STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARILLON ASSISTED LIVING OF MINT HILL	5601 MARGARET WALLACE ROAD MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg Department of Social Services conducted an annual survey on January 7-8, 2019.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision according to the resident's assessed needs, care plan, and current symptoms for 3 of 3 sampled residents with a history of falls (Resident #3, #4, and #5). The findings are: 1. Review of Resident #3's current FL2 dated 09/11/18 revealed: -Diagnoses included atrial fibrillation, hypertension, mitral valve replacement and a history of falls. -The resident was semi-ambulatory. -An order for Coumadin (a medication used to	D 270		

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thin the blood) as directed by the physician after each prothrombin time/international normalized ratio (PT/INR, a blood test used when taking a blood thinner)

Review of Resident #3's care plan dated 07/03/18 revealed:
-The resident was semi-ambulatory with the use of a wheelchair.
-The resident required extensive assistance with ambulation, toileting, bathing, dressing and grooming.
-The resident required limited assistance with transfers.

Review of Resident #3's Accident Reports revealed:
-A report dated 08/27/18 revealed at 9:45pm a personal care aide (PCA) was getting Resident #3 out of bed when he fell on his bottom. No injuries noted.
-A report dated 09/25/18 at 11:45pm but filled out on 09/26/18, revealed Resident #3 was found on the floor and his eye was swollen. A message was left for the family.
-A report dated 11/12/18 at 2:15pm revealed a fall.
-A report dated 12/24/18 at 9:15pm revealed Resident #3 was found on the floor in his room. There was blood found on the left side of his head. The Emergency Management System (EMS) was called and Resident #3 was taken to the ER.
-A report dated 12/27/18 at 5:40am revealed Resident #3 fell out of the bed, there were no injuries documented.

Review of Resident #3's Emergency Room (ER) reports revealed:
-An ER visit dated 08/04/18 diagnosed with a fall

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and facial contusion.
-An ER visit dated 09/12/18 diagnosed with a fall, contusion to face, skin tear to left side of face, and head injury.
-An ER visit dated 09/26/18 diagnosed with a fall and eye injury with blood in the eye.
-An ER visit dated 12/24/18 diagnosed with a fall, head injury with a contusion to the forehead.
-An ER visit dated 12/26/18 diagnosed with a fall, head injury and knee contusions.

Review of Resident #3's progress notes revealed no documentation of interventions after every fall.

Review of Resident #3's Home Health Log Book revealed:
-On 09/07/18 occupational therapy (OT) and physical therapy (PT) initiated for activities of daily living (ADLS) and transfers, not for falls.
-Resident #3 was seen once a week until discharged on 10/18/18 for "goals met" and "max potential".

Interview with a medication aide (MA) on 01/07/19 at 3:25pm revealed:
-Resident #3 fell mostly at night.
-Resident #3 required assistance with ambulation but really could not walk but a couple of steps.
-Resident #3 got out of his wheelchair and tries to ambulate without assistance.
-There were no interventions after his falls such as no fall mat, bed or chair alarm or increased supervision.
-The standard checks were every hour from 11:00pm to 7:00am and that was all we did.
-There were no fall mats,or bed or chair alarms in the facility at all.

Interview with the Memory Care Resident Care Coordinator (MCRCC) on 01/08/19 at 6:45am

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D 270	Continued From page 3 reveled: -Resident #3 fell a lot and she felt that was a big issue because of his Coumadin and the increased bleeding risk. -Resident #3 falls mostly in the night or early morning while in his room. She was not sure why. -Resident #3 "hit his head every time". -There was no increased checks on Resident #3 other than the normal every 2 hours during the day and every hour at night. -The every 2 hour checks during the day and every hour at night was the Memory Care Unit (MCU) policy. -Resident #3 did not have a fall mat, bed or chair alarm. Interview with a second personal care aide (PCA) on 01/08/19 at 7:00am revealed: -He worked 1st shift in the MCU. -He typically got Resident #3 up every morning that he worked. Interview with the Resident Care Director (RCD) on 01/08/19 at 12:28pm revealed: -Resident #3 fell a lot and most of the falls were in the evening or early morning. -Resident #3 could get out of his wheelchair but required supervision and assistance. -Resident #3 had 3-4 head injuries with his falls and she considered it dangerous because Resident #3 was on Coumadin. -Resident #3 was sent out to the Emergency Room (ER) every time because of taking Coumadin and the bleeding tendencies that went with it. -There was no implementation of interventions with Resident #3 such as the use of a fall mat, bed or chair alarms or increased supervision other than the normal every 2 hours during the day and every hour at night.	D 270		

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D 270	Continued From page 4 Telephone interview with Resident #3's family member on 01/08/19 at 1:06pm revealed: -She made a request at the ER to receive some help/alternatives with Resident #3. -The ER physician referred her to the Case Manager in the ER to help with other resources like Home Health, PT/OT and Hospice. -The facility staff did not offer any type of help/interventions to help decrease or stop the falls after speaking to the Administrator in September, 2018 about the falls with Resident #3. -There were no fall mats at the facility or bed and chair alarms. -There was no meeting set up with the facility staff to discuss anything that might help Resident #3 with decreasing the falls. -She was told about hospice at the ER and felt that was her only option to help Resident #3. -She expected the facility staff to put something in place to help protect Resident #3. -Resident #3 was on Coumadin because of a mechanical heart valve and could not come off of the Coumadin because it would cause a brain bleed easy. -She was not sure about how many falls Resident #3 had until the Christmas Eve trip to the ER. -The ER physician held a conference with her and voiced his concerns about the number of falls Resident #3 had and the risk of death because of Resident #3 bleeding easy while taking Coumadin. -She was aware if Resident #3 fell and hit his head that would also cause a brain bleed. -She spoke with the Administrator a few days after Christmas about hospice helping out. -She received notification today (01/08/19) during a meeting with hospice, that hospice was taking over because of the decline and falls with	D 270		

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D 270	Continued From page 5 Resident #3. Interview with the Administrator on 01/08/19 at 3:55pm revealed: -Resident #3 fell mostly at night or early morning. -Resident #3 was sent out to the ER if he hits his head primarily because of the Coumadin and the risk of a "brain bleed". -She did not know why Resident #3 did not have a fall mat, bed or chair alarm or increased checks other than the normal every 2 hours during the day and every hour at night checks when the facility fall policy outline interventions. Refer to interview with a medication aide (MA) on 01/07/19 at 3:25pm. Refer to interview with the Memory Care Resident Care Coordinator (MCRCC) on 01/08/19 at 6:45am. Refer to interview with a personal care aide (PCA) on 01/08/19 at 6:45am. Refer to interview with a second PCA on 01/08/19 at 7:00am. Refer to interview with the RCD on 01/08/19 at 12:28pm. Refer to interview with the Administrator on 01/08/19 at 3:55pm. 2. Review of Resident #4's current FL2 dated 09/05/18 revealed: -Diagnoses included anxiety, dementia, recurrent urinary tract infections hypertension and seizures. -The resident was semi-ambulatory with the use of a walker.	D 270		

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Review of Resident #4's current care plan dated 09/27/18 revealed:
-The resident was semi-ambulatory with the use of a wheelchair.
-The resident required limited assistance with ambulation.
-The resident required supervision with eating, toileting, bathing dressing grooming and transfers.

Review of Resident #4's Accident Reports revealed:
-There was no accident report filled out for the fall dated 11/12/18.
-A report dated 12/20/18 at 6:00pm revealed Resident #4 fell on her bottom.

Review of Resident #4's Emergency Room (ER) reports revealed an ER visit dated 11/12/18 diagnosed with a fall and a non-displaced fracture of the right humorous.

Review of Resident #4's orthopedic notes revealed:
-A visit dated 11/13/18 documented Resident #4 with a right non-displaced greater tuberosity fracture. Resident #4 was to wear a sling on the right arm to decrease pain and swelling and no weight bearing on the right arm and to follow up in 3 weeks.
-A visit dated 11/21/18 documented Resident #4 with increased pain. An order for the sling to be worn at all times and no active range of motion and to follow up in 4 weeks.
-A visit dated 12/20/18 documented resident #4 with diffuse pain and guards to range of motion. An order was written for PT/OT for passive range of motion times 3 weeks and then active range of motion and to follow up in 6 weeks.

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D 270	Continued From page 7 Review of Resident #4's progress notes revealed no documentation of interventions after every fall. Review of Resident #4's Home Health Log Book revealed there was no PT/OT ordered or given to Resident #4. Interview with a medication aide (MA) on 01/07/19 at 3:25pm revealed: -She knew Resident #4 fell and broke her arm in November 2018. -Resident #4 ambulated with her walker. -Resident #4 did not have any interventions after her falls. -Resident #4 was checked on every 2 hours 7:00am-11:00pm and every hour 11:00pm to 7:00am. -The standard checks were every hour from 11:00pm to 7:00am and that was all we did. -She did not know why there was no fall mat, bed or chair alarm or increased supervision. Interview with the Memory Care Resident Care Coordinator (MCRCC) on 01/08/19 at 6:45am reveled: -She did not know how Resident #4 fell on 11/12/18 and she sent Resident #4 to the ER. -The every 2 hour checks during the day and every hour at night was the Memory Care Unit (MCU) policy. -There was no increased checks on Resident #4 other than the normal every 2 hours during the day and every hour at night. -Resident #4 did not have a fall mat, bed or chair alarm. Interview with the Resident Care Director (RCD) on 01/08/19 at 12:28pm revealed: -Resident # 4 fell in November 2018 and broke her right arm.	D 270		

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D 270	Continued From page 8 -There was no implementation of interventions with Resident #4 such as the use of a fall mat, bed or chair alarms or increased supervision other than the normal every 2 hours during the day and every hour at night. Telephone interview with Resident #4's family member on 01/08/19 at 1:33pm revealed: -He was concerned about the care after the fall related to ambulation and supervision. -Resident #4 used a rolling walker to get around and could not push the walker one handed. -Resident #4 could easily fall trying to push the walker with one hand. -He was aware of 2 other falls without injuries in December and November, 2018 but not sure what happened. -There was nothing implemented after her fall to help prevent another fall. -He expected the facility staff to watch Resident #4 at least every 15-30 minutes to provide assistance with ambulation because Resident #4 could not use her right arm. Telephone interview with Resident #4's Orthopedic physician on 01/08/19 at 3:53pm revealed Resident #4 required increased supervision greater than every hour because of ambulation issues using a walker and a fractured right arm, if not could lead to more falls. Interview with the Administrator on 01/08/19 at 3:55pm revealed: -Resident #4 fell and broke her right arm on 11/12/18. -Resident #4 was capable of ambulating with her walker even with a broken arm but she did expect the staff to help with ambulation to prevent any other falls because of the limited use of the right arm.	D 270		

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D 270	Continued From page 9 -She did not know why Resident #4 did not have a fall mat, bed or chair alarm or increased checks other than the normal every 2 hours during the day and every hour at night checks when the facility fall policy outline interventions. Refer to interview with a medication aide (MA) on 01/07/19 at 3:25pm. Refer to interview with the Memory Care Resident Care Coordinator (MCRCC) on 01/08/19 at 6:45am. Refer to interview with a personal care aide (PCA) on 01/08/19 at 6:45am. Refer to interview with a second PCA on 01/08/19 at 7:00am. Refer to interview with the RCD on 01/08/19 at 12:28pm. Refer to interview with the Administrator on 01/08/19 at 3:55pm. 3. Review of Resident #5's current FL2 dated 10/15/18 revealed: -Diagnoses included dementia with behaviors, history of falls, and a coronary artery bypass graft. -The resident was semi-ambulatory. Review of Resident #5's current care plan dated 11/26/18 revealed: -The resident was semi-ambulatory. -The resident required limited assistance with ambulation and transfers. -The resident required extensive assistance with toileting, bathing, dressing and grooming.	D 270		

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Review of Resident #5's Accident Reports revealed:
-A report dated 11/21/18 at 8:30am revealed Resident #5 fell.
-A report dated 11/29/18 at 8:56pm revealed Resident #5 fell and complained of chest wall pain.
-A report dated 12/20/18 at 3:35pm revealed Resident #5 fell, hit his head and right side of ribs.
- A report dated 01/04/19 at 2:30pm revealed Resident #5 fell out of bed.

Review of Resident #5's Emergency Room (ER) reports revealed:
-An ER visit dated 11/21/18 diagnosed with a fall.
-An ER visit dated 12/20/18 diagnosed with a fall, multiple right sided closed rib fractures, contusion to the right chest wall, abdominal aortic aneurysm (AAA) without rupture.

Review of Resident #5's progress notes revealed no documentation of interventions after every fall.

Interview with a medication aide (MA) on 01/07/19 at 3:25pm revealed:
-Resident #5 fell and broke his rib on 12/20/18.
-Resident #5 used a wheelchair for mobility.
-Resident #5 did not have any interventions after her falls.
-There was no fall mat, bed or chair alarm or increased supervision.
-The standard checks were every hour from 11:00pm to 7:00am and that was all we did.
-There were no fall mats,or bed or chair alarms in the facility at all.

Interview with the Memory Care Resident Care Coordinator (MCRCC) on 01/08/19 at 6:45am reveled:

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-She knew Resident #5 fell on 12/20/18 and was sent to the ER.
-There was no increased checks on Resident #5 other than the normal every 2 hours during the day and every hour at night.
-The every 2 hour checks during the day and every hour at night was the Memory Care Unit (MCU) policy.
-Resident #3 did not have a fall mat, bed or chair alarm.

Interview with the Resident Care Director (RCD) on 01/08/19 at 12:28pm revealed:
-Resident #5 fell 12/20/18 and received fractured ribs.
-There was no implementation of interventions with Resident #5 such as the use of a fall mat, bed or chair alarms or increased supervision other than the normal every 2 hours during the day and every hour at night.

Telephone interview with a Nurse from Resident #5's physician's office on 01/08/19 at 2:45pm revealed:
-The physician was aware of the fall dated 11/21/18 and 12/20/18.
-The physician signed an order on 11/30/18 for Resident #5 to have "increased visual checks, non-skid socks and redirection" because Resident #5 was found in other resident's beds and falls.
-The physician was aware of the Abdominal Aortic Aneurysm(AAA) found on the 12/20/18 fall that was not ruptured.
-The physician expected the facility staff to follow all orders a written/directed.
-The physician considered the fall to put Resident #5 at serious risk related to further falls causing broken ribs with respiratory compromise, and causing the (AAA) to rupture and causing death.

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D 270	Continued From page 12 Interview with the Administrator on 01/08/19 at 3:55pm revealed: -She was aware of Resident #5's fall on 12/20/18 which resulted in fractured ribs. -Resident #5 used a wheelchair for ambulation. -Resident #5 did not have a fall mat, bed or chair alarm or increased checks other than the normal every 2 hours during the day and every hour at night. -She did not know why Resident #4 did not have a fall mat, bed or chair alarm or increased checks other than the normal every 2 hours during the day and every hour at night checks when the facility fall policy outline interventions. Telephone interview with Resident #5's family member on 01/08/19 at 1:33pm was unsuccessful. Refer to interview with a medication aide (MA) on 01/07/19 at 3:25pm. Refer to interview with the Memory Care Resident Care Coordinator (MCRCC) on 01/08/19 at 6:45am. Refer to interview with a personal care aide (PCA) on 01/08/19 at 6:45am. Refer to interview with a second PCA on 01/08/19 at 7:00am. Refer to interview with the RCD on 01/08/19 at 12:28pm. Refer to interview with the Administrator on 01/08/19 at 3:55pm.	D 270		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 Interview with a medication aide (MA) on 01/07/19 at 3:25pm revealed: -After a resident fell, there was an accident report filled out. -The accident report was the documentation of what happened and who was informed. -The accident report was given to the RCD and the Health and Wellness Director (HWD) and they were responsible for any implementation of interventions at that time. -A 24 hour log book was kept on all residents with falls which included any new interventions. -The normal checks on residents in the MCU is every 2 hours during the day and every hour at night. Interview with the Memory Care Resident Care Coordinator (MCRCC) on 01/08/19 at 6:45am reveled: -An accident report was completed on each resident after each fall. -The fall report contained information about the fall and who was notified. -A 24 hour report was completed every shift and contained information such as falls, injuries, and behaviors. -There was no documentation for normal every hour checks at night, every 2 hour checks during the day or increased checks if needed. Interview with a personal care aide (PCA) on 01/08/19 at 6:45am revealed: -She worked in the MCU on 3rd shift. -She checked on the resident's every hour at night. -There was no increased checks on residents after falls in the MCU. -There was no chair or bed alarms, or fall mats with any resident in the MCU.	D 270		

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D 270	Continued From page 14 Interview with a second PCA on 01/08/19 at 7:00am revealed: -The normal rounds were every 2 hours during the day and every hour at night in the MCU. -There were no bed or chair alarms, or fall mats in the MCU. -He was never instructed to increase checks or supervision on the residents in the MCU. -He was never instructed to implement any fall precautions on any resident in the MCU. Interview with the RCD on 01/08/19 at 12:28pm revealed: -An accident report was filled out on each resident with a fall. -A resident would be sent out to the ER if the resident hit their head. -She did not know of any use of fall mats, bed or chair alarms or increased supervision on any resident in the MCU. -There was no increased supervision in the MCU because they already were checking on residents more in the MCU than in the assisted living side. -She did not have a fall intervention form or an order to implement interventions after a fall. Interview with the Administrator on 01/08/19 at 3:55pm revealed: -An accident report was completed on all falls. -She did not have a copy of the fall policy with interventions available. -After the first fall an evaluation was done on the resident's feet and shoes to make sure the shoes were properly fitted and there were no issues with the feet such as sores. -Some interventions at this point were increased supervision, and non-skid socks. -After the next fall and the first interventions failed, increased supervision again and a consult for PT/OT, fall mats, bed and chair alarms.	D 270		

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D 270	Continued From page 15 -If the falls continued, she would have a meeting with the family, physician, and HWD to discuss a higher level of care. -She did not know why Resident #3, #4 and #5 did not have a fall mat, bed or chair alarm or increased checks other than the normal every 2 hours during the day and every hour at night checks when the facility fall policy outline interventions. _____ The facility failed to assure that residents (#3, #4 and #5) were supervised appropriately according to their needs which resulted in one resident (#3) falling which resulted in five emergency room visits which included head injuries while on a blood thinner, another resident (#4) falling sustaining a fractured right arm and a third resident (#5) falling causing multiple rib fractures. This failure resulted in serious physical harm and neglect to these residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/08/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 7, 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.	D 273		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up for 2 of 4 sampled residents (Resident #1, and #4) Resident #1 whose physician was not notified of medication refusals and Resident #4 not being referring to Physical Therapy and Occupational Therapy after a fractured arm.

The findings are:

1. Review of Resident #4's current FL2 dated 09/14/18 revealed diagnoses included dementia, recurrent urinary tract infections, hypertension and seizures.

Review of Resident #4's record revealed:
-A Orthopedic Physician order dated 12/20/18 for physical and occupational therapy for passive range of motion for 3 weeks then active range of motion.
-A physical therapy prescription and letter of medical necessity signed by Resident #4's physician for passive range of motion for 3 weeks then active range of motion.
-There was no documentation of a physical or occupational therapy visit.

Telephone interview with Resident #4's Orthopedic Physician on 01/08/19 at 3:53pm revealed:
-On the 12/20/18 visit he wrote for physical therapy and occupational therapy to work with Resident #4's passive range of motion to help the

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mobility of the right arm.
-He expected the facility staff to get Resident #4 started on physical therapy to help strengthen Resident #4's right arm to help prevent falls from Resident #4 trying to use her walker with one arm only.

Interview with the Memory Care Resident Care Coordinator (MCRCC) on 01/08/19 at 6:45am revealed:
-She did not know there was an order for physical therapy/occupational therapy for Resident #4.
-The Resident Care Director (RCD) and the Health and Wellness Director (HWD) were responsible for all new orders and referrals.

Interview with a medication aide (MA) on 01/08/19 at 7:00am revealed:
-She did not know there was an order for physical therapy/occupational therapy for Resident #4.
-The RCD and the HWD were responsible for all new orders and referrals.

Telephone interview with Resident #4's family member on 01/08/19 at 1:33pm revealed:
-He was with Resident #4 at the Orthopedics' office on 12/20/18 when the physician ordered the physical and occupational therapy.
-The therapy was to help Resident #4 strengthen her arm after almost 2 months of not using it.
-Resident #4 was right handed and needed the strength back to help with using her walker.
-He expected the facility staff to get the physical and occupational therapy as ordered by the physician to help prevent falls because Resident #4 could not ambulate without her walker and was not getting assistance with ambulation.
-Resident #4 fell later that evening after her visit to the Orthopedics' office on 12/20/18 because she could not push the walker correctly with one

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D 273	Continued From page 18 hand. Interview with a Physical Therapy Assistant from a home health agency on 01/08/19 at 12:25pm revealed there was no referral made to their agency for Resident #4. Interview with the RCD on 01/08/19 at 12:28pm revealed: -She did not know there was an order for Resident #4 to have physical and occupation therapy. -She along with the HWD was responsible for all new orders. -Her signature was confirmed on the physician's order documenting she faxed the order to the pharmacy. -She was responsible for faxing this new set of orders to the pharmacy and then calling home health for the physical and occupational therapy. -She "forgot to". Interview with the Administrator on 01/08/19 at 3:55pm revealed: -At the time Resident #4's order for physical and occupational therapy came in, she and the RCD were responsible for all orders being faxed to the pharmacy and contacting any referral agencies. -The RCD received the order for Resident #4's physical and occupational therapy, and faxed the order to the pharmacy but did not call the home health agency and set up the therapy. -She expected the referral to be made after the order was faxed to the pharmacy. 2. Review of Resident #1's current FL-2 dated 06/29/18 revealed diagnoses included other sequelae of cerebral infarction, muscle weakness and spinal stenosis. Review of Resident #1's record revealed:	D 273		

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D 273	Continued From page 19 -There was a fax from the facility to Resident #1's PCP dated 11/27/18 documenting Resident #1 continued to refuse Flomax every day. -There was a visit summary from Resident #1's PCP dated 12/11/18 documenting the PCP had sent an order to the facility to discontinue Resident #1's Flomax due to non-use. -There was no documentation Resident #1's PCP had been notified regarding her refusals of Miralax, Pro-Stat or famotidine. -Resident #1's last documented visit with her PCP was dated 12/04/18. a. Review of Resident #1's current FL-2 dated 06/29/18 revealed a medication order for Miralax 17gm daily (a medication used to treat constipation). Review of Resident #1's November 2018 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Miralax 17gm to be administered daily at 8:00am. -There was documentation Miralax had been administered for 29 of 30 opportunities. -There was documentation Resident #1 refused the Miralax for 1 of 30 opportunities. Review of Resident #1's December 2018 eMAR revealed: -There was an entry for Miralax 17gm to be administered daily at 8:00am. -There was documentation Miralax had been administered for 11 of 31 opportunities. -There was documentation Resident #1 refused the Miralax for 20 of 31 opportunities. -There was documentation Resident #1 refused the Miralax for 8 consecutive doses from 12/12/18 to 12/20/18 and again for 11 consecutive doses from 12/21/18 through	D 273		

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D 273	Continued From page 20 12/31/18. Review of Resident #1's January 2019 eMAR revealed: -There was an entry for Miralax 17gm to be administered daily at 8:00am. -There was documentation Resident #1 refused the Miralax for 7 of 7 opportunities (01/01/19 through 01/07/19). Observation of Resident #1's medications available for administration on 01/08/19 at 11:43am revealed Miralax was available for administration. Interview with Resident #1 on 01/08/19 at 1:33pm revealed: -The only medications she was currently taking were aspirin, Tylenol, metoprolol and Lasix. -She had been experimenting with not taking some of her medications trying to determine what might be causing her diarrhea. -She was taking Flomax up until December 2018 when her Primary Care Provider (PCP) discontinued it. -Since the discontinuation of Flomax, her diarrhea had mostly resolved and she had only experienced two episodes. -She "was not familiar" with Miralax, but knew she was not taking it. Interview with a medication aide (MA) on 01/08/19 at 11:43am revealed: -Resident #1 often refused Miralax because the resident thought it caused her to have diarrhea. -She could not remember Resident #1 complaining of any recent episodes of diarrhea. -If a resident routinely refused medications, she would notify the RCC and Resident Care Director (RCD).	D 273		

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D 273	Continued From page 21 -It was the RCC and RCD's responsibility to notify the resident's PCP of refusals.. -She had made both the RCC and RCD aware of Resident #1's medication refusals. Interview with the RCC on 01/08/19 at 12:30pm revealed: -Resident #1 refused her medications because she thought they gave her diarrhea. -Resident #1 first thought it was the Flomax causing her diarrhea so the PCP had discontinued it, but "now she thinks it's other medications." -She had educated Resident #1 regarding the importance of taking all her ordered medications. -The facility did not have a specific policy on when the PCP should be notified regarding missed medications, but if a resident was "consistently" refusing a medication, it was her and the RCD's responsibility to notify the PCP. -Resident #1's PCP visited the facility weekly. -She typically reported resident needs to the PCP during her weekly visit and rarely called or faxed her anything unless a resident needed a refill on medication. -She had verbally reported Resident #1's medication refusals during the PCP's facility visit the first week in December 2018. -She could not remember if she had documented the conversation anywhere, but if she had, it would be in Resident #1's progress notes. -The PCP said she would talk with Resident #1 about her medication refusals. -She did not know the outcome of the PCP's conversation with Resident #1. -If the PCP had given any new orders, they would have been given to the former RCD. -She was not in the facility during the PCP's most recent visit and was not sure what the RCD might have discussed with the PCP.	D 273		

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D 273	Continued From page 22 Interview with the RCD on 01/08/19 at 12:45pm revealed: -She had been at this facility for one week. -She was working the last time Resident #1's PCP visited the facility on 01/01/19. -She did not know about Resident #1's medication refusals. -If she had known, she would have contacted the PCP via phone rather than wait until her next visit. -Resident #1 was not seen by her PCP on 01/01/19. Interview with the Administrator on 01/08/19 at 3:50pm revealed: -The facility did not have a specific policy on when a resident's PCP should be notified regarding medication refusals. -Notifying the PCP about medication refusals "depended on the situation" and was typically based on consecutive refusals of the same medication. -She knew about Resident #1's refusal of Flomax but did not know about her refusals of any other medications. -With Resident #1 refusing Miralax for 18 consecutive doses, she would have expected the staff to notify Resident #1's PCP regarding each of the medications. -It was the RCC and RCD's responsibility to notify the PCP. -Notification to PCP's could be done verbally during a visit, via fax, via paperwork sent out with a resident to a PCP visit or via telephone. -All contacts with the PCP should be documented in the resident's record. Attempted telephone interview with Resident #1's PCP on 01/08/19 at 10:38am was unsuccessful.	D 273		

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b. Review of Resident #1's current FL-2 dated 06/29/18 revealed a medication order for Pro-Stat 30mL daily (a protein supplement).

Review of Resident #1's November 2018 eMAR revealed:
-There was an entry for Pro-Stat 30mL to be administered daily at 8:00am.
-There was documentation Pro-Stat had been administered for 29 of 30 opportunities.
-There was documentation Resident #1 refused the Miralax for 1 of 30 opportunities.

Review of Resident #1's December 2018 eMAR revealed:
-There was an entry for Pro-Stat 30mL to be administered daily at 8:00am.
-There was documentation Pro-Stat had been administered for 16 of 31 opportunities.
-There was documentation Resident #1 refused the Pro-Stat for 15 of 31 opportunities.
-There was documentation Resident #1 refused the Pro-Stat for 5 consecutive doses from 12/23/18 to 12/28/18 and again for 3 consecutive doses from 12/29/18 through 12/31/18.

Review of Resident #1's January 2019 eMAR revealed:
-There was an entry for Pro-Stat 30mL to be administered daily at 8:00am.
-There was documentation Resident #1 refused the Pro-Stat for 7 of 7 opportunities (01/01/19 through 01/07/19).

Observation of Resident #1's medications available for administration on 01/08/19 at 11:43am revealed Pro-Stat was available for administration.

Interview with Resident #1 on 01/08/19 at 1:33pm

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revealed:
-The only medications she was currently taking were aspirin, Tylenol, metoprolol and Lasix.
-She routinely refused Pro-Stat because she did not like the taste.

Interview with a MA on 01/08/19 at 11:43am revealed:
-Resident #1 often refused the Pro-Stat because the resident thought it caused her to have diarrhea.
-If a resident routinely refused medications, she would notify the RCC and Resident Care Director (RCD).
-It was the RCC and RCD's responsibility to notify the resident's PCP.
-She had made both the RCC and RCD aware of Resident #1's medication refusals.

Interview with the RCC on 01/08/19 at 12:30pm revealed:
-Resident #1 refused her medications because she thought they gave her diarrhea.
-Resident #1 first thought it was the Flomax causing her diarrhea so the PCP had discontinued it, but "now she thinks it's other medications."
-She had educated Resident #1 regarding the importance of taking all her ordered medications.
-The facility did not have a specific policy on when the PCP should be notified regarding missed medications, but if a resident was "consistently" refusing a medication, it was her and the RCD's responsibility to notify the PCP.
-Resident #1's PCP visited the facility weekly.
-She typically reported patient needs to the PCP during her weekly visit and rarely called or faxed her anything unless a resident needed a refill on medication.
-She had verbally reported Resident #1's

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medication refusals during the PCP's facility visit the first week in December 2018.
-She could not remember if she had documented the conversation anywhere, but if she had, it would be in Resident #1's progress notes.
-The PCP said she would talk with Resident #1 about her medication refusals.
-The RCC did not know the outcome of the PCP's conversation with Resident #1.
-If the PCP had given any new orders, they would have been given to the former RCD.
-The RCC was not in the facility during the PCP's most recent visit and was not sure what the RCD might have discussed with the PCP.

Interview with the RCD on 01/08/19 at 12:45pm revealed:
-She had been at this facility for one week.
-She was working the last time Resident #1's PCP visited the facility on 01/01/19.
-The RCD did not know about Resident #1's medication refusals.
-If she had known, she would have contacted the PCP via phone rather than wait until her next visit.
-Resident #1 was not seen by her PCP on 01/01/19.

Interview with the Administrator on 01/08/19 at 3:50pm revealed:
-The facility did not have a specific policy on when a resident's PCP should be notified regarding medication refusals.
-Notifying the PCP about medication refusals "depended on the situation" and was typically based on consecutive refusals of the same medication.
-She knew about Resident #1's refusal of Flomax but did not know about her refusals of any other medications.
-With Resident #1 refusing Pro-Stat for 10

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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consecutive doses, she would have expected the staff to notify Resident #1's PCP regarding each of the medications.
-It was the RCC and RCD's responsibility to notify the PCP.
-Notification to PCP's could be done verbally during a visit, via fax, via paperwork sent out with a resident to a PCP visit or via telephone.
-All contacts with the PCP should be documented in the resident's record.

Attempted telephone interview with Resident #1's PCP on 01/08/19 at 10:38am was unsuccessful.

c. Review of Resident #1's current FL-2 dated 06/29/18 revealed a medication order for famotidine 20mg daily (a medication used to treat gastroesophageal reflux disease and heartburn).

Review of Resident #1's November 2018 eMAR revealed:
-There was an entry for famotidine 20mg to be administered daily at 8:00am.
-There was documentation famotidine had been administered for 29 of 30 opportunities.
-There was documentation Resident #1 refused the famotidine for 1 of 30 opportunities.

Review of Resident #1's December 2018 eMAR revealed:
-There was an entry for famotidine 20mg to be administered daily at 8:00am.
-There was documentation famotidine had been administered for 16 of 31 opportunities.
-There was documentation Resident #1 refused the famotidine for 15 of 31 opportunities.
-There was documentation Resident #1 refused the famotidine for 6 consecutive doses from 12/14/18 to 12/20/18 and again for 3 consecutive doses from 12/29/18 through 12/31/18.

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D 273	Continued From page 27 Review of Resident #1's January 2019 eMAR revealed: -There was an entry for famotidine 20mg to be administered daily at 8:00am. -There was documentation famotidine had been administered for 3 of 7 opportunities -There was documentation Resident #1 refused the famotidine for 4 of 7 opportunities. -There was documentation Resident #1 refused the famotidine for 3 consecutive dose from 01/02/19 to 01/05/19. Observation of Resident #1's medications available for administration on 01/08/19 at 11:43am revealed famotidine 20mg was available for administration. Interview with Resident #1 on 01/08/19 at 1:33pm revealed: -The only medications she was currently taking were aspirin, Tylenol, metoprolol and Lasix. -She "was not familiar" with famotidine, but she knew she wasn't taking it. Interview with a MA on 01/08/19 at 11:43am revealed: -Resident #1 often refused the famotidine because the resident thought it caused her to have diarrhea. -If a resident routinely refused medications, she would notify the RCC and Resident Care Director (RCD). -It was the RCC and RCD's responsibility to notify the resident's PCP. -She had made both the RCC and RCD aware of Resident #1's medication refusals. Interview with the RCC on 01/08/19 at 12:30pm revealed:	D 273		

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-Resident #1 refused her medications because she thought they gave her diarrhea.
-Resident #1 first thought it was the Flomax causing her diarrhea so the PCP had discontinued it, but "now she thinks it's other medications."
-She had educated Resident #1 regarding the importance of taking all her ordered medications.
-The facility did not have a specific policy on when the PCP should be notified regarding missed medications, but if a resident was "consistently" refusing a medication, it was her and the RCD's responsibility to notify the PCP.
-Resident #1's PCP visited the facility weekly.
-She typically reported patient needs to the PCP during her weekly visit and rarely called or faxed her anything unless a resident needed a refill on medication.
-She had verbally reported Resident #1's medication refusals during the PCP's facility visit the first week in December 2018.
-She could not remember if she had documented the conversation anywhere, but if she had, it would be in Resident #1's progress notes.
-The PCP said she would talk with Resident #1 about her medication refusals.
-The RCC did not know the outcome of the PCP's conversation with Resident #1.
-If the PCP had given any new orders, they would have been given to the former RCD.
-The RCC was not in the facility during the PCP's most recent visit and was not sure what the RCD might have discussed with the PCP.

Interview with the RCD on 01/08/19 at 12:45pm revealed:
-She had been at this facility for one week.
-She was working the last time Resident #1's PCP visited the facility on 01/01/19.
-The RCD did not know about Resident #1's

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D 273	Continued From page 29 medication refusals. -If she had known, she would have contacted the PCP via phone rather than wait until her next visit. -Resident #1 was not seen by her PCP on 01/01/19. Interview with the Administrator on 01/08/19 at 3:50pm revealed: -The facility did not have a specific policy on when a resident's PCP should be notified regarding medication refusals. -Notifying the PCP about medication refusals "depended on the situation" and was typically based on consecutive refusals of the same medication. -She knew about Resident #1's refusal of Flomax but did not know about her refusals of any other medications. -With Resident #1 refusing famotidine for 6 consecutive doses, she would have expected the staff to notify Resident #1's PCP regarding each of the medications. -It was the RCC and RCD's responsibility to notify the PCP. -Notification to PCP's could be done verbally during a visit, via fax, via paperwork sent out with a resident to a PCP visit or via telephone. -All contacts with the PCP should be documented in the resident's record. Attempted telephone interview with Resident #1's PCP on 01/08/19 at 10:38am was unsuccessful.	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	D 276		

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D 276	Continued From page 30 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: Based on interviews, record reviews and observations the facility failed to assure physician's orders were implemented, for 1 of 4 sampled residents (Resident #4) related to a sling to be worn at all times (#4). The findings are: Review of Resident #4's current FL2 dated 09/14/18 revealed diagnoses included dementia, recurrent urinary tract infections, hypertension and seizures. Review of Resident #4's Orthopedic Physician order dated 11/13/18 revealed an order for Resident #4 to use a right arm sling, and no weight bearing for right arm. Review of Resident #4's Orthopedic Physician order dated 11/21/18 revealed an order for Resident #4 to use a right arm sling at all times, and no active range of motion for right arm. Review of Resident #4's November 2018 electronic Medication Record (eMAR) revealed: -There was no entry for Resident #4 to wear a sling. -An order transcribed as no weight bearing right	D 276		

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arm was documented 11/01/18 - 11/30/18 on 7:00am - 3:00pm shift, 3:00pm - 11:00pm shift and 11:00pm to 7:00am shift.

Review of Resident #4's December 2018 eMAR revealed:
-There was no entry for Resident #4 to wear a sling.
-An order transcribed as no weight bearing right arm was documented 12/01/18 - 12/31/18 on 7:00am - 3:00pm shift, 3:00pm - 11:00pm shift and 11:00pm to 7:00am shift.

Review of Resident #4's January 2019 eMAR revealed:
-There was no entry for Resident #4 to wear a sling.
-An order transcribed as no weight bearing right arm was documented 01/01/19 - 01/08/18 on 7:00am - 3:00pm shift, 3:00pm - 11:00pm shift and 11:00pm to 7:00am shift.

Observations of Resident #4 on 01/07/19 at 10:09am revealed the sling on her right arm was loose and allowing the right arm to hang down out of the sling.

Observation of Resident #4 on 01/07/19 at 12:15pm revealed she did not have her sling on and ambulating using walker with her left hand.

Telephone interview with Resident #4's Orthopedic Physician on 01/08/19 at 3:53pm revealed:
-Resident #4 was to wear a sling all the time since her fall on 11/13/18.
-The sling was to prevent swelling and increased pain.
-He expected the facility staff to keep the sling on at all times and for the sling to be worn correctly.

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D 276	Continued From page 32 Interview with the Memory Care Resident Care Coordinator (MCRCC) on 01/08/19 at 6:45am revealed: -She did not know there was an order for a sling to be worn at all times. -Resident #4 came back from a visit to the orthopedics office with it on. -Resident #4 did not wear the sling at times. -She did not know who put the sling on in the mornings or took it off in the evening. -The Resident Care Director (RCD) and the Health and Wellness Director (HWD) were responsible for all new orders. -The only knew of the non-weight bearing order on the eMAR. Interview with the RCD on 01/08/19 at 6:45am revealed: -Resident #4 wore a sling on her right arm after the fall in November 2018. -She did not know the sling was to be worn at all times. -Resident #4 did not wear the sling all of the time because Resident #4 would take it off. -She would see Resident #4 with the sling on but the right arm was hanging down and out of the sling while ambulating with her walker. -The only order on the eMAR was for non-weight bearing of Resident #4's right arm and she did not know there was an order for Resident #4 to wear the sling at all times. Interview with a Memory Care (MC) personal care aide (PCA) on 01/08/19 at 6:45am revealed: -Resident #4 wore a sling on the right arm some of the time. -Resident #4 did not sleep with the sling on. -She did not know the sling was to be worn at all times.	D 276		

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D 276	Continued From page 33 -She saw Resident #4 with her right arm hanging out of the sling many times while ambulating with her walker. -Sometimes she would put Resident #4's arm back in the sling after Resident #4 sat down. Interview with a second MC PCA on 01/08/19 at 7:00am revealed: -He saw the sling before on Resident #4. -The night shift PCAs typically got Resident #4 up in the mornings. -Resident #4 used a walker to ambulate and pulled the right arm out of the sling to ambulate. -He did not know how to fit the sling on correctly and did not have any instruction or training to do so. Interview with a medication aide (MA) on 01/08/19 at 7:00am revealed: -Resident #4 fell in November 2018, and did not know the right arm was broken for 3 weeks. -Resident #4 came back from the Orthopedic office visit with a sling on. -She did not know there was an order to wear the sling at all times. -She was not given any instructions on how to put the sling on or how to adjust the sling. -The RCD and the Nurse were responsible for all new orders. Telephone interview with Resident #4's family member on 01/08/19 at 1:33pm revealed: -He was with Resident #4 at the Orthopedics' office on 11/13/18 when the physician ordered the sling to be worn on Resident #4's right arm to help with pain and swelling. -He took Resident #4 back to the Orthopedic office on 11/21/18 because of increased pain and swelling. -The Orthopedist ordered the sling to be worn at	D 276		

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D 276	Continued From page 34 all times. -He expected the facility staff to keep the sling on Resident #4 at all times to help with the pain. -Resident #4 complained to him the pain was still there even after taking the pain medications. -He saw Resident #4 at meals without the sling but thought it was to be off during meals. Interview with the RCD on 01/08/19 at 12:28pm revealed: -She knew Resident #4 was to wear the sling on the right arm but did not know the order was for continuous. -She was responsible for faxing the orders to the pharmacy and making sure all orders were reflected on the eMAR correctly. -She along with the Nurse was responsible for all new orders. -The new orders were to be checked against the eMAR after the new eMAR was printed off for accuracy. -The order for Resident #4's sling to be worn at all time was missed. -The order for Resident #4 to have non-weight bearing was on the eMAR and since they were from the same order she could not figure out how it was missed. Interview with the Administrator on 01/08/19 at 3:55pm revealed: -She and the RCD were responsible for all new orders up until a month ago when the HWD was hired. -The order dated 11/13/18 was faxed to the pharmacy for Resident #4's sling and no weight bearing of the right arm but the no weight bearing was the only order that made it to the eMAR. -The order for Resident #4 to wear a sling should have been placed on the eMAR to be documented it was done.	D 276		

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D 276	Continued From page 35 -The eMAR was to be checked by the RCD at the end of each month along with the orders to verify the orders were there and correct.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure an on-site Licensed Health Professional Support (LHPS)	D 280		

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review and evaluation was completed quarterly for 1 of 4 sampled residents (Resident #4) who required application and removal of a right arm sling.

The findings are:

Review of Resident #4's current FL2 dated 09/14/18 revealed diagnoses included dementia, recurrent urinary tract infections, hypertension and seizures.

Review of Resident #4's Orthopedic Physician order dated 11/13/18 revealed an order for Resident #4 to use a right arm sling, and no weight bearing for right arm.

Review of Resident #4's Orthopedic Physician order dated 11/21/18 revealed an order for Resident #4 to use a right arm sling at all times, and no active range of motion for right arm.

Review of Resident #4's LHPS review revealed there was no assessment or review on Resident #4 after the fall in November 2018 which resulted in Resident #4 wearing a sling at all time on her right arm.

Interview with the LHPS Nurse on 01/08/19 at 12:19pm revealed:
-She started working for the facility in December.
-A list of all residents that required an updated or new LHPS was left for her at the facility every week by the RCD.
-She did not know Resident #4 required an updated LHPS.

Interview with the Resident Care Director (RCD) on 01/08/19 at 12:28pm revealed:
-She knew Resident #4 was to wear the sling on

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D 280	Continued From page 37 the right arm. -The sling was considered an LHPS task. -There was a new LHPS Nurse since December 2018. -The LHPS Nurse was responsible for all LHPS reviews and evaluations. -She was responsible for letting the LHPS Nurse know when there was a significant change in the residents that required a new LHPS task. -She did not let the LHPS Nurse know about Resident #4. Telephone interview with Resident #4's Orthopedic Physician on 01/08/19 at 3:53pm revealed Resident #4 was to wear a sling all the time since her fall on 11/13/18. Interview with the Administrator on 01/08/19 at 3:55pm revealed: -The RCD was responsible for letting the LHPS Nurse know about new residents or a significant change in a resident for their LHPS tasks. -The LHPS Nurse was responsible for all evaluations and reviews on all residents in the facility. -The new LHPS Nurse was given the information on any resident that was new, required an updated LHPS or a change that required a new LHPS task. -She expected the RCD to inform the LHPS Nurse of the residents that required the assessments, changes and reviews. -She did not know Resident #4 did not have a significant change LHPS completed.	D 280		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of	D 375		

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D 375	Continued From page 38 Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 1 sampled residents (Resident #2) had a physician's order for self-administration of medication. The findings are: Review of Resident #2's FL-2 dated 8/16/18 revealed: -Diagnoses included altered mental status, acute metabolic/toxic encephalopathy slowly improving, and agitation. -There was no order for Resident #2 to self-administer Fluticasone (a medication used to prevent nasal inflammation) 50mcg 1 spray in each nostril twice per day and Albuterol (a medication used to treat and prevent wheezing and shortness of breath) 90mcg to inhale 2 puffs four times per day as needed for wheezing. Review of Resident #2's electronic Medication Administration Record (eMAR) for November and	D 375		

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D 375	Continued From page 39 December 2018 and January 2019 revealed: -There was no documentation on the MARs that Resident #2 was able to self-administer any of her medications. -There was no order to keep medications at Resident #2's bedside. -An order transcribed for Flonase spray 50mcg 1 spray in each nostril twice a day. -An order transcribed for Albuterol 2 puffs 4 times a day as needed for wheezing. Observation of Resident #2's medications on hand on 01/8/19 at 11:40am revealed there was no Fluticasone 50mcg (1 spray in each nostril twice per day) and Albuterol 90mcg (to inhale 2 puffs four times per day as needed for wheezing) available on the medication cart. Observation of Resident #2's room on 01/08/19 at 11:40am revealed Flonase and Albuterol in Resident #3's locked nightstand drawer. Interview with a medication aide (MA) on 01/8/19 at 11:45am revealed: -She was not familiar with Resident #2 taking the Fluticasone or the Albuterol. -She had not administered neither of the medications to Resident #2. Observation of the MA in Resident #2's room on 01/8/19 at 11:50am revealed: -The MA asked Resident #2 had she ever taken Fluticasone or Albuterol. Resident #2 informed the MA she had both the Fluticasone and the Albuterol in her room. -Resident #2 informed the MA that the medications were kept in the top drawer of her locked night stand. -The MA informed Resident #2 that she needed a physician's order to keep the medications in her	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060153	A. BUILDING: _____ B. WING _____	01/08/2019

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D 375	Continued From page 40	D 375		

room and an order to self-administer the medications.

Interview with Resident #2 on 01/18/19 at 4:10pm revealed:
-The Flonase and Albuterol inhaler used to be kept on the medication cart.
-She had asked staff to leave the medication in her room and the staff did.
-She could not remember which staff gave her the medication to keep in her room.
-Staff had never asked her if she had taken the Flonase and the Albuterol inhaler as ordered.
-She last used the Albuterol inhaler in December 2018 sometime before Christmas.
-She used the Albuterol inhaler more during the fall and spring.
-"I could die" waiting for staff to bring my inhaler.

Interview with the MA on 10/8/19 at 4:17pm revealed:
-She was aware that Resident #2 kept the Flonase in her room, but she was not aware of the Albuterol inhaler in her room.
-She did not know if Resident #2 had an order to self-administer the two medications or keep the 2 medications at bedside.
-The MA was trained to remove medications from the resident's room if found.
-Resident #2 "gets so upset" when you try to remove the medications.
-She reported Resident #2 had the medications in her room to the Resident Care Director (RCD) but she could not recall when she reported the incident.
-The RCD was able to remove the medications from the room, but somehow the medications always end back in Resident #2's room.
-The MA was not aware which staff member kept giving Resident #2's medications from the med

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D 375	Continued From page 41 cart. Interview with the RCD on 1/8/19 at 1:15pm revealed: -She was not aware that Resident #2 had medications in her room. -She would explain to Resident #2 she could not keep medications by her bedside. -The MA was responsible for removing any medications found in the residents' rooms. -She was not aware that a resident could have a medication at the bedside if there was a physician order. Review of the facility's policy on Self-Administration of Medications revealed: -When a resident verbalizes a desire to self-administer medications steps must be initiated before this request is granted. -The RCD or designee will perform an assessment of the resident's mental and physical capacity to self-administer medications. -The RCD or designee must verify the resident is capable of verbalizing the correct dose and purpose of each medications before the assessment is complete. -If the resident is deemed by the RCD or designee, and order must be obtained from the physician stating the resident may self-administer medications. -If the resident is to keep the medications in their room, the order must also state "OK to keep medications at bedside." -The RCD or designee will perform continued assessment of the resident's ability to self-administer at least quarterly, and will document the resident's compliance with this process in the LHPS assessment tool. -The quarterly review must include verification that the resident had the appropriate medications	D 375		

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D 375	Continued From page 42	D 375		

on hand and continues to have a knowledge of the dose and purpose of each medication.
-If issues are identified, the RCD or designee will obtain an order to discontinue self-administration.
-The RCD or designee will be notified and an assessment completed. Based on the RCD or designee's assessment, the orders to discontinue self-administration will continue or new orders obtained as relevant.
-When residents self-administer medications, the medication is to be written on the resident's medication administration record and the words "self-administer" written on the MAR each it is verified a dose has been self-administered.

Interview with the Health Wellness Director (HWD) on 01/08/19 at 1:50pm revealed:
-She was not aware of any residents who self-administered medications.
-She was not aware that Resident #2 had Flonase and Albuterol inhaler in her room.
-She needed to review the facility's policy for administration.
-She needed to speak with the physician and to evaluate Resident #2 to determine if she could self-administer her own medications.

Attempted interview with Resident #2's physician on 01/08/19 at 12:05pm was unsuccessful.

Interview with the Administrator on 01/08/18 at 12:25pm revealed:
-She was not aware that Resident #2 had medications in her room.
-The RCD and the HWD had removed several medications from Resident #2's room last week that she did not have orders for.
-The RCD was in the process of contacting the physician about Resident #2 taking the over the

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D 375	Continued From page 43 Flonase and Albuterol. -Resident #2 had never been evaluated to self-administer any medications. -There were no residents in the facility that self-administered medications.	D 375		
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 ensure that the residents were free of neglect related to personal care and supervision. The findings are: 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 3 of 3 sampled residents with a history of falls (Resident #3, #4, and #5). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D914		