STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARILLON ASSISTED LIVING OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(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 Wake County Department of Social Services conducted a follow-up survey and complaint investigation from 10/02/18 - 10/04/18. The complaint investigation was initiated by the Wake County Department of Social Services on 09/18/18.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 6 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR). The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 02/14/17. -Staff A worked as a Medication Aide/Supervisor (MA/Supervisor). -Staff A usually worked on 3rd shift. -There was no documentation that a HCPR check was completed. Interview with Staff A on 10/04/18 at 3:30 pm revealed: -She had worked at the facility for about 1 year as	D 137		

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a MA/Supervisor.
-She usually worked 3rd shift.
-She had no idea if a HCPR check had been performed or not.

Interview with the Business Office Manager (BOM) on 10/04/18 at 11:25 am revealed:
-She had been working as the BOM for about 8 weeks.
-Staff A was hired before she became the BOM.
-The HCPR check should have been completed by the previous BOM.
-The HCPR check should have been in Staff A's personnel record, but it was not.
-She had no idea if the HCPR check was performed for Staff A.
-The BOM was responsible for maintaining the employee records for accuracy.

Interview with the Resident Care Coordinator (RCC) on 10/04/18 at 11:40 am revealed:
-The BOM was responsible for maintaining personnel records.
-The BOM assured accuracy and completion of the required documentation in employee records.

Interview with the Administrator on 10/04/18 at 11:30 am revealed:
-The BOM maintained the employee records.
-The BOM had begun auditing employee records for accuracy and made any corrections immediately.
-There was no schedule for the audits, the BOM performed the audits when she had time available to complete the task.

Review of the HCPR check for Staff A dated 10/04/18 revealed no findings.

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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 A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide the needed supervision to 3 of 5 residents (#1, #4, #5) who had a history of falls (#1, #5) and identified behavior that triggered agitation (#4). The findings are: 1. Review of Resident #1's current FL-2 dated 08/16/18 revealed: -Diagnoses included dementia, amnesia, failure to thrive, hypertension, hypercholesterolemia, peripheral vascular disease, cardiac arrhythmia, and osteoarthritis of hip. -The resident was intermittently disoriented. -The resident was ambulatory and required assistance with bathing and dressing. -The resident's level of care was Special Care Unit (SCU). Review of Resident #1's Resident Register dated 08/15/18 revealed: -The resident was admitted to the facility on 08/15/18.	D 270		

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D 270	Continued From page 3 -The resident had significant memory loss and had to be directed. Review of Resident #1's Preadmission Assessment dated 07/27/18 revealed: -The resident scored 3 (extensive hands on assistance) with toileting, ambulation, bathing, and dressing. -The resident scored 4 (totally dependent, 100% hands on assistance) with "Stability/Falls Risk, Endurance Level, Bladder/Bowel Control Assistance, Activities Assistance, and Grooming." -The resident was assessed as "Continuous Impairment" with level of awareness, time and place orientation, decision making and wandering. -There was no "Post-Admission Assessments". Review of Resident #1's LHPS dated 08/24/18 revealed: -The resident resided in the facility's SCU due to dementia. -The resident was evaluated for ambulation using assistive devices, wheelchair that required physical assistance. -The staff reported combative and aggressive behaviors continuously as they provided personal care. -The staff reported that when the resident was placed in bed, he slid out to the floor; consequently the resident was left in the chair in the dayroom. -There were numerous bruises, small and great all over his body, consistent with anti-coagulant therapy. -When staff attempt to transfer him, he would say he was ready to move but as the staff tried to raise him to move, he yelled "Wait, Wait", and the resident's body got limp. -The resident was stiff and very heavy.	D 270		

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D 270	Continued From page 4 -The resident must be observed constantly as he unexpectedly attempted to stand. Review of Resident #1's records revealed the resident had 6 falls from 08/21/18 to 08/26/18. Review of Resident #1's Progress Notes revealed: -On 08/16/18 at 9:14 pm, while staff was assisting the resident with dressing and grooming, the resident became weak and sat down on the floor; no injury reported. -On 08/21/18 at 2:38 am, the resident was found on the floor; the resident was assisted to the wheelchair and monitored by staff during 3rd shift. -On 08/21/18 at 4:08 am (late entry), the resident was found on the floor; the resident stated "I am not hurt"; the resident was placed back in bed with the help of staff. -On 08/21/18 at 6:45 am, the staff brought the resident up front (TV/day room) to watch him because he was up walking around. -On 08/22/18 at 4:00 am, the resident had difficulty falling asleep; the resident continued to get out of bed several times through-out the night; staff members assisted the resident to wheelchair and resident continued to be monitored during 3rd shift. -On 08/22/18 at 4:15 pm, the resident was sitting in the dining room and slipped out of his chair. -On 08/22/18 at 6:15 pm, the resident fell while trying to switch chairs; the resident had a skin tear from scraping the chair. -On 08/23/18 at 2:56 am, the resident continued to get out of bed and was trying to walk; the resident sat in a wheelchair and was placed in the TV room; the staff monitored the resident every hour to prevent resident from fall because he continued to try to get out of a wheelchair.	D 270		

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-On 08/23/18 at 5:07 am, the resident was sitting in a chair when he started to slide onto the floor.
-On 08/23/18 at 4:30 pm, the resident was unable to stand to transfer to chair so it took 2 staff to transfer the resident into a wheelchair.
-On 08/24/18 at 11:00 am, the Regional nurse looked at the resident and reported that the resident's blood pressure (BP) was 190/100. The resident was sent to the hospital for an evaluation. At 5:00 pm, the resident returned from the hospital, the resident was very combative and would not let staff assist him; the resident was monitored for behavior changes.
-On 08/26/18 at noon, the resident fell off his bed onto the floor and had a bruise on his right side of his head towards the top.
-Notified the Administrator and she instructed to send the resident out to the hospital to be evaluated.
-On 08/28/18 (no time), the resident's family member called to notify the facility that the resident was not coming back to the facility and he was going to hospice.

Review of Accident/Incident Reports for Resident #1 revealed:
-08/17/18 at 9:30 am, the resident had bruise on his left elbow and left buttocks area.
-08/18/18 (no time), the resident had bruises on his left hand and wrist area.
-08/19/18 at 8 am, the resident had bruises on his left rib area that had a scratch on it.
-08/22/18 at 4:30 pm, the resident had bruises on his left toes of his left foot.
-All bruises were reported to the resident's primary care physician (PCP) and the power-of-attorney (POA).
-There were no incident reports for the 08/21/18, 08/22/18 or 08/23/18 falls in the resident record.
-08/26/18 at noon, the resident fell off the bed

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onto the floor. The resident had a bruise on the right side towards top of the head. The fall was unwitnessed. The Administrator instructed the staff to send Resident #1 out to be evaluated. The resident was sent to the hospital.

Review of the Emergency Department (ED) Provider Notes dated 08/24/18 for Resident #1 revealed:
-The resident was admitted to the ED at 11:50 am due to elevated blood pressure and agitation.
-The resident had been combative recently with staff and other residents.
-The resident had fallen; he had slid out of his bed.
-When the facility staff checked the resident's blood pressure this morning, it was elevated at 190/100.
-The resident had bruising to the left hip and left foot.

Review of the Emergency Medical Services (EMS) Report for Resident #1 dated 08/26/18 revealed:
-EMS call was received at 12:05 pm.
-The staff reported that the resident was found by staff at noon on the floor by his bed; unsure of exact time of fall.
-The resident was wheelchair bound and had a fall from his bed.
-The staff placed the resident in a wheelchair in living room and then noticed he had a bruise/hematoma to head.
-The resident was unable to communicate with EMS staff due to dementia; unable to locate and verbalize pain.
-The resident was transported to trauma room.

Review of the ED Provider Notes from 08/26/18 to 08/28/18 for Resident #1 revealed:

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D 270	Continued From page 7 -The resident was admitted to the ED after a fall. -The resident had a closed nondisplaced C2 fracture; likely to worsen once intravenous fluid stopped. Interview with Resident #1's family member (FM) on 09/18/18 at 8:30 am revealed: -She placed the resident at the facility's SCU on 08/15/18 as a respite care for 2 weeks period, 08/15/18-08/29/18. -The facility staff came to the resident's house to perform a pre-assessment before the resident was placed. -During the pre-assessment, the FM reported to the assessor that the resident had been falling a lot at home and he was a high fall risk because she wanted to make sure that the facility was aware of all his needs. -The assessor told her that the resident was a perfect fit for the facility because he was not combative or aggressive. -The assessor did not address what the facility's plan was for the falls. -On 08/15/18, during the resident's admission, she noticed that the bed was a single size bed so she asked the facility if she could put bed rails to the bed since the resident was used to sleeping on double size bed at home. -The facility staff told her that the rails were considered restraints so could not put them on the bed. -On 08/26/18, the resident fell and broke his neck and his back. -She was given two different stories from a staff as to how the resident fell; the resident fell out of bed and then the resident was seated and fell as he tried to get up and an aide was with the resident prior to the fall, could not assist the resident so she left the resident to get help. -After being discharged from the hospital, the	D 270		

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D 270	Continued From page 8 resident was admitted to the hospice care. -On 08/29/18, the resident passed away. Confidential interview with a staff revealed: -The staff was not told Resident #1 was a high fall risk when the resident was initially admitted. -Soon after Resident #1 came to the unit, realized he was a fall risk because he could not walk on his own, he was in a wheelchair and needed assistance with transfers. -Resident #1 needed staff help getting in and out of bed but he tried to get out of bed by himself. -He could not be left alone. -The facility's usual protocol for fall risk was staff were not to leave the residents alone, watch them, eliminate obstacles in their rooms, and pay extra attention. -Resident #1 required assistance with dressing (sometimes took 2-3 staff to dress him), toileting and sometimes eating. -It was hard to communicate with the resident due to his dementia. -The resident was a fall risk; he could not walk by himself; used the wheelchair and most of the time the staff pushed the wheelchair. -One time the resident fell out of bed and went to the hospital. -The staff were instructed to check on the fall risk residents every 2 hours when they were in their room. -There was no specific instruction for Resident #1's fall risk. -The staff tried to keep Resident #1 in the front room with other fall risk residents to keep an eye on him. Confidential interview with a second staff revealed: -No one from the facility had told her Resident #1 was a fall risk.	D 270		

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D 270	Continued From page 9 -The resident's family told the staff that he fell and staff needed to watch him. -Resident #1 was big and heavy so sometimes the staff needed more than one staff with transfer assist and personal care. -The resident could not do much for himself. -The resident mostly stayed in the TV room. -The staff had not witnessed Resident #1's falls, but heard from other staff about the falls. -This staff was not told of any specific plan for the resident's falls other than use more staff to help him with care. Confidential interview with a third staff revealed: -Resident #1 was tall and heavy so he required physical assistance with all his activities of daily living. -Some days, the resident was combative so sometimes it required minimum of 2-3 staff to assist with care. -The staff were not aware Resident #1 was a fall risk; no one had told the staff the resident was a high fall risk. -It was during personal care the staff realized the resident was a high fall risk because the resident could not stand on his own and tried to slide down to the floor. -The staff reported the incident to the former Resident Care Director (RCD) and to the next shift supervisor. -This staff did not witness Resident #1's falls. -The former RCD gave no specific instruction as to how to deal with Resident #1's falls but to use more staff when providing personal care to the resident. -When Resident #1 sat in the wheelchair or regular chair, the resident would start sliding out of the chair. -The staff did not provide one-on-on care for Resident #1 because there were other residents	D 270		

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to care for.
-The staff did not know the facility's fall protocol so there was no way the staff could have implemented anything for the resident's falls other than place the resident in the front room.

Confidential interview with a fourth staff revealed:
-The staff was not aware that Resident #1 was a fall risk.
-The staff was told by the 3rd shift staff that the resident had fallen during their shift so the staff knew then the resident was a fall risk.
-The staff was not given instruction for Resident #1's fall risk needs.
-This staff had witnessed one fall for Resident #1; the resident tried to transfer himself from a wheelchair to a dining room chair.

Interview with the SCU Director on 10/02/18 at 2:35pm-3:15pm revealed:
-Resident #1 was a resident for 2 weeks in the SCU.
-Resident #1 was pre-assessed by the former Resident Care Director (RCD), who was a Licensed Practical Nurse (LPN), at the resident's residence prior to the admission.
-Usually after a resident falls, it was the RCD's responsibility to assess the resident's supervision needs.
-She did not know Resident #1 was a fall risk.
-She was told that someone was coming to the SCU and "he would be an easy person".
-Resident #1's family told her that the resident could walk to the bathroom, go to the bathroom by himself, and he only needed reminders.
-On the day of admission, she realized that he was a high fall risk when he could not stand on his own and it was hard to transfer the resident.
-If she had known the resident was a fall risk, she would have put interventions in place such as

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bed/chair alarms or scoop mattresses.
-There was no interventions put in place for him by the RCD.
-She had never seen him fall but had seen him aggressive and combative.
-Resident #1's 1st fall happened on 08/22/18 during lunch time when two staff were helping him transfer from a wheelchair to a chair in a dining room.
-The resident became combative and swung arms around so the staff lost hold of him and the resident had a "butt fall".
-The resident had some bruising and he was sent to the ER.
-After the 08/22/18 fall, the staff started putting the resident in his room for an hour before lunch to rest and calm him down.
-The resident was monitored in bed because he tried multiple times where he would get up from the bed, chairs in the dining room and a wheelchair.
-The resident would sit on the edge of bed to try to get up and he would slide to the floor.
-Resident #1's second fall happened on 08/26/18 in his room, staff was getting him ready for lunch and he was having episodes of combative behaviors.

Interview with the Administrator on 10/03/18 at 4:00 pm revealed:
-It was the facility's RCD's responsibility to perform preassessments of the potential residents because she was a LPN.
-The former RCD had been with the facility a little over a month and her last day of employment was 08/22/18.
-The former RCD went to Resident #1's residence to perform the assessment.
-Once the assessment was completed, the preassessment and FL-2 were submitted to their

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home office for the Regional clinical team to review to ensure the resident was a good fit for the community.
-She did not remember if she had reviewed Resident #1's preassessment form or not because she did not know the resident was a fall risk.
-Resident #1 was admitted to the facility's SCU as a respite care while the family went on a vacation.
-She was aware of Resident #1's 08/22/18 and 08/26/18 falls.
-After the former RCD left the facility's employment, she and the Assisted Living Unit Coordinator were trying to handle all of Resident #1's needs.
-She did not recall the exact date of contact, but the facility tried to communicate with Resident #1's PCP to put fall interventions in place after the falls, but the PCP had not responded to the facility's contacts and the family was out of state on vacation.
-In August 2018, there were two regional nurses who took turns coming to the facility on weekly basis (once or twice a week).
-She did not have the details of what the regional nurses did.
-She was aware that the staff were trying to monitor the resident by keeping the resident close to staff.
-She was trained on the facility's fall protocol.
-All staff were trained on the facility's fall protocol during their orientation after a hire.

Review of the facility's "Fall Prevention Protocol" revealed:
-"Should a resident be identified as having a higher pattern of falls than what is considered normal for their individual baseline, measures will be implemented for that particular resident in an effort to identify any possible changes in the

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resident's condition that may contribute to falls and to reduce the potential for future falls."
-For any resident with 2 or more falls in one week, the Regional Nurse would follow the resident for the next 6 weeks on the "CKI summary" (an internal quality assurance document) to determine if advanced levels of care were necessary.

Attempts to contact Resident #1's PCP were made on 10/03/18 at 4:50 pm and 10/04/18 at 8:00 am, however, the attempts were unsuccessful.

2. Review of Resident #5's current FL-2 dated 02/01/18 revealed:
-Diagnoses included Alzheimer's disease, essential hypertension, hypothyroidism, urinary tract infection.
-She was constantly disoriented.
-She was admitted to the Special Care Unit (SCU).

Review of Resident #5's assessment and care plan signed by physician on 07/10/18 revealed:
-She required supervision for safety when ambulating.
-She was monitored for safety during transfers.
-She was always disoriented.
-She has significant memory loss and must be directed.
-She was a wanderer.
-She was currently receiving medication for mental illness/ behavior.

Review of Resident #5's progress notes revealed:
-Progress note dated 06/12/18 at 2:00 pm that resident was pushed by another resident and landed on the floor on her left hip.

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-Progress note dated 06/13/18 at 1:00 pm that noted small scratch to left hip.
-Progress note dated 07/25/18 at 1:45 pm that resident stuck her hand in another resident's food and the resident struck her.
-Progress note dated 09/11/18 at 2:00 pm that resident was sitting on the edge of bed and slid off the bed.
-Progress note dated 09/16/18 at 6:20 pm that resident fell while walking in the dining room onto her right hip and twenty minutes later she was walking by another resident who tried to help her walk and they both fell.
-Progress note dated 09/23/18 at 12:27 pm that resident was acting like her leg was hurting and when staff tried to move her she "winced to her leg" at which time hospice was called.
-Progress note dated 09/23/18 at 2:15 pm that resident's family member was notified about resident not acting herself and pain in left leg.
-Resident #5's family member did not want resident sent to Emergency Room.
-Hospice instructed that 2:00 pm meds be held, give Tylenol for pain and monitor resident.
-Progress note dated 09/24/18 at 12:20 pm that portable x-ray was done.
-Progress note dated 10/03/18 at 5:00 pm that resident was resting in a chair and stood up quickly and fell sideways, RCD did not send out.

Review of Resident #5's Accident Reports revealed:
-An incident was witnessed by staff on 06/08/18 at 1:30 pm when Resident #5 was hit and scratched by another resident on left side of her face.
-Resident #5's family member and hospice were notified of incident and per the follow-up accident report the resident's was assessed with the intervention that the left side of her face was kept

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clean and dry.
-An incident was witnessed by staff on 06/12/18 at 2:00 pm when Resident #5 was pushed to the ground by another resident and hit her hip when she landed on the floor.
-Emergency Medical Service was called and resident was assessed with the decision that "she did not need to be sent out".
-Resident #5's family member and physician were notified, a 24-Hour Post Fall Checklist was completed on 06/13/18 at 2:00 pm and a Post Fall Checklist was completed on 06/13/18 at 9:00 am.
-There was also a follow-up accident report where the resident was assessed but there was no intervention noted.
-An incident was witnessed by staff on 09/11/18 at 10:30 am when Resident #5 was sitting on the edge of a bed and slipped unassisted off the bed onto the floor.
-Resident #5's family member and physician, who was in the facility were notified of incident and a Post Fall Checklist was completed 09/11/18 at 10:45 am.
-An incident was witnessed by staff on 09/16/18 at 6:20 pm when Resident #5 was walking in the dining room and fell onto her right hip.
-Resident #5's family member, physician and hospice were notified of incident and a Post Fall Checklist was completed 09/16/18 at 6:25 pm.
-An incident was witnessed by staff on 09/16/18 at 6:45 pm when Resident #5 was walking by another resident, that resident went to help her and they both fell.
-Resident #5's family member and physician were notified of incident and a Post Fall Checklist was completed 09/16/18 at 6:50 pm.
-An incident was witnessed by staff on 09/22/18 at 6:00 pm when Resident #5 was pushed by another resident and fell on the floor in the dining

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room at which time she had noticeable signs of discomfort in left leg.
-Resident #5 was placed in a wheelchair and given pain medication, Tylenol 500 milligram with plan to observe for next 24 hours.
-Resident #5's family member was notified 09/23/18 and no date as to when hospice was notified of incident, a 24-Hour Post Fall Checklist was completed on 09/23/18 at 6:00 pm and a Post Fall Checklist was completed on 09/23/18 at 4:05 pm.
-An incident was witnessed by staff on 10/03/18 at 4:30 pm when Resident #5 was resting in a chair, she abruptly stood up and fell sideways to the floor.
-Resident #5 was assessed by the Resident Care Director who was a Licensed Pracital Nurse and determined that facility staff would continue to monitor in house.
-Resident #5's family member, physician and hospice were notified of incident and a 24-Hour Post Fall Checklist was started on 10/03/18 at 4:30 pm.

Review of Resident #5's 24-Hour Post Fall Checklists for 09/22/18 revealed:
-At the 8 hour documentation scheduled for 09/23/18 at 2:00 am it was documented that Resident #5 had pain/ discomfort, had change in walking ability, had increased drowsiness and had trouble or was reluctant to get out bed.
-At the 16 hour documentation scheduled for 09/23/18 at 10:00 am it was documented that Resident #5 had pain/ discomfort, had increased drowsiness and had trouble or was reluctant to get out bed.
-At the 24 hour documentation scheduled for 09/23/18 at 6:00 pm it was documented that Resident #5 had pain/discomfort, had change in walking ability, had increased drowsiness and

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had trouble or was reluctant to get out bed.
-The directions given if Resident #5 had pain/ discomfort, had change in walking ability, had increased drowsiness, had trouble or was reluctant to get out bed was to "have the RCD assess if available or call the doctor for directions and notify the family or responsible party".
-There were no documentation in the progress notes that all these directions were followed.

Interview with the Regional Nurse on 10/03/18 at 2:45 pm revealed:
-The proccess of the facility's "Fall Prevention Protocol".
-That clinical key indicators (CKI) are done weekly.
-If a resident had at least two falls within a week, level I CKI was initiated which would implement physical therapy (PT) and occupational therapy (OT).
-If resident continued to fall while on level I CKI they are moved closer to nursing station and staff monitor with eyes on resident every hour.
-Level II CKI entails continued PT, OT and possible speech therapy, care conference with family concerning getting hipsters, chair/ bed alarm or assess for higher level of care.
-Level III entails looking at level I and II to see if things have been implemented, consult with physician for more interventions or higher level of care.
-She was not familiar with Resident #5's care because she was new to the position.
-However, if Resident #5 was found to be a falls risk, these were the proccess which the facility would have initiated for her.
-The facility's management staff monitored staff to make sure that they knew how to address residents' behavior and signs to watch for.
-The facility would consult home health nurse to

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in-service staff.
-If resident had a lot of falls then a higher level of care would be looked at and consult with family for possible sitter.
-The medication aides (MA) are constantly monitored to see if there was a need for in-service of staff.
-The nursing staff in the community communicated information to staff about resident's care.
-Post aggressive assessments are used to review episode of behaviors and consult physician for as needed medication.
-With incidents with behavior the facility looked to see what was already done and what needed to be done.
-That in the absence of the Resident Care Director (RCD), who is usually a nurse, The Resident Care Coordinator (RCC) on the Assisted Living would address any incidents by reaching out to Regional Nurse.
-Information about dementia was addressed in the 80 hour personal care class.

Interview with the medication aide (MA) in the SCU on 10/04/18 at 5:20 pm revealed:
-Resident #5 was a wanderer and we pay close attention to her.
-Resident #5 was redirected and tried to keep her busy.
-Resident #5 had a left hip fracture from an altercation with another resident on 09/22/18.
-The MA completed a 24 hour post fall checklist.
-Resident #5 had a portable x-ray of left hip ordered by Hospice on 09/24/18.
-The facility was instructed by Hospice to administer Morphine every 8 hours, keep resident in bed and get her up for meals.

Review of x-ray results dated 09/24/18 revealed

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that Resident #5 had an acute sub capital left femoral fracture with mild valgus angulation.

Interview with a personal care aide (PCA) in the SCU on 10/04/18 at 10:10 am revealed:
-Resident #5 was a wanderer and a falls risk.
-Staff kept an eye on her and redirected her when she wanders into another resident's room.
-We were informed about any adjustments to her care by the Resident Care Director (RCD).

Interview with the SCU Director on 10/04/18 at 10:35 am revealed:
-She monitored the facility's SCU.
-If a resident falls the RCD assessed for possible broken bones or if resident was in obvious pain and emergency medical service (EMS) would be called.
-There was no RCD on 09/22/18 when Resident #5 fell.
-The MA did an assessment and decided not to call EMS but to administer pain medication and monitored.

Interview with Resident #5's family member on 10/04/18 at 11:20 am revealed:
-She was called by the hospice nurse and informed that Resident #5 had fallen on the floor of the dining room on 09/22/18.
-She did not want Resident #5 sent to the hospital because she did not react well in that setting.
-There was nothing that the hospital would do because resident was not a candidate for surgery.

Interview with the Administrator on 10/04/18 at 11:55 am revealed:
-Resident #5 liked to walk.
-The facility tried to ensure that a staff person was watching her by keeping her in the common

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areas such as the living room or making sure she was included in activities.

Interview with Hospice Nurse on 10/04/18 at 12:39 pm revealed:
-Hospice did an as needed visit to facility on 09/23/18 when they were informed by the facility staff that Resident #5 fallen on 09/22/18.
-Hospice Nurse called Resident #5's family member and informed her of resident's fall on 09/22/18.
-Resident #5's family member did not want resident sent out to ER but was in agreement to have a portable x-ray of the left hip done.
-Facility staff monitored Resident #5 more closely by making sure they had eyes on her at all times while awake and keep her out of other residents' rooms.

3. Review of Resident #4's current FL-2 dated 02/07/18 revealed:
-Diagnoses included Alzheimer's disease, gait instability with falls, agitation, and orthostatic hypertension (HTN).
-The resident had constant disorientation.
-The resident was ambulatory and was incontinent with bladder and continent with bowel.
-The resident's level of care was Special Care Unit (SCU).

Review of Resident #4's Resident Register revealed:
-The resident was admitted to the facility on 08/27/15.
-The resident required assistance with dressing, bathing, toileting, grooming, and scheduling appointments.

Review of Resident #4's Care Plan dated 02/01/18 revealed:

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D 270	Continued From page 21 -The resident was always disoriented. -The resident has significant memory loss, must be directed -The resident required extensive assistance with toileting and limited assistance with eating, bathing, dressing, and grooming. Review of the Accident/Incident Report dated 06/12/18 for Resident #4 revealed: -At 2:00 pm Resident #4 was sitting at a table in the dining room, when another resident put her hand into Resident #4's food. -The other resident was pushed to the floor by Resident #4. -This incident was witnessed by staff. -The other resident was injured by her fall to the floor. Review of the facility's "Post Combative/Aggressive Checklist" dated 06/13/18 (for the 06/12/18 incident) for Resident #4 revealed: -The resident was able to be redirected. -A resident was harmed in the incident. -The injured resident complained of pain. -There were events that provoked the resident to become agitated/combative. Review of the Accident/Incident Report dated 09/22/18 for Resident #4 revealed: -At 6:00 pm, the Resident #4 became agitated when another resident would not leave her alone. -Before staff could redirect the other resident, the Resident #4 pushed the other resident to the floor. Review of the facility's "Post Combative/Aggressive Checklist" dated 09/22/18 for Resident #4 revealed: -The resident was able to be redirected.	D 270		

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-A resident was harmed in the incident.
-The injured resident complained of pain.
-There were events that provoked the resident to become agitated/combative.

Review of Resident #4's Progress Notes revealed:
-On 06/13/18 at 1:00pm, the resident pushed another resident on the 06/12/18; no behaviors noted today.
-On 10/02/18 at 4:30pm, the resident pushed another resident to the floor; the resident didn't display any more aggressive behavior after.

Review of Resident #4's Licensed Health Professional Support (LHPS) dated 08/10/18 revealed:
-On 06/13/18 the resident pushed another resident.
-The resident was oriented to self only.

Innterview on 10/04/18 at 9:20 am with the resident's family member/power of attorney revealed:
-The facility notified her of the incidents that had taken place with the resident.
-The resident was not an aggressive person.
-She believed that the incidents were isolated because the other residents were in Resident #4's face.

Confidential interview with a staff revealed:
-Resident #4 did not get up for breakfast, but usually got up for lunch.
-The resident sometimes got agitated with anyone who was in her personal space.
-Resident #4 gave the other residents a warning.
-The resident has not had any other incidents with pushing other residents.
-The staff believed that staff didn't get the

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resident out of Resident #4's face soon enough.
-Triggers that made the resident upset was another resident taking something from her, touching her stuff, and in her personal space.

Confidential interview with a second staff member revealed:
-The resident got agitated with all the residents who got in her personal space.
-Another resident invaded Resident #4's personal space which caused Resident #4 to push the resident.
-Resident #4 was not usually aggressive.
-Resident #4 forgot things quickly.

Confidential interview with a third staff member revealed:
-Resident #4 was a good and funny person.
-The resident got agitated when residents get in her face.
-The resident was not an aggressive person.
-Has not seen the resident push anyone else.
-Resident #4 got around good on her own.
-The resident was sensitive to people in her space.

Confidential interview with a fourth staff member revealed:
-The staff saw the resident that Resident #4 pushed stumbling down to the ground.
-Resident #4 was usually a nice person.
-Resident #4 needed assurance that things were ok.

Interview with Special Care Unit Director (SCD) on 10/03/18 revealed:
-The Resident #4 tended to get upset if people keep talking.
-She only knew of the two instances of the resident pushing another resident.

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-In the instances when Resident #4 was aggressive it was a push.
-The instances when the resident pushed another resident took place in the living room and in the dining room
-The pushing incidents were due to another resident in her personal space.
-The staff reported that the resident doesn't push the staff.
-Staff generally redirects other residents if they see them getting too close to Resident #4.
-A new staff member witnessed the 09/22/18 incident.
-The SCD believes that the other resident involved was able to get to Resident #4 because the new staff member did not know to redirect other residents from getting into Resident #4's personal space.
-To prevent future altercations, the facility would keep closer supervision and redirect other residents away from Resident #4.

Interview with Resident #4 on 10/03/18 at 8:53 am revealed:
-She got along with the other residents.
-She loved living at the facility.

Interview with the Administrator on 10/04/18 at 08:53 am revealed:
-Resident's don't know not to get into Resident #4's personal space.
-Administrator did not believe that the resident was aggressive.
-The facility protocol was to separate residents in the event of an altercation. Then notify the family and the primary care provider of the incident. The resident would be transported to the local emergency department if injury or fall involving a head injury occurred.
-The Administrator implemented training about

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D 270	Continued From page 25 signs, keys, and things to be aware of when a resident is becoming agitated. _____ The facility failed to assure that residents (#1, #2, #5) were supervised apropriately according to their needs which resulted in one resident (#1) falling causing a cervical fracture which contributed to his death, another resident (#5) falling sustaining a left hip fracture and a third resident (#4) having an altercation with another resident (#5) which resulted in the falling and fractured hip of that resident. The lack of supervision was a substantial risk to the health, safety and well being of these residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/02/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 3, 2018.	D 270		
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.	D 358		

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This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A2 VIOLATION.

The Type A2 Violation was abated.
Non-compliance continues.

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 6 residents (#6, #7) observed during the medication passes including errors with a diuretic for swelling (#6) and an oral diabetic medication (#7); and for 1 of 5 residents sampled (#3) including errors with a blood pressure medication, a lubricant eye drop, and eye drops for glaucoma.

The findings are:

1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 27 opportunities during the 8:00am, 10:00am, 12:00pm, and 1:00pm medication passes on 10/03/18.

a. Review of Resident #6's current FL-2 dated 10/09/17 revealed diagnoses included acute on chronic diastolic dysfunction, hypertension, atrial fibrillation, pleural effusion, syncope and collapse.

Review of Resident #6's physician's order dated 08/30/18 revealed an order for Lasix 80mg take 1 tablet twice a day, hold if weight decreased 3 pounds in 1 day or 3 pounds in 5 days. (Lasix is a diuretic used to treat swelling caused by excess fluid.)

Review of Resident #6's September 2018

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D 358	Continued From page 27 medication administration record (MAR) revealed: -There was an entry for Lasix 80mg take 1 tablet twice a day, hold if weight decreases 3 pounds in 1 day or 3 pounds in 5 days. -Lasix was scheduled to be administered at 8:00am and 8:00pm. -Lasix was not documented as held on 3 occasions when the resident's weight decreased by 3 pounds in 1 day or 3 pounds in 5 days. -The resident weighed 121 pounds at 8:00am on 09/03/18 and 118 pounds at 8:00am on 09/08/18 but Lasix was documented as administered on 09/08/18 instead of being held. -The resident weighed 121 pounds at 8:00am on 09/04/18 and 118 pounds at 8:00am on 09/09/18 but Lasix was documented as administered on 09/09/18 instead of being held. -The resident weighed 122 pounds at 8:00am on 09/06/18 and 117 pounds at 8:00am on 09/11/18 but Lasix was documented as administered on 09/11/18 instead of being held. Review of Resident #6's October 2018 MAR revealed: -There was an entry for Lasix 80mg take 1 tablet twice a day, hold if weight decreases 3 pounds in 1 day or 3 pounds in 5 days. -Lasix was scheduled to be administered at 8:00am and 8:00pm. -Lasix was documented as administered at 8:00pm on 10/01/18 and at 8:00am and 8:00pm on 10/02/18. -There was no weight documented at 8:00pm on 10/01/18 and 10/02/18. -The resident's last documented weight was 122 on 10/02/18 at 8:00am. Observation of the 8:00am medication pass on 10/03/18 revealed: -The medication aide (MA) weighed Resident #6	D 358		

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D 358	Continued From page 28 at 8:35am and the reading on the scale was 115.2 pounds. -The MA then prepared and administered Resident #6's morning medications, including Lasix 80mg at 8:45am. -The MA did not check the electronic MAR for any previous weights. Based on the order dated 08/10/18, the Lasix should have been held on 10/03/18 since the resident's weight on the previous day was 122 pounds. Interview with the MA on 10/03/18 at 11:45am revealed: -The Lasix order was confusing to her. -She had not asked anyone to help her with the order. -She thought she could choose to follow either the parameter for a decrease of 1 pound in 3 days or 3 pounds in 5 days. -She chose to hold the Lasix if the resident lost 3 pounds in 5 days. -The resident's weights were not visible on the electronic MAR when the order popped up. -The MAs had to go to a different screen to check previous weights. -She did not check the resident's previous weights that morning during the medication pass. -She should have held the Lasix that morning based on the resident's decrease in weight. Interview with a Regional Nurse on 10/03/18 at 12:09pm revealed: -The MAs had been trained by nursing staff to check Resident #6's weight and hold the Lasix according to the parameters in the order. -The MA should have checked the resident's previous weights that morning and held the Lasix due to the decrease in weight.	D 358		

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D 358	Continued From page 29 Interview with Resident #6 on 10/03/18 at 5:43pm revealed: -Staff weighed her twice a day to see if her Lasix needed to be held. -The Lasix had not been held to her knowledge. -The swelling in her legs was "a lot" better. b. Review of Resident #7's current FL-2 dated 01/12/18 revealed: -Diagnoses included type II diabetes, hyperlipidemia, acute pancreatitis without necrosis, chronic pancreatitis, muscle weakness, hypertension, and morbid obesity. -There was an order for Metformin ER 1,000mg twice a day. (Metformin ER is an extended-released medication used to lower blood sugar. Extended-released medications are released slowly over time.) Review of Resident #7's physician's orders dated 07/10/18 revealed an order for Metformin ER 500mg take 2 tablets (1,000mg) twice a day. Review of Resident #7's September 2018 and October 2018 medication administration records (MARs) revealed: -There was an entry on each MAR for Metformin ER 500mg take 2 tablets (1,000mg) twice a day. -Metformin ER was documented as administered at 8:00am and 8:00pm from 09/01/18 - 10/03/18. Interview with Resident #7 on 10/03/18 at 4:10pm revealed: -His blood sugar was checked 4 times a day, before meals and at bedtime. -His blood sugar usually "runs good". Observation of the 5:00pm medication pass on 10/03/18 revealed:	D 358		

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-The medication aide (MA) pulled out two supplies of Metformin for Resident #7.
-One supply was packed in a bottle from a veteran's pharmacy.
-The second supply was packaged in a bubble card from the facility's primary pharmacy.
-The MA stated she did not know why the other MAs kept putting the bubble card in the active supply.
-The MA was trying to use up the Metformin in the bottle because the resident's medications were less expensive from the veteran's pharmacy.
-The MA administered one Metformin 1,000mg tablet (immediate-released) to Resident #7 at 4:14pm instead of Metformin ER (extended-released).

Observation of Resident #7's medications on hand on 10/03/18 revealed:
-There was a supply of Metformin ER 500mg tablets dispensed and labeled by the primary pharmacy on 09/20/18.
-There were 94 of 120 Metformin ER 500mg tablets remaining.
-There was a bottle of Metformin 1,000mg tablets (immediate-released) labeled and dispensed by a veteran's pharmacy on 08/15/18.

Interview with the MA on 10/03/18 at 5:00pm revealed:
-Resident #7's medications were usually dispensed by a veteran's pharmacy and repackaged in bubble cards by the facility's primary pharmacy.
-The resident wanted to use up the medications from the veteran's pharmacy because of cost.
-She had not noticed the Metformin packaged in the bottle was not extended-released.

Interview with the Resident Care Coordinator

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(RCC) on 10/03/18 at 5:25pm revealed:
-Resident #7's medications came from a veteran's pharmacy and the facility sent them to the primary pharmacy to be repackaged in bubble cards.
-The resident had some Metformin from a veteran's pharmacy they were trying to use up.
-She was not aware there was a supply of Metformin that was not extended-released.
-The MAs had been trained to check MARs and labels and if something did not match, they were supposed to stop and not administer the medication.

A second interview with the Resident Care Coordinator (RCC) on 10/04/18 at 8:25am revealed:
-She pulled the immediate-released Metformin from the medication cart so the MAs would not administer it.
-It appeared to be an older supply of medication that may have been based on previous orders.
-The resident's physician was contacted and the resident should be receiving Metformin ER.

Interview with Resident #7 on 10/04/18 at 2:45pm revealed:
-He took Metformin ER for diabetes.
-He thought he was receiving Metformin ER and he did not realize a supply of medication from one of his pharmacy sources was not the ER formulation.

2. Review of Resident #3's current FL-2 dated 06/28/18 revealed diagnoses included glaucoma, hypertension, hypothyroidism, major depression, encephalopathy, pneumonitis, muscle weakness, difficulty walking, lack of coordination, dysphagia, other symbolic dysfunction, arthropathy, gastroesophageal reflux disease, and

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D 358	Continued From page 32 hypo-osmolality. a. Review of Resident #3's physician's orders dated 06/26/18 and 08/29/18 revealed an order for Enalapril 10mg twice a day. (Enalapril lowers blood pressure.) Review of Resident #3's August 2018 - October 2018 medication administration records (MARs) revealed: -There was an entry for Enalapril 10mg 1 tablet twice a day on each of the MARs. -It was scheduled and documented as administered at 8:00am and 8:00pm. -The resident's blood pressure was checked weekly and ranged from 129/57 - 163/63. -The last documented blood pressure was 163/63 on 09/29/18 and the next blood pressure was due to be checked on 10/06/18. Review of Resident #3's medications on hand on 10/04/18 at 10:27am revealed: -There were two bubble cards with a supply of Enalapril 20mg tablets with a label taped to the bubble card indicating a dispense date by a veteran's pharmacy on 02/27/18. -The instructions were to take 1 tablet every day for blood pressure. -There were 69 of 90 tablets remaining. -Staff handwrote they started using one card on 08/27/18 and one card on 09/18/18. Interview with a medication aide (MA) on 10/04/18 at 10:27am revealed: -She had not noticed the strength of Enalapril in the bubble cards for Resident #3 did not match the strength listed on the MARs. -She had been administering the Enalapril 20mg tablets in the bubble cards instead of 10mg as ordered.	D 358		

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D 358	Continued From page 33 -Resident #3's medications came from a veteran's pharmacy but the medications were repackaged by the facility's primary pharmacy. Telephone interview with the Operations Manager (OM) at the primary pharmacy on 10/04/18 at 3:19pm revealed: -The facility sent medications for residents who used a veteran's pharmacy to their pharmacy to be repackaged in bubble cards. -They did not repackage any medications that were dispensed by another pharmacy over 90 days ago. -The bubble card of Enalapril 20mg tablets with a dispense date of 02/27/18 would not have been repackaged recently by their pharmacy because it had been more than 90 days from the dispense date. -The facility staff probably pulled the bubble card from an old supply of medication that was no longer active. -The most current order they had on file for Enalapril was 10mg twice a day. -They would not have repackaged the Enalapril 20mg tablets if it did not match the current order. -The facility sent a supply of Enalapril 20mg tablets in July 2018 but the pharmacy did not repackage the 20mg tablets because it did not match the current order of 10mg. -Their pharmacy checked to make sure orders matched and the facility should also be checking to make sure orders matched. Interview with the Resident Care Coordinator (RCC) on 10/04/18 at 12:47pm revealed: -She spoke with Resident #3's primary care provider's (PCP) office and the resident should be receiving Enalapril 10mg twice a day instead of 20mg. -She would send a copy of the resident's vital	D 358		

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D 358	Continued From page 34 signs to the PCP. Interview with Resident #3 on 10/04/18 at 4:05pm revealed: -The resident's blood pressure was checked once or twice a week and it "runs good". -The resident was not sure what kind of blood pressure medication he took. Telephone interview with Resident #3's PCP on 10/04/18 at 4:34pm revealed: -Resident #3 should be receiving no more than 20mg of Enalapril per day (10mg twice a day). -He last saw the resident on 09/21/18 and the resident's blood pressure was 148/67. Refer to interview with the facility's Consultant on 10/04/18 at 11:29am. b. Review of Resident #3's physician's orders dated 06/26/18 revealed: -There was an order for Brimonidine 1 drop in the right eye 3 times a day. (Brimonidine is used to treat glaucoma.) -There was an order for Cosopt 1 drop in both eyes 3 times a day. (Cosopt is used to treat glaucoma.) -There was an order for Latanoprost 1 drop in both eyes at bedtime. (Latanoprost is used to treat glaucoma.) Review of Resident #3's current FL-2 dated 06/28/18 revealed -There was an order for Cosopt 1 drop in both eyes twice a day. -There was an order for Latanoprost 1 drop in both eyes at bedtime. -There was no order for Brimonidine listed on the FL-2.	D 358		

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D 358	Continued From page 35 Review of Resident #3's discharge instructions dated 06/29/18 revealed: -There was an order for Cosopt 1 drop in both eyes 3 times a day. -There was an order for Latanoprost 1 drop in both eyes at bedtime. -There was an order for Brimonidine 1 drop in the right eye 3 times a day. Review of Resident #3's physician's orders dated 08/29/18 revealed: -There was an order for Cosopt 1 drop in each eye twice a day. -There was an order for Latanoprost 1 drop in each eye at bedtime. -There was no order for Brimonidine listed on the physician's order sheet. Review of an after visit summary dated 09/19/18 for Resident #3 revealed there were active orders listed for Cosopt, Latanoprost, and Brimonidine. Review of Resident #3's August 2018 - October 2018 medication administration records (MARs) revealed: -There was an entry for Cosopt 1 drop in each eye twice a day on each MAR. -Cosopt was scheduled and documented as administered at 8:00am and 8:00pm. -There was an entry for Latanoprost 1 drop in each eye at bedtime on each MAR. -Latanoprost was scheduled and documented as administered at 8:00pm. -There was no entry for Brimonidine on either of the MARs and none was documented as administered. Observation of Resident #3's medications on hand on 10/04/18 at 10:27am revealed: -There was an opened bottle of Brimonidine eye	D 358		

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drops in the medication cart that was dispensed on 07/25/18.
-Staff had handwrote an open date of 09/07/18 on the label.
-There were two bottles of Cosopt eye drops in the medication cart.
-One bottle of Cosopt was dispensed on 12/28/17 and the other on 08/16/18.
-There was no Latanoprost in the medication cart.

Interview with a medication aide (MA) on 10/04/18 at 10:27am revealed:
-Resident #3 received the two eye drops stored in the medication cart to her knowledge.
-She did not know why Brimonidine eye drops were in the medication cart but not listed on the MARs.
-She thought staff may be administering Brimonidine instead of Latanoprost since there was an open date of 09/07/18 on the Brimonidine bottle and there was no Latanoprost in the cart.
-She would check the medication closet used to store extra supplies.

Observation of Resident #3's medications in the medication closet on 10/04/18 at 10:35am revealed there were two unopened bottles of Latanoprost dispensed on 11/02/17.

Interview with the Resident Care Director (RCD) on 10/04/18 at 11:10am revealed:
-She had just started working at the facility 5 days ago.
-She would contact the provider who prescribed Resident #3's eye medications about the eye drops.

Interview with Resident #3 on 10/04/18 at 4:05pm revealed:
-He thought he received two different eye drops.

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D 358	Continued From page 37 -He did not know the names of his eye drops. Interview with the Resident Care Director (RCD) on 10/04/18 at 4:15pm revealed: -She had contacted the provider who prescribed the eye drops for Resident #3. -The resident should be receiving all 3 eye drops for glaucoma including Cosopt, Latanoprost, and Brimonidine. -The Brimonidine should be in the right eye only and the other two should be administered in both eyes. Attempted telephone interview with Resident #3's eye care provider on 10/04/18 at 4:30pm was unsuccessful. Refer to interview with the facility's Consultant on 10/04/18 at 11:29am. _____ Interview with the facility's Consultant on 10/04/18 at 11:29am revealed: -The facility had a system to check medications on hand and medication orders. -The system was not done by former staff. -The newly hired team would implement the system to check medications and orders.	D 358		
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	D 375		

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D 375	Continued From page 38 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: 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 2 of 3 residents sampled (#8, #9) had physicians' orders to self-administer including a resident who self-administered an oral inhaler for shortness of breath (#9) and a resident who self-administered an over-the counter decongestant nasal spray (#8). The findings are: Review of the facility's self-administration policy and procedure revealed: -The Resident Care Director (RCD) or designee will perform an assessment of the resident's mental and physical capacity to self-administer medications. -The RCD or designee must verify the resident is capable of verbalizing the correct dose and purpose of each medication before the assessment is complete. -If the resident is deemed competent by the RCD, an order must be obtained from the physician stating the resident may self-administer	D 375		

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D 375	Continued From page 39	D 375		

medications.
-If the resident is to keep the medications in their room, the order must also state, "Ok to keep medications at bedside".
-The RCD or designee will perform continued assessment of the resident's ability to self-administer at least quarterly and will document the resident's compliance with this process in the assessment tool. The quarterly review must include verification that the resident has the appropriate medications on hand and continues to evidence compliant knowledge of the dose and purpose of each medication.
-If issues are identified, the RCD or designee will obtain an order to discontinue self-administration. The RCD or designee will be notified and an assessment completed. Based on the RCD or designee's assessment, the orders to discontinue self-administration will continue or new orders obtained as relevant.
-When the resident self-administers medication, the medication is to be written on the resident's medication administration record (MAR) and the words "self-administer" written on the MAR each time it is verified a dose has been self-administered.

1. Review of Resident #9's current FL-2 dated 03/28/18 revealed:
-Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure (on 2 liters of oxygen), acute hypoxemic respiratory failure, pulmonary hypertension, acute on chronic congestive heart failure, hypertension, obstructive sleep apnea, peripheral vascular disease, chronic kidney disease, atrial fibrillation, glaucoma, coronary artery disease, hyperlipidemia, arthritis, and senile macular retinal degeneration.
-The resident was oriented and required limited assistance with activities of daily living.

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D 375	Continued From page 40 -There was an order for Ventolin HFA 90mcg inhaler, inhale 2 puffs every 6 hours as needed for shortness of breath. (Ventolin HFA is a rescue inhaler used to open the air ways and make breathing easier for symptoms of lung disease.) Review of a physician's order for Resident #9 dated 04/18/18 revealed there was an order for Ventolin HFA 90mcg inhaler, take 2 puffs by mouth 4 times a day as needed. Review of Resident #9's Resident Register revealed: -The resident was admitted to the facility on 09/25/15. -The resident needed assistance with orientation to time and place. -The resident was forgetful and needed reminders. Review of Resident #9's assessment and care plan dated 01/22/18 revealed: -The resident was ambulatory with rollator walker. -The resident had limited range of motion in upper extremities. -The resident was on 2 liters of oxygen. -The resident was oriented and had adequate memory. -The resident's vision was very limited and the resident was legally blind in both eyes. Review of a Resident #9's Resident Assessment Tool dated 09/26/15 revealed: -The resident was legally blind. -The resident could see small things and shadows. Interviews with Resident #9 on 10/02/18 at 11:07am and 10/04/18 at 2:50pm revealed: -She wore oxygen continuously because of	D 375		

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D 375	Continued From page 41 breathing problems. -She had a Ventolin inhaler that she self-administered. -She used to be employed as a pharmacy technician and she was familiar with medications. -She usually took 1 or 2 puffs of the Ventolin inhaler once or twice a day if needed for shortness of breath. -On some days, she did not use the Ventolin at all if she did not need it. -The Ventolin inhaler helped if she was short of breath. -Facility staff (could not recall names) at first told her that she could not keep the Ventolin inhaler and self-administer it. -She told staff that she needed to keep it because if she was short of breath, she did not have time to call staff and then wait for them to bring the inhaler to her. -Staff were aware she was currently keeping and self-administering the inhaler. -She would let staff know when the Ventolin inhaler ran out and they would have another one on the medication cart for her. -She had some trouble with her vision but she knew how to administer the inhaler to herself. -Her vision did not interfere with her ability to administer the inhaler. Observation and interview of Resident #9 on 10/02/18 at 11:07am revealed: -She had one Ventolin HFA inhaler in her pants pocket. -The inhaler was not labeled and did not have the resident's name on it. -She thought the prescription label was on the box the inhaler came in. -She did not know where the box for the inhaler was located.	D 375		

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D 375	Continued From page 42 Interview with a medication aide (MA) on 10/02/18 at 12:05pm revealed: -She usually worked as a MA on first shift. -Resident #9 self-administered an inhaler prn (as needed) but she could not recall the name of the inhaler. Review of Resident #9's September 2018 and October 2018 medication administration records (MARs) revealed: -There was an entry on each MAR for Ventolin HFA, inhale 2 puffs by mouth 4 times a day as needed. -There was no documentation on either MAR that the Ventolin inhaler had been administered to the resident. -There was no documentation on either MAR indicating the Ventolin inhaler was to be self-administered. Review of Resident #9's physician's orders revealed there was no order for the resident to self-administer the Ventolin HFA inhaler. Observation of Resident #9's medications on hand on 10/07/18 at 2:20pm revealed: -There was one Ventolin HFA inhaler dispensed on 07/27/18 stored in the medication cart. -The Ventolin HFA inhaler in the cart was in a box with a prescription label with the resident's name and instructions to take 2 puffs 4 times a day if needed. -The inhaler was in a foil pack inside the box. -The foil pack was sealed and had not been opened. Interview with a second MA on 10/04/18 at 2:20pm revealed: -Resident #9 had not requested the Ventolin HFA inhaler when the MA worked on first shift.	D 375		

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-The resident wore oxygen continuously and had not complained of shortness of breath to the MA.
-She did not know if Resident #9 self-administered the Ventolin inhaler.
-It was usually marked on the MAR if a medication was self-administered.

Telephone interview with a nurse at Resident #9's pulmonologist's office on 10/04/18 at 3:38pm revealed:
-The resident's physician was out of the office and unavailable for interview.
-She would check with the physician regarding Resident #9's ability to self-administer the Ventolin inhaler once the physician returned to the office the next day.

Interview with the Resident Care Coordinator (RCC) on 10/04/18 at 3:05pm revealed:
-She was not sure if Resident #9 had an order to self-administer the Ventolin HFA inhaler.
-She was aware Resident #9 had an order for Ventolin inhaler but she was not aware the resident had a Ventolin inhaler and was self-administering it.
-She would contact Resident #9's physician.

Refer to interview with the RCC on 10/04/18 at 3:05pm.

2. Review of Resident #8's current FL-2 dated 08/22/17 revealed:
-Diagnoses included reflex sympathetic dystrophy and chronic pain syndrome.
-The resident's level of care was assisted living.

Review of Resident #8's Resident Register dated 08/12/16 revealed:
-The resident was admitted to the facility on 08/30/16.

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D 375	Continued From page 44 -The resident had adequate memory. Review of Resident #8's assessment and care plan dated 01/31/18 revealed the resident had adequate memory and was oriented. Observation of Resident #8's room during initial tour of facility on 10/02/18 at 10:15am revealed there was a bottle of over-the-counter (OTC) nasal spray, Oxymetazoline, on the bedside table. (Oxymetazoline is a nasal decongestant and can cause rebound nasal congestion if used too frequently.) Interview with Resident #8 on 10/02/18 at 10:15am revealed: -He used the nasal spray for his breathing. -He sprayed 1-2 sprays in his right nostril sometimes 8 to 10 times throughout the day. -He had been using it for around 30 years. -The staff was aware that he had the nasal spray at his bedside and self-administered it. -His physician was aware that he was using the nasal spray. -He did not know if there was an order from the physician for him to self-administer the nasal spray. Interview with a medication aide (MA) assigned to Resident #8's hall on 10/02/18 at 10:20am revealed: -She was aware that Resident #8 had the nasal spray at his bedside. -She was not sure if he had a physician's order to self-administer the nasal spray. -She would check his record for a self-administration order. Review of Resident #8's physician's orders revealed:	D 375		

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D 375	Continued From page 45 -There was no order for Oxymetazoline nasal spray. -There was no order for the resident to self-administer medication. Review of Resident #8's August 2018 - October 2018 medication administration records (MARs) revealed there was no entry for Oxymetazoline on the MARs. A second observation of Resident #8's room on 10/04/18 at 12:30pm revealed there was a bottle of Oxymetazoline nasal spray on the bedside table. Interview with Resident #8 on 10/4/18 at 12:30 pm revealed: -A family member brought the nasal spray for the resident because he needed it for his breathing. -The right side of his nose was broken a long time ago and as it healed, the passage from the nose to under the eye became blocked. -This made it difficult for him to breath. -He did not like breathing through his mouth so he needed the nasal spray. Interview with a second MA on 10/04/18 at 12:28pm revealed: -She was not aware Resident #8 had nasal spray in his room and was self-administering it. -She did not know if the resident had an order for the nasal spray or self-administration. Interview with the Resident Care Coordinator (RCC) on 10/04/18 at 12:35pm revealed: -She was notified of the OTC nasal spray being in Resident #8's room on the evening of 10/02/18. -Facility staff "swept" Resident #8's room and confiscated the nasal spray on 10/02/18. -She did not know there was a second bottle of	D 375		

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D 375	Continued From page 46 nasal spray in the resident's room on 10/04/18. -On 10/02/18, the resident went out with a family member and must have gotten another bottle. - She would get an order from the resident's physician for the nasal spray and self-administration. Interview with Resident #8's physician on 10/04/18 at 4:20pm revealed: -He was not aware that Resident #8 was using the Oxymetazoline nasal spray 10 times per day. -He was concerned about Resident #8's frequent use of the nasal spray because it could be addictive. -The more the Oxymetazoline was used, it could cause more nasal congestion and it could cause increased blood pressure and irregular heartbeat. -He reviewed Resident #8's blood pressures that were taken at his last three office visits and they were within normal limits. Refer to interview with the RCC on 10/04/18 at 3:05pm. _____ Interview with the Resident Care Coordinator (RCC) on 10/04/18 at 3:05pm revealed: -Facility staff usually "sweep" the residents' rooms twice a week to make sure no medications were kept in the room without orders to self-administer. -She was not sure of the facility's policy for self-administration except an order was needed and they were supposed to make sure residents were capable of self-administering. -The Resident Care Director (RCD) was responsible for evaluating residents who self-administered. -The facility's RCD position had been vacant for two months and a new RCD just started a few	D 375		

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D 375	Continued From page 47 days ago. -She did not know if the previous RCD was evaluating residents who self-administered.	D 375		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report to the County Department of Social Services, a fall which resulted in a spinal fracture for 1 of 5 sampled residents (Resident #1). The findings are: 1. Review of Resident #1's current FL-2 dated 08/16/18 revealed: -Diagnoses included dementia, amnesia, failure to thrive, hypertension, hypercholesterolemia, peripheral vascular disease, cardiac arrhythmia, and osteoarthritis of hip. -The resident was intermittently disoriented. -The resident was ambulatory and required	D 451		

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D 451	Continued From page 48	D 451		

assistance with bathing and dressing.
-The resident's level of care was Special Care Unit (SCU).

Review of Resident #1's Resident Register dated 08/15/18 revealed the resident was admitted to the facility on 08/15/18.

Review of the Accident/Incident Report for Resident #1 revealed:
-08/26/18 at noon, the resident fell off the bed onto the floor. The resident had a bruise on the right side towards top of the head.
-The fall was unwitnessed.
-The Administrator instructed the staff to send Resident #1 to the local hospital to be evaluated.

Review of Resident #1's Progress Notes revealed:
-On 08/26/18 at noon, the resident had an unwitnessed fall from his bed onto the floor and had a bruise on his right side of his head towards the top.
-The administrator was notified and she instructed staff to send Resident #1 to the hospital to be evaluated.

Review of the Emergency Medical Services (EMS) Report for Resident #1 dated 08/26/18 revealed:
-The EMS call was received at 12:05 pm.
-The staff reported that the resident was found by staff at noon on the floor by his bed; unsure of exact time of fall.
-The resident was unable to communicate with EMS staff due to dementia; unable to locate and verbalize pain.
-The resident was transported to the trauma room at the local emergency department.

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D 451	Continued From page 49	D 451		

Review of the local hospital emergency department Provider Notes from 08/26/18 to 08/28/18 for Resident #1 revealed:
-The resident was admitted to the ED after a fall.
-The resident had a closed nondisplaced C2 fracture; likely to worsen once IVF stopped.

Interview with a representative from the local county DSS on 10/02/18 at 11:45 revealed:
-The county had not received any notifications of incident/accident reports since 06/06/18.
-The last notification the county had received from the facility was on 06/06/18.

Interview with a Medication Aide (MA) on 10/04/18 at 9:45 am revealed:
-The incident/accident report was filled out as soon as possible by the MA/Supervisor.
-The MA/Supervisor also notied the family, the residents's primary care provider (PCP), and the Administrator of the incident/accident.
-The form was sent to the Resident Care Director (RCD) or the Resident Care Coordinator (RCC) who would get the Administrator to sign the form.
-The RCC notified the DSS of the incident/accident by faxing the form to the DSS office.

Interview with the RCC on 10/04/18 at 11:10 am revealed:
-She had worked as the RCC for 5 1/2 years.
-The incident/adccident report was filled out by the MA/SIC on duty.
-The Administrator signed the report.
-The RCC or RCD would fax the form to the DSS.
-The incident/accident reports had been faxed to the DSS by the former RCD, who was no longer employed by the facility.
-The RCC had not faxed the reports to DSS since the former RCD had left her position, because

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D 451	Continued From page 50 she did was not aware she was responsible for this task. -"I didn't do it because I didn't know to do it". -The RCC learned on 10/02/18 that she was responsible for faxing the incident/reports to the DSS. -The RCC would ensure the incident/accident reports would be faxed to the local DSS office in a timely manner Interview with the RCD on 10/04/18 at 11:00 am revealed: -She had been the facility RCD for 5 days. -The incident/accident report was filled out by the MA/Supervisor on duty. -The local DSS would be notified of any falls that required EMS transport to the local ED or a fall when the resident hit his or her head. -The report was signed by the ED. -The report was faxed to the DSS by the RCC. Interview on 10/04/18 at 11:15 with the Administrator revealed: -The incident/accident report was filled out as soon as possible by the MA/Supervisor. -The form was sent to the RCC or RCD. -The RCC or RCD would get the Administrator sign the form. -The RCC would fax the form to the local DSS office. -The Administrator did not know why the local DSS office wasn't notified. -She did not confirm the reports were sent to DSS after she signed them.	D 451		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents	D 454		

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D 454	Continued From page 51 And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the responsible party for one resident (Resident #1) who had an unwitnessed fall with a head injury that required an emergency room visit. Review of Resident #1's current FL-2 dated 08/16/18 revealed: -Diagnoses included dementia, amnesia, failure to thrive, hypertension, hypercholesterolemia, peripheral vascular disease, cardiac arrhythmia, and osteoarthritis of hip. -The resident was intermittently disoriented.	D 454		

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	HAL092166	A. BUILDING: _____ B. WING _____	R-C 10/04/2018

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-The resident was ambulatory and required assistance with bathing and dressing.
-The resident's level of care was Special Care Unit (SCU).

Review of Resident #1's Resident Register dated 08/15/18 revealed the resident was admitted to the facility on 08/15/18.

Review of the Accident/Incident Report for Resident #1 revealed:
-08/26/18 at noon, the resident fell off the bed onto the floor. The resident had a bruise on the right side towards top of the head.
-The fall was unwitnessed.
-The Administrator instructed the staff to send Resident #1 to the local hospital to be evaluated.
-The resident was sent to the local hospital Emergency Department (ED).

Review of Resident #1's Progress Notes revealed:
-On 08/26/18 at noon, the resident had an unwitnessed fall from his bed onto the floor and had a bruise on his right side of his head towards the top.
-The administrator was notified and she instructed staff to send Resident #1 to the hospital to be evaluated.
-On 08/28/18 (no time was documented), the resident's family member called to notify the facility that the resident would not be coming back to the facility and he was admitted to hospice.

Review of the Emergency Medical Services (EMS) Report for Resident #1 dated 08/26/18 revealed:
- The EMS call was received at 12:05 pm.
-The staff reported that the resident was found by staff at noon on the floor by his bed; unsure of

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exact time of fall.
-The resident was unable to communicate with EMS staff due to dementia; unable to locate and verbalize pain.
-The resident was transported to the trauma room at the local ED.

Review of the local emergency department Provider Notes from 08/26/18 to 08/28/18 for Resident #1 revealed:
-The resident was admitted to the ED after a fall.
-The resident had a closed nondisplaced C2 fracture; likely to worsen once intravenous fluid stopped.

Interview with Resident #1's family member on 09/18/18 at 8:30 am revealed:
-Resident #1 was admitted to the facility's Special Care Unit (SCU) on 08/15/18 for respite care for a 2 week period, from 08/15/18 to 08/29/18.
-The family was going on a vacation so she left their mobile number for the facility to reach them.
-She was not aware of any falls the resident had at the facility because she was never contacted about the falls.
-No one from the facility contacted her on the cell phone.
-On 08/24/18 a message was left on the home phone notifying the family Resident #1 had been sent to the local ED for evaluation of high blood pressure.
-The facility did not contact the family when Resident #1 was transported and admitted to the local hospital on 08/26/18 after an unwitnessed fall.
-On 08/26/18, the hospital staff contacted her about Resident #1's fall, transport to the ER and admission to the local hospital.
-The 08/26/18 fall broke Resident #1's neck and back.

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D 454	Continued From page 54 -After being discharged from the hospital on 08/28/18, the resident was admitted to the hospice care. -On 08/29/18, Resident #1 passed away. Interview with a MA on 10/04/18 at 9:45 am revealed: -Each incident/accident report was filled out as soon as possible by the MA/Supervisor. -The MA/Supervisor also notified the family, the residents's primary care provider (PCP), and the local hospital of the incident/accident. -The form was sent to the RCD or RCC who would get the Administrator to sign the form. -She was not aware why additional attempts were not made to notify Resident #1's family after the 08/26/18 fall. Interview with the RCD on 10/04/18 at 11:00 am revealed: -She had been the facility RCC for 5 days. -The incident/accident report if filled out by the MA/Supervisor on duty. -The MA/Supervisor who filled out the form was responsible for notifying the family and the PCP. -The report was signed by the Administrator. Interview with the RCC on 10/04/18 at 11:10 am revealed: -She had worked as the RCC for 5 1/2 years. -The incident/accident report was filled out by the MA/Supervisor on duty. -The MA/Supervisor who filled out the form was responsible for notifying the family and the primary care provider. -The Administrator signed the report. -After the 08/26/18 fall, she was not aware why additional attempts were not made to notify Resident #1's family via the cell phone number provided.	D 454		

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D 454	Continued From page 55 Interview with the Administrator on 10/04/18 at 11:15 revealed: -The incident/accident report was filled out as soon as possible by the MA/Supervisor. -The MA/Supervisor who filled out the form was responsible for notifying the family and the PCP. -The form was sent to the RCD, who would continue to contact the family if the MA/Supervisor was unable to contact the family. -The RCC or RCD would get the Administrator sign the form. -Resident #1 was admitted to the facility's SCU for respite care while the family went on a vacation. -She was aware of Resident #1's 08/26/18 fall. -She was aware Resident #1 had been admitted to hospice after the 08/26/18 fall. -After the 08/26/18 fall, she was not aware why additional attempts were not made to notify Resident #1's family via the cell phone number provided. -She did not know that Resident #1 had passed until recently.	D 454		
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	D912		

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D912	Continued From page 56 reviews, the facility failed to assure 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 supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide the needed supervision to 3 of 5 residents (#1, #4, #5) who had a history of falls (#1, #5) and behavior (#4) requiring increased supervision related to falls and behavior. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D912		