2's October 2017 electronic Medication Administration Record (eMAR) revealed:
-A pharmacy generated entry, clean left ankle wound with saline, apply Silvadene cream, cover with a dry dressing every evening scheduled for 8:00 pm.
-The wound care was documented as applied every evening from 10/1/17 through 10/31/17 the dressing was completed.

Review of Resident #2's November 2017 electronic Medication Administration Record (eMAR) revealed:
-A pharmacy generated entry, clean left ankle wound with saline, apply Silvadene cream, cover with a dry dressing every evening scheduled for 8:00 pm.
-The wound care was documented as applied

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D 375	Continued From page 23 every evening from 11/1/17 through 11/30/17 the dressing was completed. Review of Resident #2's December 2017 electronic Medication Administration Record (eMAR) revealed: -A pharmacy generated entry, clean left ankle wound with saline, apply Silvadene cream, cover with a dry dressing every evening. -Documented entry on eMAR from 12/01/17 through 12/10/17 staff had signed off by initials the order was completed. -Documented "DC'd" on the eMAR entry for clean left ankle wound with saline, apply Silvadene cream, cover with a dry dressing every evening was discontinued on 12/10/17. Interview on 1/31/18 at 11:55 am with the facility physician revealed: -He or the nurse practitioner were in the facility three times weekly, on Monday, Wednesday, and Friday. -He was in the facility on 1/29/18, staff had not made him aware Resideint #2 had an increase in edema to his lower extremities or an ulcer to his left ankle. -He did not know the ulcer on Resident #2's left ankle had re-opened until 1/31/18. -He did not know the Silvadene cream was in Resident #2's room or that Resident #2 had completed his own dressing changes for 2 or 3 weeks. -He had not written an order to self-administer the prescription medication Silvadene 1% cream or the wound care dressing changes. -He had written an order for Resident #2 in Septmeber 2017 for wound care and home health services to provide wound care. -He relied on the facility staff to inform him of changes in the resident's condition.	D 375		

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D 375	Continued From page 24 -If he had known Resident #2 had an ulcer to the left ankle he would had treated it when he saw Resident #2 on 1/31/18. Telephone interview on 1/31/18 at 12:15 pm with the facility contract pharmacist revealed: -The pharmacy had dispensed one 85 gram tube of Silvadene cream on 9/6/17 for Resident #2. -The pharmacy did not have an order for Resident #2 to self-administer the prescription medication Silvadene 1% cream or to complete wound care. -The Silvadene cream should had been returned to the pharmacy after the order on 12/10/17 to discontinue. -The physician order instructions did not indicate Resident #2 could self-administer the Silvadene cream," it should not be left in the resident's room." Telephone interview on 2/1/18 at 3:30 pm with the Home Health nurse revealed: -She was familiar with Resident #2 and had worked with him previously in 2015 and 2016 for an ulcer to his left foot. -She had initiated services for Resident #2 in September 2017 for a left ankle ulcer. -She ordered wound care supplies which included gauze, nonstick pads, saline, gloves, and paper tape for her weekly visits and as needed. -She instructed the facility staff and Resident #2 on the dressing changes using aseptic technique to the left ankle ulcer. -Staff informed her that they were completing Resident #2's dressing changes to the left ankle daily at 8:00 pm. -All supplies were secured in the medication room and staff had access to the supplies. -She would obtain the supplies for her weekly visit from the MAs.	D 375		

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	HAL036004	A. BUILDING: _____ B. WING _____	R 02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD ASSISTED LIVING	721 NORTH MARIETTA STREET GASTONIA, NC 28052

(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 375	Continued From page 25	D 375		

-The prescription medication Silvadene 1% cream was kept on the med cart in the medication room.
-Resident #2's left ankle ulcer had improved but not completely healed on 11/7/17 when home health services were discontinued.

Telephone interview on 2/1/18 at 11:45 pm with the third shift Medication Aide (MA) revealed:
-She completed cart audits weekly with another MA on third shift.
-She could not recall seeing Resident #2's Silvadene cream in the med cart when she had completed the cart audits.
-She could not recall the Silvadene cream listed as retuned on the pharmacy log return book.
-"If it was on the cart when the order was to DC'd then I would had returned it to the pharmacy."
-"I don't remember seeing the Silvadene cream on the med cart."
-The facility policy for self-administer medications the residents must have an order from the physician prior to self-administering the medications.
-She thought Resident #2 had an order to self-administer his medications, "like creams and stuff."
-She could not locate the order to self-administer the prescription medication Silvadene 1% cream in Resident #2's record.

Interview on 1/31/18 at 1:45 pm with the first shift Personal Care Assistant (PCA) revealed:
-She was unaware Resident #2 had dressing supplies or the Silvadene cream in his room.
-Resident #2 completed his own shower and dressing task himself every day.
-She had not assessed Resident #2's skin for areas of concerns or open wounds.

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D 375	Continued From page 26 Interview on 02/01/18 at 9:30 am with the housekeeping staff revealed: -Her job responsibility included, sweeping, mopping, cleaning resident's rooms and the common areas in the facility. -She knew of a box of disposable gloves in the top dresser drawer located in Resident #2's room. -She did not know of the medication Silvadene cream in Resident #2's room. -She knew the Administrator implemented a deep cleaning schedule for the weekly rooms. -She did not complete deep cleaning to Resident #2's room due to "he did not like anyone going in his night stand drawers or the dresser drawers." -Resident #2, "Is very independent and does not like anyone going through his stuff." Interview on 1/31/18 at 12:45 pm with the Resident Care Director (RCD) revealed: -She was unaware Resident #2 had been completing dressing changes to he left ankle ulcer for 2 or 3 weeks. -She was unaware the prescription medication Silvadene 1% cream and the dressing supplies were in Resident #2's room. -Resident #2 did not have an order to self-administer the Silvadene cream or to complete the dressing changes. -She was unsure how the Silvadene cream and the dressing supplies got into Resident #2's room. -The facility policy on self-administer medications was the physician had to write an order for self-administer medication. -Maybe Resident #2's family member brought the cream into the facility. -The facility policy was all medications and supplies are to be stored and locked in the medication room.	D 375		

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D 375	Continued From page 27 Interview on 2/31/18 at 1:05 pm with the Administrator revealed: -She was aware Resident #2 had a history of ulcers to the left foot and had wound care orders in the past. -She was aware in September 2017 the physician had ordered dressing changes for Resident #2's left ankle using the prescription medication Silvadene cream. -She knew the physician had ordered Home Health to evaluate and treat the ulcer in September 2017. -She knew Resident #2 did not have an order to self-administer the Silvadene cream or to complete wound care dressing changes. -She did not know Resident #2 had the Silvadene cream and dressing supplies in his room. -She did not know Resident #2 had completed wound care daily to the left ankle for 2 or 3 weeks without a self-administration order from the physician. -The facility policy was all medication were to be kept in the medication room under lock for all medications for the residents. -The physician must write an order for residents to self-administer medications that is the policy. -Staff knows the residents are not to have any medications in their rooms without an order to self-administer. Review of Resident #2's wound clinic notes dated 2/2/18 revealed: -Resident #2 history included previous visits to the wound clinic for treatment of ulcers on the left heel. -Resident #2 was seen at the wound clinic on 2/2/18 chef complaint "sore on my ankle". -Physical exam included 3+ edema bilaterally with mottling of the calf region. -Documentation on the left ankle there was a scar	D 375		

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D 375	Continued From page 28 with a full thickness ulcer. -Documented the physician had performed a debridement of the ulcer and removed tissue and slough. -Documented the reason for debridement was to "stimulate granulation, and help to prevent recurring infection."	D 375		
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 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure medications (Silvadene 1% cream) were stored safely and securely for 1 of 3 residents (Resident #2). The findings are: 1. Review of Resident #2's current FL2 dated 12/11/17 revealed: -Diagnoses included peripheral vascular disease (PVD), deep vein thrombosis (DVT), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD) and hypertension. -Personal care assistance was documented assist with bathing, feeding and dressing. -Ambulatory status was documented semi-ambulatory, wheelchair.	D 378		

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D 378	Continued From page 29 Review of Resident #2's record revealed: -A verbal physician order dated 9/6/17 and signed on 9/11/17 by the physician, clean left ankle wound with saline and apply Silvadene (An anti-bacterial cream used in wound care) cream cover with dry dressing every pm. -A verbal order dated 12/08/17 and signed by the physician on 12/11/17, discontinue clean left ankle wound issue resolved. Observation on 1/31/18 at 10:50 am revealed: -Resident #2 was sitting in his wheelchair in his room, he removed a used tube of cream from an unlocked night stand top drawer near his bed. -The cream had a pharmacy generated label, Silvadene 1% cream, the label had a dispensed date of 9/6/17. -The resident removed a small unlabeled bottle of clear substance from an unlocked top dresser drawer near the foot of his bed against the back wall of the room. -The resident removed the dressing supplies, (non- stick secure adhesive dressing and paper tape) from the unlocked top dresser drawer also. Interview on 1/31/18 with Resident #2 revealed: -He had completed wound care to his left ankle for the past 2 or 3 weeks. -The left ankle wound had re-opened about 2 or 3 weeks ago. -The wound to his left ankle had opened up due to "increase in swelling to his legs." -At one time he and staff had completed dressing changes to the left ankle. -Staff had brought the Silvadene cream into his room, but Resident #2 would not say which staff had brought it to him. -"I hide my supplies so staff does not find it in my room".	D 378		

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D 378	Continued From page 30 Review of Resident #2's record revealed no order to self-administer the Silvadene cream or to complete wound care. Interview on 1/31/18 at 11:55 am with the facility physician revealed: -He was not aware of the ulcer on Resident #2's left ankle. -He was not aware the Silvadene cream was in Resident #2's room. -He had not given an order for Resident #2 to self-administer the Silvadene cream or to complete dressing changes. -He relied on the facility staff to inform him of changes in the resident's condition and issues that occur. Telephone interview on 1/31/18 at 12:15 pm with the facility's contract pharmacist revealed: -The pharmacy had dispensed one tube of Silvadene 1% cream on 9/6/17. -There was not an order for Resident #2 to self-administer the Silvadene cream. -"I would hope the facility would not give the Silvadene cream to the resident after it had been discontinued." -The physician instructions do not say Resident #2 could self-administer the Silvadene cream," it should not be left in the resident's room." Telephone interview on 2/1/18 at 3:30 pm with the Home Health nurse revealed: -She initiated services for Resident #2 in September 2017 for a left ankle ulcer. -She ordered wound care supplies which included gauze, nonstick pads, saline, gloves, and paper tape for her weekly visits and as needed. -All supplies were secured in the medication room and staff had access to the supplies.	D 378		

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-She would obtain the supplies for her weekly visit from the MAs.
-She had left no supplies or the tube of Silvadene cream in Resident #2's room.
-The prescription medication Silvadene 1% cream was kept on the medication cart in the medication room.
-Resident #2's left ankle ulcer had improved but not completely healed on 11/7/17 when home health services were discontinued.

Telephone interview on 02/01/18 at 11:45 pm with the third shift Medication Aide (MA) revealed:
-The third shift MAs were responsibility for signing medications into the facility and returning medications to the pharmacy.
-The pharmacy courier delivered and picked up returned medications on third shift.
-She documented returned medication and signed off on the facility pharmacy log book.
-She was responsible for medication cart audits weekly, together with another MAs who worked third shift.
-She did not document when the cart audit were completed weekly.
-"I don't remember seeing the Silvadene cream on the med cart."
-She thought Resident #2 had an order to self-administer his medications, "like cream and stuff."
-She could not locate the order to self-administer the Silvadene cream in Resident #2's record.

Interview on 1/31/18 at 12:45 pm with the Resident Care Director revealed:
-She did not know Resident #2 had Silvadene cream and the dressing supplies in his room.
-She was unsure how the Silvadene cream got into Resident #2's room.
-The facility policy was all medications and

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supplies are to be stored and locked in the medication room.

Interview on 01/31/18 at 1:05 pm with the Administrator revealed:
-She knew Resident #2 had a history of vascular wounds to the left foot.
-She did not know Resident #2 had the Silvadene cream and dressing supplies in his room.
-The facility policy was all medications were to be kept in the locked medication room.
-Housekeeping were to complete a "deep cleaning" of 4 rooms a week, this included cleaning out all resident's drawers and cabinets.
-Staff were to report to the Administrator if anything in the resident's rooms was found.
-Staff knew the residents are not to have any medications in their rooms without an order to self-administer.

Interview on 1/31/18 at 1:45 pm with the first shift Personal Care Assistant (PCA) revealed:
-She was unaware Resident #2 had dressing supplies or the Silvadene cream in his room.
-The housekeeping staff completed deep cleaning in resident's room weekly.
-Resident #2 did not like staff going through his room or his dresser drawers.

Interview on 02/01/18 at 9:30 am with the housekeeping staff revealed:
-Her job responsibility included, sweeping, mopping, cleaning resident's rooms and the common areas in the facility.
-She knew of a box of disposable gloves were in the top dresser drawer located in Resident #2's room.
-She did not know the medication Silvadene cream was in Resident #2's room.
-She knew she was required to deep clean

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D 378	Continued From page 33 resident rooms, and she was required to complete four rooms weekly. -She did not complete deep cleaning to Resident #2's room due to "he did not like anyone going in his night stand drawers or the dresser drawers." -Resident #2, "Is very independent and does not like anyone going through his stuff." -She had not made the Administrator aware she had not completed deep cleaning to Resident #2's room. Review of the facility medication policy revealed: -"All medications will be stored properly in the med room." -"All Medication Aides (MA) have the full responsibility to assure medications are administered as ordered by the resident respective physician." -"The facility director and the MAs will have key to the medication room." -"MAs on first shift will monitor the medications administration record (MAR), controlled substance, and med storage weekly, the director will monitor all these areas monthly."	D 378		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure each resident	{D912}		

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{D912}	Continued From page 34 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 implementation. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure implementation of orders for 2 of 3 sampled residents (Residents #1 and #3) with physician orders for continuous oxygen for shortness of breath related to heart disease, respiratory failure and chronic obstructive pulmonary disease (COPD) for Resident #1, and a order to elevate the resident's leg to reduce swelling in the lower extremities for Resident #3. [Refer to tag 0276,10A NCAC 13F .0902(c)(3-4) Health Care Implementation (Type B Violation)].	{D912}		