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| SPRING ARBOR OF THOMASVILLE | 915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey from April 16, 2019 to April 18, 2019. | D 000 | | |
| D 067 | 10A NCAC 13F .0305(h)(4) Physical Environment<br><br>10A NCAC 13F .0305 Physical Environment<br>(h) The requirements for outside entrances and exits are:<br>(4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on interviews, record reviews, and observations, the facility failed to assure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 1 sampled resident (Resident #1) with dementia who exhibited exit-seeking behaviors, was a known wanderer and eloped from the facility without staff's knowledge.<br><br>The findings are:<br><br>Observations made during the tour of the facility | D 067 | | |

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| D 067 | Continued From page 1<br>on 04/16/19 between 9:15am and 11:20am revealed:<br>-At 9:00am, the door alarm to the front door of the main entrance did not sound upon entering the facility.<br>-At 9:15 the exit door at the end of the 100 hall was locked and the exit door alarm was turned on.<br>-At 10:00am the exit door in the hallway leading to the special care unit was locked and the exit door alarm was turned on.<br>-At 11:00am the exit door at the end of the 300 hall was locked and the exit alarm was turned on.<br>-At 11:10am, one exit door in the special care unit was locked and the exit alarm was turned on.<br>-All exit doors were equipped with delayed egress push bar door closures and alarm keypads for overriding the alarm system except for the front entrance doors.<br><br>Review of Resident #1's current FL2 dated 01/31/19 revealed diagnoses included senile dementia.<br><br>Review of the facility's Resident Roster revealed Resident #1 resided in the assisted living unit on the 300 hall.<br><br>Review of encounter notes for a psychiatric evaluation visit dated 02/26/19 revealed "Staff report wandering, exit seeking, and elopement. Staff state that pt [patient] got out of the facility and went out to the road. After 20 minutes a good Samaritan brought [pt] back to the facility".<br><br>Telephone interview with Resident #1's mental health physician's assistant on 04/18/19 at 10:30am revealed:<br>-She was made aware Resident #1 had gotten out of the building through the front door on | D 067 | | |

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| D 067 | Continued From page 2 | D 067 | | |

02/17/19 by staff when she saw the resident on a routine visit on 02/26/19.
-Staff have reported to her the front of the building was not locked and alarmed at night and not alarmed during the day as well.
-She had not seen the front door alarmed when she came to the facility.

Interview with a medication aide (MA) on 04/18/19 at 8:10am revealed:
-The MA occasionally worked the 3:00pm to 11:00pm shift.
-Resident #1 did not go to bed before 11:00pm.
-Resident #1 wandered around the halls using her walker in the evening.

Interview with a personal care aide on 04/18/19 at 9:00am revealed:
-The front door was locked for outsiders being able to come into the building around 7:30pm.
-The front doors did not alarm when they were opened at night or during the day.
-The other exit doors were alarmed all the time.

Interview with the Maintenance Director on 04/18/19 at 9:05am revealed:
-The facility's exit doors were locked and the exit alarm turned on at all times.
-The exit doors could be entered by entering a code into the door keypads which unlocked the door and deactivated the exit alarm until the door was opened and closed.
-The activated exit door alarms gave an audible alarm and activated staff pagers.
-The front entrance doors were not part of the facility's exit door alarm system.
-The front doors were locked on the outside at 8:00pm and unlocked at 6:00am not allowing for entrance from the outside without staff opening the door. This was to prevent outsiders from

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| D 067 | Continued From page 3 | D 067 | | |

entering the building unnoticed.
-The door could be opened from the inside for someone to exit the facility.
-The front entrance doors had 24 hour camera monitoring and a receptionist staffing the front desk in the evenings daily.
-There was no exit alarm system on the front entrance doors.

Interview with Resident #1's primary care provider nurse practitioner (NP) on 04/18/19 at 9:30am revealed:
-She was aware that Resident #1 had wandered outside of the facility without staff with her.
-The NP was concerned about Resident #1's safety and going outside unsupervised.
-She thought Resident #1 may not be appropriate for the facility and may need to be in a locked unit to keep her safe due to her wandering.

Interview with the Administrator on 04/18/19 at 4:05pm revealed:
-She was aware all exit door alarms were sounded (turned on) at all times.
-The front entrance doors were not part of the facility door alarm system.
-The front entrance had a receptionist scheduled Monday through Friday from 5:00pm to 8:00pm, and Saturday and Sunday from 11:00am to 8:00pm.
-The receptionist was responsible to monitor people coming and going from the facility and offer assistance to visitors.
-The receptionist had called in sick on the day the resident left the building; no receptionist was on duty.
-She was aware Resident #1 wandered out of the facility through the front entrance.

Based on observations, interviews and record

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| D 067 | Continued From page 4<br>review it was dteremined Resident #1 was not interviewable.<br><br>The facility failed to assure all exit doors were alarmed when there was at least one identified wanderer which resulted in a resident (#1) with a diagnosis of dementia and exit seeking behaviors wandering outside building without staff's knowledge and was gone for more than 20 minutes. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G. S. 131D-34 on 04/25/19 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 2, 2019. | D 067 | | |
| D 234 | 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio<br><br>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations<br>(a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.<br><br>This Rule is not met as evidenced by: | D 234 | | |

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| D 234 | Continued From page 5<br>Based on record reviews and interviews, the facility failed to assure 1 of 5 residents sampled (#4) was tested upon admission for tuberculosis (TB) disease.<br><br>The findings are:<br><br>Review of Resident #4's current hospital FL2 dated 02/04/19 revealed diagnoses included hypertension, diabetes mellitus, congestive heart failure, and anemia.<br><br>Review of Resident #4's Resident Register revealed the date of admission was 10/27/17.<br><br>Review of Resident #4's immunization record revealed:<br>-A TB skin test was administered on 09/29/17 and read as negative on 10/01/17.<br>-There was no documentation Resident #4 had a second TB skin test administered and read after 09/29/17.<br><br>Interview with the Resident Care Director (RCD) on 04/18/19 at 6:20pm revealed:<br>-He could only find information for the one TB skin test placed and read at the previous facility for Resident #4.<br>-The record appeared to have been thinned and maybe the TB skin test information for the second TB skin test had been removed from the resident's record.<br>-He looked through the thinned record information he was able to locate, but there was no information regarding a second TB skin test before or after admission on 10/27/17.<br>-He had been working at the facility for less than 2 weeks.<br>-He was responsible for assuring two TB skin tests were completed for residents. | D 234 | | |

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| D 234 | Continued From page 6<br>-Resident #4 had a TB skin test placed today (04/18/19).<br><br>Interview with the Administrator on 04/18/19 at 6:30pm revealed:<br>-She could only find information for one TB skin test administered at the previous facility for Resident #4.<br>-The record had just been audited, and the mistake was not caught on Resident #4's immunization's record.<br>-The first TB skin test was completed at a previous facility prior to admission to the facility.<br>-The Business Office Manager and the RCD were responsible for auditing the TB skin tests for residents.<br><br>Interview with Resident #4 on 04/18/19 at 7:30pm revealed he could not provide any information about the when he had received a TB skin test. | D 234 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION | D 270 | | |

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| D 270 | Continued From page 7<br><br>Based on observations, record reviews, and interviews, the facility failed to provide supervision for 2 of 5 sampled residents regarding a resident (#1) with a diagnosis of dementia who exhibited exit-seeking behaviors, was a known wanderer and eloped from the facility without the staff's knowledge, and a resident (#3) with a diagnosis of dementia who experienced repeated falls.<br><br>The findings are:<br><br>1. Review of Resident #1's current FL2 dated 01/31/19 revealed diagnoses included senile dementia.<br><br>Review of Resident #1's Care Plan dated 03/19/19 revealed:<br>-Resident #1 was assessed for needing supervision with eating, toileting, ambulation/locomotion, and transferring.<br>-Resident #1 needed limited assistance with bathing, dressing, and grooming/personal hygiene.<br>-There was documentation "resident has had some wandering behaviors, safety protocols and in the process of considering memory care."<br><br>Review of Resident #1's Resident Notes revealed:<br>-On 11/17/18 at 6:25pm, there was documentation for an incident when Resident #1 was "exit seeking" and went out the door on the end of the 300 hall. The resident was immediately brought back inside the facility.<br>-On 11/25/18 from 7:00pm to 7:00am, resident tried to go out the front door around 2:30am; redirected back to her room.<br>-On 02/09/19 at 2:30pm, "spoke with residents Power of Attorney (POA) to inform that resident | D 270 | | |

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attempted to exit 200 hall but was redirected by staff".
-On 02/17/19 at 2:30pm (Sunday), resident got out of the building today and was returned by "staff". Family contacted.
-On 02/17/19 from 7:00pm to 7:00am (no specific times indicated, Resident #1 was very confused, "gave staff a very hard time" by going in and out of resident rooms and refusing to go back to her room when redirected; family member called at 10:15pm to talk with resident and calm her down.
-On 02/18/19 at 10:00am, the Administrator spoke with the POA to discuss resident's safety needs. For resident safety, "resident will (missing word) daycare" in special care unit (SCU) while waiting on urine test and medication review. No female beds currently available for admission to SCU so resident will reside in assisted living unit during sleep hours with staff assignment for monitoring. Will update family after physician visit on 02/21/19, if SCU still needed will assist family to identify community to meet resident care needs.
-On 02/18/19 at 3:00pm- 11:00pm, resident stayed on cottage (SCU) side most of the day since "she keeps trying to leave the building". Resident came back to assisted living unit around 10:00pm, talked to her family member on phone and went to bed.
-On 02/19/19 at 3:00pm- 11:00pm, "staff is aware to keep an eye on resident and 3rd is aware to keep watch".
-On 02/27/19 at 2:00am, resident's [medication name] is in cart, went to bed at 12:30pm and slept; will continue to monitor. (Resident's mental health provider increased her depression/anxiety medication on 02/27/19).
On 02/27/19 at 5:00pm, the Administrator documented she spoke with POA informing him mental health provider had recommended

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increased level of care for SCU on her visit on 02/26/19 but the facility did not have a female SCU bed currently available for the resident. The Administrator would assist in placing the resident in another facility. POA requested mental health provider contact him to discuss the change. The Administrator told the POA she would have her Regional Director contact the POA to answer questions and explain the appeal process.

Continued review of Resident #1's Resident Notes revealed:
-Staff documented daily entries from 03/01/19 to 04/17/19 except on 03/18/19, 04/04/19-04/08/19.
-There was documentation regarding observing the resident but no documentation for increased supervision except for documentation regarding the resident being returned from the locked unit and behaviors on some days.
-"Will continue to observe" was documented in the notes on 03/09/19 at 7:00pm, 03/10/19 at 6:55pm, 03/11/19 at 4:00am, 03/13/19 at 6:00am, 03/15/19 at 7:00pm-7:00am, 03/16/19 at 7:00pm-7:00am, 03/17/19 at 7:00am-7:00pm, 03/19/19 at 7:00am-7:00pm, 03/20/19 at 2:55pm, 03/23/19 at 7:00pm, 03/24/19 at 6:50pm, 03/25/19 at 2:30am, 03/27/19 at 7:00pm-7:00am, 03/28/19 at 6:50pm, 03/29/19 at 3:00am, 03/31/19 at 1:30am, 04/01/19 at 6:30pm, 04/09/19 at 7:00pm, 04/12/19 at 4:00am, 04/13/19 at 4:00am, and 04/13/19 at 2:30am.

Review of the Resident #1's Incident and Accident Reports revealed:
-There was a report dated 02/17/19 at 2:20pm documenting the resident was observed outside the building and was redirected back into the building.
-There was documentation the resident's family member and physician were notified on 02/17/19.

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| D 270 | Continued From page 10<br><br>Review of psychiatric evaluation visit dated 02/26/19 revealed "Staff report wandering, exit seeking, and elopement. Staff state that pt [patient] got out of the facility and went out on the road [about one-fourth of a mile] . After 20 minutes a good Samaritan brought pt back to the facility".<br><br>Telephone interview with Resident #1's mental health physician's assistant on 04/18/19 at 10:30am revealed:<br>-She was made aware Resident #1 had gotten out of the building on 02/17/19 through the front door by staff when she saw the resident on a routine visit on 02/26/19.<br>-Staff had reported to her the front of the building was not locked and not alarmed at night.<br>-She had not seen the front door alarmed when she came to the facility.<br>-She was informed by the facility Resident #1 needed increased supervision to guard against wandering out the front door and would be placed in the special care unit (SCU) during the day for increased supervision.<br>-She agreed with the need for increased supervision and was not opposed to Resident #1 spending days in the SCU.<br><br>Telephone interview with a evening shift medication aide (MA) who worked in the facility's special care unit (SCU) revealed:<br>-She routinely worked 7:00pm to 7:00am.<br>-Resident #1 was in the SCU each time she came to work at 7:00pm.<br>-Staff from the assisted living unit routinely came to pick Resident #1 up around 9:00pm daily.<br>-She was told by team staff members Resident #1 wandered out of the building and was in the SCU for increased supervision. | D 270 | | |

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| D 270 | Continued From page 11<br>-The MA did not recall a night when Resident #1 was in the SCU past 9:00pm.<br><br>Interview with an assisted living (AL) unit MA on 04/18/19 at 8:10am revealed:<br>-The MA occasionally worked the 3:00pm to 11:00pm (second) shift.<br>-Resident #1 did not go to bed before 11:00pm.<br>-She was instructed by facility administration to take Resident #1 to the SCU during the day for increased supervision.<br>-When Resident #1 was returned to the AL unit, she was instructed to watch for the resident going toward the exit doors and redirect.<br><br>Interview with the Administrator on 04/18/19 at 8:45 am revealed:<br>-Resident #1 started being taken to the SCU on 02/18/18 for safety after the resident wandered from the facility on 02/17/19 out the front door.<br>-The facility did not have a policy or procedure for increasing supervision from routine 2 hour monitoring to constant monitoring that was required due to Resident #1's exit seeking behavior.<br><br>Interview with a PCA on 04/18/19 at 9:00am revealed:<br>-The front door was locked around 7:30pm to prevent outsiders being able to come into the building, but the front door could be opened from inside for someone to go out.<br>-The front doors did not alarm when they were opened at night or during the day.<br>-The other exit doors were alarmed all the time.<br><br>Interview with the Maintenance Director on 04/18/19 at 9:05am revealed:<br>-The facility's exit doors were locked and the exit alarm turned on at all time. | D 270 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SPRING ARBOR OF THOMASVILLE | 915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360 |

| (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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| D 270 | Continued From page 12<br>-The front entrance doors were not part of the facility's exit door alarm system.<br>-The front entrance doors had 24 hour camera monitoring and a receptionist staffing the front desk in the evenings daily for supervision.<br>-If he saw Resident #1 near an exit door, he would redirect the resident.<br>-He knew facility staff routinely checked on residents during the day but not how often.<br><br>Interview with Resident #1's primary care provider nurse practitioner (NP) on 04/18/19 at 9:30am revealed:<br>-She was aware that Resident #1 had wandered outside of the facility without staff with her on 02/17/19.<br>-The NP was concerned about Resident #1's safety and going outside unsupervised.<br>-She thought Resident #1 may not be appropriate for the facility and may need to be in a locked unit to keep her safe due to her wandering.<br>-The facility was providing increased monitoring during the day by relocating Resident #1 to the facility's locked unit during the daytime (9:00am to 8:00pm).<br>-The facility had contacted the resident's responsible party after the incident on 02/17/19 regarding upgrading the resident's care level to locked unit (special care unit) however the responsible party had not agreed to placing the resident in a locked unit full time.<br><br>Interview with a family member of Resident #1 on 04/18/19 at 10:40 am revealed:<br>-She knew Resident #1 had wandered away from the facility on 02/17/19.<br>-The facility staff were not aware Resident #1 was out of the facility for 20 minutes before she was returned to the facility by a person in the community. | D 270 | | |

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| D 270 | Continued From page 13<br>-She was told there was always a staff member on duty at the front desk which was in view of the front entrance to the building.<br>-She was aware Resident #1 got up at night and wandered around in the assisted living because she had been called at night to assist with settling the resident down.<br>-Resident #1 would look for a way out of the building but as far as she knew had only gotten out of the building one time in November 2018. The exit door alarmed and the resident was immediately redirected back into the building by staff.<br>-The facility staff did not discuss increased supervision with the family member except to say they were placing her in the SCU during the day for safety.<br>-Resident #1 did not know where she was and was confused even more by relocating to the SCU each day.<br><br>Interview with a second PCA working on the AL unit on 04/18/19 at 3:00pm revealed:<br>-She occasionally worked 11:00pm to 7:00am.<br>-She did not know of any additional supervision put in place for Resident #1 after she wandered from the building in February 2019.<br>-She checked residents every 2 hours per facility policy, but she did not document checks on any form.<br>-She had chosen on her own to spend extra time with Resident #1 when the resident got up during the night.<br>-She did not know of any resident with increased supervision like one hour or 30 minute checks.<br><br>Interview with Resident #1's POA on 04/18/19 at 2:00pm revealed:<br>-The facility left a message for Resident #1 wandering out of the building on 02/17/19. | D 270 | | |

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| D 270 | Continued From page 14<br>-He had spoken with the Administrator and was informed the resident would have day care in the locked unit of the facility for safety and supervision.<br>-The facility did not offer any additional supervision options.<br>-The facility did not have the front desk staffed from 11:00am to 8:00pm on 02/17/19 per their protocol.<br>-Without proper supervision, the resident walked out the front door without staff assistance or knowledge.<br><br>Interview with the Administrator on 04/18/19 at 4:05pm revealed:<br>-She was aware all exit door alarms were sounded (turned on) at all times.<br>-The front entrance doors were not part of the facility door alarm system.<br>-The front entrance had a receptionist scheduled Monday through Friday from 5:00pm to 8:00pm, and Saturday and Sunday from 11:00am to 8:00pm.<br>-The receptionist was responsible to monitor people coming and going from the facility and offer assistance to visitors.<br>-She was aware Resident #1 wandered out of the facility.<br>-The facility did not have a policy for increasing supervision for residents other than the routine 2 hour checks.<br>-The facility had a "Hot Box" used to identify residents that should have documentation each shift for any side effects of antibiotic therapy for the entire therapy course, shift reporting for 72 hours following a fall or return from hospital or rehabilitation.<br>-The facility did not have adequate staff to provide 30 minute checks, one hour checks, or full-time staff monitoring of a resident. | D 270 | | |

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| D 270 | Continued From page 15<br>-The facility did not document 2 hour resident checks but staff where responsible to make visual contact of residents every 2 hours.<br>-Resident #1's family was informed that the resident would be going to the SCU during the day until the resident was assessed on 02/26/19 and thereafter until the family agreed on a facility for placement after the assessment for needing a locked unit.<br>-The Administrator had discussed options with the corporate administration and the administration agreed that daycare in the SCU was best for keeping the resident safe during the routine waking hours.<br>-On 02/17/19 (Sunday), when Resident #1 eloped, the routinely scheduled receptionist was not available from 11:00am to 8:00pm and there was not a receptionist on duty to monitor the front door.<br>-She reviewed the camera footage and identified 20 minutes from the time Resident #1 went out the front door until the time she was brought back to the facility by a person from the community.<br>-On Monday to Friday, the front offices adjacent to the front entrance/exit had facility staff in view of the door from 8:00am to 5:00pm; a receptionist was routinely scheduled 5:00pm to 8:00pm (the doors were locked at 8:00pm.); staff were supposed to watch the front door or cameras during the unmanned hours.<br>-On weekends, there was receptionist coverage of the front door from 11:00 am to 8:00pm; staff were supposed to watch the front door or cameras during the unmanned hours.<br>-Resident #1 was the only identified wanderer at the facility.<br><br>Based on observations, interviews and record review it was determined Resident #1 was not interviewable. | D 270 | | |

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| D 270 | Continued From page 16<br><br>Interview with a personal care aide (PCA) on the assisted living unit on 04/18/19 at 6:40pm revealed:<br>-Staff were aware the front entrance/exit was not alarmed.<br>-Staff watched the front door when they were in view of the door for Resident #1 being near the door and redirected her from the door.<br>-The only supervision for Resident #1 was the routine 2 hours checks and watching the exit doors for her getting near the doors.<br><br>2. Review of Resident #3's current FL-2 dated 05/15/18 revealed:<br>-Diagnoses included Alzheimer's dementia, diabetes, hypertension, hypothyroidism, osteoporosis, and muscle weakness.<br>-Resident #3 was intermittently disoriented.<br>-Resident #3 was ambulatory.<br>-Resident #3 was continent of bowel and bladder.<br>-Resident #3 required assistance with bathing and dressing.<br><br>Review of Resident #3's Care Plan dated 05/15/18 revealed:<br>-Resident #3 required limited assistance with bathing and grooming, and supervision with dressing, toileting, ambulation, and transfers<br>-Resident #3 had a walker, but did not use it.<br><br>Review of Resident #3's Licensed Health Professional Support (LHPS) review dated 02/25/19 revealed Resident #3 was evaluated for ambulation using assistive devices and transferring semi-ambulatory or non-ambulatory residents.<br><br>Observation of Resident #3 on 04/17/19 between 2:15 pm and 3:00 pm revealed Resident #3 was | D 270 | | |

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| D 270 | Continued From page 17<br>walking around the Special Care Unit (SCU) independently using her walker.<br><br>Observation of Resident #3's room on 04/18/19 at 5:46 pm revealed:<br>-The bed was lowered close to the floor.<br>-The room was free of clutter.<br><br>Review of the facility's "Falls Management and Interventions" program revealed:<br>-A resident is automatically placed on the program upon move in or any readmission from a hospital or rehab stay.<br>-The resident may come off the program 30 days after the move in if he/she as not had a fall within that time period.<br>-A resident who scores at a "higher risk for falls" level upon reassessment is automatically added to the program.<br>-The resident may come off the program if his/her Fall Assessment score has decreased to a lower risk level due toan improvement in health or condition.<br>-A resident has experienced 2 falls within the last 30 days is immediately included in the program.<br>-The resident may come off the program if he/she has not had a fall in 60 days.<br>-Interventions should be developed to help manage the individual's risk of falling.<br>-The Fall Risk Awareness and Interventions form will be completed and placed in the program binder, and also in the front of the personal care services (PCS)/activities of daily living (ADL) log book.<br>-The PCS/ADL log will be update to reflect inclusion in the program.<br>-Residents, family members and staff should be informed of the specific interventions to be in place and education provided as needed to assure compliance. | D 270 | | |

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| D 270 | Continued From page 18 | D 270 | | |

-A logo card will be placed outside the room of a resident who is on the program to serve as a visual reminder of a resident at risk for falls.
-A logo decal should be placed on any assistive devices used by the resident to remind staff the resident is on the program.
-Staff on all three shifts should check on staff proactively and regularly for any unmet need, and see that the resident is safe, has a call-pendent readily available, and that indicated interventions are in place.
-Resident interventions should be reviewed during the Weekly Falls Management Meeting.

Review of Resident #3's Resident Notes revealed the resident had 6 falls between 01/07/19 and 04/12/19.

Review of Resident #3's Resident Notes dated 01/07/19 at 8:18pm revealed:
-Resident #3 fell under the table in the dining room.
-Resident #3 hit her head and said she had pain.
-Resident #3's family member was notified and told staff to give her something for pain rather than sending her to the emergency room.
-Tylenol 500 mg was given to Resident #3 at 8:00 pm.
-Staff obtained vital signs
-Staff documented Resident #3 would be observed and monitored for any discomfort or change of condition.
-There was no documentation of any increased supervision or implementation of interventions to reduce falls.

Review of Accident/Incident Reports for Resident #3 dated 01/07/19 at 7:55 pm revealed:
-Resident #3 was found on the floor in the dining room under the table with a hand full of items.

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-Resident #3 was rubbing her head in pain.
-Staff evaluated Resident #3 for injury, open wounds and bleeding; Staff took Resident #3's vital signs, called her family and put Resident #3 to bed.
-There was no indication Resident #3's Primary Care Provider (PCP) was contacted.

Review of the Weekly Falls Management Meeting Notes dated 01/14/19 revealed:
-Resident #3 fell while ambulating in the dining room.
-There had been only one incident within the last seven days.
-A medication review would be requested.
-There was no documentation of any increased supervision.

Review of a Physician Notification of Fall form dated 01/09/19 revealed:
-The facility notified the PCP Resident #3 fell on 01/07/19 which resulted in an open wound to the head.
-The form indicated Resident #3 had 2 falls within the last 3 months.
-The physician ordered physical therapy (PT) evaluation for fall risk reduction-gait, balance, safety with transfers, strengthening, and pain management.

Review of Home Health notes dated 01/14/19 revealed:
-Physical therapy start of care was completed on 01/14/19.
-PT was implemented for one week only due to falls related to Resident #3 carrying items.
-Facility staff were educated on fall prevention and home safety.
-Resident #3 was assessed for occupational therapy (OT) on 01/15/19.

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| D 270 | Continued From page 20<br><br>Attempted interview with the facility contracted Home Health provider on 04/16/19 at 4:48 pm was unsuccessful.<br><br>Review of Resident #3's Resident Notes dated 02/13/19 at 9:30pm revealed:<br>-Staff heard Resident #3 yell out for help.<br>-Staff went to Resident #3's room and observed her on the floor.<br>-Resident #3 claimed to have hit her head and had knee and back pain<br>-Resident #3's vital signs were taken and she was sent to out to the hospital.<br>-Resident #3's family and the Resident Care Director (RCD) were notified.<br>-There was no documentation of any increased supervision or implementation of interventions to reduce falls.<br><br>Review of Accident/Incident Reports for Resident #3 dated 02/13/19 at 8:35pm revealed:<br>-Resident #3 was on the floor in her room and staff heard her yelling for help.<br>-Staff checked for skin tears, range of motion, and took Resident #3's vital signs.<br>-Emergency Medical Services (EMS) was called and Resident #3 was sent to the hospital.<br>-No injuries were noted.<br>-Resident #3's family and PCP were notified.<br><br>Attempted telephone interview on 04/18/19 at 3:43pm with the SCU Supervisor who documented the Resident Note dated 02/13/19 at 9:30pm was unsuccessful.<br><br>Review of the Weekly Falls Management Meeting Notes dated 02/18/19 revealed:<br>-Resident #3 fell while ambulating without device on 01/07/19 and OT was in place. | D 270 | | |

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| D 270 | Continued From page 21<br>-Resident #3 fell on the floor of her room.<br>-Resident #3 was to be added to the Falls Management and Interventions program.<br>-There was no documentation regarding Resident #3's fall on 02/13/19.<br><br>Review of Resident #3's Resident Notes dated 02/21/19 at 10:35pm revealed:<br>-Resident #3 returned from the hospital.<br>-The Emergency Room (ER) nurse reported Resident #3 had a hematoma on her upper right forehead.<br>-An x-ray was completed and family was notified.<br>-There was no documentation of any increased supervision or implementation of interventions to reduce falls.<br><br>Review of Accident/Incident Reports for Resident #3 dated 02/21/19 at 6:20pm revealed:<br>-Staff heard Resident #3 cry out.<br>-Staff checked Resident #3 for injuries and took her vital signs.<br>-Emergency Medical Services (EMS) was called and Resident #3 was sent to the hospital.<br>-No injuries were noted on the report.<br>-Resident #3's family was notified, but there was no indication Resident #3's PCP was contacted.<br><br>Attempted telephone interview on 04/18/19 at 3:43pm with the Supervisor who documented the Resident Note dated 02/21/19 at 10:35pm was unsuccessful.<br><br>Review of the Weekly Falls Management Meeting Notes dated 03/04/19 revealed:<br>-Resident #3 had a fall on 02/13/19 and 02/21/19.<br>-There was a note indicating there were constant reminders for Resident #3 to use her walker.<br>-There was no documentation of any increased supervision. | D 270 | | |

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| D 270 | Continued From page 22<br><br>Review of Resident #3's Resident Notes dated 03/14/19 at 2:45pm revealed:<br>-Resident #3 was observed on the floor in the hallway.<br>-Resident #3 verbalized she was okay and had no pain or discomfort.<br>-Resident #3 had no bruises or skin tears.<br>-Staff obtained vital signs and would continue to observe.<br>-There was no documentation of any increased supervision or implementation of interventions to reduce falls.<br><br>Review of Accident/Incident Reports for Resident #3 revealed there was no report dated 03/14/19.<br><br>Interview with a SCU Supervisor on 04/18/19 at 6:38pm revealed:<br>-She had not been given specific instructions to increase supervision for Resident #1 or to implement any interventions to reduce falls.<br>-She knew the facility had a falls policy.<br><br>Attempted telephone interview on 04/18/19 at 3:43pm with the Supervisor who documented the Resident Note dated 03/16/19 at 3:40am was unsuccessful.<br><br>Review of Resident #3's Resident Notes dated 03/18/19 at 4:30pm revealed:<br>-Resident #3 was found on the hallway floor on her back with her walker next to her.<br>-Another resident told staff Resident #3 was trying to get out and fell.<br>-Resident stated her knees hurt from trying to get up.<br>-Staff took Resident #3's vital signs.<br>-There was no documentation of any increased supervision or implementation of interventions to | D 270 | | |

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| D 270 | Continued From page 23<br>reduce falls.<br><br>Review of Accident/Incident Reports for Resident #3 dated 03/18/19 revealed:<br>-Resident #3 was walking around the hallway with her walker and a few minutes later another resident told staff someone was in the floor.<br>-Staff found Resident #3 in the hallway on the floor on her back with her walker beside her.<br>-Staff assessed Resident #3 for injuries and took her vital signs.<br>-No injuries were found.<br>-Resident #3 indicated to staff her knees were hurting from trying to get up<br>-Resident #3's family and PCP were notified.<br><br>Attempted telephone interview on 04/18/19 at 3:42pm with the SCU Supervisor who documented the Resident Note dated 03/18/19 at 4:30pm was unsuccessful.<br><br>Review of the Weekly Falls Management Meeting Notes dated 03/18/19 revealed Resident #3 had no issues.<br><br>Review of the Weekly Falls Management Meeting Notes dated 03/25/19 revealed:<br>-Resident #3 had a fall on 03/18/19 while ambulating in the hallway.<br>-A medication review would be requested.<br>-There was no documentation of any increased supervision.<br><br>Review of the Weekly Falls Management Meeting Notes dated 04/01/19 revealed Resident #3 had no issues.<br><br>Review of Resident #3's Resident Notes dated 04/05/19 at 6:30pm revealed:<br>-Resident #3 was walking up the hall, went to turn | D 270 | | |

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the corner, lost her balance, fell, and hit her head on the floor.
-Resident #3 had a "good bump" on the back of her head and complained of pain in her back.
-EMS was called and Resident #3 was taken to the hospital.
-There was no documentation of any increased supervision or implementation of interventions to reduce falls.

Review of Accident/Incident Reports for Resident #3 dated 04/05/19 at 4:40pm revealed:
-Resident #3 rounded the corner in the hallway, lost her balance and fell on her back.
-Staff witnessed the fall.
-Staff took Resident #3's vital signs and assessed for injuries.
-Resident #3 had a "decent sized knot" on the back of her head and complained of back pain.
-EMS was called and Resident #3 was transported to the hospital.
-Resident #3's family and PCP were notified.

Attempted telephone interview on 04/18/19 at 3:42pm with the SCU Supervisor who documented the Resident Note dated 04/05/19 at 6:30pm was unsuccessful.

Review of the Emergency Department (ED) after visit summary dated 04/05/19 for Resident #3 revealed:
-The documented reason for the ED visit was fall.
-Resident #3's diagnoses included fall on same level from slipping, tripping, or stumbling, and contusion of scalp.

Review of Resident #3's Resident Notes dated 04/12/19 with no specific time indicated revealed:
-Resident #3 was in the dining room and attempted to sit on the dining room chair by sitting

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on the edge of the chair.
-The chair slid backwards and Resident #3 slid down into the floor.
-The fall was witnessed by staff.
-Staff assessed Resident #3 for injuries and no injuries were found; took her vital signs.
-Staff would continue to observe.
-There was no documentation of any increased supervision or implementation of interventions to reduce falls.

Review of Accident/Incident Reports for Resident #3 dated 04/12/19 at 4:40pm revealed:
-Resident #3 was in the dining room, sat down on the edge of a dining chair, and slid down into the floor.
-Staff witnessed the fall.
-Staff got Resident #3 up and sat her in a dining room chair where staff could keep an eye on her.
-Staff checked Resident #3's vital signs and assessed for injuries.
-No injuries were noted on the report.
-Resident #3's family and PCP were notified.

Attempted telephone interview on 04/18/19 at 3:42pm with the SCU Supervisor who documented the Resident Note dated 04/05/19 at 6:30pm was unsuccessful.

Review of a Fall Risk Awareness and Interventions form with an open date of 02/18/19 revealed:
-On 02/18/19 interventions for Resident #3 included: having ambulatory assistance equipment nearby, reviewing equipment to assure proper working conditions, and evaluating Resident #3's room for necessary furniture.
-On 03/04/19 interventions for Resident #3 included: increase supervision with mobility (There was no specific information regarding

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| D 270 | Continued From page 26<br>increasing supervision).<br>-On 04/15/19 interventions for Resident #3 included: review medications and home health PT/OT evaluation.<br>-There was no documentation of interventions put in place<br><br>Review of a Fall Risk Awareness and Interventions form with an open date of 03/04/19 revealed on 03/04/19 interventions for Resident #3 included: reminders for walker use, medication review, and increase supervision with mobility.<br><br>There were no other Fall Risk Awareness and Interventions forms provided by the Administrator.<br><br>Attempted telephone interview with Resident #3's responsible party on 04/18/19 at 2:40pm was unsuccessful.<br><br>Attempted telephone interviews with two SCU Supervisors who documented falls for Resident #3 on 04/18/19 at 3:42pm and 3:43pm were unsuccessful.<br><br>Interview with the Administrator on 04/18/19 at 4:05pm revealed:<br>-When a resident had a fall, they were placed in the "hot box" for 72 hours after the fall.<br>-During the 72 hours, staff provided documentation on each shift regarding the resident who had the fall.<br>-Every resident had a pendant to call for help and pull alarms in their rooms which were connected to staff pagers.<br>-Interventions for residents with falls were discussed in weekly fall management meetings.<br>-There was not a plan in place to increase supervision or safety checks for residents after a fall. | D 270 | | |

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| D 270 | Continued From page 27<br>-Staff should be checking on residents every two hours.<br><br>A second interview with the Administrator on 04/18/19 at 6:20pm revealed:<br>-There was a fall risk management meeting on each Monday and the facility contracted physician reviewed the meeting notes when she came to the facility on Thursdays.<br>-Residents were on the Falls Management and Interventions program for 60 days after two falls within a month.<br>-If the resident could go 60 days without a fall, then he or she would come off of the program.<br>-All new admissions were automatically on the program for 30 days and would come off the program if there were no falls within the 30 days.<br>-The Fall Risk Awareness and Interventions forms was completed by the Administrator or the Resident Care Director (RCD) after a fall.<br>-"Increased supervision with mobility" noted on the Fall Risk Awareness and Interventions form for Resident #3 should have been more specific.<br>-"Increased supervision with mobility" meant being more aware and assisting Resident #3 with walking if needed.<br>-Home Health physical therapy PT/OT evaluation was added to the Fall Risk Awareness and Interventions form on 04/15/19, but Resident #3 had not been evaluated for PT/OT as of yet.<br><br>Interview with a SCU Supervisor on 04/18/19 at 6:38pm revealed:<br>-When a resident fell, she documented the fall in the resident's record and she completed an Incident/Accident report and gave it to the Resident Care Director (RCD).<br>-She would also notify the resident's family and physician.<br>-After a fall, residents were placed in the "hot | D 270 | | |

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box" where staff would document any signs or symptoms of pain or discomfort every day for three to four days.
-There was no increased supervision for residents after a fall.
-She had never been instructed to increase safety checks for residents after a fall or given specific instructions to increase supervision for residents after a fall..
-She checked on all residents every two hours, but tried to check on them more often after a fall.
-Resident #3 had a fall about once a month.
-The only intervention she knew to be in place for Resident #3 was to make sure her walker was in place for her.

Interview with another SCU Supervisor on 04/18/19 at 6:56pm revealed:
-If a resident fell, she filled out an incident report, called the family, and called EMS if needed.
-The incident report would be given to the RCD.

Interview with the RCD on 04/18/19 at 7:13pm revealed:
-He expected for staff to make him aware when there were resident falls.
-There was a falls management and intervention program in place to help prevent falls.
-The program met once a week to discuss resident falls and interventions.
-He did not know yet about current plans to increase supervision of residents after each fall.

Interview with Resident #3's PCP on 04/18/19 at 9:56am revealed:
-She had been notified by the facility of all falls and notified Resident #3 was sent to the local emergency department (ED) due to falls.
-She had ordered a physical therapy evaluation, but Resident #3 did not qualify because of

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| D 270 | Continued From page 29<br>dementia.<br>-She was a fall risk due to carrying her purse and forgetting to use her walker.<br>-She did not know of any increased supervision for Resident #3 provided by the facility, but she knew "they watched her pretty closely."<br>_____<br>The facility failed to provide increased supervisionfor a resident with a diagnosis of dementia (#1) who eloped from the facility without staff's knowledge and a resident with a diagnosis of dementia (#3) who experienced repeated falls resulting in a head injury placing the resident at increased risk for physical injury from falls. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G. S. 131D-34 on 04/18/19 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 2, 2019. | D 270 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(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 notify the primary care provider for 1 of 5 sampled residents (Residents #2) regarding consecutive missed doses of a long term use benzodiazepine.

The findings are:

Review of Resident #2's current FL2 dated 04/15/19 revealed:
-Diagnoses included chronic obstructive pulmonary disease, Alzheimer's dementia with behavioral disturbance, anxiety, and essential hypertension.
-There was a physician's order for alprazolam (Xanax) 0.5 mg twice daily (used to treat anxiety).

-Review of a subsequent physician's order dated 04/15/19 revealed an order for alprazolam 0.25 mg twice daily.

Review of Resident #2's record revealed:
-There was a previous physician's order dated 02/14/19 to discontinue alprazolam 0.25 mg in the evening as needed and start alprazolam 0.5 mg twice daily and hold if resident was too sedated.
-There was a physician's order dated 03/12/19 for alprazolam 0.25 mg twice daily.

Review of a hospital discharge summary dated 03/12/19 revealed:
-Resident #2 was admitted to the hospital on 03/11/19 and discharged on 03/12/19.
-Resident #2's admitting diagnosis was a fall with a seizure.
-Resident #2 had a laceration to her left forehead.
-The seizure was most likely due to

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benzodiazepine withdrawal as Resident #2 did not have access to her Xanax (alprazolam) which she had taken twice daily for many years.

Review of Resident #2's electronic Medication Administration Record (eMAR) for March 2019 revealed:
-There was an entry for alprazolam 0.5 mg twice daily at 8:00am and 8:00pm; Hold if too sedated. This order was discontinued on 03/12/19.
-There was an entry for alprazolam 0.25 mg twice daily at 8:00am and 8:00pm. This entry was discontinued on the eMAR on 03/16/19.
-There was an entry for alprazolam 0.25 mg twice daily at 8:00am and 8:00pm.
-There was no documentation alprazolam 0.5 mg was administered on 03/08/19 at 8:00pm, 03/9/19 at 8:00am and 8:00pm, 03/10/19 at 8:00am and 8:00pm, and 03/11/19 at 8:00 am.
-It was documented alprazolam 0.5 mg was not administered on 03/08/19 through 03/11/19 because "Resident refused medication," "have not received medication from the pharmacy," "Resident unable to take medication," "not in stock,', and "not on cart."
-It was documented alprazolam 0.5 mg was not administered to Resident #3 on 03/11/19 at 8:00 pm and on 03/12/19 at 8:00am because she was in the hospital.
-There was no documentation alprazolam 0.25 mg was administered on 03/23/19 at 8:00am due to "resident was too sedated."

Review of Resident #2's eMAR for April 2019 revealed:
-There was an entry for alprazolam 0.25 mg twice daily at 8:00am and 8:00pm.
-It was documented alprazolam 0.25 mg was not administered Resident #3 on 04/08/19 at 8:00am, 04/09/19 through 04/14/19 at 8:00am and

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| D 273 | Continued From page 32<br>8:00pm, and 04/15/19 at 8:00am because she was in the hospital.<br><br>Review of Resident #2's Resident Notes revealed there were no notes indicating Resident #2 was not administered alprazolam or her Primary Care Physician (PCP) was notified of the 8 missed doses.<br><br>Observation of Resident #2's medications on hand on 04/16/19 at 9:02 am revealed:<br>-There was a morning bingo card of alprazolam 0.25 mg twice daily with a dispense date of 03/25/19 and 13 of 28 tablets were remaining.<br>-There was an evening bingo card of alprazolam 0.25 mg twice daily with a dispense date of 03/25/19 and 14 of 28 tablets were remaining.<br>-There was a morning bingo card of alprazolam 0.25 mg twice daily with a dispense date of 04/22/19 (This date was transcribed incorrectly on the bingo card by the pharmacy.) and 28 of 28 tablets were remaining.<br>-There was an evening bingo card of alprazolam 0.25 mg twice daily with a dispense date of 04/22/19 (This date was transcribed incorrectly on the bingo card by the pharmacy.) and 28 of 28 tablets were remaining.<br><br>Based on observation and interviews, it was determined Resident #2 was not interviewable.<br><br>Interview with a Special Care Unit (SCU) Supervisor on 04/16/19 at 12:41pm revealed:<br>-Resident #2 was just discharged from the hospital on 04/15/19.<br>-Resident #2 was hospitalized due to having a seizure.<br>-Resident #2 saw her PCP and received physician's orders and her medication through an outside care provider. | D 273 | | |

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| D 273 | Continued From page 33<br><br>Interview with another SCU supervisor on 04/17/19 at 9:18pm and on 04/18/19 at 5:42pm revealed:<br>-Resident #2 received her medication from a pharmacy through her care provider center.<br>-Resident #2's PCP sent a medication list to the facility for staff to follow and the facility staff sent the medication list to the facility contracted pharmacy so medication could be updated on the eMAR.<br>-Resident #2's medication was delivered from her care provider's center.<br>-If Resident #2 needed a refill of her medications, she would call the care provider's center and they would have her medication refilled.<br>-Medication should have been reordered within a week of it running out.<br>-She did not know about Resident #2 missing six consecutive doses of alprazolam.<br>-She would have contacted Resident #2's PCP after one missed dose, but Resident #2 should not have missed any doses of her medication.<br>-She did not know if Resident #2's PCP had been contacted regarding the missed doses of alprazolam.<br>-Contacts with Resident #2's PCP should be documented in the resident notes in their records.<br><br>Interview with a representative from Resident #2's care provider center's contracted pharmacy on 04/17/19 at 1:07pm revealed:<br>-The pharmacy received orders for medication to be filled from Resident #2's care provider's center.<br>-The pharmacy filled medications for Resident #2 and sent them to Resident #2's care provider center who then sent the medication to the facility for Resident #2.<br>-A 10 day supply (20 tablets) of alprazolam 0.5 | D 273 | | |

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mg twice daily was dispensed on 02/15/19.
-A 10 day supply (20 tablets) of alprazolam 0.5 mg twice daily was dispensed on 02/26/19. (This would have ran out on 03/08/19 which coincides with Resident #2 not being administered alprazolam from 03/08/19 at 8:00pm through 03/11/19 at 8:00am.)
-A 14 day supply (28 tablets) of alprazolam 0.5 mg twice daily was dispensed on 03/11/19 and 28 tablets were returned to the pharmacy.
-A 13 day supply (26 tablets) of alprazolam 0.25 mg twice daily was dispensed on 03/12/19.
-Alprazolam 0.25 mg was scheduled for cycle fill beginning on 03/25/19 and had not been cycle filled previously.

Interview with a pharmacy nurse from Resident #2's care provider's center on 04/18/19 at 1:52pm revealed:
-A contracted pharmacy filled prescriptions for Resident #2 and the medication was delivered to the care provider's center typically on the next day.
-Once medication was received by the care provider's center, it was delivered to the facility on the same day.
-The facility should have contact the care provider's center when a refill was needed and the care provider's center would have contacted the pharmacy for refills.
-No one from the facility contacted the care provider's center to make them aware they were out of alprazolam for Resident #2 and needed a refill.

Attempted contact with Resident #2's responsible party on 04/18/19 at 2:39pm was unsuccessful.

Attempted telephone interviews on 04/17/19 at 3:42pm and 3:45pm with two Supervisors who

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documented not administering alprazolam to Resident #2 were unsuccessful.

Interview with the Administrator on 04/18/19 at 4:05pm revealed:
-The Resident Care Director (RCD) was responsible for reviewing new medication orders for Resident #2 and the RCD or a SCU supervisor were responsible for faxing medications orders to the pharmacy to be added to the eMAR for Resident #2.
-The SCU Supervisors should be requesting a refill of medication two weeks prior to medication running out.
-She did not know, until Resident #2 returned from the hospital, about Resident #2 missing 6 consecutive doses of alprazolam and the missed doses of medication being contributed to her hospitalization.
-She expected the Supervisors to notify the RCD regarding missed doses of medication and the RCD should have notified the physician after the second missed dose.

Interview with the RCD on 04/18/19 at 7:13pm revealed:
-He expected to be made aware of any missed medication administration.
-He did not know about Resident #2 not being administered 8 consecutive doses alprazolam.
-Best practice would be to request a refill of medication at least 5 days prior to running out and to contact the physician when one dose of medication was missed.

Interview with a nurse from Resident #2's PCP's office on 04/17/19 at 10:21am revealed:
-Resident #2 attended a day program 5 days a week at the care provider center.
-The center provided medication administration,

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| D 273 | Continued From page 36<br>activities of daily living care, podiatry services, and dental services.<br>-Resident #2 was seen in the clinic as needed and for her annual assessment.<br>-Resident #2's medication were provided through the care provider center.<br>-Resident #2 had physician's orders for Xanax (alprazolam) due to anxiety, crying episodes, and behaviors that had to be redirected.<br>-The PCP was not made aware Resident #2 had missed 6 doses of alprazolam due to not having the medication from the pharmacy.<br>-Facility staff contacted the care provider center on 03/11/19 when Resident #2 was being transported by Emergency Medical Services (EMS) to the hospital with seizure like activity.<br>-The provider care center was notified on 03/11/19 by fax Resident #2 had not had her alprazolam since the previous Friday, 3/8/19.<br>-The facility staff was supposed to give a 2 day business notice to request any medication they needed for Resident #2.<br>-The facility staff should have let the PCP know Resident #2 missed her alprazolam and why she missed the alprazolam.<br>-Missing doses of alprazolam could have resulted in increased behaviors, crying episodes, agitation, increased blood pressure, increased pulse and a lot of distress.<br>-Per hospital records, it was determined Resident #2's seizure was probably due to a withdrawal from alprazolam.<br>-Alprazolam and all other medication were expected to be administered as ordered by the physician. | D 273 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights | D 338 | | |

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| D 338 | Continued From page 37<br>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.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to assure dignity, respect and consideration for one resident (#1) by taking the resident to the secured unit (special care unit) daily for daycare after the resident eloped from the facility.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 01/31/19 revealed diagnoses included senile dementia.<br><br>Review of Resident #1's Care Plan dated 03/19/19 revealed:<br>-Resident #1 was assessed for needing supervision with eating, toileting, ambulation/locomotion, and transferring.<br>-Resident #1 needed limited assistance with bathing, dressing, and grooming/personal hygiene.<br>-There was documentation "resident has had | D 338 | | |

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some wandering behaviors, safety protocols and in the process of considering memory care."

Observations during the initial tour of the Special Care Unit (SCU) on 04/16/19 from 9:15am until 9:45am revealed at 9:30am, Resident #1 was observed in the SCU sitting at a dining table looking at her picture book.

Interview with the morning shift SCU supervisor on 04/16/19 at 9:36am revealed:
-Resident #1 was not on the census for the SCU.
-Resident #1 was normally on the assisted living (AL) side of the facility.
-The AL staff had been bringing her to the SCU because she wandered from the facility on 02/17/19.
-She had been coming to the SCU for a couple of months.
-She came after breakfast and stayed until about 9:00pm.
-She slept in her room on the AL side at night.

Observation of Resident #1's interaction with SCU staff on 04/16/19 at 12:56pm revealed:
-Resident #1 stated she was supposed to go to her room.
-Resident #1 was told "they are going to have to come get you".
-Resident #1 asked "Can I to go to my sleeping room".
-The resident was told , "We will have to let somebody know so they can come and get you".

Observations of the SCU and Resident #1 on 04/17/19 from 8:00am until 5:20pm revealed:
-At 8:00am, Resident #1 was not in the SCU.
-At 2:22pm, Resident #1 was not in the SCU.
-At 3:03pm, Resident #1 was sleeping in her bed on the AL side.

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-At 4:15pm, Resident #1 was sitting on the porch of the SCU with the Activity Director.
-At 5:15pm, Resident #1 was eating her dinner in the SCU.

Interview with a family member of Resident #1 on 04/18/19 at 10:40 am revealed:
-She was told all the facility exit doors were alarmed to protect against residents wandering out of the building without staff being aware except the front entrance doors.
-She was told by the facility that there was staff at the front desk beside the entrance doors 24 hours a day to guard against residents walking out the front door.
-She knew Resident #1 had wandered away from the facility on 02/17/19.
-On 02/18/19, the facility began moving Resident #1 to the SCU for daycare and increased security to guard against the resident wandering outside the facility unsupervised.
-The facility did not discuss increased supervision with the family member except to say they placed her in the SCU during the day for safety.
-The family member came to the facility several mornings each week on her way home from her 3rd shift job.
-Resident #1 was usually in her room or in the dining room for breakfast when she arrived.
-Her understanding was, Resident #1 was escorted to the SCU after breakfast and returned late in the day, after supper.
-The family member did not agree with Resident #1 be sent to the SCU during the day, every day, because Resident #1 did not know where she was most of the time, and was confused even more by relocating to the SCU each day.
-Resident #1 had not been on an outing since 02/17/19.
-Resident #1 did not have access to her personal

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items during the time she was in the SCU.
-The family member was concerned for Resident #1 not having a bed or place to lay down and rest in the SCU.
-Resident #1 used to enjoy participating in activities in the AL like bingo and dancing or exercising; the family member was concerned that Resident #1 did not have a chance to do the same activities as other AL residents.
-Resident #1 was social and the family member was concerned the resident would not have the opportunity to interact with residents in the SCU.

Telephone interview with Resident #1's Power of Attorney (POA) on 04/18/19 at 2:00pm revealed:
-He was informed Resident #1 wandered from the building on 02/17/19 by a telephone message left for him on 02/17/19.
-He was informed on 02/18/19 by the Administrator on a telephone message that Resident #1 would be going to the SCU during the day for daycare for her safety.
-He contacted the Administrator on 02/18/19 to express concerns regarding Resident #1's being placed in the SCU for daycare and supervision.
-He was concerned that Resident #1 did not have a bed to lay down if she got tired like she had in her assigned room on the AL unit.
-He was concerned that Resident #1 did not have a private bathroom/toilet like she had in her assigned room on the AL unit. Resident #1 was continent for bowel but on rare occasion had bladder accidents. She toileted herself or told staff when she needed to go to the bathroom.
-He was concerned Resident #1 would not have access to the same activities as she did on the AL unit.
-He was told by the Administrator that the long-term plane for Resident #1 was that Resident #1 needed to be in a locked (secured)

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unit, like SCU, for her safety and supervision.
-The facility did not have a bed available for a female resident at the present time, however, Resident #1 could spend daytime hours in the SCU for increased supervision.

Interview with the Assistant Resident Care Coordinator (ARCC) on 04/18/19 at 2:40pm revealed:
-She worked primarily from the SCU.
-Resident #1 was brought to the SCU daily by AL staff around 9:00am and was still in the SCU when she left at 7:00pm.
-Resident #1 had been coming to the SCU for daycare for 2 months since she wandered out of the building on the AL unit.
-The personal care aide (PCA) staff in the SCU did not have access to Resident #1's "Resident Care Plan and Personal Care Services Sheet" used by PCAs to identify care and services assigned to staff for Resident #1 because the sheet was kept in the AL unit.
-Resident #1 informed staff when she needed to go to the bathroom, and used the staff restroom for toileting.
-Resident #1 had extra incontinent briefs in a pouch affixed to her rolling walker but routinely did not soil the brief.
-Resident #1 ate lunch and supper in the SCU unless she was with a family member outside the SCU.
-Resident #1 did not have a bed or room assigned in the SCU.
-Resident #1 napped in a recliner in the SCU if she got tired.
-Resident #1's scheduled 12:00 pm and 2:00pm medications were brought from AL unit within the scheduled grace periods daily.

Observation of Resident #1 during the ARCC

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interview on 04/18/19 at 2:40pm revealed:
-Resident #1 approached the ARCC office with her rolling walker.
-Resident #1 was agitated and looking for the exit door to the basement because she needed to check on a family member that was hurt.
-Resident #1 was redirected by the ARCC.
-Resident #1 approached the ARCC office again in 5 minutes and was taken by the ARCC to the gated patio area.

Interview with a family member of a resident in the SCU on 04/18/19 at 2:50 pm revealed:
-She visited her family member several times a week.
-She had observed Resident #1 in the SCU during her daytime visits for a few weeks now.
-Resident #1 was usually fine, talking to her (family member) and other residents. Today was the first day she had seen Resident #1 agitated and arguing with staff wanting to find a relative in the basement.

Based on observations, interviews and record review it was determined Resident #1 was not interviewable.

Interview with the Administrator on 04/18/19 at 4:50pm revealed:
-Resident #1 was taken to the SCU daily by AL staff in the mornings, for her safety.
-The facility did not have a different system to use to assure she did not wander from the AL unit.
-Staff from the AL went over to the SCU and brought Resident #1 back to the AL when informed by the SCU staff regarding Resident #1 desire to return to the AL.
-She did not know of a time when staff did not take Resident #1 back to the AL when she asked.
-She did not know about the resident request to

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go back to her bed on the AL unit on 04/16/19 and staff not honoring her request.
-Resident #1 participated in some activities in the AL unit when the AL staff brought her back to the AL (No specific dates provided).

Interview with an evening shift PCA in the SCU on 04/18/19 at 6:10pm revealed:
-The PCA worked part-time usually the 3:00pm to 11:00pm shift.
-Resident #1 used the bathroom (staff bathroom) herself; she would tell the PCA when she needed to go to the bathroom and ask for assistance finding her bathroom.
-Resident #1 watched television and talked with the other residents that would respond.
-Resident #1 had never asked the PCA where her bed was so she could lay down.
-Resident #1 occasionally would sit in a green recliner in the television area and nap.
-The AL staff (PCA) come to get her around 9:00pm each night.

Interview with an evening shift PCA for the AL unit on 04/18/19 at 6:40 pm revealed:
-The PCA worked some day and some evening shifts according to the facility's needs.
-Resident #1 liked to sleep late in the mornings because she went to bed late at night.
-Resident #1 was currently spending days in the SCU due to an incident a couple of months ago.
-She was routinely served breakfast and taken over to the SCU by a PCA around 9:30am.
-PCA staff from the AL brought Resident #1 back to the AL unit around 9:00pm to 10:00pm.
-Resident #1 toileted herself and her brief was routinely dry with 2 hour checks.
-The PCA said Resident #1 participated in AL activities 2 to 3 times a week, and had been observed by her dancing around during the

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| D 338 | Continued From page 44<br>activities.<br>-Staff was asked to be alert of Resident #1's location when she was back on the AL unit.<br>_____<br>The facility failed to assure dignity, respect and consideration for one resident (#1) by taking the resident to the SCU daily for daycare not allowing her free access to her own bathroom, bedroom, and personal possessions. This failure to assure dignity, respect and consideration was detrimental to the health, and welfare of the residents and constitutes a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G. S. 131D-34 on 04/18/19 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 2, 2019. | D 338 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures. | D 358 | | |

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policies for 2 of 4 residents (#6, and #7) observed during the medication pass including errors with a medication for circulation (#6), and an allergy medication (#7); and for 1 of 5 sampled residents (#2) related to an anti-anxiety medication not administered for 4 days resulting in a hospital visit for abrupt withdrawal symptoms for the resident.

The findings are:

1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the 8:00am medication pass on 04/17/19.

a. Review of Resident #6's current FL2 dated 04/10/19 revealed diagnoses included advanced dementia, hypertension, and history of lower extremity deep vein thrombosis (DVT).

Review of Resident #6's physician's order dated 02/21/19 revealed and order for aspirin 81 mg EC (enteric coated) one tablet daily. (Aspirin 81 mg is used to thin the blood. Enteric coated medications are designed to dissolve outside of the stomach to minimize stomach distress and should not be crushed.)

Review of Resident 6's current FL2 dated

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| D 358 | Continued From page 46<br>04/10/19 revealed aspirin 81 mg one tablet daily was ordered.<br><br>Observation of medication administration for Resident #6 on 04/17/19 at 7:28am revealed:<br>-The morning medication aide (MA) prepared 6 oral medications, including one aspirin 81 mg EC tablet.<br>-The MA emptied the medications from the paper soufflé cup used to prepare the medications into a plastic pouch and crushed the medications thoroughly using a mechanic desktop tablet crusher.<br>-The MA added one teaspoonful of vanilla pudding, mixed the ground tablets in the pudding, and administered the medications.<br><br>Observation on 04/17/19 at 12:00pm revealed there was a Do Not Crush list of medications for staff guidance posted on the bulletin board in the medication room with enteric coated aspirin listed.<br><br>Review of Resident #6's record revealed standing physicians orders dated 10/16/18 with an order to crush medications that were appropriate and place in applesauce, pudding, yogurt, or juice.<br><br>Review of Resident #6's April 2019 electronic medication administration record (eMAR) revealed:<br>-There was an entry for aspirin EC 81 mg one tablet daily scheduled for administration at 8:00 am.<br>-Aspirin EC 81 mg listed on the eMAR was not labeled "Do Not Crush" on the eMAR.<br>-Aspirin EC 81 mg was documented as administered on 04/17/19 at 8:00am.<br><br>Telephone interview with a representative for the | D 358 | | |

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contracted pharmacy on 04/17/19 at 11:18am revealed:
-The pharmacy routinely documented "Do Not Crush" on the eMAR for medications that should not be crushed.
-She was not sure why aspirin EC 81 mg for Resident #6 was listed on the eMAR without a "Do Not Crush" warning on the eMAR.
-The pharmacy routinely affixed an auxiliary label for "Do Not Crush" on the medication package for medications that should not be crushed.
-The MA would be expected to read the warning label for not crushing aspirin EC 81 mg on either the eMAR or the dispensed package.
-The pharmacy did not have information regarding Resident #6 was receiving medications by crushing.

Interview with the first shift medication aide (MA) for the Special Care Unit (SCU) on 04/17/19 at 7:42am revealed:
-She was the lead MA for the SCU.
-She had been working at the facility for more than 3 years.
-She currently was the Assistant Resident Care Coordinator.
-Resident #6 received her medication crushed and mixed in vanilla pudding because she did not do well trying to swallow the medications whole.
-Resident #6 did not like to take medications even when the medications were crushed.
-She knew enteric coated medications should not be crushed but overlooked that Resident #6's aspirin 81 mg was enteric coated.

Observation of Resident #6's medications on hand for administration on 04/16/19 at 7:35am revealed:
-There were nineteen aspirin EC 81 mg tablets remaining in a bubble pack of thirty tablets

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dispensed from the contracted pharmacy on 04/03/19.
-There was a yellow and black auxiliary label affixed to the upper left corner of the bubble pack that read "Do Not Crush".

Second interview with the first shift MA for the SCU on 04/17/19 at 11:30am revealed:
-She administered Resident #6's medication during the 8:00 am medication pass on 04/17/19.
-She did not realize aspirin EC 81 mg tablets should not be crushed.
-She overlooked the auxiliary label for "Do Not Crush" affixed to Resident #6's aspirin EC 81 mg.
-There was a list of medications that should not be crushed posted in the medication room on a bulletin board.
-She had not checked the list of medications that should not be crushed.

Based on observations, interviews, and record review it was determined Resident #6 was not interviewable.

Interview with the Resident Care Director (RCD) on 04/17/19 at 12:00pm revealed:
-He had not audited resident's records or eMARs for accuracy including if residents with orders to crush medications had only medications that could be crushed available on the medication cart.
-He would make sure Resident #6's physician was contacted for changing aspirin to a form that could be crushed.

Interview with the Administrator on 04/17/19 at 12:15pm revealed:
-Resident #6's aspirin EC should not have been crushed.
-There should be a warning for "Do Not Crush" on

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the medication package and routinely the information appeared on the eMAR as well.
-The MAs should be looking at the eMAR and/or the packing for all medications prior to crushing the medications.

b. Review of Resident #7's current FL2 dated 04/11/19 revealed diagnoses included dementia, history of psychosis, and degenerative joint disease.

Review of Resident #7's record revealed a physician's order dated 04/11/19 for Zyrtec 10 mg (used to treat seasonal allergy) one daily for allergic rhinitis.

Observation of medication administration for Resident #7 on 04/17/19 at 7:40am revealed:
-The morning medication aide (MA) prepared 5 oral medications in a paper soufflé cup.
-The MA administered the medications in the resident's room while the resident was sitting up in bed.
-Zyrtec was not one of the medications administered.

Review of Resident #7's April 2019 electronic medication administration record (eMAR) revealed:
-There were entries for five morning medications scheduled for administration at 8:00 am.
-There was no entry for Zyrtec 10 mg one daily listed for scheduled administration.
-There was no documentation Zyrtec 10 mg was administered from 04/11/19 to 04/17/19.

Telephone interview with a representative for the contracted pharmacy on 04/17/19 at 11:10am revealed:
-The pharmacy had no documentation for a

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physician's order for Resident #7's dated 04/11/19 for Zyrtec 10 mg daily.
-The pharmacy routinely scheduled medications ordered once daily at 8:00 am unless the order stated another time for administration.
-The pharmacy had not dispensed Zyrtec 10 mg tablets for Resident #7.

Observation of Resident #7's medications on hand for administration on 04/17/19 at 10:35am revealed there were no Zyrtec 10 mg tablets available for administration.

Review of the facility's New Order Tracking log revealed Resident #7's physician's order dated 04/11/19 for Zyrtec 10 mg one daily was filed in the log.

Interview with the first shift MA for the SCU on 04/17/19 at 11:30am revealed:
-She administered Resident #7's medication during the 8:00 am medication pass on 04/17/19.
-She was the Assistant Resident Care Coordinator (ARCC).
-Medication orders received by the facility were processed by the MA on duty when the order was received.
-The MA was responsible to fax the order to pharmacy, place a copy in the "New Order tracking" book for her (ARCC) or Resident Care Director (RCD) to review.
-The pharmacy entered the order into the eMAR system and put the order in a pending status for the ARCC or RCD to approve and release.
-The pharmacy had not placed Resident #7's order for Zyrtec 10 mg in pending status for to be reviewed and released as of 04/17/19.
-She was responsible to review resident's orders and release the orders along with RCD.
-She had not contacted the pharmacy regarding

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the status of Resident #7's Zyrtec 10 mg order because she had overlooked checking orders in the New Order Tracking log before today (04/17/19).

Interview with the RCD on 04/17/19 at 12:00pm revealed:
-He had not audited Resident #7's records or eMARs for accuracy including new orders.
-The ARCC had been checking the New Order Tracking log in the SCU (where Resident #7 resided).
-He did not know Resident #7 was not receiving Zyrtec 10 mg as ordered because he had not audited the residents' new orders from last week (including the Zyrtec order for Resident #7 dated 04/11/19.

Interview with the Administrator on 04/17/19 at 12:15pm revealed the ARCC and the RCD were responsible to assure medications were administered as ordered.

2. Review of Resident #2's current FL2 dated 04/15/19 revealed:
-Diagnoses included chronic obstructive pulmonary disease, Alzheimer's dementia with behavioral disturbance, anxiety, and essential hypertension.
-There was a physician's order for alprazolam (Xanax) 0.5 mg twice daily.

Review of a subsequent physician's order dated 04/15/19 revealed an order for alprazolam 0.25 mg twice daily.

Review of Resident #2's record revealed:
-There was a previous physician's order dated 02/14/19 to discontinue alprazolam 0.25 mg in the evening as needed and start alprazolam 0.5

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mg twice daily and hold if resident was too sedated.
-There was a physician's order dated 03/12/19 for alprazolam 0.25 mg twice daily.

Review of Resident #2's hospital discharge summary dated 03/12/19 revealed:
-Resident #2 was admitted to the hospital on 03/11/19 and discharged on 03/12/19.
-Resident #2's admitting diagnosis was a fall with a seizure.
-Resident #2 had a laceration to her left forehead.
-The seizure was most likely due to benzodiazepine withdrawal as Resident #2 did not have access to her Xanax (alprazolam) which she had taken twice daily for many years.

Review of Resident #2's electronic Medication Administration Record (eMAR) for March 2019 revealed:
-There was an entry for alprazolam 0.5 mg twice daily at 8:00am and 8:00pm; Hold if too sedated. This order was discontinued on 03/12/19.
-There was an entry for alprazolam 0.25 mg twice daily at 8:00am and 8:00pm. This entry was discontinued on the eMAR on 03/16/19.
-There was an entry for alprazolam 0.25 mg twice daily at 8:00am and 8:00pm.
-There was no documentation alprazolam 0.5 mg was administered on 03/08/19 at 8:00pm, 03/9/19 at 8:00am and 8:00pm, 03/10/19 at 8:00am and 8:00pm, and 3/11/19 at 8:00 am.
-It was documented alprazolam 0.5 mg was not administered on 03/08/19 through 0/11/19 because "Resident refused medication," "have not received medication from the pharmacy," "Resident unable to take medication," "not in stock,', and "not on cart."
-It was documented alprazolam 0.5 mg was not administered to Resident #3 on 03/11/19 at 8:00

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pm and on 03/12/19 at 8:00am because she was in the hospital.
-There was no documentation alprazolam 0.25 mg was administered on 03/23/19 at 8:00am due to "resident was too sedated."

Review of Resident #2's eMAR for April 2019 revealed:
-There was an entry for alprazolam 0.25 mg twice daily at 8:00am and 8:00pm.
-It was documented alprazolam 0.25 mg was not administered Resident #3 on 04/08/19 at 8:00am, 04/09/19 through 04/14/19 at 8:00am and 8:00pm, and 04/15/19 at 8:00am because she was in the hospital.

Observation of Resident #2's medications on hand on 04/16/19 at 9:02 am revealed:
-There was a morning bingo card of alprazolam 0.25 mg twice daily with a dispense date of 03/25/19 and 13 of 28 tablets were remaining.
-There was an evening bingo card of alprazolam 0.25 mg twice daily with a dispense date of 03/25/19 and 14 of 28 tablets were remaining.
-There was a morning bingo card of alprazolam 0.25 mg twice daily with a dispense date of 04/22/19 (This date was transcribed incorrectly on the bingo card by the pharmacy.) and 28 of 28 tablets were remaining.
-There was an evening bingo card of alprazolam 0.25 mg twice daily with a dispense date of 04/22/19 (This date was transcribed incorrectly on the bingo card by the pharmacy.) and 28 of 28 tablets were remaining.

Based on observation and interviews, it was determined Resident #2 was not interviewable.

Interview with a Special Care Unit (SCU) Supervisor on 04/16/19 at 12:41pm revealed:

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| D 358 | Continued From page 54<br>-Resident #2 was discharged from the hospital on 04/15/19.<br>-Resident #2 was hospitalized due to having a seizure.<br>-Resident #2 saw her primary care physician (PCP) and received physician's orders and her medication through an outside care provider.<br><br>Interview with another SCU supervisor on 04/17/19 at 9:18pm and on 04/18/19 at 5:42pm revealed:<br>-Resident #2 received her medication from a pharmacy through her care provider center.<br>-Resident #2's PCP sent a medication list to the facility for staff to follow and the facility staff sent the medication list to the facility contracted pharmacy so medication could be updated on the eMAR.<br>-Resident #2's medication was delivered from her care provider's center.<br>-If Resident #2 needed a refill of her medications, she would call the care provider's center and they would have her medication refilled.<br>-She was not working when Resident #2 was not administered alprazolam and she did not know about Resident #2 missed six consecutive doses of alprazolam.<br>-She would have contacted Resident #2's PCP after one missed dose, but Resident #2 should not have missed any doses of her medication.<br>-Supervisors were responsible for reordering and medication should have been reordered within a week of it running out.<br>-She had administered alprazolam, but she had never reordered it from the pharmacy.<br><br>Interview with a representative from Resident #2's care provider center's contracted pharmacy on 04/17/19 at 1:07pm revealed:<br>-The pharmacy received orders for medication to | D 358 | | |

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be filled from Resident #2's care provider's center.
-The pharmacy filled medications for Resident #2 and sent them to Resident #2's care provider center who then sent the medication to the facility for Resident #2.
-A 10 day supply (20 tablets) of alprazolam 0.5 mg twice daily was dispensed on 02/15/19.
-A 10 day supply (20 tablets) of alprazolam 0.5 mg twice daily was dispensed on 02/26/19. (This would have ran out on 03/08/19 which coincided with Resident #2 not being administered alprazolam from 03/08/19 at 8:00pm through 03/11/19 at 8:00am.)
-A 14 day supply (28 tablets) of alprazolam 0.5 mg twice daily was dispensed on 03/11/19 and 28 tablets were returned to the pharmacy, but she could not verify the date returned.
-A 13 day supply (26 tablets) of alprazolam 0.25 mg twice daily was dispensed on 03/12/19.
-Alprazolam 0.25 mg was scheduled for cycle fill beginning on 03/25/19 and had not been cycle filled previously.

Interview with a pharmacy nurse from Resident #2's care provider's center on 04/18/19 at 1:52pm revealed:
-A contracted pharmacy filled prescriptions for Resident #2 and the medication was delivered to the care provider's center typically on the next day.
-Once medication was received by the care provider's center, it was delivered to the facility on the same day.
-The facility should have contacted the care provider's center when a refill was needed and the care provider's center would have contacted the pharmacy for refills.
-No one from the facility contacted the care provider's center to make them aware they were

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| D 358 | Continued From page 56<br>out of alprazolam for Resident #2 and needed a refill.<br><br>Attempted contact with Resident #2's responsible part on 04/18/19 at 2:39pm was unsuccessful.<br><br>Attempted telephone interviews on 04/17/19 at 3:42pm and 3:45pm with two Supervisors who documented not administering alprazolam to Resident #2 were unsuccessful.<br><br>Interview with the Administrator on 04/18/19 at 4:05pm revealed:<br>-The Resident Care Director (RCD) was responsible for reviewing new medication orders for Resident #2 and the RCD or a SCU supervisor were responsible for faxing medications orders to the pharmacy to be added to the eMAR for Resident #2.<br>-The SCU Supervisors should be requesting a refill of medication two weeks prior to medication running out.<br>-She did not know, until Resident #2 returned from the hospital, about Resident #2 missing 6 consecutive doses of alprazolam and the missed doses of medication being contributed to her hospitalization.<br>-The Supervisors should have notified the RCD regarding missed doses of medication and the RCD should have notified the physician after the second missed dose.<br>-She expected for medication to be administered as ordered by the physician.<br><br>Interview with the RCD on 04/18/19 at 7:13pm revealed:<br>-He had worked at the facility for less than two weeks and was still in orientation.<br>-He expected to be made aware of any missed medication administration. | D 358 | | |

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| D 358 | Continued From page 57<br>-He did not know about Resident #2 not being administered 6 consecutive doses alprazolam, because it happened prior to his employment.<br>-Best practice would be to request a refill of medication at least 5 days prior to running out and to contact the physician when one dose of medication was missed.<br><br>Interview with a nurse from Resident #2's PCP's office on 04/17/19 at 10:21am revealed:<br>-Resident #2 attended a day program 5 days a week at the care provider center.<br>-The center provided medication administration, activities of daily living care, podiatry services, and dental services.<br>-Resident #2 was seen in the clinic as needed and for her annual assessment.<br>-Resident #2's medication were provided through the care provider center.<br>-Resident #2 had physician's orders for Xanax (alprazolam) due to anxiety, crying episodes, and behaviors that had to be redirected.<br>-Facility staff contacted the care provider center on 03/11/19 when Resident #2 was being transported by Emergency Medical Services (EMS) to the hospital with seizure like activity.<br>-The PCP was notified on 03/11/19 by fax Resident #2 had not had her alprazolam since the previous Friday, 3/8/19.<br>-The facility was supposed to give a 2 day business notice to request any medication they needed for Resident #2.<br>-The facility should have let the PCP know that Resident #2 missed her alprazolam and why she missed the alprazolam.<br>-Missing doses of alprazolam could have resulted in increased behaviors, crying episodes, agitation, increased blood pressure, increased pulse and a lot of distress.<br>-Per hospital records, it was determined Resident | D 358 | | |

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| D 358 | Continued From page 58<br>#2's seizure was probably due to a withdrawal from alprazolam.<br>-Alprazolam and all other medication were expected to be administered as ordered by the physician.<br>_____<br>The facility failed to assure medications were administered as ordered and in accordance with the facility's policies for 2 of 4 residents (#6, and #7) observed during the medication pass including errors with a medication for circulation (#6), and an allergy medication (#7); and for 1 of 5 sampled residents (#2) related to an anti-anxiety medication not administered for 4 days resulting in a hospital visit for abrupt withdrawal symptoms for the resident. This failure resulted in substantial risk of physical harm and neglect which constitutes a Type A2 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G. S. 131D-34 on 04/18/19 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 18, 2019. | D 358 | | |
| D 451 | 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting of Accidents and Incidents<br>(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. | D 451 | | |

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure the county department of social services (DSS) was notified of accidents and incidents which resulted in injury to 1 of 5 sampled residents (#3) who required a referral for emergency medical evaluation other than first aid.

The findings are:

Review of Resident #3's current FL2 dated 05/15/18 revealed diagnoses included Alzheimer's dementia, osteoporosis, and muscle weakness.

Review of Accident/Incident Reports for Resident #3 dated 02/13/19 at 8:35pm revealed:
-Resident #3 was on the floor in her room and staff heard her yelling for help.
-Staff checked for skin tears, range of motion, and took Resident #3's vital signs.
-Emergency Medical Services (EMS) was called and Resident #3 was sent to the hospital emergency room (ER).
-No injuries were noted on the report.
-Resident #3's family and PCP were notified, but there was no indication the report was sent to DSS .

Review of Resident #3's Resident Notes dated 02/13/19 at 9:30pm revealed:
-Staff heard Resident #3 yell out for help.
-Staff went to Resident #3's room and observed

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her on the floor.
-Resident #3 claimed to have hit her head and had knee and back pain
-Resident #3's vital signs were taken and she was sent to out to the hospital.
-Resident #3's family and the Resident Care Coordinator (RCC) was notified.

Review of Accident/Incident Reports for Resident #3 dated 02/21/19 at 6:20pm revealed:
-Staff heard Resident #3 cry out.
-Staff checked Resident #3 for injuries and took her vital signs.
-Emergency Medical Services (EMS) was called and Resident #3 was sent to the hospital.
-No injuries were noted on the report.
-Resident #3's family was notified, but there was no indication Resident #3's PCP was contacted or the report was sent to DSS.

Review of Resident #3's Resident Notes dated 02/21/19 at 10:35pm revealed:
-Resident #3 returned from the hospital.
-The ER nurse reported Resident #3 had a hematoma on her upper right forehead.
-An x-ray was completed and family was notified.

Review of Accident/Incident Reports for Resident #1 dated 04/05/19 at 4:40pm revealed:
-Resident #3 rounded the corner in the hallway, lost her balance and fell on her back.
-Staff witnessed the fall.
-Staff took Resident #3's vital signs and assessed for injuries.
-Resident #3 had a "decent sized knot" on the back of her head and complained of back pain.
-EMS was called and Resident #3 was transported to the hospital ER.
-Resident #3's family and PCP were notified, but there was no indication the report was sent to

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SPRING ARBOR OF THOMASVILLE | 915 WEST COOKSEY DRIVE THOMASVILLE, NC 27360 |

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| D 451 | Continued From page 61<br>DSS.<br><br>Review of Resident #3's Resident Notes dated 04/05/19 at 6:30pm revealed:<br>-Resident #3 was walking up the hall, went to turn the corner, lost her balance, fell, and hit her head on the floor.<br>-Resident #3 had a good bump on the back of her head and complained of pain in her back.<br>-EMS was called and Resident #3 was taken to the hospital ER.<br><br>Review of the facility's Policy for Incident and Accident Report revealed:<br>-An Incident and Accident Report must be completed in the event a resident experiences an occurrence that is unusual, improper, or harmful while at the community or while participating in a community outing.<br>-Incidents may include, but are not limited to injuries, falls, sudden illness, unexplained absence, disruptive behavior, or allegations of abuse or theft.<br>-The individual's physician, family/responsible part, and regulatory agency, if applicable, should be notified.<br>-An incident or accident resulting in death or requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid shall be reported to the appropriate regulatory authority in compliance with state regulations.<br><br>Telephone interview with a representative from the local county DSS on 04/18/19 a 10:02am revealed:<br>-There was no documentation for receipt of a faxed incident report for Resident #3 regarding falls requiring emergency medical evaluation on 02/13/19, 02/21/19, or 04/05/19. | D 451 | | |

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| D 451 | Continued From page 62<br>-She had not received any Incident and Accident Reports related to Resident #3 since 11/03/18.<br><br>Interview with a Supervisor on 04/18/19 at 6:38pm revealed:<br>-She completed an Incident Accident Report when a resident fell and gave it to the Resident Care Director (RCD).<br>-The RCD would be responsible for send the Incident Accident Reports to the local county DSS.<br>-She did not know if some or all Incident Accident Reports were sent to the local county DSS or not.<br><br>Interview with a second Supervisor on 04/18/19 at 6:56pm revealed:<br>-She would be responsible for completing Incident and Accident Reports during her shift.<br>-Incident and Accident reports were given to the RCD after they were completed.<br>-She did not know if the RCD would notify or send the Incident Accident Report to anyone else.<br><br>Interview with the RCD on 04/18/19 at 7:13pm revealed:<br>-He had been working at the facility for less than two weeks and was still in orientation.<br>-He would be responsible for sending Incident and Accident Reports to the local county DSS.<br><br>Interview with the Administrator on 04/18/19 at 4:05pm revealed:<br>-The RCD and the Administrator were responsible for notifying the local county DSS of reports of incidents and accidents.<br>-Incident and Accident Reports were usually faxed or emailed to a representative of the local county DSS.<br>-She did not know the local county DSS had not been notified regarding Resident #3 being sent to | D 451 | | |

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| D 451 | Continued From page 63<br>the emergency room for evaluation after falls.<br>-It was the facility's policy to notify a representative of the local county DSS through an Incident and Accident report when a resident was sent to the emergency room for evaluation.<br>-The facility kept a copy of the fax confirmation when reports were sent to the local county DSS.<br>-No fax confirmations were available for review documenting that the incident reports for 02/13/19, 02/21/19, and 04/05/19 had been faxed to the local county DSS. | D 451 | | |
| D 453 | 10A NCAC 13F .1212(d) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting of Accidents and Incidents<br>(d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to assure the local county Department of Social Services (DSS was notified of incidents of neglect related to 1 of 5 sampled resident (#1) who wandered from the facility.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 01/31/19 revealed Resident #1 had diagnoses that included senile dementia. | D 453 | | |

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| D 453 | Continued From page 64<br><br>Review of the Resident #1's Incident and Accident Reports revealed:<br>-There was a report dated 02/17/19 at 2:20pm documenting the resident was observed outside the building and was redirected back into the building.<br>-There was documentation the resident's family member and physician were notified on 02/17/19.<br><br>Review of encounter notes for a psychiatric evaluation visit dated 02/26/19 revealed "Staff report wandering, exit seeking, and elopement. Staff state that pt [patient] got out of the facility and went out to the road. After 20 minutes a good Samaritan brought pt back to the facility.<br><br>Telephone interview with a representative of the local county DSS revealed there was no documentation for receipt of a faxed incident report for Resident #1 dated 02/17/19.<br><br>Interview with Resident #1's primary care provider nurse practitioner (NP) on 04/18/19 at 9:30am revealed:<br>-She was aware that Resident #1 had wandered outside of the facility without staff with her.<br>-She was not sure of the exact date or time of the notification.<br><br>Telephone interview with Resident #1's mental health physician's assistant on 04/18/19 at 10:30am revealed she was made aware Resident #1 had gotten out of the building on 02/17/19 by staff when she saw the resident on a routine visit on 02/26/19.<br><br>Interview with the Administrator on 04/18/19 at 4:05pm revealed:<br>-She was aware Resident #1 wandered out of the | D 453 | | |

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| D 453 | Continued From page 65<br>facility through the front door on 02/17/19.<br>-She thought the local county DSS had been faxed the incident report.<br>-The Resident Care Director (RCD) and the Administrator were responsible for notifying the local county DSS of reports of incidents and accidents.<br>-Incident and accident reports were usually faxed or emailed to a representative of the local county DSS.<br>-Faxed information routinely had a fax confirmation attached to the information.<br>-No fax confirmation was available for review documenting the incident report was faxed to the local department of social services.<br><br>Interview with the RCD on 04/18/19 at 7:13pm revealed:<br>-He had been working at the facility for less than two weeks and was still in orientation.<br>-He would be responsible for sending Incident and Accident Reports to the local county DSS. | D 453 | | |
| D911 | G.S. 131D-21(1) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights<br>Every resident shall have the following rights:<br>1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to assure each resident was treated with dignity, respect, and consideration as related to resident rights.<br><br>The findings are: | D911 | | |

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| D911 | Continued From page 66<br><br>Based on observations, interviews and record reviews, the facility failed to assure dignity, respect and consideration for one resident (#1) by taking the resident to the secured unit (special care unit) daily for daycare after the resident eloped from the facility. [Refer to Tag D0338 10A NCAC 13F .0909 Resident Rights(Type B Violation).] | D911 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to assure the residents received care and services which were adequate, appropriate and in compliance with relevant state laws and rules related to medication administration, physical environment and personal care and supervision.<br><br>The findings are:<br><br>1. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance | D912 | | |

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| D912 | Continued From page 67<br><br>with the facilities policies for two of four residents (#6, and #7) observed during the medication pass including errors with a medication for circulation (#6), and an allergy medication (#7); and for 1 of 5 sampled residents (#) related to an anti-anxiety medication not administered for 4 days resulting in a hospital visit for abrupt withdrawal symptoms for the resident. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).]<br><br>2. Based on interviews, record reviews, and observations, the facility failed to assure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 1 sampled resident (Resident #1) with dementia who exhibited exit-seeking behaviors, was a known wanderer and eloped from the facility without staff's knowledge. [Refer to Tag D0067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)].<br><br>3. Based on observations, record reviews, and interviews, the facility failed to provide supervision for 2 of 5 sampled residents regarding a resident (#1) with a diagnosis of dementia who exhibited exit-seeking behaviors, was a known wanderer and eloped from the facility without the staff's knowledge, and a resident (#3) with a diagnosis of dementia who experienced repeated falls. [Refer to Tag D270 10A NCAC 13F .0902(b) Personal Care and Supervision (Type B Violation)]. | D912 | | |