STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060077	A. BUILDING: _____ B. WING _____	12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on 12/17/18 to 12/20/18 with an exit conference via telephone on 12/21/18. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 11/06/18.	D 000		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times who had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 48 of 60 shifts.	D 167		

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D 167	Continued From page 1 The findings are: Review of the staffing schedule dated 12/01/18 to 12/21/18 revealed: -There were three 8 hour shifts: the first shift was 7:00am-3:00pm; the second shift was 3:00pm-11:00pm and the third shift was 11:00pm-7:00am. -On the first shift, 8 of 20 days, there were no staff scheduled who had any documentation of CPR certification. -On the second shift, 20 of 20 days, there were no staff scheduled who had any documentation of CPR certification. -On the third shift, 20 of 20 days, there were no staff scheduled who had any documentation of CPR certification. 1. Review of Staff B's personnel file revealed: -Staff B was hired as a personal care aide (PCA) on 09/01/16. -He was employed as a medication aide (MA) on 08/22/18. -Staff B worked full time as a MA on third shift. -There was no documentation in Staff B's personnel file of CPR training within the last 24 months. Review of Staff B's shift schedule from 12/02/18 to 12/17/18 revealed: -On 12/02/18, Staff B worked 11:00pm to 7:00am as a MA. There were no other staff with documented CPR training on this shift. -On 12/04/18-12/07/18, Staff B worked 11:00pm to 7:00am as a MA. There were no other staff with documented CPR training on these shifts. -On 12/10/18-12/17/18 Staff B worked 11:00pm to 7:00am as a MA. There were no other staff with documented CPR training on these shifts.	D 167		

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2. Review of Staff C's personnel file revealed:
-Staff C was hired for the transportation aide of the residents on 11/09/18.
-There was no documentation in Staff C's personnel file of CPR training within the last 24 months.

Interview with Staff C on 12/19/18 at 10:14am revealed:
-He was hired on 11/09/18 as a transportation driver.
-His responsibilities included transporting the residents in the facility van to their appointments.
-Personal care staff did not accompany the residents in the van during transport.
-Management did not request CPR verification when he was hired.
-He thought he had CPR training in the past 2 years and would try to locate his card.

3. Review of Staff E's personnel file revealed:
-Staff E was hired as a MA on 03/15/17.
-She worked as a MA on third shift full time.
-There was no documentation in Staff E's personnel file of CPR training within the last 24 months.

Review of Staff E's shift schedule from 12/03/18 to 12/18/18 revealed:
-On 12/03/18, Staff E worked 11:00pm to 7:00am as a MA. There were no other staff with documented CPR training on this shift.
-On 12/08/18 and 12/09/18, Staff E worked 11:00pm to 7:00am as a MA. There were no other staff with documented CPR training on this shift.
-On 12/14/18, Staff E worked 11:00pm to 7:00am as a MA. There were no other staff with documented CPR training on this shift.
-On 12/18/18, 12/19/18 and 12/20/18, Staff E worked 11:00pm to 7:00am as a MA. There were

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D 167	Continued From page 3 no other staff with documented CPR training on this shift. Interview with the Administrator on 12/20/18 at 2:03pm revealed: -Reviewing the schedule, there was not a staff person with a current CPR certification working on each shift. -The Executive Director (ED) usually would schedule a class for employees once or twice a year. -The current ED was newly hired and in training off site. -She thought there had been a class earlier in the year but could not verify the dates, and did not have copies of any additional CPR cards. -She produced current CPR documentation for two employees, one who was no longer employed with the facility. Interview with the RCC on 12/20/18 at 4:00pm revealed: -Her responsibilities included scheduling clinical staff to cover all three shifts. -She completed the schedule by "whoever is available to work that shift." -She did not use a list of current staff who were CPR certified to complete the schedule. -She had never seen a list of staff who were CPR certified _____ The facility failed to assure there was a staff person on duty for 48 of 60 shifts, who had completed a course on CPR and choking management, within the previous 24 months. This failure was detrimental to the health, safety and welfare of the residents by not having adequately trained staff available in the event of cardiopulmonary arrest or choking, which constitutes a Type B Violation.	D 167		

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D 167	Continued From page 4 The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/19/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 8, 2019.	D 167		
D 183	10A NCAC 13F .0603(a) Management of Facilities With A Capacity Or 10A NCAC 13F .0603 Management of Facilities with a Capacity or Census of 81 or More Residents (a) An adult care home with a capacity or census of 81 or more residents shall be under the direct control of an administrator, who shall be responsible for the operation, administration, management and supervision of the facility on a full-time basis to assure that all care and services to residents are provided in accordance with all applicable local, state and federal regulations and codes. The administrator shall be on duty in the facility at least eight hours per day, five days per week and shall not serve simultaneously as a personal care aide supervisor or other staff to meet staffing requirements while on duty as an administrator or be an administrator for another adult care home except as follows. If there is more than one facility on a contiguous parcel of land or campus setting, and the combined licensed capacity of the facilities is 200 beds or less, there may be one administrator on duty for all the facilities on the campus. The administrator shall not serve simultaneously as a personal care aide supervisor in this campus setting. For staffing chart, see Rule .0606 of this Subchapter.	D 183		

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D 183	Continued From page 5 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure full time and consistent responsibility for the operation, administration, management and supervision of the facility which resulted in significant non compliance with state rules and regulations related to infection control, health care, medication administration, supervision, implementation of orders, resident records, care plans, resident funds, CPR training, nutrition and food services, transportation and resident rights. Confidential telephone interviews with two residents' family members revealed: -There was no management in the facility to address concerns. -"It has been nothing but a headache." -The room was filthy when the family member moved the resident in; "I had to mop the floor myself." -"I see no management in the facility on weekends." -"You cannot find the staff on the weekends." -Transportation was provided for dialysis residents, but other residents must find their own transportation. -One resident called their family member crying because "the facility only gave her 10.00 dollars of her monthly money." -If the staff were providing proper care and administering medications, the resident would not had been admitted to the hospital twice in 2 months.	D 183		

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D 183	Continued From page 6 Interview with a first shift medication aide (MA) on 12/19/18 at 10:00am revealed: -She had served as the Resident Care Coordinator (RCC) until October 2018. -She had stepped back down to the position of MA in October 2018 because "it was just too much." -Work had been difficult due to staff turnover and lack of management without an Administrator. -The former Administrator had resigned on 12/06/18. Interview with the Dietary Manager (DM) on 12/19/18 at 10:45am revealed: -He had been employed with this facility for two weeks. -The facility had been without a DM for "quite a while." -According to the kitchen staff, prior to him coming to work at the facility, no one had been responsible for cleaning the dining room after supper and there was no management oversight for cleanliness of the kitchen and dining room. -He had to develop a new cleaning schedule and was working to train the kitchen staff. Interview with Administrator on 12/19/18 at 11:11am revealed: -The Executive Director resigned on 12/06/18. -The newly hired Executive Director would start on 12/24/18. -"It has been hard these past 90 days." -The nursing position (Resident Care Director) had been vacant for 6 weeks. -The Resident Care Coordinator (RCC) was newly hired and was responsible for staffing, scheduling, filing paperwork and had been assuming other clinical duties in the absence of a nurse.	D 183		

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D 183	Continued From page 7 -The position of Business Office Manager (BOM) had not been filled for several months. -If there was no management in the building during the first shift, the supervisor was the responsible person. -The personal care assistants (PCAs) should notify the MAs with any resident concerns. -The MAs should notify the supervisor on first shift. -The supervisor should notify the RCC. -There was no supervisor on second or third shift. -The MA would be responsible for contacting the RCC if there were any concerns on second and third shift. -The RCC should be available by phone to all shifts "24/7". -The staff should know the "chain of command", those who were the responsible supervisors to report to on each shift -She and the regional support staff were in the building at least twice a week. -The RCC had requested from the Administrator, the need for assistance in performing the additional duties in the absence of a nurse. -The supervisor on first shift who was identified as her support person, assisting with the RCC duties, had been required to function as the MA frequently. -She and the RCC had been providing transportation to a resident for her dialysis appointments while the van was being repaired. -"We have prioritized appointments while the van has been serviced." Interview with the transportation driver on 12/19/18 at 10:20am revealed: -His responsibilities included transporting the residents to their appointments. -The RCC scheduled the appointments for the residents.	D 183		

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-The RCC notified him of appointments and he informed the residents of the departure time.
-The facility van had been out for repairs for 2-3 weeks.
-The management staff borrowed vans from their sister communities, when their vans were available.
-The borrowed vans were not wheelchair accessible, so he could not transport non-ambulatory residents to appointments.
-The RCC had requested staff to transport residents to their appointments in their private vehicles.
-He had not used his private vehicle for transportation.

Interview with the RCC on 12/19/18 at 2:00pm revealed:
-There had been a lot of staff turnover since she had been employed with this facility.
-The facility's nurse had left five days after she started working at this facility (mid October) and they did not have another nurse on staff.
-She had not been trained on the facility's policies and procedures and so was not aware of a facility fall policy.
-Many documents were missing from the residents' records because no one had done any filing in several years. "I'm still finding orders from 2017 that need to be filed."
-The nurse was responsible for auditing electronic medication administration records (eMARs) to assure orders were correct, but because the facility did not have a nurse, the responsibility had fallen on her.
-She had not audited any eMARs because she had been "too overwhelmed."
-The Executive Director (ED) had resigned on 12/06/18 and the current Administrator had been involved since 12/13/18.

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D 183	Continued From page 9 -The RCC reported to the Administrator. -The Administrator was responsible for other buildings and was not in the building every day. Interview with the second shift PCA on 12/20/18 at 4:10pm revealed: -If there was a problem with a resident, she would report to the MA. -There was no management in the building in the evening. -She did not know who the MA reported to at night. Interview with the MA on first shift on 12/19/18 at 11:04am revealed: -"I would report to the supervisor if there was an issue I could not resolve." -If the supervisor was not working, she would report to the RCC. -If the RCC was not in the building, "I guess I would have to wait or maybe call her." -She did not know how often the Administrator was in the building. -She did not go to the Administrator if there was an issue. Interview with the Activity Director on 12/19/18 at 10:45am revealed: -She had been asked to transport residents to appointments in her private vehicle. -She took the resident to dialysis because it was important, but she refused other requests to transport. -She did not feel comfortable driving residents in her private vehicle. -She was the only management staff in the building at times. -She did not have any clinical experience. If there was a concern with a residents condition, she would request the staff to call 911.	D 183		

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D 183	Continued From page 10 Non-compliance was identified at violation level in the following rule areas: A. Based on observations, interviews, and record reviews, the facility failed to assure proper infection control procedures for the use of glucometers for 5 of 7 residents sampled (Residents #3, 9, 10, 11, and 12) with orders for blood sugar monitoring. 2 of the diabetic residents in the facility had blood borne diseases. [Refer to tag 932 G.S. 131D 4.4 A(b) ACH Infection Prevention Requirements (TYPE B VIOLATION)] B. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for 5 of 7 sampled residents regarding physician notification of fingerstick blood sugar (FSBS) checks and scheduled Humalog insulin before meals to treat hyperglycemia were not administered for 19 days, resulting in a hospitalization with a blood sugar of 1200 (Resident #2); physician notification regarding blood pressure measurements outside of ordered parameters and medications not administered including Buspar (used to treat anxiety) and chlorhexidine gluconate (a mouthwash used to treat gingivitis) (Resident #5); follow-up with the pharmacy and physician related to 8 missed medications including metoprolol tartrate (used to treat high blood pressure), atorvastatin (used to treat high cholesterol), clonidine (used to treat high blood pressure), clopidogrel (used as a preventative for strokes), lisinopril (used to treat high blood pressure and heart failure), sertraline (used to treat clinical depression), amlodipine (used to treat high blood pressure and chest pain), and a multivitamin (Resident #3); a scratch to the lower right leg from a staff person's long	D 183		

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nails resulting in a wound requiring treatment at the wound clinic (Resident #13); and missed appointments due to a lack of transportation for a resident who required chemotherapy and radiation treatment for a diagnosis of breast cancer (Resident #1). [Refer to tag 0273, 10A NCAC 13F .0902 (b) Health Care (TYPE A1 VIOLATION)].

C. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 7 sampled residents including Buspar (used to treat anxiety) and chlorhexidine gluconate (a mouthwash used to treat gingivitis) (Resident #5); Novolin 70/30 insulin (used to treat high blood sugar) and amlodipine (used to treat high blood pressure and chest pain) (Resident #3); acetaminophen (prescribed for pain) (Resident #6); and related to hydralazine (used to treat high blood pressure) and Januvia (used to treat high blood sugar) (Resident #9).
[Refer to tag 0358, 10A NCAC 13F .1004 (a) Medication Administration (TYPE A2 VIOLATION)].

D. Based on observations, interviews, and record reviews, the facility failed to assure implementation of orders for 2 of 7 sampled residents including a resident diagnosed with breast cancer unable to get transportation from the facility for chemotherapy and radiation treatments, an appointment with her cardiologist for an echocardiogram and an appointment with her oncologist, resulting in the potential for a negative outcome for her cancer diagnosis (Resident #1); and a resident who had a diagnosis of chronic obstructive pulmonary disorder (COPD) with orders for a nebulizer

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treatment 4 times a day, who did not receive the medication potentially contributing to the exacerbation of their respiratory condition. [Refer to tag 0276, 10A NCAC 13F .0902 (c) (4) Health Care (TYPE A1 VIOLATION)].

E. Based on interviews and record reviews the facility failed to provide documentation of cardiopulmonary resuscitation training (CPR)for 22 of 23 employees in a 2 week scheduling period. [Refer to tag 0167 10A NCAC 13F .0507 Training on CPR (TYPE B VIOLATION)].

F. Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan and current symptoms for 1 of 2 sampled residents with a history of falls (Resident #5). [Refer to tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (TYPE B VIOLATION)].

G. Based on interviews and record reviews, the facility failed to ensure 2 of 7 sampled residents (Resident #1 and #7) were provided transportation to scheduled physician's appointments in regard to Resident #7 heart and vascular appointments, primary care medical physician appointments, and the digestive health physician appointments after hospital admissions on 11/28/18 and on 12/11/18, Resident #1 diagnosis of breast cancer had multiple chemotherapy appointments and multiple Oncologist's office appointments missed due to no transportation provided by the facility. [Refer to tag 0321, 10A NCAC 13F .0906 (a) Other Resident Care Services (Type B Violation)].

H. Based on observations, interviews, and record reviews, the facility failed to assure

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documentation was maintained in the resident's record for 5 of 7 sampled residents including emergency department discharge summaries and office visits with the mental health provider (Resident # 5); physician visit summaries and subsequent orders (Resident #6); home health treatment and services (Resident #13); physician visit summaries and follow up notes in addition to physician requested consult with pharmacist on medication administration (Resident #2); and chemotherapy and radiation treatment results and oncologist visit summaries (Resident #1). [Refer to tag 0433, 10A NCAC 13F .1201 (a) (6) Resident Records].

I. Based on observations, interviews, and record reviews, the facility failed to assure an individualized care plan was developed for 1 of 7 sampled residents (Resident #7) in conjunction with the resident assessment to be completed 30 days following admission.
[Refer to tag 0259, 10A NCAC 13F .0802 (a) Resident Care Plan].

J. Based on observations, interviews, and record reviews, the facility failed to assure that 3 of 7 residents' funds were accounted for and dispersed as required (Residents # 4,10 and 13), resulting in the potential for exploitation. [Refer to tag 0423, 10A NCAC 13F .1104 (e) Accounting for Resident Personal Funds].

K. Based on observations and interviews, the facility failed to assure the kitchen, dining and food storage areas including kitchen appliances, floors in the dining room and kitchen, and tables and chairs in the dining room were clean and protected from contamination.
[Refer to tag 0282 10A NCAC 13F .0904 (a) (1) Nutrition and Food Service].

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D 183	Continued From page 14 L. Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic menu for 5 of 5 sampled residents with physician's orders for therapeutic diets as evidenced by no mechanical soft menu for Residents #5, #14, and #17 and no puree menu for Residents #15 and #16. [Refer to tag 0296 10A NCAC 13F .0904 (c) (7) Nutrition and Food Service]. M. Based on observations and interviews, the facility failed to assure water was served to 35 of 86 residents during the lunch meal and 40 of 78 residents at the breakfast meal. [Refer to tag 0306 10A NCAC 13F .0904 (d) (3) (H) Nutrition and Food Service]. N. Based on record reviews and interviews the facility failed to assure a record of each transaction involving use of a resident's personal funds was signed by the resident, legal representative, or payee at least monthly for 5 of 7 residents (Residents #1, #5, #4, #3, and #10). [Refer to tag 0421, 10A NCAC 13 F .1104 (c) Accounting for Resdient's Personal Funds]. O. Based on interviews and record reviews, the facility failed to ensure 3 of 7 sampled residents (Residents #1, 2, and 13) were treated with consideration, respect and dignity as evidenced by delayed treatment due to missed chemotherapy appointments (Resident #1); a staff inflicted leg wound resulted in medical evaluation by a wound clinic specialist (Resident #13); and a scheduled dose of Humalog insulin before meals and the fingerstick blood sugar 4 times daily not administered for 19 days leading him to a hospitalization with a blood sugar of 1200. [Refer to tag 911, GS 131 D 21 (1)	D 183		

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D 183	Continued From page 15 Resident Rights]. P. Based on observations, interviews and record reviews, the facility failed to assure 3 of 7 residents (Resident # 4, #10, and #13) treated with respect and consideration and related to personal funds distribution and Resident #7 with consideration for missed physician appointments related to heart and vascular, gastroenterology and his primary physician. [Refer to tag 911, GS 131 D 21(1) Resident Rights]. _____ The facility's failure to assure consistent responsibility for the overall operation of the facility resulted in significant noncompliance with state rules and regulations related to infection: control protocol; medication administration; implementation and clarification of medications resulting in the hospitalization of a resident; supervision of residents with falls; insufficient documentation in resident records resulting in an exacerbation of a wound and a resident with a blood sugar of 1200; resident funds not dispersed in a timely and sufficient manner; CPR trained staff person on each shift; dining services in a dirty environment; transportation not provided for resident's appointments, including chemotherapy, radiation and wound care. This failure to assure responsibility for the overall operation, administration, management and supervision of the facility resulted in serious physical harm and neglect of other residents and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/19/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY	D 183		

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D 183	Continued From page 16 26, 2019.	D 183		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure a care plan was developed for 1 of 7 sampled residents (Resident #7) within 30 days following admission. The findings are: Review of Resident #7's current FL2 dated 10/04/18 revealed diagnoses included hypertension, renal insufficiency, Alzheimer's disease and chronic obstructive pulmonary disease. Review of Resident #7's Resident Register revealed the resident was admitted to the facility on 11/01/18 from home. Review of Resident #7's record revealed there was no care plan completed. Interview on 12/18/18 at 2:30pm with the Resident Care Coordinator (RCC) revealed: -Resident #7 was admitted to the facility on 11/05/18 not on 11/01/18.	D 259		

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-She did not know why a care plan had not been completed for Resident #7.
-The facility nurse completed the care plan assessments, but she had resigned about 3 months ago.
-She thought Resident #7 was total care but could feed himself.
-She thought staff were caring for Resident #7 and meeting his personal care needs.
-Resident #7 had used a cane on admission but currently used a wheelchair for ambulation.
-Resident #7 had been admitted to the hospital twice in 30 days of admission to the facility.

Review of Resident #7's hospital admission from 11/25/18 to 11/28/18 revealed:
-A diagnosis of a gastrointestinal bleed (GI) bleed.
-Documentation Resident #7 had lower extremity swelling and complaints of black stools for 1 month.
-Documentation Resident #7's functional status was semi-ambulatory (cane) and he required personal care assistance with bathing.

Review of another hospital admission from for Resident #7 dated 12/07/18 to 12/11/18 revealed a diagnosis of another GI bleed.

Observation of Resident #7 on 12/18/18 at 4:07pm revealed:
-He was in his room laying in the bed with his head covered with a blanket.
-He stated "my legs hurt".
-Resident #7 had bilateral edema lower extremities.
-There was a wheelchair located in the room near the bed.

Interview with a personal care aide (PCA) on

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12/19/18 at 9:35am revealed:
-She was never told what Resident #7 could or could not do for himself.
-Resident #7 needed assistance with dressing and getting out of bed.
-Resident #7 was incontinent of bowel and bladder.
-Resident #7 was walking with a cane when he was first admitted but, "he is a wanderer and always wanted to get out and go home."
-Resident #7 was now in a wheelchair so they could "keep an eye on him."
-The wheelchair belonged to another resident who was no longer in the facility.

Interview with a medication aide (MA) on 12/19/18 at 9:40am revealed:
-Resident #7 had declined since he was admitted to the facility.
-Resident #7 was in the hospital two times since his admission to the facility.
-Resident #7, "is too much for the staff to watch."
-Resident #7 had Alzheimer's and required staff to watch him all the time.
-Resident #7 tried to leave the facility on several occasions, "He said he wanted to go home."

Observation of Resident #7 on 12/19/18 at 10:53am revealed he was in the common area sleeping in a wheelchair.

Interview with a second PCA on 12/19/18 at 3:40pm revealed:
-She had been a PCA for "a long time and knew how to take care of the residents."
-Resident #7 used a wheelchair for ambulation, but he had to be watched all the time.
-The wheelchair belonged to another resident, but that resident was not in the facility anymore.
-No one had ever told her what personal care

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D 259	Continued From page 19 tasks Resident #7 required. -"He is total care, but can feed himself." Observation of Resident #7 on 12/19/18 at 1:35pm revealed: -Resident #7 was sitting in a wheelchair in the common area. -He stated, "I want to go see my family." Interview with Resident #7's Nurse Practitioner on 12/19/18 at 11:30am revealed: -Resident #7 was new to her services. -She could not recall signing a care plan for Resident #7 since his admission. -"Each time I've seen him [Resident #7] he's been in the bed." -"He [Resident #7] might possibly need skilled nursing." Interview on 12/20/18 at 3:40pm with the Administrator revealed: -The RCC was responsible for completing residents' care plans. -The care plans were to be completed within 7 days of admission to the facility. -The RCC was responsible for obtaining the physician's signature in a "timely manner".	D 259		
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.	D 270		

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

Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 1 of 2 sampled residents with a history of falls (Resident #5).

The findings are:

Review of the facility's "Falls Management Program" revealed:
-A fall risk assessment tool was to be completed for all residents admitted to determine factors that may contribute to possible falls.
-Staff were to complete an incident report for any fall.
-Staff were responsible for completing a 72 hour follow-up on resident falls to investigate possible circumstances contributing to the fall and document observations for the period of 72 hours after the fall.
-If a resident had two falls within a four week period, the physician would be contacted requesting an order for physical therapy (PT) evaluation or other treatment/interventions.
-For any fall, the resident was placed on the "hotbox and alert charting" for 72 hours for follow-up and monitoring.
-The healthcare team would review incident reports on a monthly basis.

Review of Resident #5's current FL-2 dated 09/14/18 revealed:
-Diagnoses included schizophrenia and intellectual disability.

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D 270	Continued From page 21 -The resident was documented as being semi-ambulatory. Review of Resident #5's Care Plan dated 01/19/18 revealed: -The resident was ambulatory with the use of a walker. -The resident required supervision with ambulation. -The resident required limited assistance with transfers. -The resident required extensive assistance with toileting. -The resident was fully dependent on staff for dressing. Review of Resident #5's record revealed: -On 08/28/18 at 6:47am, the resident was seen by a personal care aide (PCA) sitting on the floor beside his bed with no apparent injury, but the resident could not articulate what happened. -On the morning of 09/21/18 (exact time was not documented), the resident lost his balance and fell backwards, hitting his back on the counter in the Administrator's office; he was assessed by the Nurse Practitioner (NP) and found to have no injuries. -On 09/28/18 at 2:45pm, the resident fell getting off the bus in front of the facility; he had a small cut on his right eyelid and scrapes to his right hand knuckles; an X-ray was obtained and showed no evidence of fracture or dislocation. -On 10/02/18 at 3:11am, the resident was found on the floor beside his bed and stated he was attempting to get to the bathroom when he fell. There was no documentation as to whether any injuries were sustained. -On 10/17/18 at 1:46am, the resident was found on the floor in his room; he complained of pain and the medication aide (MA) administered	D 270		

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Tylenol.
-On 10/28/18 at 11:09am, the resident was observed lying on the floor in the television room; he stated he fell off his walker chair and complained of knee pain and hitting his head; he was sit to the Emergency Department (ED) and diagnosed with accident due to mechanical fall without injury and knee pain.
-Resident #5 had six falls from 08/28/18 to 10/28/18, one of which resulted in admission to the ED and no documentation of interventions.

Interview on 12/18/18 at 8:40am with Resident #5 revealed:
-He had fallen on 12/17/18 while standing up from his dining room chair during dinner and was sent to the ED.
-"My leg just gave out."
-"I hurt my elbow and head, but I'm okay now."

Review of incident reports provided by facility staff for Resident #5 and staff charting notes printed on 12/20/18 revealed no documentation of Resident #5's fall on 12/17/18.

Confidential interview with a resident on 12/17/18 at 9:49am revealed:
-Resident #5 "falls a lot."
-The MAs and PCAs told Resident #5 they could not come to his room to assist him "unless it was an emergency."

Telephone interview with Resident #5's responsible party (RP) on 12/18/18 at 2:48pm revealed:
-Resident #5 had "slipped and fallen" on 12/17/18 and was sent to the ED.
-An X-ray was obtained and Resident #5 was "okay."
-Resident #5 had frequent falls.

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-On 12/17/18, he was wearing flip-flop shoes which caused him to fall.
-The RP had spoken to the MAs and PCAs about not allowing Resident #5 to wear flip-flop shoes or slippers after a previous fall (she could not recall when). She had removed slippers from his room at one time.
-The RP had requested a hospital bed for Resident #5 after he had fallen out of bed several times and he was provided one "last month"
-She did not think the staff had increased supervision for Resident #5 to help prevent his falls.
-"They need to watch him more, and make sure he's not wearing shoes that will make him fall."

Interview with a PCA on 12/19/18 at 9:30am revealed:
-She was never working when Resident #5 fell, but she was aware that he was a fall risk.
-Resident #5 was "clumsy" which contributed to his falls.
-She checked on all residents every two hours.
-She had never been instructed to check on Resident #5 more often or provide increased supervision.

Interview with a second PCA on 12/19/18 at 9:40am revealed:
-Resident #5 fell frequently due to his poor vision.
-She checked on all residents every two hours and documented the checks on a reporting form.
-She had not been instructed to check on Resident #5 any more often than two hours or do anything any differently to help prevent his falls.

Interview with a MA on 12/19/18 at 10:00am revealed:
-Resident #5 had frequent falls and most falls occurred on second shift most likely because he

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was out of the facility most days during first shift.
-Resident #5 often fell because he would lose his balance.
-He had never received PT services that she was aware.
-A hospital bed had been provided to Resident #5 "a couple of months ago" to prevent him from falling out of bed.
-Resident #5's family had removed slippers from his room at one time because they were causing him to fall.
-All residents were checked on every two hours.
-There had been no increase in supervision for Resident #5.

Interview with the Resident Care Coordinator (RCC) on 12/19/18 at 2:00pm revealed:
-She had been employed with the facility since mid-October 2018.
-She was not aware of a facility falls protocol or falls management program, but staff were supposed to complete an incident report after every fall.
-Staff were to check the resident's vital signs, notify the responsible party and the Primary Care Provider (PCP) after each fall.
-If a resident hit their head during a fall, they were to be sent to the ED.
-The incident reports were supposed to be reviewed by the nurse (or herself while the nurse position was vacant) and the Administrator prior to sending them to their corporate "protocol" department.
-All falls should be reported to her (the RCC), but "that didn't always happen."
-No assessment had been done to determine why Resident #5 was having frequent falls "to her knowledge."
-Resident #5 had been provided a hospital bed due to falling out of his regular bed prior to her

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being employed at this facility.
-She did not think Resident #5 had ever received PT services.
-Staff checked on all residents every two hours.
-Supervision had not been increased for Resident #5 to help prevent his falls.
-She had considered moving Resident #5's room closer to the nurse's station because his room was "so far away," but had not done so due to most of the rooms close to the nurse's station were occupied by females.
-She was only able to locate one incident report for Resident #5 since his admission to the facility on 12/05/17.
-She did not know why there was no documentation of Resident #5's fall on 12/17/18.

Interview with Resident #5's PCP on 12/18/18 at 11:00am revealed:
-Resident #5 frequently fell due to gait instability, medications and his age.
-He had ordered a hospital bed for Resident #5 "recently" and it had helped to prevent him from falling out of bed.
-Resident #5 should have had PT services, but he could not recall if he had ordered it or if Resident #5 had received services.
-Typically the facility would identify residents who could benefit from PT services and would request an order from him.
-To help prevent Resident #5 from falling in the future, the staff should monitor him more frequently and consider moving the resident's room closer to the nurse's station.
-If Resident #5 continued to fall, it could put him at risk for injuries such as broken bones.

Interview with the Administrator on 12/20/18 at 4:20pm revealed:
-If a resident had a pattern of falls as Resident #5

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D 270	Continued From page 26 had, the staff should involve PT and refer the resident to his PCP to rule out anything "clinical." -She did not know if any interventions had been put into place to prevent Resident #5 from falling. -All resident were checked on every two hours, but she did not know if Resident #5 was checked on any more often than other residents. _____ The facility failed to provide adequate supervision for 1 of 2 sampled residents with a history of falls related to Resident #5 with a recent history of falls who had 6 falls in two months with 2 local emergency department visits. This failure was detrimental to the resident's health, safety and welfare and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/16/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 8, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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D 273	Continued From page 27 TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up for 5 of 7 sampled residents (Resident #2, #3, #4, #5, and #7) regarding physician notification for Resident #2 whose physician was not notified that his finger stick blood sugar (FSBS) four times daily and his scheduled Humalog insulin before meals was not on the electronic medication administration record (eMAR) for the month of November, 11/01/18-11/19/18, leading him to the hospital for a blood sugar (BS) of 1200 causing an insulin deficiency and dehydration; Resident #3 who missed 6 medications including metoprolol tartrate (used to treat high blood pressure), atorvastatin (used to treat high cholesterol), clonidine (used to treat high blood pressure), clopidogrel (used as a blood thinner to prevent stroke), lisinopril (used to treat high blood pressure and heart failure), and sertraline (used to treat clinical depression); Resident #4's Respimat inhaler (used to treat respiratory flare ups) refusals; Resident #5 regarding blood pressure measurements outside of ordered parameters and medications not administered including Buspar (used to treat anxiety) and chlorhexidine gluconate (a mouthwash used to treat gingivitis) and Resident #7 related to missed appointments with the gastroenterologist, heart and vascular physician and the primary care physician after a hospital discharge. 1. Review of Resident #2's current FL2 dated 09/14/18 revealed: -Diagnoses included type 2 diabetes mellitus uncontrolled, hypertension, and chronic kidney disease. -Medications included Humalog insulin, (a long	D 273		

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acting insulin used to control blood sugar spikes in diabetics), 100units/ml, inject 15 units subcutaneously (SQ) before each meal; Humalog insulin 100units/ml inject 8 units SQ with snacks; Humalog 100units/ml inject SQ per sliding scale; Lantus Solostar, (a long acting insulin used to control blood sugar spikes in diabetics),100units/ml inject 65 units SQ at bedtime.
-There was an order for FSBS checks before meals and at bedtime.

Review of Resident #2's subsequent physician's orders dated 10/11/18 revealed:
-There was a physician's order on 10/11/18 to discontinue sliding scale insulin (SSI) and discontinue 8 units of Humalog with snacks; increase Humalog insulin to 20 units before each meal from 10/11/18-10/25/18; check FSBS four times daily from 10/11/18-10/25/18 and increase Lantus insulin to 70 units at bedtime - follow up in 2 weeks to evaluate.

Review of Resident #2's record revealed:
-There was no documentation of a follow up visit in 2 weeks with the primary care physician (PCP).
-There were no new orders following this 2 week period in the resident's record.
-There was no record of a follow up visit by the physician for evaluation in the month of October.

Review of Resident #2's October 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check FSBS 4 times daily.
-FSBS values were documented daily at 7:00am with a FSBS range from 66-400 .
-FSBS values were documented daily at 11:30am with a FSBS range from 99-563 .
-FSBS values were documented daily at 4:30pm

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D 273	Continued From page 29 with a FSBS range from 74-407. -FSBS values were documented daily at 8:00pm with a FSBS range from 86-257. -There was an entry from 10/01/18-10/16/18 for Humalog KwikPen 100unit/ml to be administered before each meal and at bedtime, after the FSBS check, per sliding scale parameters. -The sliding scale Humalog insulin was documented daily at 7:00am with a range of 0-14 units administered from 10/01/18-10/16/18. -The sliding scale Humalog insulin was documented daily at 11:30am with a range of 0-14 units administered from 10/01/18-10/16/18. -The sliding scale Humalog insulin was documented daily at 4:30pm with a range of 0-8 units administered from 10/01/18-10/16/18. -The sliding scale Humalog insulin was documented daily at 8:00pm with a range of 0-8 units administered from 10/01/18-10/16/18. -There was an entry from 10/01/18-10/16/18 for Humalog KwikPen 100unit/ml, 15 units, scheduled to be administered before each meal. -There was an entry from 10/01/18-10/16/18 for Humalog KwikPen, 8 units, scheduled to be administered with snacks at 3:00pm and 8:00pm. -There was an entry from 10/01/18-10/16/18 for Lantus Solostar insulin, inject 65 units at bedtime. -There was an entry on 10/17/18 to discontinue Humalog KwikPen per sliding scale parameters. -There was an entry on 10/17/18 to discontinue Humalog Kwikpen 15 units, scheduled to be administered before each meal. -There was an entry on 10/17/18 to discontinue Humalog KwikPen 8 units, scheduled to be administered with snacks at 3:00pm and 8:00pm. -There was an entry on 10/17/18 to discontinue Lantus Solostar 65 units, scheduled to be administered at bedtime. -There was an entry on 10/17/18 for Humalog Kwikpen 20 units scheduled to be administered	D 273		

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before meals for 2 weeks, from 10/17/18-10/30/18,.
-There was an entry to check FSBS before meals and at bedtime for 14 days, from 10/17/18-10/30/18.

Review of Resident #2's November 2018 eMAR revealed:
-There was no entry to check FSBS 4 times daily.
-There was no entry for Humalog insulin to be administered before each meal.
-There was an entry for Lantus insulin 70 units at bedtime.

Telephone interview with a representative from the facility contracted pharmacy on 12/19/18 at 9:43am revealed:
-Physician orders were received from the facility staff to discontinue Humalog SSI and Humalog insulin with snacks on 10/16/18.
-There was a physician's order, dated 10/11/18, to check the FSBS 4 times a day for 2 weeks and to increase the Humalog insulin to 20 units before meals for 2 weeks.
-No further orders were received from the primary care physician (PCP) or facility regarding the FSBS 4 times daily or Humalog insulin 20 units before meals.
-Without any new orders, the Humalog insulin before meals and the FSBS 4 times a day was not entered on the November eMAR.
-The pharmacy log did not shave documentation of any further communication from the facility regarding these 2 orders.

Review of physician contracted pharmacist's visit summary on 10/31/18, not in Resident #2's record, and requested by surveyor revealed:
-The PCP had requested a pharmaceutical consult to review Resident #2's medication

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regiment.
-The pharmacist assessment of Resident #2 was "worsening-Type 2 diabetes mellitus uncontrolled".
-Resident #2 may have benefited from changing from Lantus insulin to Tresiba, which has a longer half life, and may address low morning blood sugars.
-The Humalog insulin and FSBS were not recommended for change.
-She would review and discuss with the provider recommendations for changes.

Telephone interview with the physician contracted pharmacist on 12/20/18 at 5:10pm revealed:
-She did not know the Humalog insulin and FSBS four times a day were not being administered in November.
-She saw the order for the PCP to evaluate in 2 weeks.
-She did not recommend the Humalog insulin before meals and the FSBS be discontinued on an uncontrolled diabetic.
-She had not had a conversation with the PCP since she submitted her recommendations from the 10/31/18 visit on 11/02/18.

Review of the physician visit summary report not in Resident #2's record on 11/07/18 revealed:
-PCP ordered a repeat A1C blood test to determine the 3 month average of blood glucose levels for Resident #2.
-The optimal baseline the PCP set for the results of the A1C was less than 7.0.
-Resident #2's A1C results were 8.6.
-No medication or treatment changes were ordered at this visit.
-The next scheduled visit was in 2 weeks.

Review of Resident #2's progress notes dated

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D 273	Continued From page 32 11/19/18 and timed for 2:09pm revealed: -Resident #2 was trying to open the door to the dining room when he yelled "Help" and fell to the floor. -The resident was assisted to a chair and was observed drooling. -The MA checked his FSBS with his glucometer and it registered "Hi" - above 550. -The PCP was contacted. -The FSBS was checked in 30 minutes a second time and continued to register "Hi". -The paramedics were called and checked Resident #2's FSBS-the reading was "Hi". -The paramedics transported the resident to the hospital. Interview with the PCP on 12/18/18 at 10:30am revealed: -Resident #2 was noncompliant with his diet. He ate frequently from the snack machine. -Due to his non compliance, the PCP was evaluating changes in the resident's insulin. -He discontinued the sliding scale insulin and increased the resident's insulin at bedtime (Lantus 70 units). -The PCP also increased the resident's insulin before meals (Humalog 20 units). -He wanted to see what effect that would have on Resident #2's FSBS readings over the next 2 weeks. -The PCP's contracted pharmacist was sent to review Resident #2's medications, as part of the protocol of his clinic, for consultation. -He was reviewing the A1C results and the pharmacist recommendations when he visited with the resident on 11/07/18 at the facility. -He did not know the Humalog insulin 20 units before meals was not administered until the Resident was admitted to the hospital on 11/19/18.	D 273		

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-He did not know the FSBS checks four times a day were not administered from 10/30/18 through 11/19/18.
-"If I do not have the eMAR in front of me when I come into the facility I do not know if there have been changes or omissions."
-He would have wanted the facility to inform him the Humalog insulin before meals and the FSBS 4 times a day were not on the November eMAR.
-It was not his intention to have the Humalog 20 units before meals and the FSBS 4 times a day to be discontinued.
-He does not know if this contributed to Resident #2's hospitalization since he did not know the admitting diagnosis.

Interview with the first shift MA on 12/19/18 at 11:40am revealed:
-Resident #2 was compliant and pleasant.
-He seemed a bit slower and less engaged lately.
-He seemed a bit more unsteady on his feet.
-There was nothing that would have been alarming until the day he was sent to the hospital.
-She did notice his Humalog and FSBS were not on the November eMAR, from 11/01/18 until he was admitted to the hospital on 11/19/18..
-She questioned the resident but he did not know why he was not getting FSBS checks or Humalog before meals.
-She did not report this to anyone. "I just administer the medications as listed on the eMAR."

Interview with the supervisor on 12/19/18 at 10:46 am revealed:
-She had not noticed any change in Resident #2.
-She observed the Humalog insulin and FSBS were not on the November eMAR.
-She did not oversee the eMARs.
-The nurse was responsible for verifying orders

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on the eMAR.
-In the absence of the nurse, it was the responsibility of the Resident Care Coordinator (RCC) to review the orders and the eMAR.
-If it was a physicians order she did not question it.
-She administered medications as shown on the eMAR.

Interview with Resident #2's family member on 12/20/18 at 1:15pm revealed:
-The PCP never contacted the family regarding the changes in insulin.
-She did not know Resident #2 was not getting his Humalog before meals and FSBS checks 4 times a day until the hospital requested his eMAR for the month of November.
-Before his hospitalization, he was ambulating with a walker, eating a regular diet, talking and mostly independent with his grooming.
-In the hospital was diagnosed with hyperglycemia with a blood sugar of 1200 when he arrived to the emergency room.
-Now he was bedridden, could not speak and was on a feeding tube.
-He was totally dependent for care at this time.

Review of the hospital admission records for Resident #2 dated 11/19/18 revealed:
-Resident #2 was admitted to the hospital with the diagnoses of diabetic ketoacidosis without coma from type 2 diabetes mellitus.
-He was experiencing extreme hyperglycemia with a blood sugar level of 1200 upon examination.
-During the course of his hospitalization, he had suffered a stroke.
-He was assessed as a maximum assistance of 2 plus persons to transfer and for bed mobility, expressive aphasia and right sided weakness.

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D 273	Continued From page 35 2. Review of Resident #3's current FL2 dated 10/02/18 revealed: -Diagnoses included hypertension, cerebral vascular accident, hyperlipidemia, and chronic kidney disease stage 3. -An order for atorvastatin 80mg one half tablet at bedtime (used to treat high cholesterol). -An order for clopidogrel 75mg one tablet once daily (used to prevent heart attack or stroke). -An order for clonidine 0.2mg one tablet three times daily (used to treat high blood pressure). -An order for Lisinopril 40mg one tablet daily (used to treat high blood pressure). -An order for metoprolol tartrate 50mg one tablet twice daily (used to treat high blood pressure). -An order for sertraline 50mg one half tablet once daily (used to treat depression). Review of Resident #3's November 2018 electronic Medication Administration Record (eMAR) revealed: -An entry for atorvastatin 80 mg one half tablet daily at 8:00pm, with 26 out of 30 doses documented as not administered, with "med not in facility" and "out of facility/appointment" documented. -An entry for clopidogrel 75 mg one tablet daily at daily at 8:00am, with 12 out of 30 doses documented as not administered, with "med not in facility" and "out of facility/appointment" documented. -An entry for clonidine 0.2mg one tablet three times daily at 8:00am, 12:00pm, and 8:00pm, with 61 out 88 doses documented as not administered with "med not in facility" and "out of facility/appointment". -An entry for metoprolol tartrate 50mg one tablet at 8:00am and 8:00pm, with 25 out of 60 doses documented as not administered with "med not in	D 273		

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facility" and "out of facility/appointment" documented.
-An entry for sertraline 50mg one half tablet daily at 8:00am with 11 out 30 doses documented as not administered with "med not in facility, out of facility/appointment" documented.
-Blood pressure readings ranged from 157/84-209/123.

Review of Resident #3's December 2018 eMAR revealed:
-An entry for atorvastatin 80 mg one half tablet daily at 8:00pm, with 15 out of 16 doses documented as not administered, with "med not in facility" and "out of facility/appointment" documented.
-An entry for clopidogrel 75 mg one tablet daily at daily at 8:00am, with 3 out of 17 doses documented as not administered, with "med not in facility" and "out of facility/appointment" documented.
-An entry for metoprolol tartrate 50mg one tablet at 8:00am and 8:00pm, with 7 out of 33 doses documented as not administered, with "med not in facility" and "out of facility/appointment" documented.
-An entry for Lisinopril 40mg tablet daily at 8:00pm with 7 out of 16 doses documented as not administered with "med not in facility, out of facility/appointment" documented.
-An entry for sertraline 50mg one half tablet daily at 8:00am with 11 out 16 doses documented as not administered with "med not in facility, out of facility/appointment" documented.
-Blood pressure readings ranged from 88/86-183/102.

Review of Resident #3's record revealed he was sent to the emergency room for hypertension, with a blood pressure reading of 178/88 on

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D 273	Continued From page 37 10/16/18. Interview with Resident #3 on 12/17/18 at 3:40pm revealed: -There were times the facility ran out of his medications because they were not reordered in time. -He relied on the facility to order his medications when he ran out. -He experienced high blood pressure because he missed his blood pressure medications for "several days". -"I didn't feel too good" when blood pressure medications were missed. -He ran out of depression medication and felt "down and depressed". Interview with Resident #3 on 12/18/18 at 3:20pm revealed: -He felt "dizzy and sluggish" last month when his blood pressure medications were missed. -He used a machine provided by his insurance company to check blood pressure daily and "it was very high". -He also experienced "light chest pain" when medication was missed, and he had notified staff, however he was not sure if his physician was notified. Interview with a first shift Medication Aide (MA) on 12/18/18 at 9:50am revealed: -There were some issues with getting Resident #3's medications delivered from his contracted pharmacy. -It usually took 10 days for medications to be ordered and mailed to the facility. -She could not remember who called the pharmacy to get Resident #3's medications delivered. -She remembered hearing verbally from another	D 273		

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MA that the contracted pharmacy was contacted to get medications delivered but did not know when or the specific medications.
-She did not remember calling the pharmacy to have Resident #3's blood pressure medications delivered.
-She did not notify the physician that Resident #3 was missing several doses of his blood pressure medications "I forgot".
-All MAs were responsible for ordering refill of medications.

Interview with a second shift MA on 12/18/18 at 3:33pm revealed:
-She knew that Resident #2 was out of his blood pressure, heart, depression and cholesterol medications, and she notified the Resident Care Coordinator (RCC).
-She could not remember when she notified the RCC and did not document the communication anywhere.
-She communicated with the MA when changing shift that medications were not available for Resident #3.
-She did not notify the physician of missed blood pressure, heart, or depression medications.
-She did not know who was responsible for notifying the physician when medications were missed.
-She did not know who to follow-up with when medications were missed.

Interview with another second shift MA on 12/18/18 at 3:40pm revealed:
-She knew Resident #3 was out of some of his medications in November 2018.
-She called the pharmacy "once" about Resident #3's blood pressure medication, but was not sure if they were delivered.
-The pharmacy representative informed her that

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the atorvastatin, clopidogrel, clonidine, Lisinopril, metoprolol, and sertraline was on its way.
-She thought the previous RCC handled the delivery of Resident #3's medications.
-She had not followed up with the pharmacy regarding Resident #3's missed medications, "I don't know why I didn't contact the pharmacy or physician".
-"It has been a mess, I am not sure who is responsible for following up with the pharmacy or the physician".
-There had been a "communication failure", "I thought the previous RCC ordered medications".
-She requested a "24 hour communication book", but it had not been implemented.

Telephone interview with a representative from Resident #3's primary pharmacy on 12/18/18 at 10:39am revealed:
-The resident did not receive automatic refills of his medications; the facility would need to call to have medications refilled.
-He did not see any documentation of the staff calling to request refills for sertraline, metoprolol, Lisinopril, atorvastatin, clonidine, or clopidogrel.
-Most refills for Resident #3 occurred following medical appointments with physicians.

Telephone interview with Resident #3's primary care physician on 12/19/18 at 2:47pm revealed:
-She was not aware Resident #3 was missing blood pressure, heart, cholesterol, or depression medications.
-She would expect to be notified about missed medications.
-She did not know medications had not been filled by the contracted pharmacy.
-She would want to know about missed medications so that an emergency supply of medications could be sent to administer.

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D 273	Continued From page 40 -Resident #3 was at risk for a heart attack or stroke when systolic blood pressure is over 160 due to his past medical history. Review of the facility's emergency and after hour medications policy revealed: -"Whenever there is a need to obtain medications for routine medications not available from pharmacy it should be obtain on an emergency or after hour basis". -"The supervisor-in-charge/med tech should contact the pharmacy or on-call pharmacist and communicate to him/her the medication order in its entirety". -"If all attempts to contact the pharmacist fail the SIC should take whatever steps necessary to secure the required medications, including contacting the back-up pharmacy directly". -"The community may need to pick up the medications from the back-up pharmacy or other alternate source of supply. Interview with the RCC on 12/19/18 at 2:31pm revealed: -The process for ordering medications had been "a challenge". -Medications were to be ordered 5-7 days in advanced to prevent medication from running out. -All of the MAs were responsible for contacting the pharmacy for refills and checking daily until it arrived. -All MAs were responsible for notifying the physician when a medication is missed after 3 days. -She was notified of missed clonidine doses by the nurse from the contracted home health agency. -She contacted the pharmacy about having the clonidine sent to the facility. -She thought she sent a fax notifying the	D 273		

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physician of the missed medications.
-She did not know about missed doses of Lisinopril, metoprolol, sertraline, clopidogrel, or atorvastatin and would have expected the physician to be notified.
-She was not sure why so many of the medications were missed for Resident #3.

Interview with the Administrator on 12/19/18 at 10:28am revealed:
-She did not know Resident #3's contracted pharmacy was not contacted to get Resident #3's medications in the facility.
-She expected the RCC to follow-up with the pharmacy and the physician.
-MAs should also be notifying the RCC when medication was not available and when it was missed to ensure the physician was notified and pharmacy was contacted.

3. Review of Resident #4's current FL-2, dated 9/4/18, revealed:
-Diagnoses included coronary artery disease with pervious myocardial infarction, hypertension, history of stroke, hyperlipidemia, diabetes mellitus type 2, congestive heart failure, morbid obesity, osteoarthritis, schizophrenia, and dementia.
-An order for tiotropium-olodaterol (Stiolto Respimat - indicated for long-term maintenance in patients with chronic obstructive pulmonary disease, including chronic bronchitis and/or emphysema), 2.5mcg, twice daily.

Review of Resident #4's October 2018 Medication Administration Records (MAR) revealed:
-An entry for "Stiolto Respimat 2.5/2/5 AER - Inhale 2 puffs twice a day (shake well)"
-Documentation reflected that Respimat was not

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administered to Resident #4 on 48 out of 62 opportunities in October 2018.
-Documentation on 10/1/18, by the medication aide (MA): "resident does not like this medication with her other medications at night, med tech asked resident if she would like it at another time but she just refused the medication."

Review of Resident #4's November 2018 MAR revealed:
-An entry for "Stiolto Respimat 2.5/2/5 AER Inhale 2 puffs twice a day (shake well)."
-Documentation reflected that Respimat was not administered to Resident #4 on 42 out of 60 opportunities in November 2018.
-Documentation reflected on 11/2/18, 11/3/18, 11/4/18 and 11/5/18 that "medication was not in facility".
-All other doses of Respimat missed in November were documented as "resident refused."

Review of Resident #4's December 2018 MAR (12/1/18 - 12/17/18) revealed:
-An entry for "Stiolto Respimat 2.5/2/5 AER - Inhale 2 puffs twice a day (shake well)."
-Documentation reflected Respimat was not administered to Resident #4 on 28 out of 33 opportunities because "resident refused."

Review of Resident #4's charting notes revealed on 10/4/18 a MA documented that "resident refuses Stiolto Respimat 2.5/2.5 AER consistently. Follow with [physician's name].

Interview with Resident #4 on 12/18/18 at 10:40am revealed:
-She saw her primary care physician (PCP) last week because she was sick with a cough and congestion and was not breathing as well as she usually did.

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-She often refused her Respimat inhaler at night because she felt like it "hyped her up" and prevented her from going to sleep.
-The MAs no longer offered her the inhaler. She would use the inhaler in the morning if it were offered to her. She was not aware she was supposed to be getting the inhaler twice a day.
-She had told the Resident Care Coordinator (RCC) that she wanted to see the physician again this week since she was not feeling any better.
-The RCC told her she would "add her to the list" of residents to be seen by the doctor this week.
-She was wearing her oxygen today, which she normally only wore at night, because she was not breathing as well as she usually did.

Interview with a Medication Aide (MA) on 12/18/18 at 11:30am revealed:
-Resident #4 frequently refused her Respimat inhaler in the morning. She always offered the inhaler to Resident #4 when she was administering her other morning medications.
-It was the RCC's responsibility to review a report from the MAR system to identify refusals and to communicate with physician regarding medication refusals.

Interview with a second MA on 12/18/18 at 2:20pm revealed:
-Resident #4 "almost always" refused her Respimat inhaler.
-MAs were supposed to document refusals on the MAR and the RCC was supposed to review refusals and notify the physician.

Interview with the RCC on 12/18/18 at 4pm revealed:
-She was aware that Resident #4 frequently refused her Respimat inhaler from MAs.
-When MAs notified her that Resident #4 was

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refusing the inhaler, she attempted to administer it herself, and Resident #4 "always" took the inhaler from her, however; MAs did not always notify her of refusals.
-She tried to review the "refusal report" from the electronic MAR system routinely to look for patterns of refusals.
-She was "not sure" if she had communicated with Resident #4's physician regarding refusals of her Respimat inhaler.

Interview with Resident #4's former Primary Care Physician (PCP) on 12/18/18 at 11:45am revealed:
-He last saw Resident #4 on 11/21/18.
-Resident #4 had an order for Respimat inhaler, twice daily, to treat her chronic obstructive pulmonary disease (COPD), to prevent her from having shortness of breath.
-He did not know Resident #4's had refused her Respimat inhaler.
-If he had known she was refusing her Respimat, he would have counseled her on the importance of using Respimat as directed, to slow her disease progression.
-The potential outcome of Resident #4 not using Respimat as ordered was increased shortness of breath.
-He expected the staff would inform him of refusals of medication so that he could take appropriate action to assure his patients needs were met.

Interview with Resident #4's current Primary Care Physician on 12/19/18 at 11:23am revealed:
-She had not been notified of the refusals of Resident #4's Respimat inhaler.
-She had seen Resident #4 last week because she was not feeling well and was congested.
-She was seeing Resident #4 again today and

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would talk with her regarding the importance of using the Respimat inhaler as directed.
-Refusals of Respimat could result in worsening of respiratory symptoms and disease progression.

4. Review of Resident #5's current FL-2 dated 09/14/18 revealed diagnoses included schizophrenia and intellectual disability.

a. Review of Resident #5's subsequent physician's orders dated 10/11/18 revealed an order for Buspar 5mg three times daily (a medication used to treat anxiety).

Review of Resident #5's October 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Buspar 5mg to be administered at 8:00am, 12:00pm and 8:00pm with a start date of 10/11/18.
-There was documentation Buspar was not administered for four of twenty opportunities at 12:00pm due to "out of facility/appointment."

Review of Resident #5's November 2018 eMAR revealed:
-There was an entry for Buspar 5mg to be administered at 8:00am, 12:00pm and 8:00pm.
-There was documentation Buspar was not administered for thirteen of thirty opportunities at 12:00pm due to "out of facility/appointment."

Review of Resident #5's December 2018 eMAR revealed:
-There was an entry for Buspar 5mg to be administered at 8:00am, 12:00pm and 8:00pm.
-There was documentation Buspar was not administered for nine of seventeen opportunities at 12:00pm due to "out of facility/appointment."

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D 273	Continued From page 46 Interview with a medication aide (MA) on 12/19/18 at 10:00am revealed: -She often worked day shift and administered medications to Resident #5. -Resident #5 attended psychosocial rehabilitation three days each week leaving the facility around 9:00am and returning around 2:30pm. -She did not administer 12:00pm medications to Resident #5 when he was out of the facility at rehab and would document "out of facility/appointment." -She had not considered discussing with Resident #5's Primary Care Provider (PCP) or mental health provider's Physician Assistant (PA) about him missing medications, but "I probably should have" so they could adjust his dose or dosing schedule. Interview with the Resident Care Coordinator (RCC) on 12/19/18 at 2:00pm revealed: -She sometimes worked as an MA and administered medications to Resident #5. -If Resident #5 was out of the facility during the 12:00pm medication pass, she and the other MAs would not administer medications to him and would document he was "out of facility/appointment." -She knew Resident #5 routinely missed his 12:00pm medications when he attended the rehab program, but "it never registered to me to speak with his PCP or mental health provider PA" to see if the timing of his medications could be changed. Telephone interview with Resident #5's psychosocial therapist on 12/19/18 at 8:50am revealed: -She had been providing psychosocial therapy to Resident #5 since March 2018.	D 273		

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-Resident #5 was ordered Buspar by the mental health provider's Physician's Assistant (PA) due to his diagnosis of anxiety.
-At times, Resident #5's anxiety was so severe that it affected his breathing.
-Resident #5's overall functioning was better when his anxiety was well controlled.
-It was important for Resident #5 to attend psychosocial rehabilitation meetings to teach him appropriate social skills and reduce his social anxiety, but due to his anxiety, he would often hide in the facility's bathroom when the van driver would arrive to take him to the meetings.
-She did not know Resident #5 was missing his 12:00pm dose of Buspar when attending the psychosocial rehabilitation meetings.
-She expected the facility to notify her if a resident was not receiving their mental health medications.
-She expected facility staff to notify the PA regarding Resident #5 missing doses of Buspar so the PA could determine any changes that needed to be made.
-She did not think Resident #5's PA had been notified because the PA had not communicated the information to her.

Telephone interview with Resident #5's mental health provider's PA on 12/19/18 at 11:00am revealed:
-He visited Resident #5 at the facility once monthly.
-He had ordered Buspar 5mg three times daily for Resident #5 on 10/11/18 to treat his anxiety.
-He had last visited with Resident #5 on 11/08/18 and he continued to have complaints of anxiety.
-He did not know Resident #5 was routinely missing his 12:00pm dose of Buspar.
-He would expect to be notified if a resident was routinely missing a medication so the dose or

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D 273	Continued From page 48 timing of the medication could be adjusted. Interview with Resident #5's PCP on 12/18/18 at 11:00am revealed: -Resident #5 was ordered Buspar 5mg three times daily to treat his anxiety. -He did not know Resident #5's Buspar 12:00pm dose was not being administered if he was out of the facility. -He would expect to be notified if a resident was routinely missing a medication so the dose or timing of the medication could be adjusted. -He worked closely with Resident #5's mental health provider for continuity of care. Interview with the Administrator on 12/20/18 at 4:00pm: -She did not know Resident #5's PCP had not been notified regarding him missing medications while at the rehab program. -She expected the MAs to notify the resident's PCP if the resident missed a medication. b. Review of Resident #5's current FL-2 dated 09/14/18 revealed medication orders included chlorhexidine gluconate (a mouthwash used to treat gingivitis), rinse with 15 milliliters (mls) three times a day at 8:00am, 12:00pm and 8:00pm. Review of Resident #5's October 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for chlorhexidine gluconate 15 mls to be administered at 8:00am, 12:00pm and 8:00pm. -There was documentation chlorhexidine gluconate was not administered for seven of thirty-one opportunities at 12:00pm due to "out of facility/appointment."	D 273		

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Review of Resident #5's November 2018 eMAR revealed:
-There was an entry for chlorhexidine gluconate 15 mls to be administered at 8:00am, 12:00pm and 8:00pm.
-There was documentation chlorhexidine gluconate was not administered for thirteen of thirty opportunities at 12:00pm due to "out of facility/appointment."

Review of Resident #5's December 2018 eMAR revealed:
-There was an entry for chlorhexidine gluconate 15 mls to be administered at 8:00am, 12:00pm and 8:00pm.
-There was documentation chlorhexidine gluconate was not administered for nine of seventeen opportunities at 12:00pm due to "out of facility/appointment."

Interview with a medication aide (MA) on 12/19/18 at 10:00am revealed:
-She often worked day shift and administered medications to Resident #5.
-Resident #5 attended psychosocial rehabilitation three days each week leaving the facility around 9:00am and returning around 2:30pm.
-She did not administer 12:00pm medications to Resident #5 when he was out of the facility at rehab and would document "out of facility/appointment."
-She had not considered discussing with Resident #5's PCP about him missing medications, but "I probably should have" so he could adjust his dose or dosing schedule.

Interview with the Resident Care Coordinator (RCC) on 12/19/18 at 2:00pm revealed:
-She sometimes worked as an MA and administered medications to Resident #5.

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-If Resident #5 was out of the facility during the 12:00pm medication pass, she and the other MAs would not administer medications to him and would document he was "out of facility/appointment."
-She knew Resident #5 routinely missed his 12:00pm medications when he attended the rehab program, but "it never registered to me to speak with his PCP" to see if the timing of his medications could be changed.

Interview with Resident #5's PCP on 12/18/18 at 11:00am revealed:
-He did not know Resident #5's chlorhexidine gluconate 12:00pm dose was not being administered if he was out of the facility.
-He would expect to be notified if a resident was routinely missing a medication so the dose or timing of the medication could be adjusted.

Interview with the Administrator on 12/20/18 at 4:00pm:
-She did not know Resident #5's PCP had not been notified regarding him missing medications while at the rehab program.
-She expected the MAs to notify the resident's PCP if the resident missed a medication.

c. Review of Resident #5's current FL-2 dated 09/14/18 revealed medication orders included metoprolol tartrate 50mg one tablet every morning and metoprolol tartrate 50mg one half tablet at bedtime [a medication used to treat high blood pressure (BP)].

Review of Resident #5's subsequent physician's orders dated 09/23/18 revealed an order for "metoprolol 50mg, check BP and pulse." Notify Primary Care Provider (PCP) if systolic pressure was greater than 190 or less than 90 or if diastolic

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D 273	Continued From page 51 pressure was greater than 110 or less than 60. Review of Resident #5's October 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for BP and pulse to be checked daily at 8:00am and 8:00pm. -Resident #5's BP reading was documented as 98/45 on 10/11/18 at 8:00pm. -Resident #5's BP reading was documented as 115/55 on 10/16/18 at 8:00am. -There was documentation Resident #5's pulse readings ranged from 60 to 89 at 8:00am. -There was documentation Resident #5's pulse readings ranged from 56 to 87 at 8:00pm. -There was no documentation regarding BP parameters or when to notify the PCP. -There was an entry for metoprolol tartrate 50mg one tablet to be administered at 8:00am and metoprolol tartrate 50mg one half tablet to be administered at 8:00pm. -There was documentation metoprolol tartrate 50mg one tablet was administered daily at 8:00am for 29 of 31 opportunities. -There was documentation metoprolol tartrate 50mg one half tablet was administered daily at 8:00pm for 27 of 31 opportunities. Review of Resident #5's November 2018 eMAR revealed: -There was an entry for BP and pulse to be checked daily at 8:00am and 8:00pm. -Resident #5's BP reading was documented as 102/58 on 11/06/18 at 8:00pm. -Resident #5's BP reading was documented as 120/54 on 11/07/18 at 8:00am. -Resident #5's BP reading was documented as 185/114 on 11/28/18 at 8:00pm. -Resident #5's BP reading was documented as 77/53 on 11/29/18 at 8:00am.	D 273		

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D 273	Continued From page 52 -There was documentation Resident #5's pulse readings ranged from 64 to 85 at 8:00am. -There was documentation Resident #5's pulse readings ranged from 56 to 141 at 8:00pm. -There was no documentation regarding BP parameters or when to notify the PCP. -There was documentation metoprolol tartrate 50mg one tablet was administered daily at 8:00am for 17 of 31 opportunities. -There was documentation metoprolol tartrate 50mg one half tablet was administered daily at 8:00pm for 20 of 31 opportunities. Review of Resident #5's December 2018 eMAR revealed: -There was an entry for BP and pulse to be checked daily at 8:00am and 8:00pm. -Resident #5's documented BP readings ranged from 120/61 to 145/91. -There was documentation Resident #5's pulse readings ranged from 59 to 137 at 8:00am. -There was documentation Resident #5's pulse readings ranged from 62 to 89 at 8:00pm. -There was no documentation regarding BP parameters or when to notify the PCP. -There was documentation metoprolol tartrate 50mg one tablet was administered daily at 8:00am for 17 of 17 opportunities. -There was documentation metoprolol tartrate 50mg one half tablet was administered daily at 8:00pm for 16 of 16 opportunities. Review of Resident #5's eMAR charting notes for October, November and December 2018 contained no documentation his PCP had been notified of BP readings outside of ordered parameters. Interview with a medication aide (MA) on 12/19/18 at 10:00am revealed:	D 273		

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D 273	Continued From page 53 -She had documented Resident #5's BP readings being outside ordered parameters on 10/11/18, 10/16/18 and 11/07/18. -She had never notified Resident #5's PCP regarding his BP readings being outside of ordered parameters because the parameters were not visible to her in the eMAR system. -If a MA had contacted Resident #5's PCP, it would be documented in the charting notes section on the eMAR. -MAs were responsible for faxing new orders to the facility's contracted pharmacy. -The pharmacy was responsible for entering the orders with parameters onto the eMAR. -The Resident Care Coordinator (RCC) could also manually enter orders from the facility. -After the pharmacy entered new orders, the RCC was responsible for verifying the orders were correct. -Once the orders were verified as correct and approved, they would then appear on the computer screen for the MAs to follow. -She did not know why the order to notify the PCP regarding BP readings outside ordered parameters had not been entered on the eMAR. Interview with the RCC on 12/19/18 at 2:00pm revealed: -The MAs or RCC was responsible for faxing new orders to the facility's contracted pharmacy. -The pharmacy would enter new orders onto the eMAR. -After the pharmacy entered new orders, the RCC was responsible for verifying that orders were correct. -She was not employed at this facility on 09/23/18 when the PCP gave the order to notify him if BP readings were outside the ordered parameters so she did not know how the order had been left off the eMAR.	D 273		

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-The facility's nurse was responsible for auditing the eMARs and comparing them to the physician's orders.
-The facility did not currently have a nurse so she was responsible for auditing the eMARs.
-She had not audited the eMARs because she had been "too overwhelmed with work."

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/20/18 at 8:21am revealed:
-The pharmacy was responsible for entering orders onto the eMAR when received from the facility.
-The pharmacy had received the original order for metoprolol 50mg one tablet in the morning and metoprolol 50mg one half tablet at night for Resident #5 on 08/12/18.
-They had never received the order for BP parameters dated 09/28/18.

Interview with Resident #5's PCP on 12/18/18 at 11:00am revealed:
-He had given the order to notify him if Resident #5's systolic BP was greater than 190 or less than 90 or if his diastolic BP was greater than 110 or less than 60 because Resident #5 had a history of high BP and was ordered metoprolol tartrate, a medication to lower his BP.
-He expected the facility to follow his orders and notify him if Resident #5's BP was outside the ordered parameters.
-He had not been notified Resident #5's BP readings had been documented outside of ordered parameters six times in October and November 2018.
-He expected the facility to document all contacts with him in the resident's record at the facility.

Interview with the Administrator on 12/20/18 at

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D 273	Continued From page 55 4:00pm revealed: -MAs and the RCC were responsible for faxing new orders to the facility's contracted pharmacy. -The pharmacy was responsible for entering the orders into the eMAR system and the RCC was responsible for then verifying and approving the order. -The MAs had been trained on how to audit eMARs, but they would need to be retrained "because the process was failing." 5. Review of Resident #7's current FL2 dated 10/04/18 revealed: -Diagnoses included renal insufficiency, hypertension, chronic obstructive pulmonary disease and Alzheimer's disease. -Resident #7's level of care was total care. Review of a discharge summary from a local hospital for Resident #7 dated 11/28/18 revealed: -Resident #7 was admitted to the hospital on 11/25/18 and discharged back to the facility on 11/28/18. -Resident #7 had a history of Osler Weber Rendu disease (a hereditary hemorrhagic bleeding disorder), cardiac arrhythmia (an irregular heart beat) and chronic heart failure. -Resident #7 was admitted through the emergency room with a diagnosis of gastrointestinal bleed (GI). -There was an order for Resident #7 to follow-up with the heart and vascular center on 12/05/18 at 10:30am. -There was an order for Resident #7 to follow-up with the primary care medical physician in 5 days after discharge and obtain laboratory studies regarding hemoglobin level. -There was an order for Resident #7 to follow-up with the gastroenterology and hematology physician.	D 273		

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D 273	Continued From page 56 Review of a second discharge summary from a local hospital for Resident #7 dated 12/11/18 revealed: -Resident #7 was admitted to the hospital again on 12/07/18 with diagnoses that included GI bleed and chronic heart failure. -Resident #7 was discharged back to the facility on 12/11/18. -There was an order for a follow up appointment with the gastroenterology and hematology physician in 1 week. -There was an order for a follow up appointment with the heart and vascular center on 12/18/18 at 3:30pm. -There was an order for a follow up appointment with the primary care medical physician office on 12/19/18 at 11:00am. Review of the facility appointment book calendar for November 2018 and December 2018 revealed there were no physician appointments entered for Resident #7. Telephone interview with Resident #7's heart and vascular office assistant on 12/18/18 at 2:48pm revealed: -Resident #7 had an appointment on 12/05/18 at 10:30am made by the hospital, but did not show up for the appointment. -The facility staff never called the office to reschedule the missed appointment. -The physician wanted to see Resident #7 for a follow- up visit from a recent hospital visit on 11/28/18. -Resident #7 had another follow up appointment scheduled for 12/18/18 at 3:30pm because of another hospital visit on 12/11/18. Observation of Resident #7 on 12/18/18 at	D 273		

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D 273	Continued From page 57 4:07pm revealed: -He was in his room laying in the bed with his head covered with a blanket. -He stated "my legs hurt". -Resident #7 had bilateral edema to his lower extremities. Telephone interview with Resident #7's digestive health associates office Nurse revealed: -Resident #7 was to be seen by the physician due to a recent hospital visit referral. -There was never an appointment made for Resident #7 for a follow-up visit. -Resident #7 was not seen in the office in November 2018 or December 2018. -"It is very important [Resident #7] kept his appointment to ensure the best therapy and treatment of his bleeding disorder." -Resident #7 was last seen in the office on 05/28/17. Attempted telephone interview with Resident #7's primary care medical center on 12/18/18 at 1:45pm was unsuccessful. Telephone interview with Resident #7's Power of Attorney (POA) on 12/19/18 at 11:00am revealed: -She knew Resident #7 had 2 recent hospitalizations within one month. -The facility never contacted her in regards to Resident #7's heart and vascular, primary medical physician, or the digestive health physician appointments. -She was not aware Resident #7 had missed the physician's appointments after the two hospital visits. Interview on 12/19/18 at 11:30am with the facility Nurse Practitioner for Resident #7 revealed: -Resident #7 was a new patient to her services.	D 273		

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D 273	Continued From page 58 -She had seen Resident #7 on 12/05/18 and ordered laboratory studies because "this was something she did for all new patients." -She had known Resident #7 had been in the hospital recently on 11/28/18. -She did not know Resident #7 had missed follow up appointments with the heart and vascular, primary care physician, or the digestive health physician appointments. -When the result of Resident #7's lab findings came back, she called the facility and had Resident #7 sent out to the hospital because of a low hemoglobin. -She did not know Resident #7's hospital discharge order on 11/28/18 was to follow up with the primary medical physician for lab work in 5 days after discharge. -The staff did not make her aware Resident #7 had missed any of the physicians' appointments. Interview on 12/18/18 at 3:30pm with a medication aide (MA) revealed: -She was responsible for reviewing new orders for residents and reviewing discharge summaries from the hospital. -She did not know Resident #7 had appointments with the heart and vascular center, the primary care physician, or the digestive health physician. -She was not sure why the physician appointments were missed for Resident #7. Interview with the Resident Care Coordinator (RCC) on 12/18/18 at 4:15pm revealed: -She was responsible for overseeing the clinical staff. -She knew Resident #7 had been admitted to the hospital two times in the past month. -She was not aware Resident #7 had ordered physician appointments from the two hospital discharge summaries that were not on the	D 273		

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D 273	Continued From page 59 appointment calendar. -She did not know why Resident #7 had missed the appointments. -"If I see or know of an appointment for a resident, I will put it on the appointment calendar." -She did not know Resident #7 had an appointment on 12/18/18 at 3:30pm with the heart and vascular center. -She did not know Resident #7 was in the facility on 12/18/18 at 3:30pm complaining his legs hurt and had edema bilateral to his lower legs. -She had not contacted Resident #7's physician in regards to any missed appointments. Observation of the facility census report for 12/20/18 revealed Resident #7 was in not in the facility. Interview with the RCC on 12/20/18 at 10:20am revealed Resident #7 was transported to the hospital on 12/19/18 around 11:00pm and was admitted to the intensive care unit with a diagnoses of chest pain. _____ Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up for Resident #2 whose physician was not notified that his FSBS 4 times daily and his Humalog before meals scheduled was not on the eMAR for the month of November leading him to the hospital for BS 1200; Resident #3 who missed 6 medications including metoprolol tartrate, atorvastatin, clonidine, clopidogrel, Lisinopril, and sertraline, Resident #4's Respimat inhaler refusals; Resident #5 regarding blood pressure measurements outside of ordered parameters and medications not administered including Buspar (used to treat anxiety) and chlorhexidine gluconate (a mouthwash used to treat gingivitis); and Resident #7 related to	D 273		

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D 273	Continued From page 60 missed appointments with the gastroenterologist, heart and vascular physician and the primary care physician after hospital visits on 11/28/18 and on 12/12/18 and was currently in the hospital 12/20/18 diagnosed with chest pain. This failure to assure referral and follow up to meet the resident's needs resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/19/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 26, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the 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 A1 VIOLATION Based on interviews, record reviews, and	D 276		

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observations the facility failed to assure 2 resident's orders were implemented, for 3 of 7 (Resident #1, #4 and #7) related to Resident #1 multiple appointments radiation, chemotherapy, Resident #4 ordered for nebulizer treatments and Resident #7 medications ordered.

The findings are:

1. Review of Resident #1's current FL-2,dated 9/25/18 revealed diagnoses of right breast cancer, pre-diabetes, hypertension, seizure, and hyperlipidemia.

Review of Resident #1's register revealed that she was admitted to the facility on 10/11/18.
Review of Resident #1's record revealed:
-An "After Visit Summary" from an appointment on 10/4/18, documented that Resident #1 was seen for "malignant neoplasm of upper-outer quadrant of right breast" and she had a chemotherapy appointment scheduled for 10/25/18 at 12pm and a physician's visit with her oncologist scheduled for 11/5/18 at 10:20am.

Review of Resident #1's charting notes revealed there was no documentation regarding medical appointments.

Telephone interview with a nurse from Resident #1's Oncologist's office on 12/7/18 at 10:18am revealed:
-Resident #1 was supposed to receive chemotherapy "every 3 weeks."
-Resident #1 had last received a chemotherapy treatment on 10/4/18.
-Resident #1 had missed a total of 3 chemotherapy treatments on 10/25/18, 10/29/18, and 11/19/18.
-Resident #1 also missed an office visit

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D 276	Continued From page 62 scheduled for 11/5/18. Follow-up telephone interview with a nurse from Resident #1's Oncologist office on 12/18/18 at 11:18am revealed: -Resident #1 had not attended any chemotherapy treatments since she had moved into the facility. -Resident #1 had missed a total of 4 chemotherapy appointments, on 10/25/18, 10/29/18, 11/19/18 and 12/17/18. -Resident #1 had missed an office visit on 11/5/18. -Resident #1 missed an appointment for an echocardiogram on 12/4/18. -Resident #1 was supposed to have chemotherapy directly after an office visit on 12/10/18, however, due to missing the echocardiogram on 12/4/18, she could not receive chemotherapy as scheduled. -At the time of the visit on 12/10/18, the physician's office contacted the Resident Care Coordinator (RCC) at the facility to make the facility aware of appointments that were being rescheduled, which included: An echocardiogram was rescheduled for 12/11/18, and chemotherapy was rescheduled for 12/17/18. She stressed the importance of Resident #1 attending the appointments. The RCC assured her that Resident #1 would have transportation to the appointments. -Resident #1 was receiving chemotherapy to "decrease the risk of recurrent disease." -Per Resident #1 oncologist, "Sub-optimal care, including not attending necessary cancer treatments such as radiation, chemotherapy, tests and appointments with her physicians, could negatively impact her outcome regarding her diagnosis of breast cancer." Telephone interview with a representative from	D 276		

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the Radiation Treatment office on 12/6/18 at 3:01pm revealed:
-Resident #1 had missed 2 appointments, on 11/18/18 and 11/27/18.
-Any missed appointments were generally added to the end of series of daily radiation treatments.
-Resident #1 finished her radiation treatments on 12/3/18.

Review of the transportation appointment calendar on 12/18/18 at 3:11pm revealed:
-In October, Resident #1 had the following appointments, noted as "Radiation/Oncology": 10/25/18, 10/26/18 and 10/29/18.
-In November, Resident #1 had the following appointments, noted as "Radiation/Oncology": 11/5/18, 11/19/18, and 11/27/18. There was no appointment listed on 11/18/18 for radiation.
-On 12/17/18, Resident #1 had an appointment, noted as "Radiation/Oncology".
-On 12/4/18, Resident #1 had an appointment, noted as "radiation/oncology", but it had been marked through.

Telephone interview with Resident #1's Responsible Party (RP) on 12/6/18 at 3:10pm revealed:
-At the time of moving Resident #1 into the facility, he provided the facility with information on her upcoming medical appointments, including her daily radiation appointments. He had also provided the facility a copy of the paperwork from her last doctor's appointment that had upcoming appointments listed on it, including her next scheduled chemotherapy treatment.
-He became aware that Resident #1 missed some of her radiation and chemotherapy appointments because he received a call from the physician's office to reschedule an appointment.

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-He went to the facility after learning that she had missed multiple appointments and spoke with "someone" who assured him that they would make sure she got to her radiation and chemotherapy appointments.

Interview with the transporter on 11/7/18 at 9:15am revealed:
-Resident #1's RP came to the facility yesterday and was concerned because he had received a call from the resident's physician's office stating that she had missed a chemotherapy appointment.
-Prior to the RP coming to the facility, she had not been aware that Resident #1 was supposed to be attending any chemotherapy treatments.
-She thought Resident #1 was only receiving chemotherapy every 3 weeks.
-She recalled recently receiving a message from the former business office manager to return a call to the radiation treatment office to schedule an appointment for Resident #1. She had called the radiation office and set up Resident #1's radiations treatments, which began on 10/22/18.
-She was supposed to be notified in writing of any scheduled appointments or treatments that needed to be scheduled for new residents upon admission by the Resident Care Director (RCD) or Resident Care Coordinator (RCC).
-The facility nurse had quit working in the facility very soon after Resident #1 had been admitted, so no one had reviewed the record and informed her of Resident#1's appointments that needed to be on the transport calendar.

Interview with transporter on 12/6/18 at 2:45pm revealed:
-Since 11/7/18, Resident #1 had missed two more radiation appointments, of which she was aware. One of those days she was out sick and staff did

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not get anyone else to transport Resident #1 to radiation appointment. She was unsure of the exact date.
-The second appointment Resident #1 had missed was on 11/18/18. She was not working that day but had arranged for another staff member to assure Resident #1 attended her radiation appointment. She called the facility the day before to make sure staff hadn't forgotten about the appointment. The next day, about the time of the appointment, she called the facility again to make sure someone was taking her and found out staff had not transported the resident to her appointment.
-She called Resident #1's radiation office, which was about to close for the day, and they offered to wait for her to arrive. She notified staff the radiation office was waiting for Resident #1 to come in late for her appointment, and it was her understanding a staff was taking her.
-She later learned that the Administrator told staff to call and reschedule the appointment.

Interview with Resident #1's Primary Care physician (PCP) on 12/18/18 at 11:45am revealed:
-He had been Resident #1's PCP since she had moved into the facility in October.
-He could tell that "something was not right" with Resident #1 and was aware that she had missed some treatment sessions for her diagnosis of breast cancer.
-He had stressed to the RCC the importance of Resident #1 attending her cancer treatments.
-There was a potential outcome of Resident #1's cancer progressing due to missing treatments.

Interview with the RCC on 12/6/18 at 2:15pm revealed:
-She was not aware that Resident #1 had missed

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some appointments prior to Adult Protective Services notifying her of this.
-She had discovered that there was some confusion about who would be transporting Resident #1 to her radiation appointment on 11/18/18.
-She spoke with Resident #1's responsible party who informed her the resident had missed 2 radiation treatments since living in the facility.
-Resident #1 was admitted to the facility the same week that she had started working the facility, so she was not familiar with her and was not aware of her appointments for her cancer treatments.
-She was not aware that Resident #1 had missed any chemotherapy appointments.
-The RCD normally reviewed any records for new admissions to the facility to assure that transportation was scheduled for any upcoming medical appointments, however, the facility had been without an RCD since just after Resident #1 had been admitted. Since the facility had been without an RCD, she was trying to review records for new admissions to assure all needed services were in place, including transportation, as much as she could with her other responsibilities.

Interview with RCC on 12/18/18 at 4pm revealed:
-She was not aware that Resident #1 had missed another chemotherapy treatment yesterday, 12/17/18.
-She was aware that the facility's van was in the shop for service yesterday and that some appointments had to be rescheduled, but she was not aware that Resident #1's appointment was one of them.
-Previously, the activity director who was filling in as the transport driver was responsible for writing appointments in the transportation calendar.
-She recalled speaking to the nurse from the oncologist's office on 12/11/18 regarding

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upcoming appointments that had been scheduled, including an echocardiogram on 12/11/18 and chemotherapy on 12/17/18.
-She would have given this information the new transportation driver to put into the transportation calendar.

Interview with transporter on 12/18/18 at 3:23pm revealed:
-Resident #1 did not attend her chemotherapy appointment yesterday because the van was in the shop for repairs. The plan was that the van would be ready yesterday morning, but there was a delay, which caused there to be missed appointments.
-Usually, when the facility van was not working, the facility borrowed a vehicle from a nearby sister facility so that residents could attend appointments as scheduled.
-The facility had not previously made arrangements with a sister facility to borrow a vehicle for yesterday, because the van was supposed to have been repaired in time for resident appointments. This caused a few residents had missed appointments.
-When the RCC notified him of an upcoming appointment, he would add the appointment to the transportation calendar.

Interview with Administrator on 12/6/18 at 3:50pm revealed:
-She did not become aware that Resident #1 had missed any medical appointments until Adult Protective Services inquired about it on 11/7/18.
-When a new resident was admitted to the facility, it was the nurse's responsibility to review the record to assure any transportation for appointments was set up either through the family or by the facility.
-The facility's nurse had quit about the time that

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D 276	Continued From page 68 Resident #1 was admitted, which resulted in no one looking thoroughly at the record to see the documentation the family had provided with information about upcoming appointments. -She and the RCC had also been trying to assist with reviewing records for new residents, but they had not revealed Resident #1's record. -She was not aware there was documentation in Resident #1's chart with information about upcoming medical appointments on 10/25/18 at 12pm for chemotherapy and 11/5/18 at 10:20am for an appointment with her oncologist. 2. Review of Resident #4's current FL-2 dated 9/4/18 revealed diagnoses included coronary artery disease with pervious myocardial infarction, hypertension, history of stroke, hyperlipidemia, diabetes mellitus type 2, congestive heart failure, morbid obesity, history of right adrenal mass status post right adrenalectomy 2014, osteoarthritis, schizophrenia, and dementia. Review of Resident #4's record revealed: -An ordered dated 12/12/18 for albuterol 0.083% 2.5mg/3ML nebulizer treatments every 4 hours "around the clock - hold while sleeping" for 2 days. Review of Resident #4's December 2018 electronic Medication Administration Record (eMAR) revealed: -An entry dated 12/12/18 for "albuterol 0.083% 2.5 MG/3ML NEB (used to help open up the airways in your lungs to make it easier to breathe) - use 1 vial via nebulizer every 4 hours around the clock - hold while sleeping for 2 days" -Resident #1's albuterol nebulizer treatment was documented as being administered on 12/13/18 at 4:00pm and 8:00pm, and on 12/14/18 at 12:00am and 4:00am.	D 276		

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-Resident #1's albuterol nebulizer treatment was documented as "not administered" on 12/14/18 at 8:00am with a reason of "resident refused"; "not administered" on 12/14/18 at 12:00pm with a reason of "med not in facility - no nebulizer machine"; "not administered" on 12/14/18 at 4:00pm with a reason of "med not in facility"; and "not administered" on 12/14/18 at 8:00pm with a reason of "resident refused."

Review of Resident #4's charting notes revealed no documentation regarding nebulizer treatments.

Interview with Resident #4 on 12/17/18 at 3:35pm revealed:
-She saw her PCP week because she was sick with a cough and congestion and was not breathing as well as she usually did.
-She had not received any nebulizer treatments since she had lived in the facility.
-She was not aware she was supposed to have received any nebulizer treatments since seeing her PCP last week.
-She had told the Resident Care Coordinator (RCC) that she wanted to see the physician again this week since she was not feeling any better. The RCC told her she would "add her to the list" of residents to be seen by her PCP this week.
-She was wearing her oxygen today, which she normally only wore at night, because she was not breathing as well as she usually did.

Interview with a Medication Aide (MA) on 12/18/18 at 11:30am revealed:
-Resident #4 had never had a nebulizer machine in the facility, so nebulizer treatments could not have been administered to her.
-She had not currently administered Resident #4's medications recently.
-She had not administered medications to

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D 276	Continued From page 70 Resident #4 during the time she was supposed to be receiving nebulizer treatments every 4 hours for 2 days. -It was the RCC's responsibility to order necessary equipment for new orders, such as a nebulizer machine. Interview with another MA on 12/18/18 at 2:20pm revealed: -Resident #4 had never had a nebulizer machine in the facility. -On 12/14/18 she had documented on the eMAR that Resident #4's nebulizer treatments were not administered because she had "no nebulizer machine." -She thought she "probably told" the RCC that Resident #4 needed a nebulizer machine at the time she entered the note into on the eMAR, but she was not certain. Interview with the RCC on 12/18/18 at 4pm revealed: -When a resident needed medical equipment, such as a nebulizer machine, she contacted the healthcare equipment company and put in an order. The equipment usually arrived within a day. -She was not aware that Resident #4 did not have a nebulizer machine and that she had not received any nebulizer treatments that had been ordered on 12/12/18. -No MA had informed her that Resident #4 needed a nebulizer machine. Interview with Resident #4's Primary Care Physician on 12/19/18 at 11:23am revealed: -She assessed Resident #4 last week because she was not feeling well. -Due to Resident #4 sounding very congested, she had ordered nebulizer treatments for "a few days" and nebulizer treatments "as needed" going	D 276		

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forward.
-Resident #4's oxygen saturation at the time of the visit last week was 95%.
-She was not aware that Resident #4 never received any of the nebulizer treatments she had ordered for her last week.
-Resident #4's order for nebulizer treatments not being implemented as ordered could potentially result in worsening of her respiratory symptoms.
-She was scheduled to see her again today, as she had not improved since last week's visit.
-Her expectation was that her orders for resident's healthcare needs would be implemented immediately by staff.

3. Review of Resident #7's current FL2 dated 10/04/18 revealed:
-Diagnoses included renal insufficiency, hypertension, chronic obstructive pulmonary disease and Alzheimer's disease.
-Medication orders included the following medications:
-Fosamax (used to treat osteoporosis) 70 mg once weekly
-Ferrous sulfate (an iron supplement used to treat anemia) 324mg twice weekly
-CVS vitamin (helps to prevent bone disorders) D3 2000 units daily
-Tizanidine (a muscle relaxant) 2mg daily as needed for pain/spasms.
-Lotrisone (an antifungal) 1%-0.05% topical cream apply two times daily to rash.
-Aricept (used to treat Alzheimer disease) 5mg every evening.
-Bumetanide (used to treat fluid retention) 0.5mg take every one tablet every 2 days.
-Toprol XL (used to treat high blood pressure) 25mg daily.
-Prilosec (used to treat heartburn and gastroesophageal reflux) 40mg take two times

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D 276	Continued From page 72 daily. Review of Resident Register revealed the resident was admitted to the facility on 11/01/18 from home. Interview on 12/18/18 at 2:30pm with the Resident Care Coordinator (RCC) revealed Resident #7 was admitted to the facility on 11/05/18 not on 11/01/18. a. j. Review of Resident #7's record revealed a subsequent physician order dated 12/06/18 for compression stockings knee high-on in the AM off QHS (every night). Review of Resident #7's December 2018 electronic medication administration record (eMAR) revealed: -There was an entry "Jobst hose (a brand of compression stockings) need size" on in the morning and off at bedtime scheduled for 8:00am and 8:00pm. -There was no documentation the Jobst compression stockings had been applied during the month of December 2018. Review of Resident #7's facility charting notes revealed: -On 11/24/18 at 1:07pm Resident #7 was using a wheelchair because he was having a difficult time walking because his legs hurt. -On 11/25/18 at 6:01pm Resident #7 had complained of difficulty breathing, swelling was noted to face and lower extremities. Resident was sent to Emergency Room (ER) for evaluation "per request." Interview on 12/18/18 at 3:30pm with a medication aide (MA) revealed: -Her responsibly included reviewing new orders	D 276		

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for residents and faxing the order to the pharmacy.
-If she faxed orders to the pharmacy she would made a copy for the Resident Care Coordinator (RCC) to review.
-She filed the new order in the resident's record after the RCC had reviewed the new order.
-She did not know Resident #7 had an order for compression stocking written on 12/06/18.
-The compression stockings had never "popped up" on the eMAR when she administered medications in the mornings to Resident #7.
-She never contacted the physician concerning Resident #7's order for compression stockings.

Interview on 12/18/18 at 3:45pm with a second MA revealed:
-The RCC was responsible faxing orders to the pharmacy.
-She did not know Resident #7 had an order dated 12/06/18 for compression stockings.
-She had never seen Resident #7 with compression stockings on.
-She had never removed compression stockings from Resident #7 at bedtime.
-She had never seen the order or noticed the compression stockings on Resident #7's eMAR for December 2018.

Observation of Resident #7 on 12/18/18 at 4:07pm revealed:
-He was in his room laying in the bed with his head covered with a blanket.
-He stated "my legs hurt".
-A personal care aide (PCA) was present in the room and uncovered his legs.
-Resident #7 had no compression stocking on his legs.
-Resident #7 had bilateral edema lower extremities.

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D 276	Continued From page 74 Interview with the PCA present in Resident #7's room on 12/18/18 at 4:07pm revealed: -She told the Resident Care Coordinator (RCC) and the MA Resident #7 was not feeling well and his legs were hurting on 12/18/18. -She had never seen Resident #7 wear any socks except for the "non-skid socks from the hospital." -She never seen Resident #7 wear compression stocking. -Resident #7 always wore flip flops because his feet were always swollen. Interview with the RCC on 12/18/18 at 4:20pm revealed: -She was not told Resident #7 legs were hurting or that he was not feeling well on 12/18/18. -She knew Resident #7 had a history of edema to his lower extremities. -Resident #7 was admitted to the hospital with "swelling in his legs". -She did not know Resident #7 had an order written on 12/06/18 for compression stockings. -The MAs were responsible for faxing orders to the pharmacy and following through with the orders. -She relied on the MAs to complete orders written by the physician. Interview with a third MA on 12/18/18 at 4:36pm revealed: -Her responsibilities included faxing orders to the pharmacy and reviewing the orders on the eMAR. -She did not know Resident #7 had an order for compression stocking used for reducing edema to his legs. -She did not know how to measure for compression stocking, "probably a home health Nurse would do that." -"He would not wear them, he complains his legs	D 276		

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hurt all the time."
-She was made aware on 12/18/18 Resident #7 was not feeling well and his legs were hurting.
-The first shift MA had reported to her Resident #7's was lying in bed not feeling well.
-She had obtained Resident #7's vital signs on 12/18/18.
-"Resident #7's legs were swelled and hurting."

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am revealed:
-Resident #7's Nurse Practitioner faxed an order to the pharmacy on 12/06/18 for compression stockings knee high-on in the AM off QHS (every night).
-The pharmacy placed the ordered for the compression stockings (Jobst) on in the morning and off at bedtime scheduled for 8:00am and 8:00pm on Resident #7 profile on the December 2018 eMAR.
-The compression stocking required proper sizing of Resident #7's legs.
-The staff never contacted the pharmacy with the size of the compression stocking.
-It was the staff's responsible to obtain Resident #7's size of the compression stockings so they would adequately work to reduce edema.

Interview on 12/19/18 at 11:30am with Resident #7 Nurse Practitioner revealed:
-Resident #7 was new to her services and she had first seen Resident #7 in the facility on 12/05/18.
-The RCC had requested she see Resident #7 on 12/19/18.
-Resident #7's had edema bilateral to his legs on 12/19/18 when she had seen him in the facility.
-She had written an order for Resident #7 to have compression stockings on 12/06/18 due to

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D 276	Continued From page 76 edema. -She did not know Resident #7 had never had the compression stocking on or that he was never fitted for the compression stockings. -The MAs or the RCC had never mentioned Resident #7 did not have the compression stocking on. -She expected the facility to follow her orders as she had written. Review of the facility census report for 12/20/18 revealed Resident #7 was in not in the facility. Interview with the RCC on 12/20/18 at 10:20am revealed Resident #7 was transported to the hospital on 12/19/18 around 11:00pm and was admitted to intensive care unit with a diagnoses of chest pain. Review of the facility policy on therapy and equipment orders revealed: -Medication staff who receives order for physical therapy, occupational therapy, speech therapy, or medical equipment will: 1. Fax the order for home health, wound clinic or durable medical equipment provider. 2. Date and initial the order. 3. Document receipt of the order in the resident chart. 4. Place the order in the case manager's "box" of review file. -The care manager will then" 5. Contact the appropriate agency to confirm the order of services/equipment has been received. 6. Date and initial the order only after confirmation that the order has been properly processed. 7. After completion of all steps above, the order should be filed in the resident chart.	D 276		

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b. Review of Resident #7's hospital discharge dated 12/11/18 revealed a signed physician order for Carafate (a medication used to treat gastro esophageal reflux)1 gram/ 10ml four times daily with meals and at bedtime.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am revealed:
-There was no order on file for Resident #7's Carafate 1 gram/ 10ml four times daily with meals and at bedtime.
-The staff were responsible for faxing new orders to the pharmacy so the pharmacy could place the medication on the residents profile and on the eMAR.
-The Carafate was never profiled or placed on Resident #7's December 2018 eMAR.
-Carafate was used to treat stomach ulcers and gastro esophageal reflux.

Review of Resident #7's December 2018 electronic medication administration record (eMAR) revealed there was no entry for Carafate 1 gram/ 10ml four times daily with meals and at bedtime.

Interview on 12/18/18 at 3:30pm with a medication aide (MA) revealed:
-Her responsibly included reviewing new orders for residents and faxing the order to the pharmacy.
-If she faxed orders to the pharmacy she would made a copy for the Resident Care Coordinator (RCC) to review.
-She filed the new order in the resident's record after the RCC had reviewed the new order.
-She did not know Resident #7 had an order from the hospital discharge on 12/11/18 for Carafate.
-The RCC is responsible for reviewing the

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	HAL060077	A. BUILDING: _____ B. WING _____	12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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hospital discharge for new orders when a resident returned to the facility.

Interview with the RCC on 12/18/18 at 4:20pm revealed:
-She did not know Resident #7 had an order for Carafate.
-She had not reviewed Resident #7's hospital discharge summary date 12/11/18.
-The MAs were responsible for faxing orders to the pharmacy and following through the orders.
-She relied on the MAs to complete orders written by the physician.

Interview on 12/19/18 at 11:30am with Resident #7 Nurse Practitioner revealed:
-Resident #7 was new to her services and she had first seen Resident #7 in the facility on 12/05/18.
-The MAs or the RCC had never mentioned Resident #7 had an order for Carafate.
-She expected the facility to follow the discharge orders from the hospital physician, or if the facility staff had a concern about the order to contact her.

c. Review of Resident #7's November 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for Fosamax 70mg weekly at 7:00am.
-There was no documentation from the admission date of 11/05/18 to 11/12/18 Fosamax had been administered.
-There was documentation the Fosamax was administered on Monday, 11/19/18.
-There was documentation on 11/26/18 Fosamax was not administered reason "resident in the hospital."

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D 276	Continued From page 79 Review of Resident #7's December 2018 eMAR revealed Fosamax was administered as ordered. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am. Refer to interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner. Refer to interview on 12/18/18 at 3:30pm with a medication aide (MA). Refer to interview on 12/18/18 at 3:45pm with a second MA. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/18 at 11:32am. Refer to interview with the interim Administrator on 12/20/18 at 3:40pm. Refer to review of the facility policy on new medication orders. d. Review of Resident #7's November 2018 eMAR revealed: -There was an entry for ferrous sulfate 324mg twice weekly at 8:00am. -There was no documentation from the admission date of 11/05/18 to 11/12/18 the ferrous Sulfate had been administered as ordered. -There was documentation the ferrous sulfate had been administered on 11/15/18, 11/19/18, and on 11/22/18. -There was documentation the ferrous sulfate was not administered on 11/26/18 "resident in the hospital." Review of Resident #7's December 2018 eMAR	D 276		

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D 276	Continued From page 80 revealed ferrous sulfate was administered as ordered. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am. Refer to interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner. Refer to interview on 12/18/18 at 3:30pm with a medication aide (MA). Refer to interview on 12/18/18 at 3:45pm with a second MA. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/18 at 11:32am. Refer to interview with the interim Administrator on 12/20/18 at 3:40pm. Refer to review of the facility policy on new medication orders. e. Review of Resident #7's November 2018 eMAR revealed: -There was an entry for vitamin D3 2000 units daily at 8:00am. -There was no documentation from the admission date of 11/05/18 to 11/12/18 the vitamin D3 2000 units had been administered as ordered. -There was documentation on 11/13/18 and on 11/14/18 "resident refused". -There was documentation on 11/15/18 through 11/26/18 the vitamin D3 was administered. -There was documentation on 11/26/18 through 11/29/18 "resident out of facility". -There was documentation on 11/30/18 vitamin D3 was administered.	D 276		

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D 276	Continued From page 81 Review of Resident #7's December 2018 eMAR revealed vitamin D3 was administered as ordered. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am. Refer to interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner. Refer to interview on 12/18/18 at 3:30pm with a medication aide (MA). Refer to interview on 12/18/18 at 3:45pm with a second MA. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/18 at 11:32am. Refer to interview with the interim Administrator on 12/20/18 at 3:40pm. Refer to review of the facility policy on new medication orders. f. Review of Resident #7's November 2018 eMAR revealed: -There was an entry for Tizanidine 2mg daily as needed for pain/spasms. -There was no documentation from the admission date of 11/05/18 Tizanidine 2mg had been administered in November 2018. Review of Resident #7's December 2018 eMAR revealed Tizanidine was on the eMAR at a "PRN" but not administered in December. Refer to telephone interview with a pharmacist at	D 276		

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D 276	Continued From page 82 the facility's contracted pharmacy on 12/19/18 at 8:10am. Refer to interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner. Refer to interview on 12/18/18 at 3:30pm with a medication aide (MA). Refer to interview on 12/18/18 at 3:45pm with a second MA. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/18 at 11:32am. Refer to interview with the interim Administrator on 12/20/18 at 3:40pm. Refer to review of the facility policy on new medication orders. g. Review of Resident #7's November 2018 eMAR revealed there was not an entry for Lotrisone 1%-0.05% topical cream apply two times daily to rash. Review of Resident #7's December 2018 eMAR revealed Lotrisone was not on the eMAR. Observation of medications on hand for Resident #7 on 12/18/18 at 3:45pm revealed all the above medications were available for administration except for the Lotrisone 1%-0.05% topical cream. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am. Refer to interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner.	D 276		

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D 276	Continued From page 83 Refer to interview on 12/18/18 at 3:30pm with a medication aide (MA). Refer to interview on 12/18/18 at 3:45pm with a second MA. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/18 at 11:32am. Refer to interview with the interim Administrator on 12/20/18 at 3:40pm. Refer to review of the facility policy on new medication orders. h. Review of Resident #7's November 2018 eMAR revealed: -There was an entry for Aricept 5mg every evening at 5:00pm. -There was no documentation from the admission date of 11/05/18 to 11/12/18 the Aricept had been administered as ordered. -There was documentation on 11/12/18 and on 11/13/18 Aricept 5mg "resident refused". -There was documentation on 11/14/18 through 11/24/18 Aricept 5mg was administered. -There was documentation on 11/25/18 through 11/29/18 "resident out of facility". -There was documentation on 11/30/18 Aricept 5mg was administered. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am. Refer to interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner. Refer to interview on 12/18/18 at 3:30pm with a	D 276		

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D 276	Continued From page 84 medication aide (MA). Refer to interview on 12/18/18 at 3:45pm with a second MA. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/18 at 11:32am. Refer to interview with the interim Administrator on 12/20/18 at 3:40pm. Refer to review of the facility policy on new medication orders. i. Review of Resident #7's November 2018 eMAR revealed: -There was an entry for Bumetanide 0.5mg take every one tablet every 2 days at 8:00am. -There was no documentation from the admission date of 11/05/18 to 11/12/18 the bumetanide had been administered as ordered. -There was documentation bumetanide was not administered on 11/14/18 "resident refused." -There was documentation on 11/16/18 through 11/24/18 bumetanide was administered. -There was documentation on 11/26/18 through 11/291/8 bumetanide was not administered "resident in the hospital." -There was documentation on 11/30/18 bumetanide was administered. Review of Resident #7's December 2018 eMAR revealed Bumetanide was administered as ordered. Interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner revealed: -There were several medications Resident #7 took that concerned her if missed for more than a few days.	D 276		

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D 276	Continued From page 85 -The bumetanide was used for edema and there was documentation Resident #7 had edema prior to the hospital admission on 11/25/18. "The missed bumetanide could possibly contributed to the hospital visit on 11/25/18." Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am. Refer to interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner. Refer to interview on 12/18/18 at 3:30pm with a medication aide (MA). Refer to interview on 12/18/18 at 3:45pm with a second MA. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/18 at 11:32am. Refer to interview with the interim Administrator on 12/20/18 at 3:40pm. Refer to review of the facility policy on new medication orders. j. Review of Resident #7's November 2018 eMAR revealed: -There was an entry for Toprol XL 25mg daily at 8:00am. -There was no documentation from the admission date 11/05/18 to 11/12/18 Toprol XL had been administered as ordered. -There was documentation on 11/13/18 and on 11/14/18 the Toprol XL was not administered "resident refused". -There was documentation on 11/15/18 through 11/25/18 Toprol XL was administered.	D 276		

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D 276	Continued From page 86 -There was documentation on 11/26/18 through 11/29/18 "resident out of facility". -There was documentation on 11/30/18 Toprol XL was administered. Review of Resident #7's December 2018 eMAR revealed Toprol XL was administered as ordered. Interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner revealed: -There were several medications Resident #7 took that concerned her if missed for more than a few days. -The Toprol was used for blood pressure and could cause higher blood pressures if not administered as ordered. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am. Refer to interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner. Refer to interview on 12/18/18 at 3:30pm with a medication aide (MA). Refer to interview on 12/18/18 at 3:45pm with a second MA. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/18 at 11:32am. Refer to interview with the interim Administrator on 12/20/18 at 3:40pm. Refer to review of the facility policy on new medication orders.. k. Review of Resident #7's November 2018	D 276		

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D 276	Continued From page 87 eMAR revealed: -There was an entry for Prilosec 40mg take two times daily at 7:00am and at 5:00pm. -There was no documentation from the admission date 11/05/18 to 11/12/18 the Prilosec had been administered as ordered. -There was documentation on 11/12/18 and on 11/14/18 at 7:00am the Prilosec was not administered "resident refused". -There was documentation on 11/14/18 at 5:00pm through 11/25/18 at 7:00am Prilosec was administered. -There was documentation on 11/25/18 at 5:00pm through 11/29/18 "resident out of facility". -There was documentation on 11/30/18 Prilosec was administered at 7:00am and at 5:00pm. Review of Resident #7's December 2018 eMAR revealed Prilosec was administered as ordered. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am. Refer to interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner. Refer to interview on 12/18/18 at 3:30pm with a medication aide (MA). Refer to interview on 12/18/18 at 3:45pm with a second MA. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/18 at 11:32am. Refer to interview with the interim Administrator on 12/20/18 at 3:40pm. Refer to review of the facility policy on new	D 276		

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D 276	Continued From page 88 medication orders. _____ Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/18 at 8:10am revealed: -The staff faxed Resident #7's current FL2 dated 10/04/18 to the pharmacy on 11/12/18. -The pharmacy had dispensed to the facility Resident #7's medications from the FL2 on 11/12/18 which included Fosamax, ferrous sulfate, vitamin D3 2000, Tizanidine, Aricept , Bumetanide, Toprol XL and Prilosec. -She was not aware Resident #7 was admitted to the facility on 11/05/18. -It was the staff's responsibility to fax over FL2 orders for new residents. -The pharmacy had dispensed all medication refills again for Resident #7 on 12/07/18. Interview on 12/19/18 at 11:30am with Resident #7's Nurse Practitioner revealed: -Resident #7 was new to her services and she had first seen Resident #7 in the facility on 12/05/18. -She did not know Resident #7 was not administered medications from his admission date of 11/05/18 to 11/12/18 as ordered on the FL2. -There were several medications Resident #7 took that concerned her if missed for more than a few days. -The staff had a responsibly to follow orders and administer medications as ordered. -"I would like to know when a resident missed medications or refused medications, the facility never told me." Interview on 12/18/18 at 3:30pm with a medication aide (MA) revealed: -Resident #7 was new to the facility he was	D 276		

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admitted sometime in November 2018.
-She was responsible for reviewing new orders for residents and reviewing discharge summaries from the hospital.
-She faxed orders to the pharmacy, made a copy for the Resident Care Coordinator (RCC) to review.
-She filed the new order in the resident's record after the RCC had reviewed the new order.
-She did not know why the FL2 for Resident #7 was not faxed until 11/12/18.
-The RCC was responsible for reviewing new admissions and faxing FL2 to the pharmacy.
-She never contacted the physician concerning Resident #7's missed medications from 11/05/18 to 11/12/18.

Interview on 12/18/18 at 3:45pm with a second MA revealed:
-Resident #7 had been in the facility for about 2 months.
-The RCC was responsible for new admissions and faxing orders to the pharmacy.
-She could not recall when she started administering medications to Resident #7.
-She never contacted the physician concerning Resident #7's missed medications from 11/05/18 to 11/12/18, "Why would I call if I do not know about them."

Interview with the Resident Care Coordinator (RCC) on 12/18/18 at 11:32am revealed:
-Her duties included overseeing the clinical staff.
-She was responsible for new admissions and reviewing the FL2.
-Resident #7 was admitted on 11/05/18.
-She was not aware the FL2 orders were not faxed to the pharmacy for Resident #7 until this interview on 12/18/18.
-She had given the FL2 to a MA to fax to the

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D 276	Continued From page 90 pharmacy. -She did not know Resident #7 was not administered his medications from 11/05/18 to 11/12/18. -The MAs could fax orders to the pharmacy, "I am not sure why they did not fax the FL2 for [Resident #7]." -She never contacted the physician concerning Resident #7's missed medications from 11/05/18 to 11/12/18. Interview with the Administrator on 12/20/18 at 3:40pm revealed: -The RCC was responsible for overseeing all clinical staff which included the MAs. -She relied on the RCC to complete new admissions and FL2. -The RCC was responsible for faxing the FL2s to the pharmacy. Review of the facility policy on new medication orders revealed: -When a medication order is received from a prescribing provider, the medication staff member who receives the order will: 1. Verify the order is complete. 2. Fax the order to the pharmacy if after 5pm, on a weekend or holiday, enter the order on quick MAR. 3. Date and initial the order. 4. Call the pharmacy to verify receipt of the order. 5. Enter the order onto Quick Mar. 6. Document receipt of the order in the residents chart. 7. Place the order in the case manager's box or review file. -The case manager will then: 8. Review the order and compare it to the order in the Quick MAR to assure that it has been transcribed accurately.	D 276		

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EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

(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 276	Continued From page 91 9. Date and initial the medication order ONLY after it has been reviewed and determined to have been properly processed. 10. After completion of all steps above, the medication order should be filed in the resident chart. 11. Discontinue the medication order that was entered into the Quick MAR by the medication staff only after the pharmacy has entered the order into the Quick MAR. _____ Based on interviews, record reviews, and observations the facility failed to assure resident's orders were implemented, for Resident #1 who had breast cancer missed multiple appointments for her cancer treatments including: radiation, chemotherapy, an echocardiogram and an appointment with her oncologist, resulting in the potential for negative outcome related to her breast cancer diagnosis; Resident #4 who had a diagnosis of chronic obstructive pulmonary disorder had an order for nebulizer treatments for treatments every 4 hours, however, the nebulizer was never obtained and treatments were never administered, potentially contributing to the worsening of her respiratory symptoms related to her COPD diagnosis; Resident #7 medication ordered from the FL2 were not implemented for 5 days after admission, compression stockings used for reducing edema and Carafate a medication used for gastro-intestinal reflux were never implemented as ordered by the physician; Resident #7 had two hospital admissions in less than one month after being admitted to the facility and was currently in the hospital 12/20/18 diagnosed with chest pain. This failure to assure implementation of orders resulted resulted in serious physical harm and neglect of residents and constitutes a Type A1 Violation.	D 276		

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D 276	Continued From page 92 The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/19/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 26, 2019.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to assure the kitchen, dining and food storage areas including kitchen appliances, floors in the dining room and kitchen, and tables and chairs in the dining room were clean and protected from contamination. The findings are: Observation of the dry food storage area of the kitchen on 12/17/18 at 9:28am revealed: -The floor was covered in food crumbs and dirt. -There was a plastic spoon, plastic lid and unopened packs of crackers on the floor. -Cardboard boxes containing food were being stored on the floor including cookies and non-dairy creamer. Observation of the main kitchen area on 12/17/18	D 282		

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D 282	Continued From page 93 at 9:35am revealed: -The sides of the stove and oven were covered in built up grease. -The bottom shelf of a food prep table was covered in food crumbs and built up grease. -The floors underneath the food prep sink were covered in crumbs and dirt. -The inside of the ice machine had a black substance covering the area where the lid closed. Observation of the dining room on 12/17/18 at 11:56am revealed: -There were no residents in the dining room. -The lunch meal service had not begun. -There were 86 place settings of utensils and drinks on the tables. -The chairs at each of the place settings had food crumbs built up in the crease of the chair where the back connected to the seat. -The chairs were not cleaned prior to residents entering the dining room at 12:00pm. Observation of the dining room on 12/18/18 at 7:33am revealed: -There were no residents in the dining room. -The breakfast meal service had not begun. -There were 78 place settings of utensils and drinks on the tables. -The chairs at each of the place settings still had food crumbs built up in the crease of the chair where the back connected to the seat. -Many chairs had food crumbs and spots of dried liquids spread across the seat. -Every table had food crumbs, sticky spots or both on its surface. -The floor of the dining room was covered in food crumbs, dirt, straw wrappers and a fork. -There was a large (approximately 4 inches by 6 inches) sticky orange substance with smaller spots surrounding it dried to the floor underneath	D 282		

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one of the tables.
-The dining room was not cleaned prior to the residents entering for their breakfast meal at 8:00am.

Review of the dietary cleaning schedule posted in the kitchen on 12/18/18 revealed:
-The floors should be swept and mopped after every meal.
-The dining room tables should be wiped and sanitized daily.
-The dining room chairs should be wiped down after every meal.
-The dish area should be swept and mopped daily.
-The ice machine should be cleaned monthly.

Interviews with three residents on 12/19/18 at various times revealed:
-One resident was bothered by the dining room being so dirty. "The dirty floors bother me the most."
-A second resident reported the dining room was often dirty. She sometimes had to use her own napkin and dip it in her water glass to clean off her table. She had complained to the dietary servers before, but "it's still dirty a lot."
-A third resident reported the dining room was dirty at most meals. The dirty floors did not bother him, but "the tables being dirty did." He had never complained to any staff.

Interview with a housekeeper on 12/18/18 at 1:57pm revealed:
-Two housekeepers worked Monday through Friday from 7:00am to 2:30pm.
-One housekeeper worked on Saturdays and Sundays from 7:00am to 2:30pm.
-The housekeeping staff was responsible for cleaning the dining room every day after the

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breakfast and lunch meal services.
-After the breakfast and lunch meal services, the housekeeping staff would sweep, mop, wipe down the chairs and wipe down the walls (if there were any spots on them) in the dining room.
-The dietary staff was responsible for clearing and wiping down the dining room tables.
-She did not know who cleaned the dining room after the dinner meal service because the housekeeping staff left at 2:30pm every day.

Interview with a cook on 12/18/18 at 3:45pm revealed:
-Some days she worked as a cook and other days she worked as a dietary aide.
-She did not work the day prior on 12/17/18.
-The cooks were responsible for wiping down "everything in the kitchen" including the food prep tables, steam tables, oven and fryer daily.
-The cooks were also responsible for sweeping and mopping the kitchen area daily.
-The dietary aides were responsible for cleaning the dining room after the dinner meal service.
-She followed the cleaning schedule posted in the kitchen.

Interview with a dietary aide on 12/18/18 at 3:47 pm revealed:
-Some days she worked as a cook and other days she worked as a dietary aide.
-On 12/17/18, she worked as a cook and another one of the kitchen staff worked as the dietary aide.
-On 12/17/18, she only had time to clean food prep tables and did not have time to clean the fryer or stove and oven. "We have to be out of here between 7:30pm and 8:00pm."
-The dietary aides were responsible for clearing the place settings from the dining room tables and sanitizing the tables after the meal service.

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D 282	Continued From page 96 -The dietary aides were also responsible for sweeping and/or mopping "whichever was needed" in the dining room after the dinner meal service. -She did not know why the dining room was not cleaned after the dinner meal service on 12/17/18. Interview with the Dietary Manager (DM) on 12/19/18 at 10:45am revealed: -The housekeeping staff was responsible for sweeping and mopping the dining room after the breakfast and lunch meal services. -The kitchen staff was responsible for clearing the dining tables and wiping down the tables and chairs after every meal. -He was responsible for the oversight of the kitchen staff. -He typically came into work at 7:30am, but on 12/18/18, he came into work around 8:15am after the breakfast meal service had begun. -According to the kitchen staff, prior to him coming to work at the facility, no one had been responsible for cleaning the dining room after the dinner meal service and there was no management oversight for cleanliness of the kitchen and dining room. -The cleaning schedule posted in the kitchen was an old one. -He had created a new cleaning schedule, and although he had not posted it yet, he had verbally communicated it to all dietary staff. -He had made it the responsibility of the cook to clean the kitchen areas and the responsibility of the dietary aide to either "spot sweep or spot mop" the dining room after the dinner meal service. -He noticed the dining room was dirty on both 12/17/18 and 12/18/18 when he came into work on those mornings.	D 282		

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D 282	Continued From page 97 -The dietary aide who was responsible for cleaning the dining room after the dinner meal services on 12/16/18 and 12/17/18 was returning to work today (12/19/18) and he would speak to him about it. -He was also working with the cooks to get the kitchen areas cleaned up. Interview with the Administrator on 12/20/18 at 4:20pm revealed: -The DM was responsible for creating the cleaning schedule for the kitchen and dining room and assuring the tasks were completed by the dietary staff. -The housekeeping staff was responsible for cleaning the floors in the dining room after the breakfast and lunch meal services. -The dietary staff was responsible for cleaning the dining room after the dinner meal service. -She had noticed the lack of cleanliness in the kitchen and dining room and planned to begin using "in house" housekeepers rather than a contract company and planned to do "some re-education" with the dietary staff.	D 282		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching	D 296		

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D 296	Continued From page 98 therapeutic menu for 5 of 5 sampled residents with physician's orders for therapeutic diets as evidenced by no mechanical soft (MS) menu for Residents #5, #14, and #17 and no pureed menu for Residents #15 and #16. The findings are: Observation of the food serving line in the kitchen on 12/17/18 and 12/18/18 revealed: -There was one menu ("weekly menu") posted for guidance of the food service staff, and it listed foods for residents on a regular diet. -The menu did not list what foods should have been served to residents on a pureed diet or MS diet. 1. Review of Resident #15's current FL-2 dated 09/14/18 revealed: -Diagnoses included Alzheimer's dementia. -The diet order was regular. Review of Resident #15's diet order dated 09/14/18 revealed an order for a pureed diet. Review of the therapeutic diet list posted in the kitchen on 12/17/18 revealed Resident #15 was to be served a pureed diet. Review of the facility menus revealed there was no therapeutic menu for a pureed diet. Observation of the lunch meal service on 12/17/18 between 12:00pm and 1:10pm revealed: -Resident #15 was served pureed stuff cabbage, mashed potatoes, pureed mixed vegetables, applesauce with whipped cream, unsweetened tea and water. -Resident #15 consumed 100% of the meal.	D 296		

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Observation of the breakfast meal service on 12/18/18 from 7:45am to 8:35am revealed:
-Resident #15 was served pureed sausage, pureed eggs, grits, apple juice and water.
-Resident #15 consumed 100% of the meal.

Refer to interview with the Dietary Manager (DM) on 12/17/18 at 10:40am.

Refer to interview with a first shift cook on 12/17/18 at 11:45pm.

Refer to interview with a second shift cook on 12/18/18 at 3:45pm.

Refer to the second interview with the DM on 12/19/18 at 10:45am.

Refer to interview with the Administrator on 12/20/18 at 4:20pm.

2. Review of Resident #16's current FL-2 dated 03/12/18 revealed:
-Diagnoses included senile dementia, late affected cerebrovascular accident and seizure disorder.
-The diet order was pureed.

Review of the therapeutic diet list posted in the kitchen on 12/17/18 revealed Resident #16 was to be served a pureed diet.

Review of the facility menus revealed there was no therapeutic menu for a pureed diet.

Observation of the lunch meal service on 12/17/18 between 12:00pm and 1:10pm revealed:
-Resident #16 was served pureed stuff cabbage, mashed potatoes, pureed mixed vegetables,

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applesauce with whipped cream, unsweetened tea and water.
-Resident #16 consumed 100% of the meal.

Observation of the breakfast meal service on 12/18/18 from 7:45am to 8:35am revealed:
-Resident #16 was served pureed sausage, pureed eggs, grits, apple juice and water.
-Resident #16 consumed 100% of the grits, apple juice and water and 50% of the sausage and eggs.

Refer to interview with the Dietary Manager (DM) on 12/17/18 at 10:40am.

Refer to interview with a first shift cook on 12/17/18 at 11:45pm.

Refer to interview with a second shift cook on 12/18/18 at 3:45pm.

Refer to the second interview with the DM on 12/19/18 at 10:45am.

Refer to interview with the Administrator on 12/20/18 at 4:20pm.

3. Review of Resident #5's current FL-2 dated 09/14/18 revealed:
-Diagnoses included schizophrenia, intellectual disability and gastroesophageal reflux.
-The diet order was mechanical soft (MS) with nectar thickened liquids.

Review of the therapeutic diet list posted in the kitchen on 12/17/18 revealed Resident #5 was to be served a "chopped entire meal" diet.

Review of the facility menus revealed there was no therapeutic menu for a MS diet.

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D 296	Continued From page 101 Observation of the lunch meal service on 12/17/18 between 12:00pm and 1:10pm revealed Resident #5 was out of the facility and did not eat lunch in the dining room. Observation of the breakfast meal service on 12/18/18 from 7:45am to 8:35am revealed: -Resident #5 was served ground sausage, scrambled eggs, chopped hashbrown, grits, nectar thick milk and nectar thick water. -Resident #5 consumed 100% of the meal. Refer to interview with the Dietary Manager (DM) on 12/17/18 at 10:40am. Refer to interview with a first shift cook on 12/17/18 at 11:45pm. Refer to interview with a second shift cook on 12/18/18 at 3:45pm. Refer to the second interview with the DM on 12/19/18 at 10:45am. Refer to interview with the Administrator on 12/20/18 at 4:20pm. 4. Review of Resident #14's current FL-2 dated 10/10/18 revealed: -Diagnoses included depression and diabetes. -The diet order was mechanical soft (MS) with nectar thick liquids. Review of the therapeutic diet list posted in the kitchen on 12/17/18 revealed Resident #14 was not listed. Review of the facility menus revealed there was no therapeutic menu for a MS diet.	D 296		

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D 296	Continued From page 102 Observation of the lunch meal service on 12/17/18 between 12:00pm and 1:10pm revealed: -Resident #14 was served pulled pork, mashed potatoes, chopped mixed vegetables, applesauce with whipped cream and nectar thick orange juice. -Resident #14 consumed 100% of the meal. Observation of the breakfast meal service on 12/18/18 from 7:45am to 8:35am revealed: -Resident #14 was served ground sausage, scrambled eggs, chopped hashbrown, grits, cereal, nectar thick milk and nectar thick water. -Resident #14 consumed 100% of the meal. Refer to interview with the Dietary Manager (DM) on 12/17/18 at 10:40am. Refer to interview with a first shift cook on 12/17/18 at 11:45pm. Refer to interview with a second shift cook on 12/18/18 at 3:45pm. Refer to the second interview with the DM on 12/19/18 at 10:45am. Refer to interview with the Administrator on 12/20/18 at 4:20pm. 5. Review of Resident #17's current FL-2 dated 09/14/18 revealed: -Diagnoses included cerebrovascular accident. -The diet order was mechanical soft (MS). Review of the therapeutic diet list posted in the kitchen on 12/17/18 revealed Resident #17 was to be served a "chopped entire meal" diet.	D 296		

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D 296	Continued From page 103 Review of the facility menus revealed there was no therapeutic menu for a MS diet. Observation of the lunch meal service on 12/17/18 between 12:00pm and 1:10pm revealed: -Resident #17 was served pulled pork, mashed potatoes, chopped mixed vegetables, applesauce with whipped cream and unsweetened tea. -Resident #17 consumed 100% of the meal. Observation of the breakfast meal service on 12/18/18 from 7:45am to 8:35am revealed: -Resident #17 was served ground sausage, scrambled eggs, chopped hashbrown, grits, apple juice and water. -Resident #17 consumed 100% of the sausage, eggs and hashbrown and 50% of the grits. Refer to interview with the Dietary Manager (DM) on 12/17/18 at 10:40am. Refer to interview with a first shift cook on 12/17/18 at 11:45pm. Refer to interview with a second shift cook on 12/18/18 at 3:45pm. Refer to the second interview with the DM on 12/19/18 at 10:45am. Refer to interview with the Administrator on 12/20/18 at 4:20pm. _____ Interview with the Dietary Manager (DM) on 12/17/18 at 10:40am revealed the only menu used to prepare and serve food to the residents was the "weekly menu" containing only menu items for residents on a regular diet.	D 296		

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D 296	Continued From page 104 Interview with a first shift cook on 12/17/18 at 11:45pm revealed: -The only menu she used to serve food to the residents was the "weekly menu" for regular diets. -All current residents were on either a regular diet, a pureed diet, a "chop entire meal" diet or a "chop only meats diet." -For residents listed on the therapeutic diet list under "pureed," she pureed all the food on the "weekly menu" in the food processor. -For residents on the "chop entire meal" diet, she chopped all the food on the "weekly menu" in the food processor. Interview with a second shift cook on 12/18/18 at 3:45pm revealed: -The only menu she used to serve food to the residents was the "weekly menu" for regular diets because it was the only menu posted. -The facility had been without a DM for some time, but when the former DM was there, she kept all the regular diet menus, therapeutic diet menus and recipes in a notebook. -Since the new DM had started about one week ago, he had posted the "weekly menu" for regular diets on the serving line and she could no longer locate the therapeutic diet menus or recipes. -She had not told the DM she could not locate the therapeutic diet menus or recipes. -For residents on a pureed diet, she pureed all the food on the "weekly menu" to a baby food consistency in the food processor. -For residents on a "chopped entire meal" diet, she chopped all the food on the "weekly menu" either with a knife or the food processor. -She knew how to prepare pureed diets and chopped diets because she had formerly worked in a hospital.	D 296		

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D 296	Continued From page 105 A second interview with the DM on 12/19/18 at 10:45am revealed: -He had therapeutic diet menus filed in a notebook, but not posted for guidance of food service staff. -Staff had never been made aware of the notebook. -He had only been employed at this facility for one week and was in the process of training dietary staff. Interview with the Administrator on 12/20/18 at 4:20pm revealed: -She thought the dietary staff were using therapeutic diet menus for guidance. -She knew they had used them when the former Administrator was there. -The former Administrator had been gone for about ten days so "this was a recent problem that had arisen."	D 296		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure water was served to residents during the lunch and breakfast meals. The findings are:	D 306		

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Interviews with five residents from 12/17/18 to 12/19/18 at various times revealed:
-He was never served water at meals, but if water was served, he would drink it.
-He was only served water occasionally. He would like water at every meal.
-He was served water at meals "sometimes." He would drink water if it were served. He had never requested water because "staff were too busy to bring it."
-She was not served water with every meal. When water was served to her, sometimes it tasted good and sometimes it did not. If the water tasted good, she would drink it.
-She was not offered water at meals, but instead was given two glasses of tea at lunch. If water was provided, she would drink it.

Observation of the lunch meal service on 12/17/18 from 12:00pm to 1:10pm revealed:
-A dietary aide placed pre-poured beverages on the dining tables prior to residents entering the dining room.
-No residents were asked what they wanted to drink.
-Beverages served to residents included tea and water.
-Thirty-five of 86 residents were not served water.

Observation of the breakfast meal service on 12/18/18 from 7:30am to 8:35am revealed:
-All beverages were pre-poured and on the dining tables prior to residents entering the dining room.
-No residents were asked what they wanted to drink.
-Beverages served to residents included juice, milk and water.
-Forty of 78 residents were not served water.

Interview with the dietary aide who pre-poured the

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beverages on 12/17/18 at 11:59am revealed:
-The dietary aides were responsible for serving beverages during meals.
-The residents sat at the same place for every meal.
-He would pre-pour and serve the beverages prior to residents entering the dining room.
-He did not ask residents what they wanted to drink each time a meal was served and did not automatically serve water to every resident.
-He pre-poured beverages based on what residents told him they liked to drink when he first started working at the facility eight months ago.

Interview with the Dietary Manager (DM) on 12/19/18 at 11:15am revealed:
-Residents were to be served beverages based on what was listed on the menu which was typically juice, milk and water for breakfast, tea and water for lunch, orange drink, milk and water for dinner.
-Beverages were pre-poured and served five to ten minutes before residents came into to the dining room for every meal.
-The dietary aides were responsible for pouring and serving the beverages.
-Dietary aides did not serve water to every resident because they thought some of the residents did not like water.
-Within his two weeks at this facility, he had discussed with the dietary aides the need to serve water in addition to other beverages at every meal.

Interview with the Administrator on 12/20/18 at 4:20pm revealed:
-She knew water should be served to each resident at each meal, in addition to other beverages.
-She knew the dietary aides did not always serve

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D 306	Continued From page 108 water to the residents because they thought residents did not always want water. -The dietary staff would need to be retrained. -It was the DM's responsibility to train the dietary staff and ensure water was served at all meals. -It was her responsibility as the Administrator to provide oversight to the DM.	D 306		
D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 7 sampled residents (Resident #1 and #7) were provided transportation to scheduled physician's appointments in regard to Resident #7 heart and vascular appointments, primary care physician appointments, and the digestive health physician appointments after hospital admissions on 11/28/18 and on 12/11/18, and chemotherapy and	D 321		

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oncology appointments for Resident #1 who had a diagnosis of breast cancer resulting in delays in care and treatment.

The findings are:

1. Review of Resident #7's current FL2 dated 10/04/18 revealed:
-Diagnoses included renal insufficiency, hypertension, chronic obstructive pulmonary disease and Alzheimer.
-Resident #7's level of care was documented total care.

Review of Resident #7's record revealed there was no care plan assessment.

Review of a discharge summary from a local hospital for Resident #7 dated 11/28/18 revealed:
-Resident #7 was admitted to the hospital on 11/25/18 and discharged back to the facility on 11/28/18.
-There was an order for Resident #7 to follow-up with the heart and vascular center on 12/05/18 at 10:30am.
-There was an order for Resident #7 to follow-up with the primary care medical physician in 5 days after discharge and obtain laboratory studies regarding hemoglobin level.
There was an order for Resident #7 to follow-up with the gastroenterology and hematology physician.

Review of a second discharge summary from a local hospital for Resident #7 dated 12/11/18 revealed:
-Resident #7 was admitted to the hospital on 12/07/18 with diagnoses which included GI bleed and chronic heart failure.
-Resident #7 was discharged back to the facility

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on 12/11/18.
-There was an order for a follow up appointment with the gastroenterology and hematology physician in 1 week.
-There was an order for a follow- up appointment with the heart and vascular center on 12/18/18 at 3:30pm.
-There was an order for a follow up appointment with the primary care medical physician office on 12/19/18 at 11:00am.

Review of the facility appointment book calendar for November and December 2018 revealed there were no physician appointments made for Resident #7.

Telephone interview with Resident #7's heart and vascular office on 12/18/18 at 2:48pm revealed:
-Resident #7 had an appointment for 12/05/18, but did not show up for the appointment.
-The facility never called the office to reschedule the missed appointment.
-The physician was seeing Resident #7 for a follow- up from a hospital visit on 11/28/18.
-Resident #7 had another appointment scheduled for 12/18/18 at 3:30pm from another hospital visit on 12/11/18.
-The physician office did not provide transportation to appointments, the facility was responsible for obtaining transportation for Resident #7.

Telephone interview with Resident #7's gastroenterology office Nurse revealed:
-Resident #7 was not seen in the office in November 2018 or December 2018.
-Resident #7 was to be seen by the physician due to a recent hospital visit referral.
-It was very important [Resident #7] kept his appointment to ensure the best therapy and

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treatment of his bleeding disorder.
-Resident #7 was last seen in the office on 05/28/17.
--The physician office did not provide transportation to appointments, the facility was responsibility for transporting Resident #7 to the physician office.

Attempted telephone interview with Resident #7's primary care provider on 12/18/18 at 1:45pm was unsuccessful.

Telephone interview with Resident #7 Power of Attorney (POA) on 12/19/18 at 11:00am revealed:
-When resident #7 was admitted to the facility she was told the facility had a van for transportation.
-The Resident Care Coordinator (RCC) had told her it would be hard to transport Resident #7 to physician appointments due to "dialysis residents come first."
-She knew Resident #7 had 2 recent hospital visit within one month.
-The facility never contacted her in regards to Resident #7's heart and vascular, primary medical physician, or the gastroenterology physician appointments.
-She was not aware Resident #7 had missed the physician's appointments after the two hospital visits.
-She worked a full time job and relied on the facility to transport Resident #7 to physician's appointments.

Interview with a medication aide (MA) on 12/18/18 at 3:30pm revealed:
-The Activity Director or the RCC were responsible for scheduling appointments for the residents.

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-She was responsible for reviewing new orders for residents and reviewing discharge summaries from the hospital.
-She did not know Resident #7 had physician appointments on the hospital discharge summary dated 11/28/18 or 12/12/18 with the heart and vascular center, the primary care physician, or the gastroenterology physician.
-There was a facility van used for transportation for the residents to the physician appointments, but it had been broken for about 2 weeks.
-The facility used another facility's van to transport residents to physician appointments during that time.
-She was not sure why the physician appointments were missed for Resident #7.

Interview with the Activity Director (AD) on 12/18/18 at 4:00pm revelaed:
-She did not handle or schedule any transportation for residents to physician appointments.
-The AD prior to her hire schedule resident's transportation, but she did not.
-The transporter was responsible for transportation and scheduling all appointments.

Interview with the Resident Care Coordinator (RCC) on 12/18/18 at 4:15pm revealed:
-The facility van had "broken down" about 2 weeks ago and they had used another facilities van for transportation.
-Transportation and the Activity Director were to work together to transport residents to physician appointments.
-"If I see or know of an appointment for a resident I will put in on the appointment calendar."
-She was not aware Resident #7 had ordered physician appointments from the two hospital discharge summary that were not on the

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appointment calendar.
-She did not know why Resident #7 had missed the appointments.
-She did not know Resident #7 had an appointment on 12/18/18 at 3:30pm with the heart and vascular center and was in the facility at that time complaining of leg pain and swelling.
-The transportation person was to make the residents aware of their physician appointments on the morning of the appointment so they could be ready to go on time.

Interview with the facility transporter on 12/19/18 at 11:45am revealed:
-He had been hired about a month ago for transportation.
-He was the only one who transported residents to appointments.
-He had never transported Resident #7 to any physician appointments.
-He was not in charge of scheduling appointments; "The MA tells me who and where to go."
-"The MA never ask me transport [Resident #7]."
-The RCC or the MA put the resident's appointments in the transportation book calendar.
-He was not aware Resident #7 had missed physician appointments.

Interview with the RCC on 12/20/18 at 10:20am revealed Resident #7 was transported to the hospital on 12/19/18 around 11:00pm and was admitted to intensive care unit with a diagnoses of chest pain.

Interview with the facility Nurse Practitioner on 12/19/18 at 11:30am revealed:
-Resident #7 was a new patient to her services.
-She had seen Resident #7 on 12/05/18 and ordered laboratory studies because "this was

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something she did for all new patients".
-She had known Resident #7 had been in the hospital recently on 11/28/18.
-She did not know Resident #7 had missed follow-up appointments with the heart and vascular, primary care physician, and the gastroenterology physician appointments.
-When the result of Resident #7's lab findings came back she called the facility and had Resident #7 sent out to the hospital for a low hemoglobin.
-She did not know Resident #7's hospital discharge order on 11/28/18 was to follow-up with the primary medical physician for lab work in 5 days after discharged.
-The facility did not make her aware of any of Resident #7's missed physician's appointments.
-The physician appointments were important for follow-up care from the hospital visits.
-The facility was responsible for transportation of Resident #7 to the physician's appointments.

2. Review of Resident #1's current FL-2, dated 9/25/18 revealed diagnoses included breast cancer, prediabetes, hypertension, seizure, and hyperlipidemia.

Review of Resident #1's register revealed she was admitted to the facility on 10/11/18.

Review of "After Visit Summary" from appointment on 10/4/18 revealed:
-Resident #1 was seen for malignant neoplasm of upper-outer quadrant of the right breast and she had a chemotherapy appointment scheduled for 10/25/18 at 12pm and a physician's visit with her oncologist scheduled for 11/5/18 at 10:20am.

Review of the transportation appointment

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calendar on 12/18/18 at 3:11pm revealed:
-In October 2018, Resident #1 had the following appointments listed in the calendar, noted as "Radiation/Oncology": 10/25/18, 10/26/18 and 10/29/18.
-In November 2018, Resident #1 had the following appointments listed in the calendar, noted as "Radiation/Oncology": 11/5/18, 11/19/18, and 11/27/18. There was no appointment listed on 11/18/18 for radiation.
-On 12/17/18, Resident #1 had an appointment listed in the transportation calendar, noted as "Radiation/Oncology".
-On 12/4/18, Resident #1 had an appointment listed on the calendar for "radiation/oncology", but it had been marked through.

Review of Resident #1's charting notes revealed there was no documentation regarding medical appointments.

Telephone interview with Oncologist's office nurse on 12/7/18 at 10:18am revealed:
-Resident #1 was supposed to receive chemotherapy "every 3 weeks."
-Resident #1 had last received a chemotherapy treatment on 10/4/18.
-Resident #1 had missed a total of 3 chemotherapy treatments on 10/25/18, 10/29/18, and 11/19/18.
-Resident #1 also missed an office visit scheduled for 11/5/18.
-Due to Resident #1 delay in chemotherapy treatment due to missed appointments, more treatments would have to be added to make up for those missed, lengthening her treatment course.

Telephone interview with Resident #1's Oncologist office nurse on 12/18/18 at 11:18am

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D 321	Continued From page 116 revealed: -Resident #1 had not attended any chemotherapy treatments since she had moved into the facility. -Resident #1 had missed a total of 4 chemotherapy appointments, on 10/25/18, 10/29/18, 11/19/18 and 12/17/18. -Resident #1 had missed an office visit on 11/5/18. -Resident #1 missed an appointment for an echocardiogram on 12/4/18. -Resident #1 was supposed to have chemotherapy directly after an office visit on 12/10/18, however, due to missing the echocardiogram on 12/4/18, she could not receive chemotherapy as scheduled. -At the time of the visit on 12/10/18, the physician's office contacted the Resident Care Coordinator (RCC) at the facility to make the facility aware of appointments that were being rescheduled, which included: An echocardiogram was rescheduled for 12/11/18, and chemotherapy was rescheduled for 12/17/18. She stressed the importance of Resident #1 attending the appointments. The RCC assured her that Resident #1 would have transportation to the appointments. -Resident #1 was receiving chemotherapy to "decrease the risk of recurrent disease." -Per Resident #1 oncologist, "Sub-optimal care, including not attending necessary cancer treatments such as radiation, chemotherapy, tests and appointments with her physicians, could negatively impact her outcome regarding her diagnosis of breast cancer." Telephone interview with Radiation Treatment office representative on 12/6/18 at 3:01pm revealed: -Resident #1 had missed 2 appointments, on 11/18/18 and 11/27/18.	D 321		

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D 321	Continued From page 117 -Any missed appointments were generally added to the end of series of daily radiation treatments. -Resident #1 finished her radiation treatments on 12/3/18, which is when she would have completed the treatments originally. She was not sure why treatments had not been added. Telephone interview with Resident #1's Responsible Party (RP) on 12/6/18 at 3:10pm revealed: -At the time of moving Resident #1 into the facility, he provided the facility with information on her upcoming medical appointments, including her daily radiation appointments. He had also provided the facility a copy of the paperwork from her last doctor's appointment that had upcoming appointments listed on it, including her next scheduled chemotherapy treatment. -He became aware that Resident #1 missed some of her radiation and chemotherapy appointments because he received a call from the physician's office to reschedule an appointment. -He went to the facility after learning that she had missed multiple appointments and spoke with "someone" who assured him that they would make sure she got to her radiation and chemotherapy appointments. Interview with the transporter on 11/7/18 at 9:15am revealed: -She had been working in the capacity of transporter for about a month. -Resident #1's RP came to the facility yesterday and was concerned because he had received a call from the resident's physician's office stating that she had missed a chemotherapy appointment. -Prior to the RP coming to the facility, she had not been aware that Resident #1 was supposed to be	D 321		

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attending chemotherapy treatment appointments.
-After talking with the RP, it was her understanding that Resident #1 was only receiving chemotherapy every 3 weeks.
-She recalled recently receiving a message from the former Business Office Manager (BOM) to return a call to the radiation treatment office to schedule an appointment for Resident #1. She had called the radiation office and set up Resident #1's radiations treatments.
-She began transporting Resident #1 to daily radiation treatments on 10/22/18.
-She was supposed to be notified in writing of any scheduled appointments or treatments that needed to be scheduled for new residents upon admission by the Resident Care Director (RCD) or Resident Care Coordinator (RCC).
-The facility nurse had quit working in the facility very soon after Resident #1 had been admitted, so no one had reviewed the record and informed her of Resident#1's appointments that needed to be on the transport calendar.

Interview with the transporter on 12/6/18 at 2:45pm revealed:
-Since 11/7/18, Resident #1 had missed two more radiation appointments, of which she was aware. One of those days she was out sick and the facility did not get anyone else to transport Resident #1 to radiation appointment. She was unsure of the exact date.
-The second appointment Resident #1 had missed was on 11/18/18. She was not working that day but had arranged for another staff member to assure Resident #1 attended her radiation appointment. She called the facility the day before to make sure staff hadn't forgotten about the appointment. The next day, about the time of the appointment, she called the facility again to make sure someone was taking her, and

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found out staff had not transported the resident to her appointment. She called Resident #1's radiation office, which was about to close for the day, and they offered to wait for her to arrive. She notified the facility the radiation office was waiting for Resident #1 to come in late for her appointment, and it was her understanding a staff member was taking her. She later learned that the Executive Director told staff to call and reschedule the appointment.

Interview with Resident #1's primary care physician (PCP) on 12/18/18 at 11:45am revealed:
-He had been Resident #1's PCP since she had moved into the facility in October 2018.
-He could tell that "something was not right" with Resident #1 and was aware that she had missed some treatment sessions for her diagnosis of breast cancer.
-He had stressed to the RCC the importance of Resident #1 attending her cancer treatments.
-There was a potential outcome of Resident #1's cancer progressing due to missing treatments.

Interview with the RCC on 12/6/18 at 2:15pm revealed:
-She did not know that Resident #1 had missed some appointments.
-She had discovered there was some confusion about who would be transporting Resident #1 to her radiation appointment on 11/18/18.
-She spoke with Resident #1's RP who informed her the resident had missed 2 radiation treatments since living in the facility.
-Resident #1 was admitted to the facility the same week that she had started working the facility, so she was not familiar with her and was not aware of her appointments for her cancer treatments.
-She did not know that Resident #1 had missed

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any chemotherapy appointments.
-The RCD normally reviewed any records for new admissions to the facility to assure that transportation was scheduled for any upcoming medical appointments; however, the facility had been without an RCD since just after Resident #1 had been admitted. Since the facility had been without an RCD, she was trying to review records for new admissions to assure all needed services were in place, including transportation, as much as she could with her other responsibilities.

Interview with RCC on 12/18/18 at 4pm revealed:
-She did not know Resident #1 had missed chemotherapy treatment yesterday, 12/17/18.
-The facility's van was in the shop for service yesterday (12/17/18) and some appointments had to be rescheduled, but she was not aware that Resident #1's appointment was one of them.
-Previously, the activity director who was filling in as the transporter was responsible for writing appointments in the transportation calendar.
-She recalled speaking to the nurse from the oncologist's office on 12/11/18 regarding upcoming appointments that had been scheduled, including an echocardiogram on 12/11/18 and chemotherapy on 12/17/18, and was certain that she had given this information to the activity director to put on the calendar at that time.

Interview with transporter on 12/18/18 at 3:23pm revealed:
-Resident #1 did not attend her chemotherapy appointment yesterday (12/17/18) because the van was in the shop for repairs. The van was supposed to be ready yesterday morning in time for appointments, but there was a delay, which caused there to be missed appointments.
-Usually, when the facility van was not working,

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the facility borrowed a vehicle from a nearby sister facility so that residents could attend appointments as scheduled.
-The facility had not previously made arrangements with a sister facility to borrow a vehicle for yesterday, because the van was supposed to have been repaired in time for resident appointments. This caused a few residents to have missed appointments.
-When the RCC notified him of an upcoming appointment, he would add the appointment to the transportation calendar.

Interview with Executive Director on 12/6/18 at 3:50pm revealed:
-She did not become aware that Resident #1 had missed any medical appointments until Adult Protective Services inquired about it on 11/7/18.
-When a new resident was admitted to the facility, it was the nurse's responsibility to review the record to assure any transportation for appointments was set up either through the family or by the facility.
-The facility's nurse had quit about the time that Resident #1 was admitted, which resulted in no one looking thoroughly at the record to see the documentation the family had provided with information about upcoming appointments.
-She and the RCC had also been trying to assist with reviewing records for new residents, but they had not revealed Resident #1's record.
-She did not know there was documentation in Resident #1's chart with information about upcoming medical appointments on 10/25/18 at 12pm for chemotherapy and 11/5/18 at 10:20am for an appointment with her oncologist.

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The facility failed to assure coordination of the provision of transportation for Resident #1 who had a diagnosis of breast cancer to oncology

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D 321	Continued From page 122 treatments and appointments, resulting in a delay in treatment and for Resident #7 to cardiac and vascular appointments, resulting in a hospitalization for chest pain. The facility's failure to ensure transport was in place resulted in potential risk for disease progression for both residents and was detrimental to their health, safety, and welfare, constituting a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/16/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBUARY 08, 2018.	D 321		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility neglected to assure staff providing personal care were in compliance with the facility policy regarding fingernails resulting in	D 338		

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D 338	Continued From page 123 a trauma wound to one resident (#13). The findings are: Review of the facility employee's dress and personal appearance from the employee handbook revealed: -The ED/ supervisor was responsible for assuring adherence to this policy and he or she is the final authority in determining whether the policy has been met. -Long fingernails and false fingernails that could harm residents were not permitted. Review of Resident #13's current FL2 dated 07/10/18 revealed: -Diagnoses included bipolar, anxiety, and muscle wasting. -Ambulatory status was non ambulatory. -Personal care assistance required were bathing, dressing and toileting. -Resident was incontinent of bowel and bladder. Interview with Resident #13 on 12/19/18 at 12:53pm revealed: -She had a dressing to her lower right leg. -The wound had occurred about one and half months ago. -A staff person had "scratched her leg while pulling her pajamas bottoms up." -The staff person had on "long artificial nails." -"The staff person was not wearing gloves." -"The wound is really bad." -"I went to the hospital last week because my leg hurt so bad." -She had told the Home Health (HH) Nurse and a family member when it happened that a staff person had scratched her who was wearing long artificial nails. -She did not want to get the staff person in	D 338		

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D 338	Continued From page 124 trouble, "I know they are not to have those artificial nails." Review of Resident #13's facility progress notes revealed: -On 10/26/18 at 11:13pm, the resident had a skin tear on her left leg and a medication aide (MA) had placed a bandage on it. -On 11/29/18 at 11:19am, the resident complained of pain and requested to have her leg dressing changed because it was leaking. There was redness and swelling to the right lower extremity. The Resident Care Coordinator (RCC) changed the dressing and notified the physician of the resident leg pain/swelling. -On 12/02/18 at 2:04pm, "Resident doing well today. Is currently taking clindamycin (an antibiotic used to treat bacterial infections) 300mg TID [three times a day] for 10 days. -On 12/14/18 at 11:33am, RCC scheduled an appointment at the wound clinic for 12/21/18 at 10:00am. Interview with the Resident Care Coordinator (RCC) on 12/19/18 at 3:45pm revealed: -She first knew Resident #13 had a "skin tear" when a family member had called her in October 2018. -The family member was concerned and wanted the RCC to look at Resident #13's leg and the skin tear. -"It was like a small skin tear." -Resident #13 never told the RCC a staff person with long fake nails had scratched her leg while assisting with pulling her pajamas up. -She looked at Resident #13's wound again on 11/29/18 because Resident #13 had complained her leg hurt and the dressing had leaked. -The RCC documented in the progress notes on 11/29/18 Resident #13's right lower leg was	D 338		

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swollen and red, and she notified the physician of the redness and swelling.

Review of an emergency room (ER) visit dated 12/09/18 for Resident #13's record revealed:
-The diagnosis was documented as a wound infection/leg pain.
-The ER had requested she follow up with her primary physician.

Review of the facility Nurse Practitioner (NP) visit note dated 11/07/18 for Resident #13 revealed:
-Resident #13 had indicated she had an open wound on her leg.
-The NP noted to get HH to evaluate and treat the leg wound.
-Diagnoses included injury unspecified, initial encounter wound.
-Plans were for HH to evaluate the wound and treat accordingly.

Review of the facility NP's visit note dated 11/28/18 for Resident #13 revealed:
-Resident #13 was seen on 11/28/18 for a "leg ulcer follow up."
-The HH nurse had obtained a wound culture.
-"The wound looks intact and free from infection."
-Resident #13 was ordered a broad spectrum antibiotic until the culture is back.
-HH wound continue to follow up with treatments.
-The NP would consider sending Resident #13 to the wound clinic next week, if no improvement.
-Diagnoses included injury unspecified, initial encounter, primary diagnosis wound.
-An order for Clindamycin 300mg three times daily for 10 days.

Review of the facility NP visit note dated 12/18/18 for Resident #13 revealed:
-Resident #13 was seen on 12/18/18 for a

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"chronic leg ulcer follow up."
-Resident #13 was sent to the ER for pain and was concerned with the leg wound.
-Home Health was still following patient.
-Resident #13 had completed a course of antibiotics.
-Resident #13 had an appointment scheduled a for wound clinic this week.
-Diagnoses included injury unspecified, initial encounter, primary diagnosis wound.
-There was an order for an X-ray of tibia / fibula to rule out osteomyelitis.

Telephone interview with Resident #13's NP 12/20/18 at 10:47am revealed:
-The HH nurse had informed him on 10/30/18 that Resident #13 had a wound to the right lower leg.
-He could not recall the HH nurse referring to the wound as a "trauma wound."
-The HH nurse contacted him in regards to obtaining a wound culture around the middle of October 2018.
-He ordered a board spectrum antibiotic for Resident #13 after the culture was obtained.
-Resident #13 never told him a staff person wearing long artificial nails had scratched her leg causing the trauma wound.
-He referred to Resident #13's leg wound in his notes as an ulcer, "The reason I used ulcer in my notes was due to I actually did not know what it was."
-He ordered a wound clinic consult for Resident #13 and thought it was on 12/21/18.

Telephone interview with a family member of Resident #13 on 12/19/18 at 5:30pm revealed:
-She talked with Resident #13 three times weekly and was in the facility every week.
-Resident #13 called her on 10/30/18 and told her

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D 338	Continued From page 127 a staff person had scratched her leg while pulling her pajamas bottoms up. -The staff person had "long fake nails" on. -She called the RCC on 10/30/18 and told her what had happened to Resident #13, and the RCC was to look at Resident #13's leg. -Resident #13 called her again about 2 weeks later and told her the wound was "looking real bad." -Resident #13 had HH following the wound but the visits had to be increased to every day. -Resident #13 had been sent to the ER 12/12/18 with leg pain and infected wound. -"I keep asking how bad is the leg, they tell me it's not bad." -"If the wound is not bad why is she going to the wound clinic." Interview with the Resident Care Coordinator (RCC) on 12/20/18 at 8:10am revealed: -Resident #13 had told her on 12/19/18 a staff person with fake nails scratched her right leg resulting in the trauma wound. -The RCC said Resident #13 had not told her when the incident happened in October 2018 because "she did want to get the staff person in trouble." -She remembered Resident #13's family member calling her on 10/30/18 but could not recall the family member mentioning a staff person with fake nails scratched Resident #13's leg. -The HH nurse never told the RCC a staff person had scratched Resident #13's leg resulting in a diagnosis of a trauma wound. -She had never seen the HH nurse visits notes because "We do not keep them in the record." -She was not sure the physician was aware Resident #13 was scratched by a staff person. -"I have talked several times to the girls about fake nails, they are not allowed to have them."	D 338		

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D 338	Continued From page 128 -"I would had completed an incident report if I knew a staff person had scratched Resident #13's leg, especially now that the wound is bad and requiring wound the clinic." -The staff were to report any incidents resulting in an injury to a resident to the RCC. Observation of Resident #13 leg wound with the HH Nurse present on 12/20/18 at 8:45am revealed: -The leg wound was located on the top of the lower right leg about 4 inches below the knee. -When the dressing was removed the dressing was saturated with a purulent yellowish-green drainage. -The wound was approximately 2.5 inches long and approximately 2 inches in width. -The wound center was covered with a whitish-yellow slough (dead tissue build up that impedes healing). -The outer wound bed was bright red and raised approximately 1/8 inch from the slough. Interview with the HH Nurse on 12/20/18 at 8:45am revealed: -Resident #13 had told her about the leg wound on 10/30/18, a staff person had scratched Resident #13's leg while assisting with her pajamas. -She told the RCC and the physician about the wound on 10/30/18 and received an order to evaluate and treat the wound. -She had documented in her initial notes "trauma wound due to a nail scratch from staff." -The RCC and the physician were both aware of the trauma wound diagnosis, but she was not sure they were aware a staff person had scratched Resident #13. -When she started treating the wound it was 0.5 centimeters (cm) x 1cm.	D 338		

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-"It was like a small scratch with an open center area."
-She measured the wound last week and it measured 5cm x 4cm.
-She contacted the physician in November 2018 when the wound appeared to be getting bigger and worse.
-She obtained a wound culture and the physician ordered an antibiotic for 10 days.
-Resident #13 had an X-ray of the leg ordered on 12/18/18, but she was not sure it had been done.
-"The wound looks pretty bad."
-The physician ordered a wound clinic evaluation for Resident #13 and was scheduled for 12/21/18.

Interview with the Resident #13 on 12/20/18 at 8:00am revealed:
-The RCC had spoken to her on 12/19/18 about the leg wound.
-She had told the RCC on 12/19/18 a staff person had scratched her leg and the staff was wearing fake nails.
-The RCC told her the staff were not to wear fake nails.

Review of Resident #13's wound care clinic noted dated 12/21/18 revealed:
-The wound was caused by trauma.
-The wound was on the right lower leg and measured 7cm in length X 4cm in width X 0.1cm in depth.
-There was no underling tunneling of the wound.
-There is a medium amount of serosanguineous (a thin, blood tinged, watery drainage) drainage to the wound.
-There is a large area (67%-100%) of necrotic (dead of cells in living tissue) tissue within the wound bed including slough (dead tissue that is yellowish or white in appearance).
-The resident could not tolerate light touch to the

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D 338	Continued From page 130 area, therefore no debridement (the removal of dead tissue) could be performed. _____ Based on observations, interviews and record reviews, the facility neglected to assure staff providing personal care were in compliance with the facility policy regarding fingernails resulting in a trauma wound to one resident (#13) requiring medical evaluation at the wound clinic for treatment. The facility's failure was detrimental to the health and safety of the residents and constitutes a Type B violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/16/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 08, 2018.	D 338		
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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D 358	Continued From page 131 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 7 residents (Resident #3, #5, #6) including Novolin 70/30 insulin and amlodipine (Resident #3), Buspar and chlorhexidine gluconate (Resident #5), and acetaminophen (Resident #6). The Findings are: 1. Review of Resident #3's FL2 dated 10/02/18 revealed diagnoses included type 2 diabetes, post cerebral vascular accident, and diabetic neuropathy. a. Review of Resident #3's FL-2 dated 10/02/18 revealed: -There was a medication order for Novolog Flexpen 100 units (a rapid acting insulin used to lower blood sugar), check finger stick blood sugar (FSBS) before each meal and inject per sliding scale: 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, if greater than 401 go the emergency room or urgent care. -There was a medication order for Novolin 70/30 (a combination of 70% intermediate acting insulin and 30% rapid acting insulin used to lower blood sugar), inject 100 units every morning before breakfast. Review of Resident #3's August 2018 electronic Medication Administration Record (eMAR) revealed:	D 358		

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D 358	Continued From page 132 -There was an entry for Novolog 100 units, check FSBS before each meal and administer per sliding scale at 7:30am, 11:30am, and 4:30pm. -The resident's FSBS reading on 08/03/18 at 7:30am was 252, he received 6 units of Novolog insulin. -There was an entry for Novolin 70/30 inject 100 units every morning before breakfast at 7:00am. -On 08/03/18, the resident received 100 units of Novolin 70/30 insulin. Review of progress note regarding Resident #3's appointment with the Nephrologist on 08/02/18 revealed: -Resident #3 was late to his scheduled appointment at 8:00am and was therefore rescheduled for 1:00pm. -Resident #3 arrived at 1:00pm appointment and attempted to be weighed, however the resident was "unsteady on his feet and his speech was slurred". -The resident reported he had not had anything to eat prior to coming to the appointment. -The glucose check was 27, "normal range is between 70 and 110". -After receiving food, juice, and sugar packets, the blood glucose elevated to 98. -The resident was unable to complete appointment and was rescheduled to 08/03/18. Review of Resident #3's October 2018 eMAR revealed: -There was an entry for Novolog 100 units, check FSBS before each meal and administer per sliding at 7:30am, 11:30am, and 4:30pm. -The resident's FSBS reading on 10/23/18 at 7:30am was 108, he received 0 units of Novolog insulin. -There was an entry for Novolin 70/30 inject 100 units every morning before breakfast at 7:00am.	D 358		

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D 358	Continued From page 133 -On 10/23/18, the resident received 100 units of Novolin 70/30 insulin. Review of progress note regarding Resident 3's primary care physician (PCP) appointment on 10/23/18 revealed: -Resident #3 arrived at follow-up appointment and he was "shaky, sweaty, and his blood sugar was 35". -Resident #3 reported to staff that he gets insulin but at times did not get breakfast because he had to leave to go to his appointment. Interview with Resident #3 on 12/17/18 at 3:40pm revealed: -He knew he was on insulin to control his blood sugar. -He received insulin daily before meals. -He remembered going to medical appointments and his blood sugar dropping. -He did not eat on those days he received insulin and his blood sugar dropped. -He was going out to his appointment and, "I forgot that I needed to eat". -The staff did not ask him if he was going to eat prior to administering his insulin. -The insulin was still administered even though he had not eaten breakfast before going to his doctor's appointment. Interview with a medication aide (MA) on 12/19/18 at 2:00pm revealed: -She had administered insulin to Resident #3 "sometimes". -She always checked the blood sugar before administering insulin. -She tried to make sure residents ate before going to appointments. -She usually administered insulin before residents go to the dining room.	D 358		

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-She thought Resident #3 always went to the dining room to eat breakfast after insulin was administered, "I never check on him, he always eats".

Interview with a first shift MA on 12/19/18 at 1:50pm revealed:
-She administered Resident #3's medications according to the order.
-She knew residents were supposed to eat after receiving insulin.
-She did not administer insulin if the resident did not plan to eat.
-She would not administer insulin if blood sugar was less than 100.

Interview with the primary care physician (PCP) on 12/19/18 at 2:47pm revealed:
-She expected Resident #3 to receive insulin as ordered.
-Resident #3 needed to eat after insulin was administered.
-Insulin should not be administered if Resident #3 was not planning to eat.
-If the resident did not eat after receiving insulin his blood sugar would drop and he would be at risk for passing out, seizure, or hospitalization.

Interview with the Resident Care Coordinator (RCC) on 12/19/18 at 2:31pm revealed:
-She did not know about the incidents regarding Resident #3's blood sugars.
-She expected medications to be administered as ordered.
-Insulin should not be administered without eating.
-She was not sure what training the MAs had received regarding diabetes.

Interview with the Administrator on 12/19/18 at

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D 358	Continued From page 135 10:28am revealed: -She expected staff to administer medications as ordered and following instructions of physician. -All MAs receive diabetes training before administering insulin and should know how to administer. -There was no nurse available in the facility for MAs to consult. b. Review of a physician's order dated 11/01/18 for Resident #3 revealed an order for amlodipine 10mg (used to treat high blood pressure and chest pain), 1 tablet every morning for heart. Review of Resident #3's November 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for amlodipine 10 mg, one tablet every morning for heart at 8:00am entered on 11/27/18. -Resident #3 missed 27 out of 30 doses of amlodipine. -Amlodipine was documented as administered once daily at 8:00am on 11/28/18-11/30/18. -Blood pressure readings ranged from 157/84-209/123. Interview with Resident #3 on 12/18/18 at 3:20pm revealed: -He felt "dizzy and sluggish" last month when his blood pressure medication was missed. -He also experienced "light chest pain" when medication was missed, and he had notified staff, however he was not sure if his physician was notified. -There was a problem getting refills from the contracted pharmacy. -He could not remember how long he went without amlodipine. -He was not familiar with amlodipine or why it was	D 358		

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D 358	Continued From page 136 prescribed. Telephone interview with a representative from Resident #3's contracted pharmacy on 12/18/18 at 10:39am revealed: -The order for amlodipine was received on 11/01/18. -A 90 day supply of amlodipine 10mg was filled for the resident on 11/01/18 and delivered via mail to the facility. -There had been no refills for the amlodipine. Telephone interview with the pharmacist at the facility's contracted pharmacy on 12/20/18 at 10:18am revealed: -They provided eMAR services for the facility. -Orders were faxed from the facility and added to the eMAR when received. -The pharmacy received the order for amlodipine on 11/27/18 for Resident #3 and that was when it was entered on the eMAR. -They had not filled amlodipine for Resident #3, as he received his medications from another pharmacy. Interview with a first shift Medication Aide (MA) on 12/18/18 at 9:50am revealed: -She did not know why Resident #3 amlodipine was not administered until 11/27/18. -All MAs were responsible for faxing the order to the pharmacy to be added to the eMAR. -She administered medication according to the eMAR and did not administer if it did not appear on the screen. -She was not sure what happened with the amlodipine. Interview with a second shift MA on 12/18/18 at 3:33pm revealed: -Resident #3 was out of his some of his	D 358		

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medications, and she notified the Resident Care Coordinator (RCC).
-She did not know Resident #3 was ordered amlodipine on 11/01/18.
-She administered medications as they appeared on the eMAR.

Interview with another MA on 12/18/18 at 3:40pm revealed:
-She knew Resident #3 was out of some of his medications in November.
-She was not sure what happened with Resident #2's amlodipine.
-"It has been a mess, I am not sure who is responsible for following up with orders".

Telephone interview with Resident #3's primary care physician on 12/19/18 at 2:47pm revealed:
-She was not aware Resident #3 missed 27 doses of amlodipine.
-She would expect to be notified about missed medications.
-She would want to know about missed medications so that she could adjust medications if needed.
-Resident #3 was at risk for chest pain and elevated blood pressure when the amlodipine was missed.

Interview with the RCC on 12/19/18 at 2:31pm revealed:
-She worked at the facility as the RCC for 2 months.
-She did not know about missed doses of amlodipine and would have expected the medication order to be faxed immediately to the pharmacy.
-She expected MAs to fax orders to the pharmacy once received.
-The amlodipine order should have been faxed to

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the facility pharmacy to be added to the eMAR.
-She did not know why Resident #3 missed 27 doses of amlodipine.

Interview with the Administrator on 12/19/18 at 10:28am revealed:
-She did not know Resident #3 missed 27 doses of amlodipine.
-She expected the RCC to follow physician orders and fax orders when received.
-The RCC was responsible to ensure all orders were faxed to the pharmacy when received.

2. Review of Resident #6's current FL2 dated 08/14/18 revealed:
-Diagnoses included acute osteomyelitis, right fibula fracture, and stress fracture.
-There was a medication order for acetaminophen 1000mg every 6 hours.

Review of a subsequent physician order dated 10/05/18 revealed acetaminophen was discontinued.

Review of Resident #6's October 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for acetaminophen 1000mg to be administered at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-Acetaminophen 1000mg was documented as administered daily at 12:00am, 6:00am, 12:00pm, and 6:00pm from 10/01/18-10/31/18 with the exception of 2 doses on 10/21/18 at 6:00pm with "resident refused" and 10/24/18 at 6:00pm with "out of facility/appointment" documented as exceptions.

Review of Resident #6's November 2018 eMAR revealed:

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D 358	Continued From page 139 -There was an entry for acetaminophen 1000mg to be administered at 12:00am, 6:00am, 12:00pm, and 6:00pm. -Acetaminophen 1000mg was documented as administered daily at 12:00am, 6:00am, 12:00pm, and 6:00pm from 11/01/18-11/30/18 with the exception of 3 doses on 11/11/18, 11/15/18, and 11/23/18 at 6:00pm with "resident refused" documented as the exception. Review of Resident #6's December 2018 eMAR revealed: -There was an entry for acetaminophen 1000mg to be administered at 12:00am, 6:00am, 12:00pm, and 6:00pm. -Acetaminophen 1000mg was documented as administered daily at 12:00am, 6:00am, 12:00pm, and 6:00pm from 12/01/18-12/19/18. Based on review of Resident #6's October, November, and December 2018 eMARs , the resident continued to receive acetaminophen 1000mg every 6 hours after it was discontinued on 10/05/18 due to physician visit notes/orders not being the record. Interview with Resident #6 on 12/20/18 at 3:15pm revealed: -He thought he was receiving his medications as ordered by his primary care provider (PCP). -He received acetaminophen four times per day for pain. -He did not know if any of his pain medications had been discontinued. Observation of Resident #6's medications on hand on 12/20/18 at 2:57pm revealed: -There were 2 medication cards with 56 bubbles of acetaminophen 500mg available to be administered.	D 358		

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D 358	Continued From page 140 -There was 1 bubble pack that contained 24 bubbles of acetaminophen 500mg tablets. -Each bubble on the medication card contained 2 tablets to equal 1000mg per dose. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/20/18 at 10:18am revealed: -The order for Resident #6's acetaminophen 1000mg every hours was received on 08/14/18. -The acetaminophen order was still current and a discontinue order had not been received. -The pharmacy dispensed 224 pills (a 28 day supply) on 12/07/18, 11/09/18, and 10/12/18. Interview with a first shift medication aide (MA) on 12/19/18 at 3:40pm revealed: -She administered Resident #6's medications according to the eMAR system. -She did not know Resident #6's acetaminophen had been discontinued on 10/05/18. -Physician orders were normally written by the physician and provided to the RCC before he left the facility. -The facility was going through a transition and Resident Care Coordinator (RCC) may have missed the order to discontinue acetaminophen. -The MAs were responsible for removing discontinued medications from the medication cart. Interview with the RCC on 12/20/18 at 3:15 revealed: -She worked at the facility for 2 months. -The order for Resident #6's acetaminophen changed when she first starting working at the facility. -The order should have been faxed to the pharmacy. -Orders to discontinue medications were faxed to	D 358		

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the pharmacy and the pharmacy was responsible for removing orders for the eMAR.
-She was responsible for making sure the MAs had entered all new medication orders into the eMAR correctly.

Interview with Resident #6's PCP on 12/19/18 at 3:00pm revealed:
-The resident's acetaminophen was supposed to be discontinued in October 2018.
-He did not want the resident to be administered too much of this pain medication because it would effect the resident's liver over a period of time.
-He expected the facility to follow his orders as written.

Interview with the Administrator on 12/19/18 at 10:28am revealed:
-Residents were to be administered medication as ordered.
-The RCC was responsible for making sure orders were reviewed and followed.
-The RCC and MAs were responsible for faxing orders to the pharmacy so the eMAR could be accurate.
-The pharmacy was responsible fore removing discontinued medications from the eMAR.
-The RCC and MAs were responsible for removing discontinued medications from the medication cart.

3. Review of Resident #5's current FL-2 dated 09/14/18 revealed diagnoses included schizophrenia and intellectual disability.

a. Review of Resident #5's physician's orders dated 10/11/18 revealed an order for Buspar 5mg three times daily (a medication used to treat anxiety).

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Review of Resident #5's mental health provider's notes revealed:
-Resident #5 was evaluated and provided psychotherapy for moderate generalized anxiety disorder on 06/06/18, 06/13/18, 06/20/18, 07/04/18, 07/18/18, 08/01/18, 08/08/18, 08/15/18, 08/22/18, 09/05/18, 09/26/18, and 10/03/18.
-Resident #5 was seen by the mental health physician's assistant (PA) for medication management on 06/07/18, 06/21/18, 08/02/18, 08/30/18, and 10/11/18.
-On 10/11/18, the PA ordered Buspar 5mg three times daily due to patient reports of feeling anxious and not safe.

Review of Resident #5's October 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Buspar 5mg to be administered at 8:00am, 12:00pm and 8:00pm with a start date of 10/11/18.
-There was documentation Buspar was not administered on 10/13/18, 10/14/18, 10/25/18 and 10/29/18 at 12:00pm for four of twenty opportunities due to "out of facility/appointment."

Review of Resident #5's November 2018 eMAR revealed:
-There was an entry for Buspar 5mg to be administered at 8:00am, 12:00pm and 8:00pm.
-There was documentation Buspar was not administered on 11/01/18, 11/03/18, 11/04/18, 11/05/18, 11/06/18, 11/12/18, 11/13/18 11/20/18, 11/22/18, 11/24/18, 11/27/18, 11/28/18, 11/29/18 at 12:00pm for thirteen of thirty opportunities due to "out of facility/appointment."

Review of Resident #5's December 2018 eMAR revealed:
-There was an entry for Buspar 5mg to be

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administered at 8:00am, 12:00pm and 8:00pm.
-There was documentation Buspar was not administered on 12/01/18, 12/03/18, 12/04/18, 12/05/18, 12/06/18, 12/07/18, 12/11/18, 12/14/18, and 12/17/18 at 12:00pm for nine of seventeen opportunities due to "out of facility/appointment."

Observation of Resident #5's medications available for administration on 12/17/18 at 4:29pm revealed Buspar 5mg was available for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/18/18 at 1:24pm revealed:
-Resident #5's Buspar was on a 28 day automatic refill cycle.
-The pharmacy had dispensed 24 tablets of Buspar 5mg for Resident #5 on 10/11/18, 48 tablets on 10/30/18, 84 tablets on 11/11/18 and 84 tablets on 12/07/18.

Interview with Resident #5 on 12/18/18 at 8:40am revealed:
-He went to "school" a few times each week.
-He did not carry any medications to "school" with him.

Telephone interview with Resident #5's peer support specialist on 12/18/18 at 2:29pm revealed:
-Resident #5 had problems with social anxiety and stress.
-Her responsibility was to help Resident #5 with coping skills, encourage him to socialize with peers and encourage him to attend psychosocial rehabilitation (rehab) group meetings.
-Resident #5 usually left for psychosocial rehab meetings around 9:00am three times per week and she would be at the facility during those times

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to encourage him to go.
-Resident #5 often had to be coaxed into attending the meetings because his anxiety was so high.
-She had not observed Resident #5 leaving the facility with any medications to be taken at the psychosocial rehab facility.

Interview with a medication aide (MA) on 12/19/18 at 10:00am revealed:
-Resident #5 attended psychosocial rehabilitation three days each week leaving around 9:00am and returning around 2:30pm.
-She did not administer 12:00pm medications to Resident #5 when he was out of the facility at rehab and would document "out of facility/appointment."
-She had not considered discussing with Resident #5's Primary Care Provider (PCP) or mental health provider's physician assistant (PA) about him missing medications, but "I probably should have" so he could adjust his dose or dosing schedule.

Interview with the Resident Care Coordinator (RCC) on 12/19/18 at 2:00pm revealed:
-She sometimes worked as an MA and administered medications to Resident #5.
-If Resident #5 was out of the facility during the 12:00pm medication pass, she and the other MAs would not administer medications to him and would document he was "out of facility/appointment."
-The psychosocial rehabilitation facility would not take on the responsibility of administering medications to residents.
-She knew Resident #5 routinely missed his 12:00pm medications when he attended the rehab program, but "it never registered to me to speak with his PCP or mental health provider's

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D 358	Continued From page 145 PA to see if the timing of his medications could be changed." Telephone interview with Resident #5's psychosocial therapist on 12/19/18 at 8:50am revealed: -She had been providing psychosocial therapy to Resident #5 since March 2018. -Resident #5 was ordered Buspar by the mental health provider's Physician's Assistant (PA) due to his diagnosis of anxiety. -At times, Resident #5's anxiety was so severe that it affected his breathing. -Resident #5's overall functioning was better when his anxiety was well controlled. -It was important for Resident #5 to attend psychosocial rehab meetings to teach him appropriate social skills and reduce his social anxiety, but due to his anxiety, he would often hide in the facility's bathroom when the van driver would arrive to take him to the meetings. -She did not know Resident #5 was missing his 12:00pm dose of Buspar when attending the psychosocial rehabilitation meetings, but it was the policy of the rehab facility to not administer medications to residents. -She expected facility staff to notify the PA regarding Resident #5 missing doses of Buspar so the PA could determine any changes that needed to be made. -She did not think Resident #5's PA had been notified because the PA had not communicated the information to her. -Resident #5 missing doses of Buspar would cause him to continue to have symptoms of anxiety and would impede his treatment goals. Telephone interview with Resident #5's mental health provider's PA on 12/19/18 at 11:00am revealed:	D 358		

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-He visited Resident #5 at the facility once monthly.
-He had ordered Buspar 5mg three times daily for Resident #5 on 10/11/18 to treat his anxiety.
-He did not know Resident #5 was missing doses of Buspar.
-He had last visited with Resident #5 on 11/08/18 and he continued to have complaints of anxiety.
-Missing doses of Buspar could cause Resident #5 to have increased levels of anxiety.
-He would expect to be notified if a resident was routinely missing a medication so the dose or timing of the medication could be adjusted.

Interview with Resident #5's PCP on 12/18/18 at 11:00am revealed:
-Resident #5 was ordered Buspar 5mg three times daily to treat his anxiety.
-He did not know Resident #5's Buspar 12:00pm dose was not being administered if he was out of the facility.
-Missing doses of Buspar could be contributing to Resident #5's continued anxiety.

Interview with the Administrator on 12/20/18 at 4:00pm:
-She did not know Resident #5 was not being administered his 12:00pm medications when he was routinely out of the facility.
-She expected the MAs to discuss the issue with Resident #5's PCP and ideally he would give an order to change the dosing schedule of his medications to allow for Resident #5 to have all ordered doses administered.

b. Review of Resident #5's current FL-2 dated 09/14/18 revealed a medication order for chlorhexidine gluconate (a mouthwash used to treat gingivitis), rinse with 15 milliliters (mLs) three times a day at 8:00am, 12:00pm and

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D 358	Continued From page 147 8:00pm. Review of Resident #5's October 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for chlorhexidine gluconate 15 mLs to be administered at 8:00am, 12:00pm and 8:00pm. -There was documentation chlorhexidine gluconate was not administered for seven of thirty-one opportunities at 12:00pm due to "out of facility/appointment." Review of Resident #5's November 2018 eMAR revealed: -There was an entry for chlorhexidine gluconate 15 mLs to be administered at 8:00am, 12:00pm and 8:00pm. -There was documentation chlorhexidine gluconate was not administered for thirteen of thirty opportunities at 12:00pm due to "out of facility/appointment." Review of Resident #5's December 2018 eMAR revealed: -There was an entry for chlorhexidine gluconate 15 mLs to be administered at 8:00am, 12:00pm and 8:00pm. -There was documentation chlorhexidine gluconate was not administered for nine of seventeen opportunities at 12:00pm due to "out of facility/appointment." Observation of Resident #5's medications available for administration on 12/17/18 at 4:29pm revealed there was no chlorhexidine gluconate available for administration. Interview with a medication aide (MA) on 12/17/18 at 4:29pm revealed she had placed a	D 358		

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pharmacy order for Resident #5's chlorhexidine gluconate and it would be available for administration that night (12/17/18).

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/18/18 at 1:24pm revealed:
-The pharmacy had dispensed a 473 milliliter (mL) container (10 day supply) of chlorhexidine gluconate for Resident #5 on 07/17/18, 10/09/18 and 11/30/18.
-The pharmacy received a refill request from the facility on 12/17/18 and would dispense another 473 mL container today (12/18/18).
-Resident #5's chlorhexidine gluconate was not on an automatic refill cycle so facility staff had to reorder it each time.

Interview with Resident #5 on 12/18/18 at 8:40am revealed:
-He went to "school" a few times each week.
-He did not carry any medications to "school" with him.

Interview with a medication aide (MA) on 12/19/18 at 10:00am revealed:
-Resident #5 attended psychosocial rehabilitation (rehab) three days each week leaving the facility around 9:00am and returning around 2:30pm.
-She did not administer 12:00pm medications to Resident #5 when he was out of the facility at rehab and would document "out of facility/appointment."

Interview with the Resident Care Coordinator (RCC) on 12/19/18 at 2:00pm revealed:
-If Resident #5 was out of the facility during the 12:00pm medication pass, she and the other MAs would not administer medications to him and would document he was "out of

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facility/appointment."
-The psychosocial rehabilitation facility would not take on the responsibility of administering medications to residents.
-She knew Resident #5 routinely missed his 12:00pm medications when he attended the rehab program, but "it never registered to me to speak with his PCP to see if the timing of his medications could be changed."

Interview with Resident #5's PCP on 12/18/18 at 11:00am revealed:
-He did not know Resident #5's chlorhexidine gluconate 12:00pm dose was not being administered if he was out of the facility.
-He expected all medication orders to be followed and for facility staff to notify him if any changes needed to be made to assure the residents were administered all medications.

Interview with the Administrator on 12/20/18 at 4:00pm:
-She did not know Resident #5 was not being administered his 12:00pm medications when he was routinely out of the facility.
-She expected the MAs to discuss the issue with Resident #5's PCP and ideally he would give an order to change the dosing schedule of his medications to allow for Resident #5 to have all ordered doses administered.

_____

Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for Resident #3 received 100 units of Novolin 70/30 insulin without eating breakfast or lunch and was sent to a physician appointment and arrived with symptom of dizziness and weakness and a blood sugar of 27 and Resident #3 missed 27 out of 30 doses of

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D 358	Continued From page 150 amlodipine on November 2018, Resident #5 including Buspar (used to treat anxiety) and chlorhexidine gluconate (a mouthwash used to treat gingivitis), Resident #6 administered acetaminophen without an order for 3 months and Resident #9 related to hydralazine (used to control blood pressure) was not administered 27 times out of 49 times in December 2018 and Januvia (used to treat diabetes) not administered 12 times out of 17 times in December 2018. This failure to assure medication administration resulted in substantial risk that serious physical harm of residents will occur and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/19/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 26, 2019.	D 358		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home. This Rule is not met as evidenced by:	D 421		

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The facility failed to assure a record of each transaction involving use of a resident's personal funds was signed by the resident, legal representative, or payee at least monthly for 5 of 7 residents (Residents #1, #3, #4, #5, and #10).

The findings are:

Interview with the Regional Business Office Manager (BOM) on 12/20/18 at 10:15am revealed:
-Since she had been assisting in the facility in the absence of a BOM, she had been paying pharmacy bills for residents.
-She had not discussed their pharmacy bills with the residents prior to paying on them and she had not had them sign a statement reflecting how much would be paid to the pharmacy from their account.
-She had instructed the new BOM, who was no longer employed, not to pay more than "around $40.00" per resident toward their pharmacy bill. She had not paid more than "around $40.00" per resident since she had been assisting in the community as well.
-Residents were not provided a copy of their pharmacy bill unless they requested it.

1. Review of Resident #1's personal fund trust account ledger revealed:
-On 11/09/18 the pharmacy was paid $3.51.
-On 12/09/18 the pharmacy was paid $39.05.

Review of Resident #1's personal fund cash transaction log did not reflect the resident had signed for the pharmacy transactions on 11/09/18 or 12/09/18.

Review of Resident #1's "Addendum to Resident Agreement - Resident's Personal Funds

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Management Election" document revealed on 10/11/18 Resident #1 elected to "manage his/her own personal funds, with the exception of that portion required for payment of medication and drug expense which the Resident or Responsible Party authorizes the Community to deduct from the Resident's monthly personal funds allowance."

Refer to the interview with the Administrator on 12/06/18 at 3:50pm.

2. Review of Resident #5's personal fund trust account ledger revealed:
-On 11/01/18, the pharmacy was paid $7.00.
-On 11/09/18, the pharmacy was paid $48.00.
-On 12/09/18, the pharmacy was paid $25.00.

Review of Resident #5's personal fund cash transaction log did not reflect the resident had signed for the pharmacy transactions on 11/01/18, 11/09/18 or 12/09/18.

Review of Resident #5's "Addendum to Resident Agreement - Resident's Personal Funds Management Election" document revealed on 12/01/17 Resident #5 elected to "manage his/her own personal funds, with the exception of that portion required for payment of medication and drug expense which the Resident or Responsible Party authorizes the Community to deduct from the Resident's monthly personal funds allowance."

Refer to the interview with the Administrator on 12/06/18 at 3:50pm.

3. Review of Resident #4's personal fund trust account ledger revealed:
-On 11/09/18, the pharmacy was paid $6.10.

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D 421	Continued From page 153 -On 12/09/18, the pharmacy was paid $60.18. Review of Resident #4's personal fund cash transaction log did not reflect the resident had signed for the pharmacy transactions on 11/09/18 or 12/09/18. Review of Resident #4's "Addendum to Resident Agreement - Resident's Personal Funds Management Election" document revealed on 09/04/18 Resident #4 elected to "manage his/her own personal funds, with the exception of that portion required for payment of medication and drug expense which the Resident or Responsible Party authorizes the Community to deduct from the Resident's monthly personal funds allowance." Interview with Resident #4 on 12/17/18 at 3:35pm revealed: -Last month, she was only able to withdraw $40.00 from her personal funds account because the facility "made her pay on her pharmacy bill." -This month, the Executive Director (ED) had told the residents that "no one was getting any money this month because it was all going to pharmacy bills." -She had asked the ED for a number to call in a complaint and she "looked at her and walked off." -The prior business office manager used to review her pharmacy bill with her and have her sign on the agreed upon amount to pay toward her pharmacy bill. -Since the old business office manager left a few months ago, she no longer even saw a copy of her pharmacy bill or had a say in how much was paid toward it. -She had not agreed to pay $60.18 toward her pharmacy bill from her account this month and no one had told her this is how much had been paid.	D 421		

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D 421	Continued From page 154 Refer to the interview with the Administrator on 12/06/18 at 3:50pm. 4. Review of Resident #3's personal fund trust account ledger revealed: -On 11/09/18, the pharmacy was paid $7.65. -On 12/09/18, the pharmacy was paid $7.65. Review of Resident #3's personal fund cash transaction log did not reflect the resident had signed the pharmacy transactions on 11/09/18 or 12/09/18. Review of Resident #3's "Addendum to Resident Agreement - Resident's Personal Funds Management Election" document revealed on 09/01/16 Resident #3 elected "the community will manage the Resident's personal funds following procedures outlined in the Resident Agreement and by State regulation and will pay the Resident or Responsible Party all personal spending monies due to the Resident on a regular monthly basis after appropriate collections and disbursements." Refer to the interview with the Administrator on 12/06/18 at 3:50pm. 5. Review of Resident #10's personal fund trust account ledger revealed: -On 11/01/18, the pharmacy was paid $50.00 -On 11/09/18, the pharmacy was paid $3.05. -On 12/09/18, the pharmacy was paid $115.00. Review of Resident #10's personal fund cash transaction log did not reflect the resident had signed for the pharmacy transactions on 11/01/18, 11/09/18, or 12/09/18.	D 421		

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D 421	Continued From page 155 Review of Resident #10's "Addendum to Resident Agreement - Resident's Personal Funds Management Election" document revealed it was incorrectly completed by Resident #10 on 08/18/17, who chose all options on the form, when only one should have been selected. Interview with Resident #10 on 12/20/18 at 3:15pm revealed: -The facility had never had her sign her pharmacy statement or discussed how much she wanted to pay toward her pharmacy bill from her personal funds account. -She only signed documentation regarding her personal funds to acknowledge she was withdrawing cash from her personal funds account. -She had not agreed to pay $115.00 toward her pharmacy bill in December 2018. No one had informed her this amount would be paid from her account. Refer to the interview with the Administrator on 12/06/18 at 3:50pm. Interview with another resident on 12/20/18 at 3:25pm revealed: -The facility had not shown her a pharmacy bill or discussed with her the amount to be paid out of her personal funds account toward her pharmacy bill. She did not have a say in how much was paid toward her pharmacy bill. -She only signed documentation regarding her personal funds to acknowledge she was withdrawing cash from her personal funds account. _____ Interview with the Administrator on 12/06/18 at 3:50pm revealed: -The facility did not have a one-on-one discussion	D 421		

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D 421	Continued From page 156 with each resident regarding their pharmacy bill and how much would be paid each month. -The facility "gave residents the option to keep some money and the rest went toward their pharmacy bill." -The facility did not have a policy regarding how pharmacy bills should be paid related to personal funds accounts. -Resident's or RPs signed a consent form upon admission related to personal funds accounts and pharmacy bills. As long as the option selected reflected that the "facility had the right to manage the portion of the funds that went toward pharmacy payments", no further consent was needed to pay the pharmacy bills, and no communication with the resident regarding the amount paid was required. -Residents often did not understand that not everyone's money was received by the facility at the same time. The facility had received funds for "about half" the residents last week. Once the money was received, their room and board had to be paid and then the facility had to "look at their pharmacy bill" before money from their personal funds account could be disbursed.	D 421		
D 423	10A NCAC 13F .1104(e) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (e) All or any portion of a resident's personal funds shall be available to the resident or his legal representative or payee upon request during regular office hours, except as provided in Rule .1105 of this Subchapter. This Rule is not met as evidenced by: Based on interviews, record reviews, and	D 423		

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	HAL060077	A. BUILDING: _____ B. WING _____	12/21/2018

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D 423	Continued From page 157 observations, the facility failed to assure that 3 of 7 residents' (Residents #4, #10, #13) funds were accounted for and available as required. 1.) Review of Resident #10's personal funds account log on 12/19/18 revealed her balance "as of 12/19/18" was $71.03. Interview with Resident #10 on 12/20/18 at 3:15pm revealed: -She went to the office yesterday to request $40.00 and was told that she could only have $25.00 because "if they had given her what she had requested, they wouldn't have enough left to hand out to other people in line who were requesting funds." She had more than $40.00 in her account at the time she made the request. -She had wanted to purchase a few Christmas gifts this week for family members, but because she could only get $25 from her account, rather than the $40.00 she had requested, she would not be able to buy for everyone that she'd planned to. -The facility often ran out of money during banking hours and anyone who was in line at that time was just "out of luck" for that day. -Banking days at the facility were frequently canceled, and residents were "out of luck" then as well. -The facility frequently varied the banking hours from what was posted. -Recently, she had requested funds and was asked what the funds were for. She did not agree that she should have to disclose why she wanted her personal funds but reluctantly told the office staff. She was then told that she could not have funds for that because "she should have gone to the recent trip to the store to purchase what she needed." She was not given any money that day.	D 423		

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D 423	Continued From page 158 2.) Review of Resident #4's personal funds account log on 12/19/18 revealed her balance "as of 12/19/18" was $50.72. Interview with Resident #4 on 12/17/18 at 3:35pm revealed: -This month she wanted to get her $66.00 personal funds to purchase Christmas gifts for family and to get a few things she needed. -She had not yet been able to get any of her personal funds this month because there had not been any banking hours in which the office had been open. -Last month, she was only able to get $40.00 because the facility "made her pay on her pharmacy bill." -The facility just took money from me from to pay the pharmacy and I had no choice." -December 2018, the Executive Director (ED) told the residents that "no one was getting any money this month because it was all going to pharmacy bills." Interview with Resident #13 on 12/20/18 at 3:25pm revealed: -Banking days were supposed to be Tuesday and Thursday from 11:00am-4:00pm but the office was rarely open for banking during those hours. -Yesterday, she tried to get some of her money, but she was only given $10.00. When she asked why she could not have more, she was told there were "too many people in line and there wouldn't be enough for everyone to get money if they gave her more." She had more than $10.00 in her account. -It was a common occurrence that she received less than the amount she requested, even though she should have had funds available. -Residents were frequently asked what they needed money for. Last month she had	D 423		

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D 423	Continued From page 159	D 423		

requested money and told the office it was to purchase Christmas gifts for her children, to which she was told "we will give you $20.00; $10.00 to spend on each child." She did not think it was right that the office decided how much she could have to spend if she had funds available.

Telephone interviews with Resident #13's family member revealed:
-The resident was her own guardian but called her when there was a problem in the facility.
-The resident called me crying because the facility only gave her $10.00 of her monthly money.
-She wanted to purchase a Christmas present for another resident in the facility.
-The resident has told the family member "they ran out of money."
-"I do not think this is fair to the residents when they only get $66.00 a month."

Interview with Business Office Manager (BOM) on 12/06/18 at 2:00pm revealed:
-She was aware that there was a gap in time when residents were not getting their personal funds as scheduled because there was no BOM on staff and she was just recently hired.
-She had not yet disbursed any personal funds and was currently reviewing resident's account information to assure there was no balance and that they had money to request in their accounts.
-She was currently in training and had not yet learned how the bank account for personal funds was replenished.
-She was not sure of the specific banking schedule for the facility, but she was planning to start disbursing funds as scheduled to residents next week.

Interview with the Executive Director on 12/06/18

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D 423	Continued From page 160 at 3:50pm revealed: -There was "about a week" in the past few weeks that residents were not able to request personal funds because the previous BOM had left employment in the facility. She was not sure of the exact dates this might have happened. -The facility had just hired a new BOM that started this week and was being trained. -Due to the new BOM being trained and currently reviewing resident funds accounts, next Tuesday (12/11/18) would be the nest scheduled banking day that residents would be able to request their funds. -Residents often do not understand that not everyone's money was received by the facility at the same time. The facility had received funds for "about half" the residents last week. Once the money was received, their room and board had to be paid and then the facility had to "look at their pharmacy bill" before money from their personal funds account can be disbursed. Interview with the Regional BOM on 12/20/18 at 10:15am revealed: -Last week the facility had disbursed personal funds to residents. -This week, the facility did not have sufficient funds to disburse to all residents who wanted funds because the BOM did not follow the process last week to assure the account was replenished. The BOM failed to enter the amount disbursed in into a corporate tracking system, which resulted in the personal funds account not being replenished with funds to disburse personal funds to residents this week. -Because the bank account was not replenished this week, the facility was short on the amount of cash they had to disburse to residents requesting personal funds and they were waiting on their corporate office to deposit more money into the	D 423		

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D 423	Continued From page 161 account. -She was not sure why the BOM had not followed the process. The BOM had only worked in the facility a few weeks and was still learning. -She was unable to disburse cash to resident's yesterday during banking hours because there were no funds in the account. -Prior to the former BOM leaving in October, she had posted banking hours on the days she thought she would be in the facility to assist until a new BOM was hired. The Executive Director was responsible for assuring funds were disbursed if she was not in the facility, until a BOM was hired. -The facility did not keep enough cash on hand to cover all resident's personal funds at all times upon request of the residents as it would be a risk to have that amount of cash in the facility. Observation on 12/20/18 at 11:20am revealed: -Regional Director informed a resident that Resident Funds were not being disbursed because they had to "get files." Interview with the Administrator on 12/20/18 at 3:28pm revealed: -Some of the residents were in a negative balance and do not have money to receive. -We had conversations with residents about personal funds. -"Yes, residents can ask for all their money." -Room and board came out of the resident's personal funds as well as their pharmacy bill. -There was not currently enough cash on hand to disburse personal funds to residents. -"Our funds are off this week due to the distribution of previous funds." -"The previous BOM distributed too much funds to residents the last time money was reimbursed."	D 423		

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D 423	Continued From page 162 -"The funds are in the process of being replenished by the corporate office." -Yesterday the BOM went to get the money from the bank , but it was already closed. -The process that was supposed to be followed required entering all funds that were disbursed into a corporate tracking system so that the personal fund bank account could be replenished by the corporate office before funds were scheduled to be disbursed again.	D 423		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter;	D 433		

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D 433	Continued From page 163 (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure resident records were maintained in an orderly manner by updating and maintaining current documentation for 3 of 7 residents (Resident #13, #6, and #5). The findings are: Review of Resident #13's current FL2 dated 07/10/18 revealed diagnoses included bipolar, anxiety, and muscle wasting. Interview with Resident #13 on 12/19/18 at 12:53pm revealed: -She had a dressing to her lower right leg. -The wound had occurred about one and half months ago. -"The wound is really bad." -She had told the Home Health (HH) Nurse and a family member when it happened that a staff person had scratched her who was wearing long artificial nails.	D 433		

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D 433	Continued From page 164 Review of Resident #13's record revealed a subsequent physician ordered dated 10/30/18 for HH wound care consult to evaluate and treat. Interview with the Resident Care Coordinator (RCC) on 12/20/18 at 8:10am revealed: -Resident #13 had told her on 12/19/18 a staff person with fake nails had scratched her right leg resulting in the trauma wound. -The HH nurse never told the RCC a staff person had scratched Resident #13's leg resulting in a diagnosis of a trauma wound. -She had never seen the HH nurse visits notes because "We do not keep them in the record." -The HH nurse only documents a short narrative. -She was not sure the physician was aware Resident #13 was scratched by a staff person. Interview with the HH Nurse on 12/20/18 at 8:45 revealed: -On 10/30/18 Resident #13 told her a staff person had scratched her on the leg. -She told the RCC and the physician about the wound on 10/30/18 and received an order to evaluate and treat the wound. -The RCC and the physician were both aware of the trauma wound diagnosis, but she was not sure they were aware a staff person had scratched Resident #13's leg. -The facility could request her HH notes at any time for Resident #13's record. Refer to interview with RCC on 12/20/18 at 3:36pm. Refer to interview with Administrator on 12/20/18 at 4:00pm.	D 433		

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D 433	Continued From page 165 2. Review of Resident #6's current FL-2 dated 08/14/18 revealed: -Diagnoses included acute osteomyelitis, stress fracture, and right fibula fracture. -There was an order for acetaminophen 1000mg every 6 hours. Review of Resident #6's facility record revealed: -There were a no physician visit notes from the primary care provider (PCP) since 08/17/18. Review of additional resident records faxed by the PCP's office on 12/19/18 and not contained in the facility records revealed there was an order documented on the visit note dated 10/05/18 discontinue acetaminophen 1000mg every 6 hours. Based on review of Resident #6's October, November, and December 2018 eMARs , the resident continued to receive acetaminophen 1000mg every 6 hours after it was discontinued on 10/05/18 due to physician visit notes/orders not beingin the record. Interview with Resident #6's PCP on 12/19/18 at 3:00pm revealed: -The resident's acetaminophen was supposed to be discontinued in October 2018. -He did not want the resident to be administered too much pain medication which would affect resident's liver over a period of time. -He expected the facility to follow his orders as written. Refer to interview with RCC on 12/20/18 at 3:36pm. Refer to interview with Administrator on 12/20/18 at 4:00pm.	D 433		

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D 433	Continued From page 166 3. Review of Resident #5's current FL-2 dated 09/14/18 revealed diagnoses included schizophrenia and intellectual disability. Review of Resident #5's record on 12/17/18 revealed one documentation note from Resident #5's mental health provider dated 07/18/18. Review of Resident #5's mental health provider's notes printed by the Resident Care Coordinator (RCC) on 12/19/18 revealed: -Resident #5 was evaluated and provided psychotherapy for moderate generalized anxiety disorder on 06/06/18, 06/13/18, 06/20/18, 07/04/18, 07/18/18, 08/01/18, 08/08/18, 08/15/18, 08/22/18, 09/05/18, 09/26/18, and 10/03/18. -Resident #5 was seen by the mental health physician's assistant (PA) for medication management on 06/07/18, 06/21/18, 08/02/18, 08/30/18, and 10/11/18. Telephone interview with Resident #5's mental health provider's PA on 12/19/18 at 11:00am revealed: -He visited Resident #5 at the facility once monthly with his last visit being on 11/08/18. -He did not know why the facility did not have records of his or the psychosocial therapist's visits with Resident #5. -He securely emailed all visit notes to the RCC and the Administrator the day after each visit. -If the mental health notes had been in the resident's record, the staff would have been aware of his continued anxiety and could have evaluated the administration of his anxiety medication (Buspar). Refer to interview with RCC on 12/20/18 at	D 433		

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D 433	Continued From page 167 3:36pm. Refer to interview with Administrator on 12/20/18 at 4:00pm. _____ Interview with the RCC on 12/20/18 at 3:36pm revealed: -She and some of the medication aides (MA) were responsible for filing documents in residents' records. -The filing was behind "several years." -She was still finding physicians' orders from 2017 that needed to be filed. -The facility had recently brought an MA over from a sister facility to help her with the filing until a new nurse could be hired. -The MA had started helping her to file on 12/17/18. -The MA had shadowed other MAs at the facility the weekend prior to 12/17/18 in case she needed to "fill in for them and administer medications." -The MA would only be helping her part-time and would continue working at both this facility and the sister facility. Interview with the Administrator on 12/20/18 at 4:00pm revealed: -We have a system for filing alphabetically by resident's name. -"We do not have time to file in residents' records." -The RCC is new and we have a regional support person helping with the residents' records and the filing system. -The RCC is responsible for filing the orders in the resident's record. -"It's hard for the RCC to stay on top of the filing." -"It's not the responsibility of the whole staff to file in resident's records."	D 433		

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D 433	Continued From page 168 -"The system has worked well in other facilities."	D 433		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 7 residents were treated with respect and consideration related to (Resident # 7) requiring a cane for ambulation but was placed in another resident's wheelchair. The findings are: Review of Resident #7's current FL2 dated 10/04/18 revealed diagnoses which included hypertension, renal insufficiency, Alzheimer and chronic obstructive pulmonary disease. Review of Resident #7's Resident Register revealed the resident was admitted to the facility on 11/01/18 from home. Review of Resident #7's record revealed there was no care plan completed. Interview on 12/18/18 at 2:30pm with the Resident Care Coordinator (RCC) revealed: -Resident #7 was admitted to the facility on 11/05/18 not on 11/01/18. -She thought Resident #7 was total care but could feed himself.	D911		

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D911	Continued From page 169	D911		

-Resident #7 had used a cane on admission but currently used a wheelchair for ambulation.
-Resident #7 had been admitted to the hospital twice in 30 days of admission to the facility.
-Resident #7's legs hurt all the time that was why he was using the wheelchair.
-Resident #7 did not have an order for a wheelchair.

Review of Resident #7's record revealed:
-A hospital admission from 11/25/18 to 11/28/18 diagnosed with a gastrointestinal bleed (GI) bleed.
-Documentation Resident functional status was semi-ambulatory (cane) and personal care assistance with bathing.
-There was no physician order for a wheelchair.

Telephone interview with Resident #7 Power of Attorney (POA) on 12/19/18 at 11:00am revealed:
-She knew Resident #7 had 2 recent hospital visit within one month.
-Resident #7 had used a cane at home for ambulation prior to the admission to the facility.
-She was unsure why he was using a wheelchair in the facility.

Observation of Resident #7's on 12/18/18 at 4:07pm revealed:
-He was in his room laying in the bed with his head covered with a blanket.
-There was a wheelchair located in the room near the bed.

Interview with a personal care aide (PCA) on 12/19/18 at 9:35am revealed:
-Resident #7 needed assistance with dressing and getting out of bed.
-Resident #7 was walking with a cane when he first was admitted but, "he is a wanderer and

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	HAL060077	A. BUILDING: _____ B. WING _____	12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TOWNE	4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

(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
D911	Continued From page 170	D911		

always wanted to get out and go home."
-He is now in a wheelchair so we can "keep an eye on him."
-The wheelchair belonged to another resident who was no longer in the facility.

Interview with a medication aide (MA) on 12/19/18 at 9:40am revealed:
-Resident #7 had declined since he was admitted to the facility.
-Resident #7, "is too much for the staff to watch."
-Resident #7 had Alzheimer and required staff to watch him all the time.
-Resident #7 tried to leave the facility on several occasions, "He said he wanted to go home."

Interview with a personal care aide (PCA) on 12/19/18 at 3:40am revealed:
-She had been a PCA for "a long time and knew how to take care of the residents."
-Resident #7 used a wheelchair for ambulation, but he had to be watched all the time.
-The wheelchair belonged to another resident but that resident was not in the facility anymore.
-"We can keep an eye on him better in the wheelchair."

Observation of Resident #7's on 12/19/18 at 1:35pm revealed:
-Resident #7 was sitting in a wheelchair in the common area.
-He could not recall where he was or know what day it was.
-He stated, "I want to go see my family."

Interview with the facility Nurse Practitioner on 12/19/18 at 11:30am revealed:
-Resident #7 was a new patient to her services.
-She had not ordered a wheelchair for Resident #7.

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D911	Continued From page 171 -"Each time I've seen him [Resident #7] he's been in the bed." Interview with a second shift MA on 12/19/18 at 3:22pm revelaed: -She was walking into the facility and noticed Resident #7 was near the front door exit. -Resident #7 was not in his wheelchair. -Resident #7 was not to be near the front door without a staff nearby. -Resident #7 had Alzheimer and was a wanderer. -"He could had gotten out."	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care referral and follow-up, management of facility, medication administration, infection prevention requirements, health care implementation of orders, resident records, distribution of resident funds, and cardio-pulmonary resuscitation (CPR) certification.	D912		

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D912	Continued From page 172 The findings are: 1. Based on observations, interviews, and record reviews, the Administrator failed to assure fulltime and consistent responsibility for the operation, administration, management and supervision of the facility which resulted in significant non compliance with state rules and regulations related to infection control, health care, medication administration, supervision, implementation of orders, resident records, care plans, resident funds, CPR training, nutrition and food services, transportation and resident rights. [(Refer to tag 183, 10A NCAC 13F .0603 Management of Facilities with a Capacity or Census of 81 or More Residents (a) (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for 5 of 7 sampled residents regarding physician notification of fingerstick blood sugar (FSBS) checks and scheduled Humalog insulin before meals to treat hyperglycemia were not administered for 19 days, resulting in a hospitalization with a blood sugar of 1200 (Resident #2); physician notification regarding blood pressure measurements outside of ordered parameters and medications not administered including Buspar (used to treat anxiety) and chlorhexidine gluconate (a mouthwash used to treat gingivitis) (Resident #5); follow-up with the pharmacy and physician related to 8 missed medications including metoprolol tartrate (used to treat high blood pressure), atorvastatin (used to treat high cholesterol), clonidine (used to treat high blood pressure), clopidogrel (used as a preventative for strokes), lisinopril (used to treat high blood pressure and heart failure), sertraline (used to treat clinical depression), amlodipine	D912		

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D912	Continued From page 173 (used to treat high blood pressure and chest pain), and a multivitamin (Resident #3); a scratch to the lower right leg from a staff person's long nails resulting in a wound requiring treatment at the wound clinic (Resident #13); and missed appointments due to a lack of transportation for a resident who required chemotherapy and radiation treatment for a diagnosis of breast cancer (Resident #1). [(Refer to tag 0273, 10A NCAC 13F .0902 (b) Healthcare Referral and Followup (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 7 sampled residents including Buspar (used to treat anxiety) and chlorhexidine gluconate (a mouthwash used to treat gingivitis) (Resident #5); Novolin 70/30 insulin (used to treat high blood sugar) and amlodipine (used to treat high blood pressure and chest pain) (Resident #3); acetaminophen (prescribed for pain) (Resident #6); and related to hydralazine (used to treat high blood pressure) and Januvia (used to treat high blood sugar) (Resident #9). [(Refer to tag 0358, 10A NCAC 13F .1004 (a) Medication Administration (Type A2 Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to assure implementation of orders for 2 of 7 sampled residents including a resident diagnosed with breast cancer unable to get transportation from the facility for chemotherapy and radiation treatments, an appointment with her cardiologist for an echocardiogram and an appointment with her oncologist, resulting in the potential for a negative outcome for her cancer diagnosis (Resident #1); and a resident who had a	D912		

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D912	Continued From page 174 diagnosis of chronic obstructive pulmonary disorder (COPD) with orders for a nebulizer treatment 4 times a day, who did not receive the medication potentially contributing to the exacerbation of their respiratory condition. [(Refer to tag 0276, 10A NCAC 13F .0902 (c) (4) Healthcare Implementation of Orders (Type A1 Violation)]. 5. Based on interviews and record reviews the facility failed to provide documentation of cardiopulmonary resuscitation training (CPR)for 22 of 23 employees in a 2 week scheduling period. [(Refer to tag 0167, 10A NCAC 13F .0507 Training on CPR (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to assure proper infection control procedures for the use of glucometers for 5 of 7 residents sampled (Residents #3, #9, #10, #11, and #12) with orders for blood sugar monitoring. 2 of the diabetic residents in the facility had blood borne diseases. [(Refer to tag 932, G.S. 131D 4.4 A Infection Prevention Requirements (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents are free of neglect in compliance with federal and	D914		

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D914	Continued From page 175 state laws and rules and regulations related to staff providing personal care were in compliance with the facility policy regarding fingernails resulting in a trauma wound to one resident (#13); proper infection control procedures for the use of glucometers for 4 of 7 diabetic residents sampled (Residents #3, #10, #11 and #12); medications and treatments not administered or followed up with prescribing physician for clarification (Residents #1, #2, #3, #5, and #13); implementation of orders (Resident #1 and #4 The findings are: 1. Based on observations, interviews and record reviews, the facility neglected to assure staff providing personal care were compliance with the facility policy regarding fingernails resulting in a trauma wound to one resident (#13). [Refer to Tag 338, 10A NCAC 13F. 0909 Resident Rights (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to assure proper infection control procedures for the use of glucometers for 5 of 7 residents sampled (Residents #3, 9, 10, 11, and 12) with orders for blood sugar monitoring. 2 of the diabetic residents in the facility had blood borne diseases. [Refer to tag 932 G.S. 131D 4.4 A(b) ACH Infection Prevention Requirements (TYPE B VIOLATION)] . 3. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for 5 of 7 sampled residents regarding physician notification of fingerstick blood sugar (FSBS) checks and scheduled Humalog insulin before meals to treat hyperglycemia were not administered for 19 days, resulting in a	D914		

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D914	Continued From page 176	D914		

hospitalization with a blood sugar of 1200 (Resident #2); physician notification regarding blood pressure measurements outside of ordered parameters and medications not administered including Buspar (used to treat anxiety) and chlorhexidine gluconate (a mouthwash used to treat gingivitis) (Resident #5); follow-up with the pharmacy and physician related to 8 missed medications including metoprolol tartrate (used to treat high blood pressure), atorvastatin (used to treat high cholesterol), clonidine (used to treat high blood pressure), clopidogrel (used as a preventative for strokes), lisinopril (used to treat high blood pressure and heart failure), sertraline (used to treat clinical depression), amlodipine (used to treat high blood pressure and chest pain), and a multivitamin (Resident #3); a scratch to the lower right leg from a staff person's long nails resulting in a wound requiring treatment at the wound clinic (Resident #13); and missed appointments due to a lack of transportation for a resident who required chemotherapy and radiation treatment for a diagnosis of breast cancer (Resident #1). [Refer to tag 0273 10A NCAC 13F .0902 (b) Health Care (TYPE A1 VIOLATION)].

4. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 3 of 7 sampled residents including Buspar (used to treat anxiety) and chlorhexidine gluconate (a mouthwash used to treat gingivitis) (Resident #5); Novolin 70/30 insulin (used to treat high blood sugar) and amlodipine (used to treat high blood pressure and chest pain) (Resident #3); acetaminophen (prescribed for pain) (Resident #6); and related to hydralazine (used to treat high blood pressure) and Januvia (used to treat high blood sugar)

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D914	Continued From page 177 (Resident #9). [Refer to tag 0358 10A NCAC 13F .1004 (a) Medication Administration (TYPE A2 VIOLATION)]. 5. Based on observations, interviews, and record reviews, the facility failed to assure implementation of orders for 2 of 7 sampled residents including a resident diagnosed with breast cancer unable to get transportation from the facility for chemotherapy and radiation treatments, an appointment with her cardiologist for an echocardiogram and an appointment with her oncologist, resulting in the potential for a negative outcome for her cancer diagnosis (Resident #1); and a resident who had a diagnosis of chronic obstructive pulmonary disorder (COPD) with orders for a nebulizer treatment 4 times a day, who did not receive the medication potentially contributing to the exacerbation of their respiratory condition (Resident #4). [Refer to tag 0276 10A NCAC 13F .0902 (c)(3)(4) Health Care (TYPE A2 VIOLATION)]. 6. Based on interviews and record reviews the facility failed to provide documentation of cardiopulmonary resuscitation training (CPR)for 22 of 23 employees in a 2 week scheduling period. [Refer to tag 0167 10A NCAC 13F .0507 Training on Cardiopulmonary Resuscitation (TYPE B VIOLATION)]. 7. Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan and current symptoms for 1 of 2 sampled residents with a history of falls (Resident #5). [Refer to tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (TYPE B	D914		

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D914	Continued From page 178 VIOLATION)].	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy.	D932		

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D932	Continued From page 179 (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed, consistent with the Federal Center for Disease Control and Prevention guidelines, to assure proper infection control procedures for the use of glucometers for 4 of 7 diabetic residents sampled (Residents #3, #10, #11 and #12) with orders for blood sugar monitoring resulting in sharing of glucometers between diabetic residents. The findings are: Observations on 12/17/18 at 10:00am revealed: -The facility had 1 medication cart for the A hall containing 10 residents' glucometers stored in plastic containers. -The containers were each labeled with the resident's name and included black pouches labeled with the resident's name and each container had one Brand A glucometer, labeled	D932		

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D932	Continued From page 180 with the resident's name. Observation on 12/17/18 at 10:18am revealed: -The facility had 1 medication cart for the B hall containing 10 residents' glucometers stored in plastic containers. -The containers were each labeled with the resident's name and included black pouches labeled with the resident's name and each container had one Brand A glucometer, labeled with the resident's name Observations on 12/17/18 at 10:25am revealed: -The facility had 1 medication cart for the C hall containing 11 residents' glucometers stored in plastic containers. -The containers were each labeled with the resident's name and included black pouches labeled with the resident's name and each container had one Brand A glucometer, labeled with the resident's name Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer was to be used for more than one person, it should be cleaned and disinfected per the manufacturers instructions. If the manufacturer does not list disinfection information the glucometer should not be shared between residents. Review of the owner's manual for Brand A glucometer revealed: -The glucometer was "intended to be used by a single person and should not be shared." -The glucometer "should be cleaned whenever it is visibly dirty by wiping the outside of the meter using a cloth dampened with either mild detergent	D932		

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D932	Continued From page 181	D932		

mixed with water or 70% isopropyl alcohol."
-"If the glucometer is being operated by a second person, who is providing testing assistance to the user, the device should be decontaminated prior to use by the second person."

Telephone interview with the manufacturer's representative of the Brand A glucometer on 12/17/18 at 10:08am revealed:
-The Brand A glucometer was not recommended for use by more than one person, and should not be shared.
-The use of alcohol to wipe the glucometers would not kill all bacterial germs.
-Hepatitis and the HIV virus would stay on surface areas for hours, even days.

Observation on 12/17/18 at 11:50am of a first shift medication aide (MA) revealed:
-The MA put on disposable gloves, obtained a glucometer for a resident (labeled with the resident's name and stored in a black pouch labeled with the resident's name).
-The MA used an alcohol swab to cleanse the resident's left middle finger, and obtained a blood sample using a single use disposable lancing device.
-The MA used standard infection control techniques for obtaining the FSBS value and disposing of the FSBS supplies.
-The MA did not wipe the glucometer before or after use with any cleansing wipe.
-There were no Environmental Protection Agency (EPA) approved disinfecting wipes observed on the medication cart.

Interview with the MA who performed the resident blood sugar on 12/17/18 at 11:50am revealed:
-She cleaned the glucometers on the weekends when she worked.

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D932	Continued From page 182 -She used alcohol to clean the glucometers. -She did not document when she cleaned the glucometers. -The lead MA told the MAs when the glucometers were to be cleaned. Interview with the Administrator on 12/17/18 at 3:45pm revealed: -The facility policy was for the single use of glucometers for all residents with FSBS orders. -The MAs were trained to perform FSBS on residents with their individually labeled glucometers. -There were no house glucometers on the medication carts. -The clinical consultant for the facility provided training to the MAs regarding the single use of glucometers, cleaning the glucometers and clearing the glucometers of readings weekly. -There were no residents receiving FSBS diagnosed with blood borne diseases. Record review of residents diagnosed with diabetes in the facility revealed 2 residents receiving FSBS checks were also diagnosed with blood borne infections. Interview with the clinical consultant for the facility on 12/18/18 at 8:00am revealed: -He had trained the MAs to clean the glucometers with an alcohol wipe and erase the blood sugar readings from the glucometer history once a week. -The glucometers were for single resident use only. -He had instructed the facility to label all glucometers with the residents' names as well as the black pouches and plastic containers the glucometers were stored in. -He provided staff training quarterly, or as	D932		

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needed, to instruct the MAs on infection control and the importance of coumadin and blood sugar monitoring for the health of the residents.
-Bleach should be used to clean the glucometer if there was any evidence of blood on the glucometer itself.

Interview with the first shift MA on 12/18/18 at 9:30am revealed:
-There was no bleach in the facility to clean the glucometers.
-She does not recall any bleach being stocked in the medication room for cleaning blood from glucometers.

1. Review of Resident #12's current FL2 dated 10/12/18 revealed:
-The diagnoses included diabetes mellitus.
-There was a physician's order for fingerstick blood sugar checks three times a day before meals, and 2 hours after meals, scheduled at 7:30am, 9:30am, 11:30am, 2:30pm, 4:30pm and 6:30pm.

Observation on 12/17/18 at 11:28am of Resident #12's glucometer revealed:
-The glucometer was located on the C hall medication cart in a black pouch.
-The black pouch was contained in a plastic container with Resident #12's name labeled on the lid of the container.
-The black pouch was labeled with Resident #12's name.
-The Brand A glucometer was located in the black pouch and was labeled with Resident #12's name.
-There was a dark red dried stain on the back of the glucometer.

Review of Resident 12's glucometer history

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D932	Continued From page 184 revealed: -The glucometer history was recorded from 12/13/18-12/17/18. -FSBS values recorded in the glucometer's history compared to values documented on Resident #3's eMAR dated 12/13/18 -12/17/18 were inconsistent. -On 12/15/18 at 11:30am, there was no FSBS value recorded in the glucometer history. The results documented on the eMAR was 365. -On 12/15/18 at 4:30pm, the FSBS result recorded in the glucometer history was 437. The results documented on the eMAR was 401. -On 12/16/18 at 1130am, there was no FSBS result recorded in the glucometer history. The results documented on the eMAR was 395. -On 12/16/18 at 4:30pm, there was no FSBS result recorded in the glucometer history. The results documented on the eMAR was 279. -On 12/16/18 at 6:30pm, there was no FSBS result recorded in the glucometer history. The results documented on the eMAR was 213. -On 12/17/18 at 9:30am, there was no FSBS result recorded in the glucometer history. The results documented on the eMAR was 396. Review of Resident #12's December electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS 6 times daily, scheduled for 7:30am, 9:30am, 11:30am, 2:30pm, 4:30pm and 6:30pm. -FSBS results were documented daily at 7:30am with a FSBS range from 200-355. -FSBS results were documented daily at 9:30am with a FSBS range from 187-396. -FSBS results were documented daily at 11:30am with a FSBS range from 209-395. -FSBS results were documented daily at 2:30pm	D932		

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with a FSBS range from 209-546.
-FSBS results were documented daily at 4:30pm with a FSBS range from 236-415 .
-FSBS results were documented daily at 6:30pm with a FSBS range from 213-458.

Review of Resident#12's glucometer history compared to Resident #12's eMAR from 12/14/18-12/17/18, 6 of the 17 FSBS results recorded in the glucometer's history were inconsistent with the documentation on the eMAR.

Attempted telephone interview with Resident #12 on 12/18/18 at 2:45pm was unsuccessful.

Refer to interview with a first shift MA on 12/18/18 at 9:30am.

Refer to interview with a second first shift MA on 12/18/18 at 10:35am.

Refer to interview with another second shift MA on 12/17/18 at 4:18pm.

Refer to interview with the lead MA on 12/18/18 at 3:05pm.

Refer to interview with the Resident Care Coordinator (RCC) on 12/17/18 at 11:32am.

Refer to interview with the facility's Clinical Consultant on 12/18/18 at 8:35am.

2. Review of Resident #3's current FL2 dated 10/04/18 revealed:
-Diagnoses included diabetes mellitus.
-There was a physician's order to to measure the fingerstick blood sugar (FSBS) three times a day before meals, scheduled at 7:30am, 11:30am and

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D932	Continued From page 186 4:30pm. Observation on 12/17/18 at 11:12am of Resident #3's glucometer revealed: -The glucometer was located on the C hall medication cart in a black pouch. -The black pouch was contained in a plastic container with Resident #3's name labeled on the lid of the container. -The black pouch was labeled with Resident #3's name. -The Brand A glucometer was located in the black pouch and was labeled with Resident #3's name. Review of Resident #3's glucometer history revealed: -The glucometer history was recorded from 12/10/18-12/17/18. -The FSBS values recorded in the glucometer's history compared to values documented on Resident #3's eMAR dated 12/10/18 -12/17/18 were inconsistent. -On 12/10/18 at 4:30pm, the FSBS value recorded in the glucometer history was 296. The value documented on the eMAR was 267. -On 12/11/18 at 11:30am, the FSBS value recorded in the glucometer history was 270. The value documented on the eMAR was 180. Review of Resident #3's December eMAR revealed: -There was an entry to check FSBS 3 times daily, scheduled for 7:30am, 11:30am and 4:30pm. -FSBS values were documented daily at 7:30am with a FSBS range from 158-298. -FSBS values were documented daily at 11:30am with a FSBS range from 122-322. -FSBS values were documented daily at 4:30pm with a FSBS range from 109-344.	D932		

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D932	Continued From page 187 Review of Resident#3's glucometer history compared to Resident #3's eMAR from 12/10/18-12/17/18, 2 of the 20 FSBS values recorded in the glucometer's history were inconsistent with the documentation on the eMAR. Interview on 12/18/18 at 4:07pm with Resident #3 revealed: -He did not know what glucometer the MA used to perform the FSBS. -He thought it was his glucometer but he did not pay much attention to the process. Refer to interview with a first shift MA on 12/18/18 at 9:30am. Refer to interview with a second first shift MA on 12/18/18 at 10:35am. Refer to interview with another second shift MA on 12/17/18 at 4:18pm. Refer to interview with the lead MA on 12/18/18 at 3:05pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/17/18 at 11:32am. Refer to interview with the facility's Clinical Consultant on 12/18/18 at 8:35am. 3. Review of Resident #10's current FL2 dated 08/31/18 revealed the diagnoses included diabetes mellitus. Review of Resident #10's record revealed a physician order dated 11/16/18 for Finger Stick Blood Sugar (FSBS) every morning and at bedtime.	D932		

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D932	Continued From page 188 Observation on 12/17/18 at 10:08am of Resident #10's black glucometer pouch revealed: -The black glucometer pouch was located on the B hall medication cart. -The black pouch was contained in a plastic container with the resident's name labeled on the lid of the container. -The black pouch was labeled with Resident #10's name. -The Brand A glucometer was located in the black pouch and was labeled with Resident #10's name. -The Brand A glucometer labeled with Resident #10 name had dark reddish dried blood smeared on the back of the glucometer. Review of Resident 10's glucometer history: -The glucometer history was recorded from 06/04/18 to 06/11/18 and was not set to current date or time. -The glucometer history had 20 FSBS readings recorded. -FSBS results recorded in the glucometer's history compared to results documented on Resident #10's eMAR were inconsistent. -The first 6 reading in the glucometers history matched Resident #10"s December eMAR. -On 06/08/18 at 9:44am the FSBS result recorded in the glucometer history was 136. The result was not documented on the eMAR. -On 06/08/18 at 3:31pm the FSBS result recorded in the glucometer history was 232. The result was not documented on the eMAR. -On 06/07/18 at 12:37pm the FSBS result recorded in the glucometer history was 204. The result was not documented on the eMAR. -On 06/07/18 at 9:01pm the FSBS result recorded in the glucometer history was 205. The result was not documented on the eMAR.	D932		

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D932	Continued From page 189 Review of Resident #10's December electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS 2 times daily, scheduled for 8:00am and 8:00pm. -FSBS checks ranged from 119-393. Review of Resident#10's glucometer history compared to Resident #10's December 2018 eMAR revealed 4 of 20 FSBS values recorded in the glucometer's history were inconsistent with the documentation on the eMAR. Interview with Resident #10 on 12/19/18 at 8:52am revealed: -The MAs took her blood sugar two times a day. -She had never noticed her name on the glucometer or the pouch. -'I think they use their glucometer, I don't have my own." Refer to interview with a first shift MA on 12/18/18 at 9:30am. Refer to interview with a second first shift MA on 12/18/18 at 10:35am. Refer to interview with another second shift MA on 12/17/18 at 4:18pm. Refer to interview with the lead MA on 12/18/18 at 3:05pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/17/18 at 11:32am. Refer to interview with the facility's Clinical Consultant on 12/18/18 at 8:35am.	D932		

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D932	Continued From page 190 4. Review of Resident #11's current FL2 dated 09/14/18 revealed: -A diagnoses included diabetes mellitus. -There was an order to measure Finger Stick Blood Sugar (FSBS) daily. Observation on 12/17/18 at 10:40am of Resident #11's glucometer revealed: -The glucometer was located on the A hall medication cart in a black pouch. -The black pouch was contained in a plastic container with Resident #11's name labeled on the lid of the container. -The black pouch was labeled with Resident #11's name. -The Brand A glucometer was located in the black pouch and was labeled with Resident #11's name. Review of Resident 11's glucometer history revealed: -The glucometer history was set to the current date and time 12/14/18 at 10:35. -The glucometer history had 8 FSBS readings recorded. -The FSBS results recorded in the glucometer's history compared to results documented on Resident #11's eMAR were inconsistent. -On 12/12/18 at 8:00am the FSBS result documented on the eMAR was 140. The result was not recorded in the glucometer. -On 12/09/18 at 8:00am the FSBS result documented on the eMAR was 201. The result was not recorded in the glucometer. Review of Resident #11's December electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS daily, scheduled for 8:00am.	D932		

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D932	Continued From page 191 -The FSBS readings ranged from 140-299. Review of Resident#11's glucometer history compared to Resident #11's December 2018 eMAR revealed 2 of 8 FSBS values recorded in the glucometer's history were inconsistent with the documentation on the eMAR. Interview with Resident #11 on 12/19/18 at 9:30am revealed: -The MAs took her blood sugar once in the morning. -She thought her name was on the glucometer. Refer to interview with a first shift MA on 12/18/18 at 9:30am. Refer to interview with a second first shift MA on 12/18/18 at 10:35am. Refer to interview with another second shift MA on 12/17/18 at 4:18pm. Refer to interview with the lead MA on 12/18/18 at 3:05pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/17/18 at 11:32am. Refer to interview with the facility's Clinical Consultant on 12/18/18 at 8:35am. _____ Interview with a first shift MA on 12/18/18 at 9:30am revealed: -The MAs cleaned the glucometers and cleared the history weekly. -She thought it was last week on Tuesday she cleaned the glucometers. -She used an alcohol wipe to clean the	D932		

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glucometers.
-She did not document she had cleaned of the glucometers.
-"The glucometers should not have blood on them."

Interview with a second first shift MA on 12/18/18 at 10:35am revealed:
-The policy required each resident to have their own glucometer.
-The glucometers were not to be shared between residents.
-She was responsible for FSBS checks in the morning and at lunch when she worked.
-The glucometers were to be cleaned with an alcohol wipe.
-The facility did not have bleach in the building to clean the glucometers.

Interview with another second shift MA on 12/17/18 at 4:18pm revealed
-She checked FSBS at 4:00pm and 8:00pm for the residents with physician orders.
-The facility policy required every resident to have their own glucometer.
-There were no "house" glucometers. Each resident received their own glucometer.
-The glucometers were cleared of their history every week by the MA who was on the cart on Monday or Tuesday.
-The glucometers were cleaned with an alcohol pad when they were dirty or once a week.

Interview with the lead MA on 12/18/18 at 3:05pm revealed:
-The facility policy required every resident to have their own glucometer.
-Glucometers were not shared between residents.
-Each resident's glucometer was labeled with the

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D932	Continued From page 193 resident's name, placed in a black labeled pouch in a labeled plastic container and kept on the medication cart. -Every Monday the MAs were to clean the glucometers with an alcohol wipe and delete the glucometer history. Interview with the Resident Care Coordinator (RCC) on 12/17/18 at 11:32am revealed: -The facility policy required each resident to have their own glucometer. -Glucometers were not shared between residents. -Every Monday the MAs were to clean the glucometers with an alcohol wipe and delete the glucometer history. -The facility did not use bleach to clean or disinfect the glucometers. -The facility had a clinical consultant who did in services and education on the glucometers and insulin use. Interview with the facility's clinical consultant on 12/18/18 at 8:35am revealed: -He worked for the facility completing staff education and training on infection prevention. -The staff were aware they should not share glucometers. -The policy was one glucometer for each resident and it was to be used only for that resident. -The glucometers were to be cleaned and the memory cleared every week. -He did not know residents' glucometers had dried blood on the back smeared on the glucometers. -He recommended Clorox for disinfection instructions along with cleaning the medications cart as well. -Alcohol will not kill all bacterial virus.	D932		

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D932	Continued From page 194 The facility's failure to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines were followed for placed residents receiving finger stick blood sugar at risk due to possible exposure of blood borne pathogens diseases for (Residents #3, #10, #11 and #12). This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/17/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 08, 2018.	D932		