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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 02/12/19 - 02/15/19 and 02/18/19 - 02/20/19.	D 000		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 2 of 5 non-licensed staff sampled (A, B) had been competency validated for licensed health professional support tasks by return demonstration including oxygen administration and monitoring; feeding techniques for residents with swallowing problems; positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter prior to the staff performing these tasks. The findings are:	D 161		

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1. Review of Staff A's personnel record revealed Staff A was hired as a personal care aide (PCA) on 02/15/18 and also became a medication aide (MA) on 10/14/18.

Review of Staff A's licensed health professional support (LHPS) competency validation checklist completed on 03/02/18 revealed the task for oxygen administration and monitoring (controls and cleaning of machine) was marked "N/A" (not applicable).

Review of residents' February 2019 medication administration records (MARs) revealed:
-Staff A documented monitoring oxygen administration for 2 residents on 7 days from 02/01/19 - 02/19/19.
-Staff A initialed monitoring oxygen administration on 02/02/19, 02/03/19, 02/05/19, 02/07/19, 02/14/19, 02/16/19, and 02/17/19.

Interview with Staff A on 02/19/19 at 12:15pm revealed:
-She had worked as a MA and a PCA at the facility for about a year.
-She monitored and assisted residents with oxygen each shift she worked.
-She would checked for the correct setting for liters per minute and made sure the tubing was clean.
-She helped residents turn on their portable oxygen tanks when they went to meals.
-She remembered having training on oxygen in a classroom setting when she was first hired.
-No one observed her or had her to demonstrate any tasks related to oxygen monitoring or administration.

Interview with the Executive Director (ED) on

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D 161	Continued From page 2 02/19/19 at 4:12pm revealed: -She did not know Staff A had not been LHPS validated on oxygen administration and monitoring. -Staff A assisted with oxygen administration and monitoring and should be competency validated. -She did not know why Staff A had not been validated on oxygen administration and monitoring. Interview with the Health and Wellness Director (HWD) on 02/19/19 at 3:16pm revealed: -She completed the LHPS competency validation for Staff A. -Staff A assisted residents with oxygen administration and monitoring at the facility. -Staff A should have been competency validated and checked off for oxygen. -She did not know why it was not done. Refer to interview with the Business Office Coordinator (BOC) on 02/19/19 at 2:24pm. Refer to interview with the HWD on 02/19/19 at 3:16pm. Refer to interview with the ED on 02/19/19 at 4:12pm. 2. Review of Staff B's personnel record revealed Staff B was hired as a personal care aide (PCA) and medication aide (MA) on 07/24/14. Review of Staff B's licensed health professional support (LHPS) competency validation checklist completed on 07/31/14 revealed the tasks for feeding techniques for residents with swallowing problems and positioning and emptying of the urinary catheter bag and catheter care were marked "N/A" (not applicable).	D 161		

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D 161	Continued From page 3 Observation on 02/15/19 at 12:26pm revealed Staff B was in a resident's room feeding yogurt mixed with a medication to the resident. Review of the resident's physician's orders revealed the resident had orders to crush medications and to receive a pureed diet due to swallowing problems. Interview with Staff B on 02/19/19 at 3:05pm revealed: -He had worked as a MA and a PCA at the facility since 2014. -There were currently at least 2 residents with urinary catheters in the facility. -He emptied catheter bags and provided catheter care. -Catheter care was not documented by staff to his knowledge. -He also helped assist residents with feeding, including when he would crush residents' medications and put them in applesauce or yogurt and feed the residents. -He recalled attending a class on catheter care but he could not recall when. -No one had observed him or asked him to demonstrate catheter care or feeding techniques. Interview with the Executive Director (ED) on 02/19/19 at 4:12pm revealed: -She did not know Staff B had not been LHPS competency validated on feeding techniques and urinary catheters. -Staff B assisted with catheter care and feeding assistance to residents. -Staff B's LHPS competency validation was done in 2014 when the facility had a different Health and Wellness Director (HWD). -She did not know why Staff B was not	D 161		

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competency validated on those tasks.

Interview with the HWD on 02/19/19 at 3:16pm revealed:
-She did not know Staff B's LHPS competency validation was incomplete.
-She did not complete the LHPS competency validation for Staff B.
-Staff B assisted residents with feeding and catheter care.
-Staff B should have been competency validated and checked off for those tasks.

Refer to interview with the Business Office Coordinator (BOC) on 02/19/19 at 2:24pm.

Refer to interview with the HWD on 02/19/19 at 3:16pm.

Refer to interview with the ED on 02/19/19 at 4:12pm.

____

Interview with the BOC on 02/19/19 at 2:24pm revealed:
-She started working as the BOC in December 2018.
-She had made an excel spreadsheet on the computer for a tracking system for the personnel records.
-She had started working on a complete audit of the personnel records but she had only completed about a third of the audit.
-When a new staff was hired, the BOC gave checklists, including the LHPS validation form, with the new staff's name to the HWD.
-The HWD was responsible for competency validating staff on the LHPS tasks.

Interview with the HWD on 02/19/19 at 3:16pm revealed:

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D 161	Continued From page 5 -She was a registered nurse and she was responsible for completing the LHPS competency validation checklists for staff. -She observed staff performing the tasks on the LHPS checklist and should include all tasks performed at the facility. Interview with the ED on 02/19/19 at 4:12pm revealed: -There was not a system in place to check the LHPS competency validations to ensure the checklists were completed and included all tasks performed by staff at the facility. -The HWD was responsible for completing the LHPS competency validation checklists.	D 161		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION	D 167		

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D 167	Continued From page 6 Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times who had completed a course on cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months on third shift for 9 of 11 days sampled in January 2019 and February 2019. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 09/07/18. -Staff C's position changed to a medication aide (MA) on 10/14/18. -There was no documentation Staff C had training on cardio-pulmonary resuscitation (CPR). Interview with Staff C on 02/19/19 at 11:12am revealed: -She had worked at the facility since October 2018. -She had not completed CPR training. -She had signed up to take a CPR class on 03/16/19. Interview with the Executive Director (ED) on 02/19/19 at 1:02pm revealed: -She did not know Staff C had no CPR training. -Other staff on third shift should have CPR training. -She would check for CPR training for all third shift staff. Interview with the Executive Director (ED) on 02/19/19 at 1:30pm revealed: -She made a list of third shift staff and she was unable to locate any current CPR training for	D 167		

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either of the 6 staff.
-The list included one staff who had CPR training but only worked on third shift occasionally as she routinely worked other shifts.
-She did not know third shift staff did not have CPR training.
-There should be staff on duty on all shifts who had current CPR training.
-The facility had a CPR class in July 2018 but only two staff showed up for the training.
-There had been no follow-up after that to her knowledge.
-The Business Office Coordinator (BOC) was responsible for the personnel records and ensuring required training, including CPR, was on file for staff.

Review of a list of third shift staff provided on 02/19/19 revealed:
-There were 6 staff who routinely worked third shift.
-There was documentation beside each of the 6 staff names that they had "no active CPR".
-A seventh staff listed had active CPR training but only occasionally worked third shift.

Review of documentation provided by the facility on 02/20/19 revealed one of the 6 third shift staff had current CPR training that expired in July 2020.

Review of personnel records, resident census reports, staffing schedules, and time punch detail reports revealed:
-The facility had 3 shifts: first shift was 7:00am - 3:00pm, second shift was 3:00pm - 11:00pm, and third shift was 11:00pm - 7:00am.
-There were no staff on third shift who had training on CPR for 9 of 11 days.
-The 9 days included, 01/01/19, 01/13/19,

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02/03/19, 02/05/19, 02/08/19 - 02/11/19, and 02/13/19.
-The facility's census was between 76 - 82 residents during the 9 shifts when no staff were on duty who had CPR training.

Interview with the BOC on 02/19/19 at 2:24pm revealed:
-She started working as the BOC in December 2018.
-She was in the process of doing an audit on the personnel records but she had only completed about one-third of the records.
-She knew some of the staff needed CPR training and they were in the process of setting up a class (no date set).
-She did not know staff with current CPR training had to be on duty at all times.

Interview with the ED on 02/19/19 at 2:22pm revealed:
-She set up CPR training class for 02/20/19 at 9:30am at the facility.
-They were contacting all third shift staff to attend the class.

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The facility failed to assure there was staff on duty who had training on CPR and choking management in the last 24 months on third shift for 9 of 11 days sampled. The facility's census was between 76 - 82 residents during the 9 shifts when no staff were on duty who had CPR training. The failure to have staff on duty at all times who had training in CPR and choking management was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/19/19 for

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D 167	Continued From page 9 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 6, 2019.	D 167		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to	D 188		

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meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

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

Based on observations, interviews, and record reviews, the facility failed to assure aide hours met the minimum requirements on 14 of 33 shifts for 11 days sampled from January 2019 - February 2019 resulting in inadequate staff to meet the supervision and personal care needs of residents.

The findings are:

Review of the facility's 2019 license revealed the facility had a capacity of 104 residents.

Review of the facility's resident roster dated 02/12/19 revealed the facility had a current census of 83 residents.

Interview with a medication aide (MA) on 02/12/19 at 12:37pm revealed:
-First shift staff hours were from 7:00am to 3:00pm.
-Second shift staff hours were from 3:00pm to 11:00pm.

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-Third shift staff hours were from 11:00pm to 7:00am.

Confidential interview with a resident revealed:
-Sometimes there were not enough staff working in the facility.
-Staff usually responded to the resident's call bell in about 15 to 20 minutes but the resident had waited as long as one hour.
-The resident could not recall when or how often the resident waited one hour for staff assistance.

Confidential interview with a second resident revealed:
-The facility was short of staff on every shift.
-They needed to hire more people, especially on Saturdays and Sundays.

Confidential interview with a third resident revealed:
-There was high staff turnover here, "the staff don't stay long".
-It was hard to find staff for help sometimes on second shift.

Confidential interview with a resident's family revealed:
-The resident reported to the family that the call bell response from staff on second shift had been long at times.
-The facility had high turnover in staff.

Confidential interview with a second resident's family revealed:
-It was hard to get assistance during second and third shifts.
-Sometimes it took an hour to get assistance on second and third shifts.
-The family relied on the staff to provide incontinence care for the resident.

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Confidential interview with staff revealed:
-All personal care aides (PCAs) were required to help serve meals in the dining room during each meal.
-There was usually one dietary aide in the dining room and the other staff who served meals were the PCAs.
-There were usually 3 PCAs and 2 MAs on duty on first and second shifts and 2 PCAs and 1 MA on third shift.
-When the PCAs took their 30 minute lunch breaks, the MAs were supposed to provide assistance to residents.

Confidential interview with a second staff revealed:
-They worked short staffed all of the time.
-There were usually 2 MAs and 3 PCAs on first and second shifts.
-The B side of the facility had very heavy care residents.
-The resident's families complained and questioned staff why there was no staff available to assist residents.
-Staff passed out coffee and checked off a list to make sure residents were present for meal times.
-Staff, including MAs, had to serve food because of staff shortage.

Confidential interview with a third staff revealed:
-There were not enough staff at the facility.
-If the staff person was assisting a resident with dressing and another resident was ringing the call bell and needed assistance, staff was delayed in getting to the other resident.
-The staff person had to go back and forth between the residents.
-The call bell reminder on the staff's pager sometimes rang 5 or 6 times before staff could

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get to the other resident.
-The call bell reminder rang about every 4 to 5 minutes if unanswered.
-Staff were supposed to answer call bells by the third reminder ring but they had a lot of heavy care residents and that did not always happen.
-Staff had reported concerns about being short staffed to the facility's nursing staff during monthly staff meetings but were told the budget did not allow for more staff.
-Staff mentioned their concerns about being short staffed in monthly staff meetings to the Executive Director (ED) but there was no response.
-Staff were supposed to provide incontinence care every 2 hours for about 20 residents as well as 2 hour routine checks on all residents.
-At least two residents had be checked every 30 minutes.
-Second shift staff usually started washing the laundry and third shift staff usually dried and folded the laundry.
-Third shift staff also set up the dining room including washing table cloths, folding silverware in napkins, and setting up the glasses on the tables.
-Third shift staff were also required to sweep, vacuum, and empty trash.
-There were usually only 3 staff on third shift, 1 MA and 2 PCAs.
-"It's a lot" to do and there was a lot of staff turnover.

Confidential interview with a fourth staff revealed:
-There were not enough staff in the facility.
-There was usually 1 MA and 2 PCAs on third shift.
-There were a lot of heavy care residents in the facility.
-There were 5 residents on B side and 5 residents on C side that required 30 minute

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checks.
-The 30 minute checks could not be done with all of the other tasks staff were required to do.
-Third shift staff had to set up the dining room and do 3 or 4 loads of laundry on each side of the facility.
-All of that could not be done while trying to supervise residents especially when residents wandered out of their rooms.
-One resident constantly tried to get out of bed.
-Staff were sometimes delayed in answering call bells because they were helping other residents.
-Third shift staff also gave baths to 4 residents on B side and 2 residents needed assistance with bathing on C side.
-Staff had reported their concerns about being short staff during staff meetings but there was no response to their concerns.

Confidential interview with a fifth staff revealed:
-There was usually 1 MA and 2 PCAs on third shift.
-Staff clocked out for 30 minute lunch breaks each shift and did not work on the floor during that time.
-The MA on third shift usually gave medications for about 2 hours which only left 2 staff on the floor to care for over 80 residents.
-If a PCA was providing care to a resident and a call bell rang, there would be a delay in answering a call bell.
-Sometimes the call bell reminder would ring up to 9 times before staff could answer it.
-Staff were supposed to answer the call bell by the third ring which was about 10 to 15 minutes.
-Staff had to provide incontinence care every 2 hours for 15 to 20 residents.
-Staff were supposed to check on all residents every 2 hours and some residents required 30 minute or 1 hour checks.

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-The size and layout of the building made these tasks difficult to do with only 3 staff.
-A resident had complained to the staff about waiting for assistance but the staff could not recall when the resident complained or the name of the resident.

Review of a resident census report dated 01/01/19 (Tuesday and a Holiday) revealed the facility's in-house census was 78 residents, which required at least 40 hours of staff duty on first shift and at least 24 hours on third shift.

Review of the punch time detail report dated 01/01/19 (Tuesday and a Holiday) revealed:
-There were 38.65 staff hours provided on first shift, leaving the shift short staffed by 1.35 hours.
-There were 23.73 staff hours provided on third shift, leaving the shift short staffed by 0.27 hours.

Review of a resident census report dated 01/13/19 (Sunday) revealed the facility's in-house census was 76 residents which required at least 40 hours of staff duty on second shift.

Review of the punch time detail report dated 01/13/19 (Sunday) revealed there were 38.88 staff hours provided on second shift, leaving the shift short staffed by 1.12 hours.

Review of a resident census report dated 02/03/19 (Sunday) revealed the facility's in-house census was 79 residents which required at least 40 hours of staff duty on first and second shift and at least 24 hours on third shift.

Review of the punch time detail report dated 02/03/19 (Sunday) revealed:
-There were 39.25 staff hours provided on first shift, leaving the shift short staffed by 0.75 hours.

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-There were 39.52 staff hours provided on second shift, leaving the shift short staffed by 0.48 hours.
-There were 23.73 staff hours provided on third shift, leaving the shift short staffed by 0.27 hours.

Review of a resident census report dated 02/05/19 (Tuesday) revealed the facility's in-house census was 80 residents which required at least 24 hours of staff duty on third shift.

Review of the punch time detail report dated 02/05/19 (Tuesday) revealed there were 23.62 staff hours provided on third shift, leaving the shift short staffed by 0.38 hours.

Review of a resident census report dated 02/08/19 (Friday) revealed the facility's in-house census was 81 residents which required at least 44 hours of staff duty on second shift and at least 24 hours on third shift.

Review of the punch time detail report dated 02/08/19 (Friday) revealed:
-There were 40.78 staff hours provided on second shift, leaving the shift short staffed by 3.22 hours.
-There were 23.40 staff hours provided on third shift, leaving the shift short staffed by 0.60 hours.

Review of a resident census report dated 02/09/19 (Saturday) revealed the facility's in-house census was 81 residents which required at least 44 hours of staff duty on first and second shift.

Review of the punch time detail report dated 02/09/19 (Saturday) revealed:
-There were 43 staff hours provided on first shift, leaving the shift short staffed by 1 hour.

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-There were 33.72 staff hours provided on second shift, leaving the shift short staffed by 10.28 hours.

Review of a resident census report dated 02/10/19 (Sunday) revealed the facility's in-house census was 81 residents which required at least 44 hours of staff duty on first and second shift.

Review of the punch time detail report dated 02/10/19 (Sunday) revealed:
-There were 41.32 staff hours provided on first shift, leaving the shift short staffed by 2.68 hours.
-There were 39.77 staff hours provided on second shift, leaving the shift short staffed by 4.23 hours.

Review of a resident census report dated 02/13/19 (Wednesday) revealed the facility's in-house census was 82 residents which required at least 24 hours on third shift.

Review of the punch time detail report dated 02/13/19 (Wednesday) revealed there were 23.02 staff hours provided on third shift, leaving the shift short staffed by 0.98 hours.

Review of incident logs, progress notes, post fall reports and interviews revealed:
-There were falls for 3 of 7 sampled residents on 9 of the 14 shifts that were short staffed.
-Short staffed shifts with resident falls included: first shift on 01/01/19, 02/03/19, 02/09/19, and 02/10/19; second shift on 01/13/19, 02/08/19, 02/09/19, and 02/10/19; and third shift on 01/01/19.
-[Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision].

Interview with the ED on 02/18/19 at 9:40am

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revealed:
-The Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) were responsible for making the staffing schedule.
-They used information from the facility's electronic system which indicated how many clinical hours they were supposed to staff based on the current on-site census and the regulations.
-The RCC made the schedule and the HWD checked and signed it.
-Staff were required to take 30 minute lunch breaks and were off the floor and not working during their lunch breaks.

Interview with the RCC on 02/18/19 at 4:37pm revealed:
-She had made the staffing schedule for the facility since January 2019.
-She asked the HWD how many staff were needed for each shift.
-The HWD would check the facility's electronic system to determine how many staff were needed.
-She made the schedule monthly based on the resident census at that time.
-Once the monthly schedule was made, there was not a system to account for increased or decreased needs of staff based on admissions or discharges.
-All floor staff, including MAs and PCAs took a 30 minute lunch break each shift.
-They were required to take a lunch break if they worked more than 6 hours in a 24 hour period.
-Staff clocked out for the lunch break and clocked back in when they returned to work.
-She did not take the 30 minute lunch breaks into account when she made the schedule because she did not think about it decreasing the amount of available aide hours.
-Staff were supposed to call out 3 hours prior to

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their shift.
-If someone called out for a shift, they tried to get coverage.
-If they were not able to find coverage, the RCC would come in and work.
-Prior to today, she usually scheduled 2 MAs and 3 PCAs for first and second shifts and 1 MA and 2 PCAs for third shift.
-She was currently working on revising the schedule to account for the current census of more than 81 residents and for 30 minute lunch breaks for staff.
-She was revising the schedule for 2 MAs and 4 PCAs for first and second shifts and 1 MA and 3 PCAs for third shift.

Interview with the HWD on 02/19/19 at 3:16pm revealed:
-She used the facility's electronic system which indicated the number of staff hours required based on the resident census.
-The staffing amount required had recently gone up from 40 to 44 for first and second shifts because of the facility's census.
-She would let the RCC know how many hours were needed and the RCC would make the schedule.
-Staff were required to take a 30 minute lunch break and she was not taking those breaks into account when she told the RCC how many hours to staff.
-They had a lot of call outs.
-Staff were supposed to call out at least 2 hours before the start of their shift but some would call out 30 minutes before their shift.
-Staff who called out were supposed to find their own coverage but that was not happening.
-The RCC or the HWD would cover the shifts but there may be a delay in coverage if they were not aware of the call out before the start of the shift.

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D 188	Continued From page 20 ______________________________ The facility failed to assure adequate staffing for 14 shifts resulting in inadequate staff to respond to the personal care and supervision needs of residents. The failure of the facility to provide adequate staffing resulted in substantial risk of neglect and serious injury to residents which constitutes a Type A2 Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/18/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 22, 2019.	D 188		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the residents' physicians authorized and certified personal care services by signing and dating the care plan within 15 calendar days of completion of the	D 263		

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assessments for 2 of 7 residents (#3, #4) sampled for review.

The findings are:

1. Review of Resident #3's current FL-2 dated 12/12/18 revealed:
-Diagnoses included hypertension, hyperlipidemia, diabetes mellitus, arthritis, and Parkinson's disease.
-Resident #3 was ambulatory with a rollator.

Review of the Resident Register for Resident #3 revealed she was admitted to facility on 12/26/18.

Review of Resident #3's Care Plan dated 12/26/18 revealed:
-Resident #3 needed moderate assistance with eating.
-The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transfers.
-The Care Plan was signed by the primary care physician (PCP) on 02/11/19.

Review of a second Care Plan for Resident #3 dated 01/21/19 revealed:
-The resident was independent with ambulation, dressing, grooming, transfers, required moderate assistance with eating and extensive assistance with toileting and grooming.
-The Care Plan was signed by the PCP on 02/11/19.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.

Interview with a medication aide (MA) 02/19/19 at 10:59am revealed:

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-Resident #3 needed assistance with transfers and ambulating to and from dining room.
-Resident #3 needed assistance with toileting.
-Resident #3 needed assistance with getting dressed and undressed.

Interview with a personal care aide (PCA) 02/19/19 at 10:59am revealed:
-Staff assisted Resident #3 with her transfers and ambulation to and from the dining room.
-Staff assisted Resident #3 with all toileting needs.
-Staff assisted Resident #3 with getting dressed in the mornings and getting undressed at bedtime.
-Staff also assisted Resident #3 with bathing.

Interview with the Health and Wellness Director (HWD) on 02/20/19 at 12:42pm revealed:
-The assessments and care plans completed by her on 12/26/18 and 01/21/19 for Resident #3 were signed by the physician on the same day, 02/11/19.
-She forgot to give the first assessment and care plan to Resident #3's PCP to be reviewed and signed.

Interview with Resident #3's PCP on 02/19/19 at 5:15pm revealed:
-She could not recall being given a Care Plan by the facility for Resident #3 to review and sign until recently.
-She was not the PCP at the facility when Resident #3 was admitted on 12/26/18.
-She was aware Resident #3 required more assistance with her transfers and ambulation due to the advancement of her Parkinson's disease.

Refer to interview with the HWD on 02/20/19 at 12:42pm.

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Refer to interview with Executive Director (ED) on 02/20/19 at 1:42pm.

2. Review of Resident #4's current FL-2 dated 11/05/18 revealed diagnoses included acute cystitis with hematuria, disease of thyroid gland; chronic anemia, falls, and weakness.

Review of Resident #4's Resident Register revealed:
-There was an admission date of 06/21/17.
-The resident required assistance from staff for dressing, bathing, toileting, and hair/grooming.

Review of a care plan for Resident #4 revealed:
-There was a handwritten note in the top right hand corner of the copy: original sent out for signature.
-The care plan was dated 03/23/18.

Telephone interview with a nurse from Resident #4's primary care physician's office on 02/15/19 at 11:27am revealed the Health and Wellness Director (HWD) called that morning 02/15/19 at 9:10am requesting the physician review and sign an updated care plan for Resident #4 that she faxed over.

Interview with two personal care aides (PCAs) on 02/13/19 at 11:18am revealed:
-Staff assisted Resident #4 with getting out of bed, combing her hair, bathing, dressing, and grooming.
-Resident #4 required assistance ambulating to the bathroom.
-Resident #4 was able to stand with one person assistance but usually used either her rolling walker or wheelchair to ambulate.

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Interview with a PCA on 02/14/19 at 2:33pm revealed:
-Staff provided assistance to Resident #4 for dressing, showers, toileting, and grooming.
-The resident would use her call bell to notify staff when she needed to go to the bathroom.

Interview with a medication aide (MA) on 02/14/19 at 12:10pm revealed staff provided assistance to Resident #4 for dressing, bathing, toileting, and grooming.

Interview with the HWD on 02/20/19 at 12:42pm revealed:
-It slipped her mind and she did not follow up with Resident #4's physician for the care plan dated 03/23/18.
-She updated the care plan for Resident #4 and requested the physician to review and sign it on 02/15/19.

Refer to interview with the HWD on 02/20/19 at 12:42pm.

Refer to interview with Executive Director (ED) on 02/20/19 at 1:42pm.

____

Interview with the HWD on 02/20/19 at 12:42pm revealed:
-She was responsible for completing assessments and care plans for the facility's residents.
-The assessment and care plans were completed pre-admission, upon admission, 14-30 days after resident admission, and then every six months.
-A new assessment and care plan was done if there was a significant change in a resident's level of care.
-If she noticed or was informed of a change in a resident's level of care, the resident's family

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member was called and the changes were discussed with the family.
-She tried to discuss any changes with the resident's level of care with a family member within a few days.
-She would complete another care plan within 14-30 days of discussing of changes with a resident's family member.
-When a resident was readmitted to the facility from the hospital and there were changes in their level of care, a new care plan was completed within a week of their readmission.
-The care plan was sent to the physician's office and the facility staff preferred the care plan be signed by the physician and returned to facility within ten days.
-She did not have a system in place to assure the assessments and care plans for the residents were reviewed and signed by their physicians within the fifteen calendar days of completion of the assessments.
-She would put a system in place that assured the assessments and care plans were reviewed and signed by the resident's physician within the fifteen calendar days of completion of the assessments were required.

Interview with the ED on 02/20/19 at 1:42pm revealed:
-The HWD was responsible for making sure the residents' assessments and care plans were completed and the residents' physicians received them to be reviewed and signed.
-If the HWD was not able to complete the resident care plans, the Resident Care Coordinator would complete the resident care plans.

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D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure personal care was provided for 1 of 7 residents sampled (#4) who required assistance with nail care. The findings are: Review of Resident #4's current FL-2 dated 11/05/18 revealed diagnoses included acute cystitis with hematuria, disease of thyroid gland; chronic anemia, falls, and weakness. Review of Resident #4's Resident Register revealed: -There was an admission date of 06/21/17. -The resident required assistance from staff for dressing, bathing, toileting, hair/grooming, and scheduling appointments. Review of Resident #4's record revealed there was not a completed care plan for Resident #4. Observation of Resident #4's toenails on 02/12/19	D 269		

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at 11:29am revealed the toenails on each foot were one inch long, thick, jagged, yellowish colored; the toenails were curved over the toes with dried scaly skin around both big toes.

Interview with Resident #4 on 02/12/19 at 11:30am revealed all of her toenails on both feet were a little long, she would like them trimmed.

Review of occupational therapist (OT) progress notes for Resident #4 revealed:
-On 01/07/19, the OT conferred with the facility's licensed practical nurse (LPN), regarding Resident #4's need to have fingernails and toenails trimmed.
-On 01/08/19, the OT placed a phone call to Resident #4's guardian; guardian informed of request made to facility LPN for fingernails and toenails to be trimmed.
-On 01/14/19, the OT met with Resident #4's guardian regarding coordinating a doctor appointment for toenail care, or facility beautician to provide fingernail care.

Telephone interview with Resident #4's guardian on 02/15/19 at 11:17am revealed he was not aware if Resident #4's nails were trimmed.

Telephone interview with Resident #4's primary care physician's nurse on 02/15/19 at 11:27am revealed:
-There were no incoming phone call records from the facility staff requesting an appointment for nail care treatment for Resident #4.
-She did not know of any requests or orders for nail care services for Resident #4.
-She did not know if Resident #4's nails were trimmed.

Attempted telephone interviews with OT on

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02/19/19 at 2:04pm and 02/20/19 at 3:39pm were unsuccessful.

Interview with a personal care aide / medication aide (PCA/MA) on 2/18/19 revealed:
-Staff provided assistance to Resident #4 for dressing, bathing, toileting, and grooming.
-Staff did not provide nail care for the resident.
-There was a podiatrist that would come to the facility and provide monthly services for the residents.
-The facility's beautician would provide fingernail or toenail care services to residents who did not have any health care challenges, or diabetes.
-Staff would notify management, in daily morning stand up meetings of residents who needed to be added to the monthly podiatrist schedule.
-The Resident Care Coordinator (RCC) , or the Health and Wellness Director (HWD) were responsible for adding residents to the list.
-Staff would just go directly into the RCC and HWD's office and tell them in person to add a resident to the list because they shared an office and it was just easier to tell them in person.
-If a request came up after hours, staff would slide a note under the HWD door with the resident name and nail care services needed to be scheduled.
-She was not sure if Resident #4 was added to the list for a monthly podiatrist visit.

Interview with another PCA/MA on 02/20/19 revealed staff saw Resident #4's toenails about three weeks ago and they were long.

Interview with the RCC on 02/19/19 at 2:43pm revealed:
-The podiatrist initially came monthly, but due to insurance and billing, the podiatrist came quarterly now.

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-The last podiatrist visit was in January 2019.
-The podiatrist was part of a large physician provider group who saw many residents at the facility.
-Resident #4 was not listed as being seen by the podiatrist in January 2019.
-Resident #4's physician was not a part of the larger physician provider group with the podiatrist.
-She was not aware of any request for nail care services for Resident #4.
-She had not requested any order from Resident #4's physician that she could recall.

Interview with HWD on 02/19/19 at 2:50pm revealed she was not aware of any request for nail care services for Resident #4.

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10A NCAC 13F .0901(b) Personal Care and Supervision

10A NCAC 13F .0901 Personal Care and Supervision
(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

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

Based on observations, interviews, and record reviews, the facility failed to assure adequate supervision was provided for 1 of 7 residents

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sampled (#3) who had multiple falls requiring multiple visits to the emergency room resulting in rib fractures and head injuries.

The findings are:

Review of Resident #3's current FL-2s dated 12/12/18 revealed:
-Diagnoses included hypertension, hyperlipidemia, diabetes mellitus, arthritis, and Parkinson's disease.
-Resident #3 was ambulatory with Rollator.

Review of the Resident Register revealed Resident #3 was admitted to facility on 12/26/18 at 2:15pm.

Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 12/27/18 revealed:
-Resident #3 required physical assistance with ambulation with her walker.
-Resident #3 had multiple falls and remained a falls risk.

Review of the Care Plan for Resident #3 dated 12/26/18 revealed:
-Resident #3 needed extensive assistance with ambulation and transfers.
-The Care Plan was signed by Resident #3's primary care provider (PCP) on 02/11/19.

Review of the Care Plan for Resident #3 dated 01/21/19 revealed:
-Resident #3 was independent with ambulation and transfers.
-The Care Plan was signed by Resident #3's PCP on 02/11/19.

Interview with a medication aide (MA) during the

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initial tour of the facility on 02/12/19 at 11:41am revealed:
-Resident #3 was a falls risk.
-She had fallen the most of all the residents.

Review of Resident #3's Preliminary Draft Notes of a Reported Incident and Post Fall Evaluation Form revealed:
-Resident #3 fell on 12/26/18 (date of admission) at 6:20pm near her bed while putting lotion on her legs.
-Resident #3 fell on 01/01/19, no time was documented, when she lost her balance.
-Resident #3 fell on 01/19/19 at 11:45pm in her room while getting off bed.
-Resident #3 fell on 02/03/19 at 9:30, did not document a.m. or p.m., in her bathroom and had pain level 4 on scale of 1-10.
-Resident #3 fell on 02/05/19 at 12:15pm in her living room while trying to get to chair with family member in room.
-Resident #3 complained of having pain due to fall last week.
-Resident #3 fell on 02/09/19 at 10:15am in her room and had a knot on the back of her head.
-Emergency Medical Services (EMS) was called but was unclear if Resident #3 was sent to emergency room (ER).
-Resident #3 had an unwitnessed fall on 02/13/19 at 12:20am in her room with no apparent injury.
-Resident #3 had an unwitnessed fall on 02/13/19 at 1:20am in her room with no apparent injury.

Review of "Progress Notes" for Resident #3 revealed:
-On 12/26/18 at 9:36pm, Resident #3 fell (unwitnessed) at 6:20pm when she tried to put lotion on her legs; there was no injury.
-On 01/01/19 at 2:51am Resident #3 fell (unwitnessed) at 1:10am while using restroom,

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she attempted to use walker but fell and hit her head on the walker.
-Resident #3 was not able to answer simple questions such as name, date of birth and was sent to the ER.
-On 01/01/19 at 10:21am, Resident #3 was found in the sitting position on the floor in her room near the hallway door and her kitchen.
-Resident #3 stated she was fine, she lost her balance and did not want to be sent out to the ER.
-On 01/01/19 at 9:21am, Resident #3 fell (unwitnessed) that day during the morning and required 30 minute checks.
-On 01/02/19 at 2:45am, Resident #3 fell (unwitnessed) at 11:45pm on 01/01/19 when she tried to get up from her bed.
-On 01/13/19 at 1:40pm, Resident #3 fell (unwitnessed) that morning while going to the bathroom.
-Resident #3 stated that she was okay and there was no injuries noted.
-On 01/20/19 at 2:37pm, Resident #3 fell (unwitnessed) this morning between checks.
-The personal care aide (PCA) and the MA heard a "boom" from down the hall and checked rooms, Resident #3 said she tripped over her walker while trying to get ice from her freezer.
-Resident #3 complained of pain but refused to be sent out.
-On 02/03/19 at 10:30am, Resident #3 had a fall (unwitnessed) that morning when getting out of bed with no injuries.
-On 02/08/19 at 3:59am, Resident #3 was found in another room across from her room, lying on the floor.
-Resident #3 stated she went into the room because she saw a lady lying on the floor and she went down to help the lady up, then Resident #3 laid down because she could not get up by

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herself.
-On 02/08/19 at 11:17pm, Resident #3 fell two times (both unwitnessed) tonight at 5:15pm and 6:55pm, she was not hurt either fall.
-On 02/09/19 at 11:55pm, Resident #3 fell (unwitnessed) at 6:55pm with no injuries.
-On 02/10/19 at 2:06pm, Resident #3 fell (unwitnessed) that morning, bumped her head and had a knot on the back of her head.
-Resident #3 was sent out to the ER.
-On 02/10/19 at 11:33pm, Resident #3 returned from the hospital at 5:15pm, she had no breaks from fall.
-On 02/10/19, Resident #3 was found on the floor again at 6:55pm.
-On 02/13/19 at 12:31am, Resident #3 fell (unwitnessed) when she tried to get up from her bed without using her walker.
-On 02/13/19 at 1:45pm, Resident #3 fell (unwitnessed) at 1:20am when attempting to get up to go home.

Observation of Resident #3 on 02/13/19 at 8:55am revealed:
-Resident #3 was lying on the floor on her left side beside the bed with her head near the closet door.
-A physical therapy assistant (PTA) was in the room walking toward the door and said she found the resident on the floor and she was going to get help.
-The resident told the MA that her hip was hurting.
-The MA rolled the resident onto her back and put a pillow under the resident's head.
-The MA got more staff in the room to help.
-The MA left the room to call 911.

A second interview with the MA on 02/13/19 at 8:55 a.m. revealed she was going to call 911 and

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have the resident sent to the ER because this was the third time the resident had fallen since last night.

Observation and interview with physical therapy (PT) on 02/13/19 at 9:00am revealed:
-The PT found Resident #3 on the floor by the bed on her left side with her head up against the closet door.
-When she found Resident #3, she was lying on her stomach.
-When the MA rolled Resident #3 over onto her back, Resident #3 winced a little when her left hip was touched.
-EMS was called and arrived in Resident #3's room at 9:07am and assisted the resident onto the stretcher.
-A family member was called and was to meet Resident #3 at the ER.

Interview with a PCA on 02/13/19 at 9:20am revealed Resident #3 had fallen at least 2 or 3 times last night on third shift and was found in another resident's room sleeping.

Review of the facility's Resident Checks records for Resident #3 revealed:
-Resident #3 was checked on at 9:10am after fall on 01/20/19.
-On 02/03/19 at 9:03am, Resident #3 rang out, when staff came to resident's room she was on the floor.
-Staff picked Resident #3 up, resident stated she was not hurt.
-Resident #3 was on floor on 02/07/19 when a PCA brought her breakfast at 8:50am and Resident #3 was put in chair.
-Resident #3 had a fall on 02/09/19 at 6:55pm.
-Resident #3 was on floor on 02/10/19 at 10:30am.

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-Resident #3 was on the floor on 02/12/19 at 10:02am and was gotten up and put in bed.
-Resident #3 had a fall on 02/12/19 at 7:40pm while getting up to close the door.

Review of Resident #3's hospital records revealed:
-The resident was treated in the ER after a fall on 01/01/19.
-Resident #3 had no new injuries and was discharged back to facility.
-On 02/10/19, the resident was treated after a fall with complaint of back and shoulder pain.
-There was a history of recent rib fractures from a fall per family member at bedside.
-Resident #3 had no new injuries and was discharged back to facility.
-On 02/13/19, the resident was treated after a fall.
-An x-ray of Resident #3's bilateral shoulders showed possible rotator cuff tear on the right based on superior migration of the humeral head.
-Resident #3 was stable and discharged back to the facility on the same day, 02/13/19.

Review of Resident #3's record revealed there were no completed Incident/Accident Reports for Resident #3 available for review.

Review of the facility's Falls Management Policy revealed:
-Residents have the potential to fall and therefore the facility has identified universal fall precautions applicable to residents.
-A fall risk evaluation is completed at the time of move in.
-A witnessed or reported unwitnessed fall with or without injury is reported in their Incident Reporting System.
-Residents who sustain a fall should have a post-fall evaluation to consider interventions to

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decrease potential for future falls and injury.
-A fall refers to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed with or without injury.
-The Executive Director (ED) is responsible for verifying that associates have completed their Falls Management Training Course during orientation and annually thereafter.
-Resident falls are noted in the resident record and entered into their incident report system.
-A post-fall evaluation is completed after a resident fall, individual interventions are considered, and the evaluation is part of the resident record.
-When a fall occurs: assist the resident and provide first aid or call 911 as indicated and follow directions of the 911 operator; notify the Health and Wellness Director (HWD) and ED; notify the physician or healthcare provider for evaluation, care, and treatment if indicated and document in the resident record; notify the resident's responsible party and document in the resident record; document resident fall / injuries, resident response, and interventions taken in the resident record; service plan is reviewed for potential fall interventions and updated as necessary; review fall at next stand up meeting; and discuss resident falls and next collaborative care review.

Interview with the HWD on 02/13/19 at 9:30 a.m. revealed:
-Resident #3 had gotten up at 1:40am and again around 3:00am on the third shift that morning, 02/13/19.
-Resident #3 slid out of her bed when she got up both times.
-Resident #3 was walking down the hallway jiggling other residents' door around 5:00am.
-The MA found Resident #3 and escorted her back to her room.

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-The MA recommended to resident that she use the call bell and told her what time it was in the morning.
-When Resident #3 was admitted her family member said she was a frequent faller.
-Usually new admits were checked on every 2 hours but Resident #3 was started on increased checks of anywhere from 30 minutes to 1 hour when she was admitted 12/26/18.
-When there was a resident fall, they were to be checked on every 30 minutes for the first 24 hours, then every hour for the next 24 hours and then every 2 hours for another 24 hours.
-If the resident continued to have falls, a referral was made to have an assessment for Physical Therapy.
-There were no other interventions other than the 30 minutes check and the PT.

Review of Resident #3's hospital after visit summary dated 02/13/19 revealed:
-There were diagnoses of fall and Parkinson's disease.
-There were instructions to follow-up with neurologist in two days.
-It wad recommended that Resident #3 may be best to remain in a wheelchair until evaluation by neurology.

A third interview with the same MA on 02/13/19 at 11:54am revealed Resident #3 also fell on second shift on Saturday, 02/09/19, on third shift on Sunday, 02/10/19, and on first shift on Sunday, 02/10/19 at 10:00am and was sent to the ER.

Interview with Resident #3's family on 02/13/19 at 4:00pm revealed:
-Resident #3 had returned from the ER and had no new fractures.

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-Resident had appointment with the neurologist on 03/14/19 which was the earliest appointment available.
-A family member had asked the facility's staff about having a bed alarm for Resident #3 and was told that bed alarms were not allowed in the facility.

Second interview with the HWD on 02/13/19 at 3:52pm revealed:
-Resident #3 had been checked every 30 minutes and was referred to PT.
-She would be meeting with the family to discuss having a sitter at nights for Resident #3.
-For the times she had been to Resident #3's room during the day, there had been someone in the room with her such as a family member.
-The family member asked about having a bed alarm but the facility did not allow bed alarms, chair alarms, or bed rails.

Second interview with Resident #3's family member on 02/14/19 at 11:20am revealed:
-Resident #3 was falling at home for years.
-The facility was made aware of her falls and they were doing checks every 30 minutes.
-The falling had gotten worst over the last couple of weeks.
-Resident #3 went over to another resident's room across the hall from her room two weeks ago on 02/08/19 because she thought the other resident had called her; that resident had passed away the day before on 02/07/19.
-Resident #3 did not remember falling yesterday, 02/13/19.
-A friend of the family sat with Resident #3 last night.
-Resident #3 had an appointment scheduled for Monday, 02/18/19 at 11:00 a.m. for her first visit with a new neurologist.

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-Resident #3 had been having more difficulty following directions in last couple weeks.
-Her speech had also decreased in the last couple of weeks.
-The facility staff called him each time the resident fell.
-She fell twice the other night and again that morning, 02/13/19.
-She also fell Sunday before last Sunday and fractured her ribs 8 and 9 on the left side.
-The family member could not recall the exact date.
-Occupational Therapy stopped a couple of weeks ago because the resident was having difficulty following directions.
-PT came today, 02/14/19, to work with her but she could not do much because the resident was tired.

Second interview with the PT on 02/15/19 at 12:50pm revealed:
-Resident #3 started PT on 01/01/19 due to continued falls.
-Resident #3 had falls and declined in mental and physical status.
-Resident #3 started out doing very well, then she started to have a decline in her mental and physical health, more so her mental health, which caused an increase in her falls.
-The resident's decline and increase in falls started around the end of January 2019, the beginning of February 2019.
-She attempted PT with Resident #3 on 02/14/19 and the resident did not participate in the PT (active assist).
-It was the first time during PT (active assist) which the resident was not able to do as she was instructed.
-Resident #3 was made 24/7 supervision (1:1) right after she returned from the ER on 02/13/19.

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-Prior to that, the facility was doing periodic checks, not sure how frequent checks were.
-There was a paper next to the sink in resident's room where staff would document what was going on such as a PT session, which usually last 40-45 minutes each session depending on resident's involvement.
-The facility staff would check in on resident about once during PT session.

Interview with another PCA on 02/19/19 at 3:19pm revealed:
-Resident #3 was on 30 minute checks.
-Staff was told by the HWD that Resident #3 needed assistance because she would fall backwards.

Interview with another MA on 02/19/19 at 10:59am revealed:
-The PCAs do 30 minute checks on Resident #3.
-After all the falls Resident #3 has had, she would say that Resident #3 needed assistance with transfers and ambulation.
-Resident #3 got up on her own without calling for assistance.
-There had been a change in the last two weeks when Resident #3 tried to function (do activities of daily living).
-She mentioned the changes with Resident #3 to the HWD last week.

Interview with Resident #3's PCP on 02/19/19 at 5:15pm revealed:
-She did not consider all the falls as falls because she had witnessed a few of them when Resident #3 just sat down on the ground by herself.
-The facility had notified her after each resident fall.
-Blood sugar levels and orthostatic hypotension for falls had been ruled out.

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-She discussed concerns about falls and a recent neurology visit with the family.
-She was informed by the family member that the results of Resident #3's neurology visit was the neurologist reported the resident's Parkinson's disease was advancing and there was nothing that could be done about it.
-The family member told the PCP that it was the same results received from another neurologist that Resident #3 visited a while back.

Interview with the Executive Director (ED) on 02/20/19 at 1:42pm revealed:
-Any interventions required due to falls were put into place by the HWD.
-If there was ever a need for a resident to have 1:1 supervision, the HWD would communicate with her concerning this need before putting such an intervention in place.

____

The facility failed to provide adequate supervision for Resident #3 who had at least 21 falls in a 7 week period, from 12/26/18 through 02/13/19, resulting in visits to the emergency room with head injuries and rib fractures which placed the resident at substantial risk of serious injury and constitutes a Type A2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/13/19 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 22, 2019.

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10A NCAC 13F .0902(b) Health Care

10A NCAC 13F .0902 Health Care

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(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure a referral for physical therapy for 1 of 7 residents sampled (#4) with a physician order for physical therapy and occupational therapy treatment.

The findings are:

Review of Resident #4's current FL-2 dated 11/05/18 revealed:
-Diagnoses included acute cystitis with hematuria, disease of thyroid gland; chronic anemia, falls, and weakness.
-There was an order for physical therapy (PT) and occupational therapy (OT) treatment three times a week.

Review of Resident #4's Resident Register revealed the resident was admitted on 06/21/17.

Review of a physician's order for Resident #4 dated 12/26/18 revealed a second order for PT and OT assessment/evaluation.

Review of Resident #4's PT/OT notes revealed no documentation of PT/OT starting prior to the second order dated 12/26/18.

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Review of the PT/OT order for Resident #4 dated 12/26/18 revealed PT services started on 12/26/18.

Review of physician's order for Resident #4 dated 12/26/18 revealed OT services were started on 12/30/18.

Interview with the physical therapy assistant (PTA) on 02/15/19 at 12:06pm revealed:
-Resident #4 started PT services on 12/26/18.
-She did not know if there were any other orders for PT services prior to 12/26/18.

Attempted telephone interviews with occupational therapist on 02/19/19 at 2:04pm and 02/20/19 at 3:39pm were unsuccessful.

Interview with the Health and Wellness Director (HWD) on 02/18/19 at 2:43pm revealed:
-She was not aware of any therapy order for Resident #4 to start on 11/05/18.
-There was a coordinator change within the therapy department, and the ball was dropped she believed for Resident #4's therapy services to start.
-She admitted unfortunately, they did not follow-up with the therapy department during coordinator transition regarding therapy order for Resident #4.

Interview with Executive Director (ED) on 02/20/19 revealed:
-The clinical department was responsible for coordinating physician's orders.
-She expected her clinical department to initiate and start services in a timely manner.
-She was not aware of any therapy order for Resident #4 to start on 11/05/18.
-She would be meeting with her clinical

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D 273	Continued From page 44 department regarding physician orders and services starting for residents timely.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a registered nurse completed an on-site Licensed Health Professional Support (LHPS) review and	D 280		

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evaluation quarterly including all tasks and a physical assessment for 6 of 7 residents sampled (#1, #3, #4, #5, #6, #7) including tasks for transferring, ambulation with assistive devices, medication through inhalation, medication through injection, testing of fingerstick blood sugars, physical therapy, feeding techniques for swallowing problems, urinary catheter care, clean dressing changes, and care of pressure ulcers.

The findings are:

1. Review of Resident #5's current FL-2 dated 06/29/18 revealed:
-Diagnoses included stroke, Parkinson's disease, chronic obstructive pulmonary disease, congestive heart failure, hypertension, hyperlipidemia, and gastroesophageal reflux disease.
-There was an order to resume physical therapy (PT).

Review of Resident #5's Resident Register dated 06/01/18 revealed:
-The resident was admitted to the facility on 06/01/18.
-The resident required assistance with dressing, bathing, and toileting.
-The resident used a walker, wheelchair, and electric scooter.

Review of Resident #5's assessment and care plan dated 07/06/18 revealed the resident required extensive assistance with all activities of daily living, including ambulation, toileting, and transferring.

Review of physical therapy (PT) visit notes for Resident #5 revealed the resident had PT from 01/15/19 and the most current visit was 02/18/19.

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Review of Resident #5's physician's orders dated 12/03/18 revealed an order for Duoneb 1 vial via nebulizer 4 times a day (Duoneb is used to treat breathing problems.)

Interview with Resident #5 on 02/19/19 at 1:50pm revealed:
-He needed assistance with transfers but he did not always call for help.
-He could use his walker, wheel chair, and scooter but he was still learning how to use the scooter.
-He was taking PT to help learn how to use the scooter.
-He sometimes needed assistance with ambulation when he was weak and because his feet stayed swollen.
-He had a fall in the bathroom over the weekend trying to transfer from the toilet by himself and got a bad skin tear on his arm.
-He had a nebulizer machine but he did not use it because he did not need it.

Review of Resident #5's current Licensed Health Professional Support (LHPS) review dated 12/04/18 revealed:
-The nurse documented the resident's LHPS tasks as transferring and ambulation with an assistive device.
-The nurse noted the resident required transfers and escort assistance along with daily activities of daily living.
-PT or medication through inhalation were not documented as tasks on the LHPS review.
-There was no physical assessment related to the resident's LHPS tasks.
-There were no recommendations other than to monitor for increased needs.

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Interview with the Health and Wellness Director (HWD) on 02/19/19 at 3:35pm revealed:
-She was a registered nurse and she completed the LHPS review for Resident #5.
-Resident #5 was a one person transfer assist.
-Resident #5 could bear weight and use his walker but his gait was unsteady and he needed some assistance with ambulation.
-The resident was currently receiving PT due to falls and learning to use his new scooter.
-She was not aware the resident was not using the Duoneb.
-She did not realize she needed to document a physical assessment on the LHPS reviews.
-She did not know why all tasks were not addressed in the LHPS review.

2. Review of Resident #7's current FL-2 dated 08/08/18 revealed:
-Diagnoses included dementia, breast cancer, secondary lung cancer, and neuromuscular dysfunction of the bladder.
-The resident was intermittently disoriented, non-ambulatory and incontinent.
-The resident required assistance with bathing and dressing.

Review of Resident #7's Resident Register dated 08/11/18 revealed:
-The resident was admitted to the facility on 08/11/18.
-The resident required assistance with dressing, bathing, grooming, and toileting.
-The resident used a wheelchair.

Review of Resident #7's assessment and care plan dated 08/13/18 revealed the resident required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

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Review of Resident #7's current Licensed Health Professional Support (LHPS) review dated 11/16/18 revealed:
-The nurse documented the resident's LHPS tasks as clean dressing changes and wound care.
-The nurse did not include transferring, assistance with ambulation, or feeding techniques for swallowing problems as tasks.
-There was no physical assessment related to the resident's LHPS tasks.
-The nurse noted the resident was under hospice care, received wound care and was repositioned often.
-There were no recommendations other than "hospice care".

Based on observations, interviews, and record review, it was determined Resident #7 was not interviewable.

Interview with Resident #7' family member on 02/18/19 revealed:
-Resident #7 was bed bound and was supposed to be moved to an inpatient hospice center today.
-The resident could not transfer or ambulate on her own and needed assistance with those tasks.
-The resident required assistance with feeding and was on a pureed diet.
-The resident had a wound on her buttocks that hospice was currently treating.
-He thought the wound was getting better.

Interview with the Health and Wellness Director (HWD) on 02/19/19 at 3:35pm revealed:
-She was a registered nurse and she completed the LHPS review for Resident #7.
-Resident #7 was receiving hospice care and was totally bed bound.

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-Resident #7 required assistance with feeding.
-Resident #7 had a sacral wound but it was being treated by hospice so she had not seen the wound.
-According to the hospice nurse, the wound was not infected.
-She did not realize she needed to document a physical assessment on the LHPS reviews.
-She did not know why all tasks were not addressed in the LHPS review.

3. Review of Resident #4's current FL-2 dated 11/05/19 revealed diagnoses included acute cystitis with hematuria, disease of thyroid gland; chronic anemia, falls, and weakness.

Record review of licensed health professional support (LHPS) task form signed 11/13/18 by the Health and Wellness Director (HWD) for Resident #4 revealed:
-There was a marked tasked of positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter.
-There was monthly Foley care provided by the home health provider.
-Further review, there was no documentation of a physical assessment of the resident related to resident's current condition requiring LHPS task.

Record review of physician/healthcare provider visit form signed 12/27/18 for Resident #4 revealed, change Foley every 3 to 4 weeks.

Interview with the HWD on 02/20/19 at 12:42pm revealed:
-Staff assisted Resident #4 with emptying of her urinary catheter bag.
-She completed all LHPS forms for all the residents for the facility.
-She did not know she was responsible for

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documenting a physical assessment of the resident's current condition requiring LHPS task.
-She was not told to provide that documentation in her initial HWD training.

Interview with the Executive Director (ED) on 02/20/19 at 1:42pm revealed:
-The completion of the LHPS reviews were the responsibility of the HWD.
-She expected the HWD to complete all LHPS reviews in a timely manner.
-She did not know that there was no documentation of a physical assessment as related to the resident's current condition requiring LHPS task for Resident #4.
-She would be meeting with her HWD regarding completing the physical assessment for LHPS task.

4. Review of Resident #6's current FL-2 dated 1/16/19 revealed diagnoses included fracture of right pubis-pelvic fracture, hypertension, hyperlipidemia, fatigue, dementia, depression, and tricuspid regurgitation.

Review of Resident #6's Resident Register revealed there was an admission date of 07/09/18.

Review of Resident #6's record revealed a physician order dated 02/03/19 for bilateral foot dressings.

Review of Resident #6's skin observation form dated and signed on 02/06/19 by the Health and Wellness Director (HWD) revealed:
-Resident #6 had redness on both heels.
-The Braden scale for predicting pressure sore risk total was 18.
-The total score can range from 6 to 23 with a

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lower score indicating a higher risk.
-There was no sensory perception impairment.
-There was occasional moisture.
-The residents mobility was slightly limited.
- The resident nutrition was adequate.
-There was no apparent friction and shear problem.

Review of emergency department provider notes on 02/11/19 revealed Resident #6 had been seen at the emergency department and admitted to the hospital on 02/11/19 for acute renal failure, severe dehydration, urinary tract infection (UTI), anorexia (chronic), and pressure ulcer of both heels stage 2.

Review of Resident #6's hospital records and skin assessment pictures taken by hospital personnel dated 02/12/19 revealed Resident #6 had diagnoses of pressure ulcers of both heels staged 2.

Review of licensed health professional support (LHPS) evaluation dated 02/06/19 for Resident #6 revealed:
-Transferring semi-ambulatory or non-ambulatory residents and ambulation using assistive devices that required physical assistance were the only LHPS marked tasks.
-There was no documentation clean dressing changes, or care of pressure ulcers up to and including a Stage II pressure ulcer as marked task.
-There was no documentation of a physical assessment of the resident as related to resident's current condition requiring LHPS task.

Interview with the HWD on 02/20/19 at 12:42pm revealed:
-She completed all LHPS forms for the residents

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at the facility.
-She did not know she was responsible for completing and documenting a physical assessment of the resident's current condition requiring LHPS task.

Interview with the Executive Director (ED) on 02/20/19 at 1:42pm revealed:
-The completion of LHPS reviews was the responsibility of the HWD.
-She expected the HWD to complete all LHPS reviews.
-She did not know there was no documentation of a physical assessment for both heels for Resident #6.

5. Review of Resident #1's current FL-2 dated 12/20/18 revealed diagnoses included pneumonia, disorder of prostate, sepsis, unsteadiness on feet, type 2 diabetes, hypoglycemia, cognitive communication deficit, hyperlipidemia, sensorineural hearing loss, essential (primary) hypertension, allergic rhinitis due to pollen, and muscle weakness.

Review of Resident #1's records revealed a physician's order dated 01/08/19 for his fingerstick blood sugars (FSBS) to be done twice per day.

Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation dated 11/20/18 revealed:
-Resident #1's FSBS were to be done by staff.
-There were no notes regarding the resident's blood sugar levels.
-There were no notes documenting Resident #1 received insulin injections or descriptions of fingerstick or injection sites.

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D 280	Continued From page 53 Review of Resident #1's progress notes revealed: -Resident #1 was found sitting in his recliner chair unresponsive with a streak of blood that ran from his mouth and was sent to the emergency room (ER) on 11/15/18. -Resident #1 did not return to the facility until 12/21/19. Review of Resident #1's previous Licensed Health Professional Support (LHPS) evaluations dated 02/05/18, 05/09/18 and 08/20/18 revealed Resident #1 performed his own FSBS checks. Interview with the Health and Wellness Director (HWD) on 02/20/19 at 12:42pm revealed she was not aware an LHPS evaluation with physical assessment was required. Interview with the Executive Director (ED) on 02/20/19 at 1:42pm revealed: -The HWD was responsible for performing the LHPS evaluations. -If the HWD for the facility was not available then the Regional Nurse or HWD would be responsible for performing the LHPS evaluations. 6. Review of Resident #3's current FL-2 dated 12/12/18 revealed: -Diagnoses included hypertension, hyperlipidemia, diabetes mellitus, arthritis and Parkinson's disease. -Resident #3 was ambulatory with a Rollator. Review of the Resident Register for Resident #3 revealed she was admitted to facility on 12/26/18 and used a walker. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 12/27/18 revealed:	D 280		

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D 280	Continued From page 54 -Resident #3 required physical assistance with ambulation with her walker. -Resident #3 had multiple falls and remained a falls risk. -Resident #3 had a Foley catheter. -There was no physical assessment or description of Foley insertion site or urine output. -There was no physical assessment or description of Resident #3's gait. Interview with the Health and Wellness Director (HWD) on 02/20/19 at 12:42pm revealed she was not aware an LHPS evaluation with physical assessment was required. Interview with the Executive Director (ED) on 02/20/19 at 1:42pm revealed: -The HWD was responsible for performing the LHPS evaluations. -If the HWD for the facility was not available then the Regional Nurse or HWD would be responsible for performing the LHPS evaluations.	D 280		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure snacks were consistently offered or made available to all	D 298		

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residents three times daily.

The findings are:

Review of the facility's Daily Diet Modification Summary Report for 02/12/19 - 02/15/19 and 02/18/19 - 02/19/19 revealed:
-There was a row for mid-morning snacks, mid-afternoon snacks, and mid-evening snacks.
-There were no beverages listed for snacks.
-On 02/12/19, the snacks to be served were banana muffin, mandarin oranges, and animal crackers.
-On 02/13/19, the snacks to be served were fruit yogurt cup, fresh grapes, assorted cold cereal, and milk.
-On 02/14/19, the snacks to be served were apple butter bread, pineapple chunks, and vanilla pudding with vanilla wafers.
-On 02/15/19, the snacks to be served were lemon pudding, chilled pears, and assorted crackers with cheese.
-On 02/18/19, the snacks to be served were cranberry bread, fresh fruit salad, and graham crackers.
-On 02/19/19, the snacks to be served were fruit yogurt cup, apricot halves, and English muffin pizza.

Confidential interview with a resident revealed:
-The resident only received a snack once a day or once every other day.
-Staff brought the snack to the resident's room.

Confidential interview with a second resident revealed:
-The resident received a banana today (02/12/19) for a snack at approximately 11:00am.
-The resident did not receive 3 snacks a day.
-The resident usually got snacks twice a day.

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Confidential interview with a third resident revealed:
-The resident received a banana today (02/12/19) for a snack.
-The resident received a snack at night.
-Sometimes staff would "show up" with a snack and "sometimes not".

Confidential interview with a fourth resident revealed:
-Snacks were brought by staff to the resident's room.
-The resident received snacks twice a day on some days but only once a day on other days.

Confidential interview with a fifth resident revealed:
-The resident usually received a snack once a day at 10:00am or 11:00am.
-The resident received a banana for snack today (02/12/19) around 11:00am.

Interview with a medication aide (MA) on 02/19/19 at 3:05pm revealed:
-Snacks were passed out by the personal care aides (PCAs) on second shift.
-The snack cart usually had bananas and graham crackers.
-The MA had not seen any snacks passed out to residents during first shift.

Observation of B hall on 02/19/19 at 2:00pm revealed:
-There was a PCA pushing a snack cart down the hall passing out snacks to residents.
-The snack cart had bananas, animal crackers, and graham crackers.
-There were no beverages on the snack cart.

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Interview with the PCA passing out snacks on 02/19/19 at 2:00pm revealed:
-Snacks were supposed to be served 3 times a day at 10:00am, 2:00pm, and 7:00pm.
-The snack cart was supposed to be prepared by the kitchen staff and PCAs were supposed to pass out snacks.
-Snacks had not been offered to residents 3 times a day in 2 to 3 months.
-The PCAs were usually tied up with resident care duties and did not have enough time to pass snacks to residents 3 times a day.

Interview with a second PCA on 02/19/19 at 2:17pm revealed:
-The staff person had seen snacks passed out about 2 or 3 times a week.
-Snacks were not passed out every day.
-The PCAs did not have time to pass out snacks.

Interview with a third PCA on 02/19/19 at 2:35pm revealed:
-The snacks were supposed to be given out to the residents at 10:00am and 2:00pm on first shift.
-The MAs typically passed out the morning snacks for the PCAs.
-The PCAs did not have the time to pass out the morning snacks to the residents.

Observations at various times from 02/12/19 - 02/15/19 and 02/18/19 - 02/20/19 revealed:
-A snack was passed out to residents at 11:00am on 02/12/19.
-A snack was passed out to residents at 2:00pm on 02/19/19.
-No other snacks were observed to be passed out to residents.

Interview with the Dietary Manager on 02/19/19 at

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10:40am revealed:
-Snacks were served at 10:00am, 2:00pm, and 8:00pm.
-The personal care aides (PCAs) were responsible for passing out the snacks.
-The dietary aides in the kitchen prepared the snacks and placed them on little black carts.
-The carts with the snacks were then placed outside the kitchen door to be passed out by the PCAs.
-The snacks for 8:00pm were prepared at 7:00pm and placed in the medication room.
-The snack today (02/19/19) at 10:00am was fruit yogurt, including blueberry, peach, and strawberry.

Interview with a dietary aide on 02/19/19 at 2:35pm revealed the residents were prepared bananas, cheese crackers, and water for snack that morning at 10:00am.

Interview with the Health and Wellness Director (HWD) on 02/19/19 at 4:05pm revealed:
-Snacks were passed out every shift.
-Dietary staff prepared and set out the snacks for the PCAs to pass out.
-Snacks were stressed for the residents who were diabetic.
-All snacks included liquid hydration.
-It was noted on the staff schedule which staff were assigned to pass out the snacks.

Interview with the Executive Director (ED) on 02/19/19 at 4:20pm revealed:
-The residents were supposed to receive snacks 3 times a day.
-Snacks were usually put on a cart by kitchen staff and passed out by the personal care aides (PCAs).
-Snacks were supposed to be served after

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D 298	Continued From page 59 breakfast, after lunch, and at bedtime. -She had seen the snack cart in the lobby near the dining room at times so she thought snacks were being passed out to residents. -There was no system to check to make sure snacks were being offered to residents 3 times a day.	D 298		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 5 of 7 residents (#8, #9, #10, #11, #12) observed during the medication passes, including errors with insulin (#10), a	D 358		

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thyroid medication (#9), a medication for digestive tract spasms (#12), a supplement used to lower triglycerides (#11), a medication for acid reflux (#8), a vitamin B supplement (#8), and a calcium with vitamin D supplement (#9); and for 2 of 7 residents sampled (#5, #7) for record review including errors with eye drops for redness and dryness (#7), and a laxative for treating and preventing constipation (#5, #7).

The findings are:

1. The medication error rate was 28% as evidenced by the observation of 7 errors out of 25 opportunities during the 8:00am medication pass on 02/13/19, the 1:00pm medication pass on 02/14/19, and the 10:00am/11:00am medication pass on 02/15/19.

a. Review of Resident #8's current FL-2 dated 10/16/18 revealed diagnoses included diabetes mellitus type II, coronary artery disease, hypertension, anxiety with depression, urinary tract infection - complicated, status post placement of ureteral stent, and obstruction of right ureteropelvic junction due to kidney stone.

Review of Resident #8's physician's orders dated 10/22/18 revealed an order for Biotin take 1 tablet daily for vitamin insufficiency. (Biotin is a B vitamin that converts nutrients into energy. Biotin may be used for its role in the health of hair, skin, nails, and it may be used for nerve damage.)

Interview with the medication aide (MA) on 02/13/19 at 9:15am revealed:
-She was supposed to administer Biotin 5mg to Resident #8 with her other medications scheduled for 8:00am.
-Resident #8 did not have any Biotin available for

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administration.
-The Biotin was on order and it had been ordered again yesterday.
-She was not sure how long the resident had been out of Biotin.
-She would call the pharmacy about the Biotin today.

Observation of Resident #8's medications on hand during the medication pass on 02/13/ at 9:15am revealed there was no Biotin available for administration.

Observation of the 8:00am medication pass on 02/13/19 revealed:
-The MA administered Resident #8's medications scheduled for 8:00am at 9:18am.
-The MA did not administer Biotin 5mg to the resident when she received her other 8:00am medications.

A second interview with the MA on 02/13/19 at 9:24am revealed:
-She just called the pharmacy and they would send the Biotin in the pharmacy tote tonight.
-The facility did not get monthly cycle fills so the MAs had to order the medications when needed.
-The MAs were supposed to pull the sticker and fax it to the pharmacy once the medications got down to the last strip on the bubble card, which was blue.
-Once they faxed the refill order, the medications were usually delivered in the pharmacy tote that same night.
-If not, the MAs should call the pharmacy to find out why a medication was not received.
-She was not sure how long Resident #8 had been out of Biotin, but she did not receive it yesterday or today.

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Review of Resident #8's February 2019 medication administration record (MAR) revealed:
-There was an electronic entry for Biotin 5mg 1 tablet once a day for vitamin insufficiency scheduled to be administered at 8:00am.
-Biotin was documented as administered on 02/01/19, 02/04/19, 02/06/19 - 02/10/19, and 02/12/19.
-Biotin was not documented as administered on 6 days including 02/02/19, 02/03/19, 02/05/19, 02/11/19, and 02/13/19 due to the medication being unavailable.

Review of Resident #8's January 2019 MAR revealed:
-There was an electronic entry for Biotin 5mg 1 tablet once a day for vitamin insufficiency scheduled to be administered at 8:00am.
-Biotin was documented as administered on 01/01/19 - 01/16/19, 01/18/19, 01/21/19, 01/22/19, and 01/24/19 - 01/31/19.
-Biotin was not documented as administered on 4 days including 01/17/19, 01/19/19, 01/20/19, and 01/23/19 due to the medication being unavailable.

Interview with a second MA on 02/15/19 at 12:34pm revealed:
-He mostly worked as a MA on the C-side of the facility but he had administered medications to Resident #8 occasionally on the B-side of the facility.
-He recalled Resident #8 did not have Biotin available for administration on at least one occasion when he administered her medications in January 2019.
-He did not recall any specifics about why she was out of the medication.
-He did not recall if he called the pharmacy when he noticed the Biotin was unavailable.
-The MAs usually tried to call the pharmacy if a

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medication was unavailable because it might just need a refill.
-The facility did not receive cycle fills so they had to order the medications themselves.
-He usually tried to reorder medications when the supply got down to the blue strip on the bubble card.
-If a medication was not available to administer, the MAs were supposed to document it was not administered on the MAR and note the reason.
-Contacts with the pharmacy should be documented in the progress notes.

Interview with the Resident Care Coordinator (RCC) on 02/13/19 at 1:35pm revealed:
-The MAs were supposed to reorder medications when there was a 10 day supply remaining.
-If the medication was not received that night, the MAs should call the pharmacy and notify either of the RCCs or the Health and Wellness Director (HWD).
-She was aware Resident #8 was out of Biotin on Monday, 02/18/19, because she had administered medications to the resident that day.
-She called the pharmacy on Monday, 02/18/19, and they were supposed to send the Biotin the next day.
-She did not document her call to the pharmacy or who she spoke with.
-She had not followed up to see if the Biotin had been delivered from the pharmacy.

Interview with the Health and Wellness Director (HWD) on 02/13/19 at 1:50pm revealed:
-She was not aware Resident #8's Biotin was unavailable.
-The MAs were responsible for reordering medications by faxing the refill requests to the pharmacy.
-The MAs should reorder medications when there

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was a 7 day supply remaining.
-If faxed by 3:00pm or 3:30pm, the medication would be delivered to the facility that same night but if after that time, it would not be delivered until the next night.
-If a medication was not received after being ordered, the MAs should call the pharmacy to follow up.
-If it was an emergency, the facility could get a 1 or 2 day supply from the back up pharmacy.
-The MAs should not document a medication was administered if it was unavailable.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/19 at 12:35pm revealed:
-The pharmacy had dispensed a 30 day supply of Biotin 5mg tablets each on 06/29/18, 07/23/18, 08/20/18, 09/19/18, 10/28/18, and 11/23/18 for Resident #8.
-The facility requested another refill on 12/26/18 but there were no refills.
-Either the pharmacy or the facility could contact the physician for refills.
-She was not sure if the pharmacy or the facility contacted the physician to get refills for the Biotin because she did not see any notes in their records.
-There had been no requests by the facility to refill the Biotin since 12/26/18 until today, 02/13/19.
-The Biotin would be delivered to the facility tonight, 02/13/19.

Interview with Resident #8 on 02/19/19 at 2:05pm revealed:
-The facility had run out of her medications at times.
-She could not recall which medications they had run out of or the last time they had ran out.

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-She thought they had ran out at times around the holidays.

b. Review of Resident #8's current FL-2 dated 10/16/18 revealed:
-Diagnoses included diabetes mellitus type II, coronary artery disease, hypertension, anxiety with depression, urinary tract infection - complicated, status post placement of ureteral stent, and obstruction of right ureteropelvic junction due to kidney stone.
-There was an order for Protonix 40mg twice a day 30 minutes before meals. (Protonix is used to treat acid reflux disease.)

Review of Resident #8's physician's orders dated 10/22/18 revealed an order for Protonix 40mg twice a day.

Review of Resident #8's February 2019 medication administration record (MAR) revealed:
-There was an electronic entry for Protonix 40mg 1 tablet twice a day.
-Protonix was scheduled to be administered at 8:00am and 8:00pm.

Observation of the 8:00am medication pass on 02/13/19 revealed:
-The medication aide (MA) prepared Resident #8's morning medications for administration by punching the medications from bubble cards.
-The MA punched a Protonix 40mg tablet from a bubble card but the tablet stuck to the paper on the back of the card and did not go into the medication cup with the other pills.
-The MA put the Protonix bubble card back into the medication cart without noticing the pill was stuck on the back of the card.
-The MA then locked the cart and started walking toward the resident's room to administer the

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D 358	Continued From page 66 medications. -Surveyor intervened and asked the MA to go back to the medication cart and count the pills in the cup. -After counting the pills and looking at the MAR, the MA realized there was a missing tablet but she was not sure which tablet. -The MA was asked to check the back of the Protonix bubble card and then realized the Protonix had not been punched into the cup. -The MA had poured the pills into different cups while checking them to make sure all pills could be seen. -The MA then punched a Protonix tablet from the next bubble into one of the medication cups with Resident #8's medications. -The first Protonix tablet was still stuck on the back of the card and the MA put the card back in the cart. -The MA then poured all of the pills into one cup but she did not notice the Protonix she had punched in one of the cups stuck to the bottom of the cup. -The MA stacked the empty cups together on top of the cup with the Protonix tablet and threw the cups away. -The MA locked the cart and began walking to Resident #8's room to administer her morning medications. -The surveyor intervened and asked the MA to go back to the cart and check the cup. -The MA was told how the second Protonix tablet she punched had gotten stuck on the bottom on one of the cups she discarded. -The MA then got the Protonix bubble card and put the Protonix tablet that was still stuck to the back of the card in the medication cup to administer to the resident. -The Protonix was administered to the resident with her other morning medications at 9:18am.	D 358		

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Interview with the MA on 02/13/19 at 9:26am revealed:
-She had not noticed the Protonix tablet got stuck twice during the medication pass.
-Some of the pills sometimes stuck to the paper on the back of the bubble cards when she was preparing medications and she usually saw them.
-She would be more careful about checking to make sure the pills were punched into the medication cups.

Interview with the Health and Wellness Director (HWD) on 02/13/19 at 1:50pm revealed:
-The MAs were supposed to make sure pills in the bubble cards did not get stuck on the back of the cards when they were preparing medications.
-The MAs were supposed to check the cups to make sure the pill went into the cup when punched from the bubble card.

c. Review of Resident #9's Resident Register revealed the resident as admitted to the facility on 02/08/19.

Review of Resident #9's admission FL-2 dated 02/07/19 revealed there was an order for Levothyroxine 88mcg daily. (Levothyroxine is used to treat hypothyroidism. Levothyroxine is not absorbed properly unless taken on an empty stomach.)

Review of Resident #9's current FL-2 dated 02/12/19 revealed:
-Diagnoses included hypothyroidism, osteopenia, type 2 diabetes - diet controlled, vascular dementia, gastroesophageal reflux disease, and primary open angle glaucoma.
-There was an order for Levothyroxine 88mcg 1 tablet every morning at 6:00am.

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Observation of the 8:00am medication pass on 02/13/19 revealed:
-Resident #9 was administered her morning medications, including Levothyroxine, at 9:48am.
-Levothyroxine was not administered at 6:00am as ordered.

Review of Resident #9's February 2019 medication administration record (MAR) revealed:
-There was an electronic entry for Levothyroxine 88mcg 1 tablet once a day for hypothyroidism.
-Levothyroxine was scheduled for administration at 8:00am.
-There was no entry for the order dated 02/12/19 for Levothyroxine to be administered at 6:00am.

Interview with the medication aide (MA) on 02/13/19 at 1:16pm revealed:
-He administered the Levothyroxine with the other medications scheduled for 8:00am because it popped up on the electronic MAR to be administered at that time.
-He was not aware of an order for Levothyroxine to be administered at 6:00am.

Interview with the Resident Care Coordinator (RCC) on 02/13/19 at 1:30pm revealed:
-The facility's default time on the electronic MARs for once daily medications was 8:00am.
-The MAs or the RCCs or the Health and Wellness Director (HWD) were responsible for implementing and tracking new orders, including entering orders into the electronic MAR system.
-The order on the FL-2 dated 02/12/19 for Levothyroxine to be administered at 6:00am should have been added to the MAR and the time changed to 6:00am.
-She did not know why the time was not changed to 6:00am.

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-She could not find an order tracking form for the FL-2 dated 02/12/19 so she would fax the form to the pharmacy.

Interview with the Resident Care Coordinator / Licensed Practical Nurse (RCC/LPN) on 02/13/19 at 2:07pm revealed:
-The original order on the FL-2 dated 02/07/19 was for Levothyroxine once daily.
-The facility staff entered their own orders into the electronic MAR system and the administration time for once daily medications usually defaulted to 8:00am.
-Resident #9 was seen by the facility's house PCP on 02/11/19 and a new FL-2 was completed but the PCP forgot to sign it before she left the facility.
-They had the PCP to sign Resident #9's new FL-2 on 02/12/19, which included an order for the Levothyroxine to be administered at 6:00am.
-She thought she changed the time to 6:00am on the electronic MAR on 02/12/19.
-She did not know why the time on the MAR still showed 8:00am for the Levothyroxine because it should have been scheduled for 6:00am.
-She would correct the time on the MAR.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/19 at 12:35pm revealed:
-The pharmacy received Resident #9's FL-2 dated 02/07/19 on 02/08/19 at 3:47pm with an order for Levothyroxine to be administered daily.
-The facility staff entered their own orders and they may have the default time for once daily medications set at 8:00am.
-Levothyroxine should be administered on an empty stomach and was usually administered at 6:00am before the morning meal and before any other medications were administered due to

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absorption issues.
-The pharmacy did not receive Resident #9's FL-2 dated 02/12/19 until today, 02/13/19, which had an order for Levothyroxine to be administered at 6:00am.
-The facility would have been responsible for entering the time change on the MAR from the new order on 02/12/19.

Interview with Resident #9 on 02/18/19 at 11:15am revealed:
-She usually got her medications at the same time in the morning but she could not give a timeframe.
-She could not recall if she received any medication prior to eating breakfast.

d. Review of Resident #9's Resident Register revealed the resident as admitted to the facility on 02/08/19.

Review of Resident #9's admission FL-2 dated 02/07/19 revealed there was an order for Oscal D but the strength, dosage, and frequency to be administered were not included. (Oscal D is a calcium supplement with Vitamin D used to prevent and treat calcium deficiency and reduce the risk of osteoporosis.)

Review of Resident #9's current FL-2 dated 02/12/19 revealed:
-Diagnoses included hypothyroidism, osteopenia, type 2 diabetes - diet controlled, vascular dementia, gastroesophageal reflux disease, and primary open angle glaucoma.
-There was an order for Oscal D 500/200 take 1 tablet daily.

Review of Resident #9's February 2019 medication administration record (MAR) revealed:

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-There was an electronic entry for Oscal D 500/200 1 tablet once a day for vitamin supplement and it was scheduled to be administered at 8:00am.
-Oscal D was not documented as administered from 02/09/18 - 02/12/19 with no reason for the omissions documented.

Observation of the 8:00am medication pass on 02/13/19 revealed:
-The medication aide prepared and administered morning medications to Resident #9 at 9:48am.
-The resident was not administered any Oscal D as ordered.
-There was no Oscal D available for administration for Resident #9.

Interview with the MA on 02/13/19 at 9:48am revealed:
-He did not administered Oscal D to Resident #9 because there was none to administer.
-They were waiting for the medication to come in from the pharmacy.
-He would check with the pharmacy about the Oscal D.

A second interview with the MA on 02/13/19 at 10:56am revealed:
-He just called the pharmacy and they did not have a copy of Resident #9's FL-2 dated 02/12/19 with the complete order for Oscal D.
-He just faxed the FL-2 dated 02/12/19 to the pharmacy and they would send the Oscal D to the facility tonight.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/13/19 at 12:35pm revealed:
-The pharmacy received Resident #9's FL-2 dated 02/07/19 on 02/08/19 at 3:47pm and the

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Oscal D order was incomplete.
-They had contacted the provider to get clarification of the order and did not receive a complete order until today, 02/13/19.
-They received the FL-2 dated 02/12/19 from the facility with the complete order for Oscal D on today, 02/13/19.
-If they had received the new order on 02/12/19, they would have dispensed it and it would have been delivered to the facility on the night of 02/12/19.

Interview with the Resident Care Coordinator (RCC) on 02/13/19 at 1:30pm revealed:
-She thought she tried to contact Resident #9's provider who signed the 02/07/19 FL-2 to clarify the Oscal D order.
-She was not sure if she documented that she tried to call the provider.
-The resident was seen by the facility's house primary care provider (PCP) on 02/11/19 and a new FL-2 was completed but the PCP forgot to sign it.
-The PCP signed the new FL-2 on 02/12/19 but she was not sure if a copy was faxed to the pharmacy.
-The facility staff were supposed to use an order tracking form to track the implementation of the orders.
-She could not find an order tracking form for the FL-2 dated 02/12/19.

Interview with the Health and Wellness Director (HWD) on 02/13/19 at 1:50pm revealed:
-Resident #9 was admitted to the facility last week from another state and they were in the process of switching the resident to the facility's house primary care provider (PCP)
-The Resident Care Coordinator/Licensed Practical Nurse (RCC/LPN) had tried contacting

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the provider who signed the FL-2 dated 02/07/19 to clarify the Oscal D order.
-The RCC/LPN had been unsuccessful in getting clarification from the previous provider.
-The resident saw the facility's PCP on 02/11/19 and a new FL-2 was written but the PCP forgot to sign it.
-They had the PCP to sign the new FL-2 on 02/12/19 and it should have been faxed to the pharmacy on 02/12/19.

Interview with the RCC/LPN on 02/13/19 at 2:07pm revealed:
-She tried to contact Resident #9's provider who wrote the FL-2 dated 02/07/19 with the incomplete order for Oscal D multiple times.
-The facility was in the process of switching the resident to the facility's house PCP.
-The resident was seen by the facility's PCP on 02/11/19 and a new FL-2 was signed on 02/12/19 which included a complete order for the Oscal D.
-The new FL-2 should have been faxed to the pharmacy on 02/12/19 but she was not sure why it was not faxed.
-The new FL-2 was faxed to the pharmacy today, 02/13/19, and the Oscal D would be delivered to the facility tonight.

Interview with Resident #9 on 02/18/19 at 11:15am revealed:
-She usually got her medications about the same time every day.
-She did not know which medications she was received.
-She thought the facility usually had her medications on hand but she was not sure.

e. Review of Resident #10's current FL-2 dated 02/21/18 revealed:
-Diagnoses included diabetes,

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hypercholesterolemia, coronary artery disease, left breast cancer, anemia, atherosclerotic heart disease, and osteoarthritis.
-There was an order for Humalog KwikPen inject 4 units daily. (Humalog is rapid-acting insulin used to lower blood sugar. The manufacturer instructs a new needle should be pushed and twisted onto the pen prior to each use. The Humalog KwikPen should be primed after the needle is attached with a 2 unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)

Review of Resident #10's February 2019 medication administration record (MAR) revealed:
-There was an entry for Humalog KwikPen inject 4 units subcutaneously once a day and it was scheduled for administration at 1:00pm.
-The resident's blood sugar was checked once daily at 6:00am and it ranged from 201 - 324 from 02/01/19 - 02/14/19.

Observation of the 1:00pm medication pass on 02/14/19 revealed:
-The medication aide (MA) got Resident #10's Humalog KwikPen from the top drawer of the medication cart.
-The MA dialed the dosage to 4 units but she had not put a needle on the pen.
-The MA went into the resident's room and got a pen needle from the resident.
-The MA pushed and twisted the needle onto the pen.
-The MA administered Humalog to the resident at 12:47pm.
-The MA did not perform a 2 unit air shot after applying the needle to the pen and she had already dialed the dose prior to applying the needle.

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Interview with the MA on 02/14/19 at 12:50pm revealed:
-She had diabetes training by the Health and Wellness Director (HWD).
-She remembered talking about insulin pens and doing air shots.
-She did not usually do an air shot with the insulin pens because she felt like she was wasting insulin by doing the air shot.
-Resident #10 bought and kept her own needles for the insulin pens in her room.
-The MAs would get a needle from the resident each time.
-She was not aware the needle should be applied to the pen prior to the air shot or prior to dialing the dose.

Interviews with the HWD on 02/14/19 at 2:12pm revealed:
-She was a registered nurse and she had done diabetes training with the MAs at least annually.
-The training included the use of insulin pens.
-The MAs were supposed to put a safety needle on the insulin pen prior to performing a 2 unit air shot, then dialing the ordered dose.
-She would re-educate the MAs to assure this was being done.

Interview with Resident #10 on 02/14/19 at 1:00pm revealed:
-Her blood sugar was usually checked once a day in the mornings before breakfast.
-Her blood sugar had always ran high, in the 200s or 300s.
-She bought her own needles for the insulin pens and kept them in her room.
-The MAs would get a pen needle from her each time they gave her an injection.
-She had seen the MAs do air shots sometimes when using the Humalog insulin pen but "mostly

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they just dial to 4".

f. Review of Resident #11's current FL-2 dated 03/07/18 revealed:
-Diagnoses included hyperlipidemia, anxiety, seizures, anemia, Vitamin D deficiency, asthma, and dry eye syndrome.
-There was an order for Fish Oil 1000mg take 1 capsule 3 times daily. (Fish Oil is a supplement that may be used to lower triglycerides.)

Review of Resident #11's February 2019 medication administration record (MAR) revealed:
-There was an electronic entry for Fish Oil 1000mg take 1 capsule 3 times a day for supplement.
-Scheduled administration times were 800am, 1:00pm, and 8:00pm.

Observation of the 1:00pm medication pass on 02/14/19 revealed:
-The medication aide (MA) retrieved a large over-the-counter manufacturer bottle from the medication cart that was not labeled with any resident's name.
-The MA indicated the bottle belonged to Resident #11 and she got 1 gel capsule from the bottle and put in a medication cup.
-The manufacturer label was Fish Oil 1200mg with Vitamin D3 2000units.
-The MA administered 1 of the Fish Oil 1200mg with Vitamin D3 capsules to Resident #11 instead of Fish Oil 1000mg as ordered.

Interview with the MA on 02/14/19 at 2:10pm revealed:
-She made a mistake and administered another resident's Fish Oil capsule to Resident #11 during the 1:00pm medication pass.
-Resident #11 used to have an over-the-counter

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bottle of Fish Oil but she now had a supply in a bubble card from the primary pharmacy.
-She did not notice the Fish Oil she administered was the wrong strength and product and the other resident's name should have been written on the bottle.

Observation of Resident #11's medications on hand on 02/14/19 at 2:10pm revealed the resident had a bubble card of Fish Oil 1000mg capsules dispensed on 01/21/19.

Interview with the Health and Wellness Director (HWD) on 02/14/19 at 2:24pm revealed:
-The MAs had been trained to compare the medication labels with the MARs 3 times when administering medications.
-If something did not match, the MA should stop and determine why there was a discrepancy prior to administering the medications.
-Over-the-counter medication bottles should at least have the resident's name written on them.

g. Review of Resident #12's current FL-2 dated 02/13/18 revealed diagnoses included Parkinson's disease, acute metabolic encephalopathy, pneumonia, urinary tract infection, weakness, and hypothyroidism.

Review of Resident #12's current hospice physician's orders dated 08/22/18 revealed an order for Dicyclomine 10mg 1 tablet every 6 hours as needed for abdominal pain. (Dicyclomine is used to treat spasms of the digestive system.)

Review of Resident #12's February 2019 medication administration record (MAR) revealed:
-There was an electronic entry for Dicyclomine 10mg before meals and at bedtime for abdominal

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pain with scheduled administration times of 7:00am, 11:00am, 4:00pm, and 8:00pm.
-Dicyclomine was documented as administered before meals and at bedtime from 02/01/19 - 02/15/19.
-There was no entry for Dicyclomine as needed (prn) on the MAR.

Observation of the 11:00am medication pass on 02/15/19 revealed:
-The medication aide (MA) prepared and administered Dicyclomine 10mg to Resident #12 at 11:43am.
-The resident did not request the medication and he did not complain of any abdominal pain.

Observation of Resident #12's medications on hand on 02/15/19 at 2:13pm revealed there were two supplies of Dicyclomine on hand and both labels had instructions to take it every 6 hours as needed for abdominal pain.

Interview with the MA on 02/15/19 at 2:13pm revealed:
-She had not noticed the instructions on the labels for Dicyclomine did not match the instructions on the MAR.
-She had always administered the Dicyclomine as a scheduled medication as noted on the MAR.
-The resident usually complained of abdominal pain about once a week.
-The resident had not complained of abdominal pain today, 02/15/19.

Interview with the Health and Wellness Director (HWD) on 02/15/19 at 12:14pm revealed:
-It appeared the order was entered incorrectly by a MA on the electronic MAR.
-The order was entered as scheduled instead of prn.

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-She would contact the hospice provider about the Dicyclomine.

Interview with Resident #12's hospice nurse on 02/15/19 at 1:36pm revealed:
-Resident #12 was prescribed Dicyclomine for symptoms of abdominal pain caused by stomach motility problems.
-The medication seemed to be helping the resident so she was going to check with the hospice physician about changing the current order from a prn to a scheduled medication.

Based on observations, interviews, and record reviews, it was determined Resident #12 was not interviewable.

2. Review of Resident #7's current FL-2 dated 08/08/18 revealed the resident's diagnoses included dementia, breast cancer, secondary lung cancer, and neuromuscular dysfunction of the bladder.

a. Review of Resident #7's physician's orders dated 08/14/18 revealed an order for Natural Balance Tears 0.4% 2 drops in both eye twice a day for dry eyes. (Natural Balance Tears is a lubricating eye drop used for dry eyes.)

Observation of Resident #7 on 02/12/19 at 5:12pm revealed:
-The resident was lying in bed and did not speak when asked questions.
-Both of the resident's eyes and eyelids were very red with the left eyelid more than the right.

Review of Resident #7's February 2019 medication administration record (MAR) revealed:
-There was an electronic entry for Natural Balance Tears Solution 0.4% instill 2 drops in

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both eye two times a day for dry eyes.
-The eye drops were scheduled for administration at 8:00am and 7:00pm from 02/01/19 - 02/05/19 then changed to 9:30am and 7:00pm on 02/06/19.
-Natural Balance Tears was documented as administered twice daily from 02/01/19 - 02/13/19.

Observation of Resident #7's medications on hand on 02/15/19 at 4:24pm revealed:
-There was one bottle of Opti-Clear 0.05% eye drops dispensed on 09/07/18. (Opti-Clear is a decongestant eye drop used to treat redness of the eyes but is not the same as Natural Tears Balance eye drops. Opti-Clear should only be used 3 to 4 days at a time because overuse may result in increased redness due to rebound effect.)
-There was no bottle of Natural Tears Balance eye drops for the resident in the medication cart.

Review of Resident #7's physician's orders revealed no order for Opti-Clear eye drops.

Interview with a medication aide (MA) on 02/15/19 at 4:24pm revealed:
-The Opti-Clear eye drops was the only bottle of eye drops currently on hand for Resident #7.
-Opti-Clear was the eye drops they were using for the entry on the MAR for Natural Tears Balance.
-The MA was not sure if Opti-Clear and Natural Tears Balance was the same medication.
-The resident had a different bottle in the past that they used but she could not find it and she did not recall how long it had been since she last saw or used the other bottle.
-Both of the resident's eyes were red and they had been red for "months".

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Interview with the Health and Wellness Director (HWD) on 02/18/19 at 4:00pm revealed:
-The MAs had been trained to compare the medication labels with the MAR 3 times when administering medications.
-If the label and the MAR did not match, the MAs were not supposed to administer the medication until the discrepancy was resolved.
-She thought the MA had found another bottle of eye drops in Resident #7's room.

A second interview with the MA on 02/18/19 at 4:03pm revealed:
-She found another bottle of eye drops in Resident #7's room in a storage drawer.
-This was the bottle she thought they had used previously to administer to the resident instead of the Opti-Clear.
-She thought this bottle may have been left in the resident's room by accident by a MA.
-She did not know how long the bottle had been in the resident's room.
-The resident would sometimes turn her head when the MA tried to put the Opti-Clear eye drops in her eyes.
-The resident could not tell you if her eyes hurt or were burning and dry.

Observation of the eye drop bottle found by the MA on 02/18/19 at 4:03pm revealed:
-The name of the drops was Dry Eye Relief 0.2% lubricating eye drops. (Dry Eye Relief is a lubricating eye drop like Natural Balance Tears but it was 0.2% instead of 0.4%.)
-There was a label taped on the bottle with the resident's name and Natural Balance Tears typed on the label.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/18/19 at

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3:37pm revealed:
-The pharmacy had an order on the FL-2 dated 08/08/18 for Natural Tears for Resident #7.
-The pharmacy had not dispensed any Natural Tears for the resident.
-They had dispensed a bottle of Opti-Clear on 09/07/18.
-He could not find an order for the Optic-Clear on file.
-He was not sure why the Opti-Clear was dispensed.
-Both Opti-Clear and Natural Tears were over-the-counter eye drops and did not require a prescription.

Observation of Resident #7 on 02/18/19 at 10:55am revealed:
-The resident was lying in bed and would not speak when asked questions.
-Both of the resident's eyelids were red with more redness in the left eye.
-There was a small amount of yellow drainage in the outer corner of the resident's right eye.

Interview with Resident #7's family member on 02/18/19 at 10:55am revealed:
-The MAs administered eye drops to the resident every day but he was not sure what kind was administered.
-The resident's eyes and eyelids had been red for at least 2 months and the hospice provider was aware.
-The resident did not complain about her eyes.

b. Review of Resident #7's current FL-2 dated 08/08/18 revealed an order for Miralax 17gm daily. (Miralax is a laxative used to treat and prevent constipation.)

Review of Resident #7's February 2019

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medication administration record (MAR) revealed:
-There was an entry for Miralax give 17gm in liquid once a day for constipation.
-Miralax was scheduled for administration at 8:00 from 02/01/19 - 02/05/19 then it changed to 9:30am on 02/06/19.
-Miralax was not documented as administered on 7 days including 02/01/19, 02/04/19, 02/06/19, 02/07/19, and 02/09/19 - 02/11/19 due to the medication being out and waiting on the pharmacy.

Observation of Resident #7's medications on hand on 02/15/19 at 4:24pm revealed:
-There was one bottle of Miralax (30 day supply) dispensed on 02/07/19.
-The bottle was over 3/4ths full of Miralax powder.

Interview with the medication aide (MA) on 02/15/19 at 4:24pm revealed:
-She did not recall Resident #7 running out of Miralax but she usually worked on second shift.
-The MAs were supposed to reorder medications before they ran out.
-If the medication did not come in, the MAs were supposed to call the pharmacy.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/18/19 at 3:37pm revealed:
-They first dispensed a 30 day supply of Miralax for Resident #7 on 11/24/18.
-There was no request to refill the Miralax again until 02/07/19 when another 30 day supply was dispensed.

Interview with the Health and Wellness Director (HWD) on 02/18/19 at 4:00pm revealed:
-She was not aware Resident #7 had run out of Miralax this month.

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D 358	Continued From page 84 -The MAs were responsible for ordering medications before they ran out. -If the medication was not received, the MAs were supposed to call the pharmacy and report it to her. -The MAs should check the medication cart thoroughly and any back up supplies to make sure they are not overlooking a medication that may be available. -She did not know why the resident ran out of Miralax. Interview with Resident #7's family member on 02/18/19 at 10:55am revealed: -The resident was supposed to get Miralax every day and he assumed she was getting it every day because he thought it was already mixed in the water when the MAs came into the room. -He did not know if the facility had run out of the Miralax at any time. -The resident was not having any current bowel issues. Based on observations, interviews, and record review, Resident #7 was not interviewable. 3. Review of Resident #5's current FL-2 dated 06/29/18 revealed: -Diagnoses included stroke, Parkinson's disease, chronic obstructive pulmonary disease, congestive heart failure, hypertension, hyperlipidemia, and gastroesophageal reflux disease. -There was an order for Miralax 17gm twice a day. (Miralax is a laxative used to treat and prevent constipation.) Review of Resident #5's December 2018 - February 2019 medication administration records (MARs) revealed:	D 358		

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-There were electronic entries on each MAR for Miralax give 1 tablespoon mixed with 8 ounces of water as needed for constipation.
-No Miralax was documented as administered from 12/01/18 - 02/14/19.
-There was no entry on any of the MARs for Miralax to be administered twice daily as ordered.

Review of Resident #5's current list of medication orders from the primary care provider (PCP) dated 12/03/18 revealed:
-There was an order for Miralax 1 measured capful and mix in 8 ounces of water or juice twice daily.
-There was no order for Miralax to be administered as needed (prn).

Observation of Resident #5's medications on hand on 02/19/19 at 1:35pm revealed there was 1 bottle of Miralax dispensed on 05/23/18 with instructions to measure 1 capful (17gm) and mix in 8 ounces of water or juice twice a day.

Interview with the medication aide (MA) on 02/19/19 at 1:35pm revealed:
-She only administered the Miralax as needed as indicated on the MAR.
-She had not noticed the label on the bottle did not match the MAR.
-She thought the Miralax order was changed to prn but she could not recall when it may have changed.
-The resident had not complained of constipation to her knowledge.

Review of Resident #5's physician's order revealed no order changing the Miralax from scheduled to prn.

Interview with the Health and Wellness Director

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(HWD) on 02/19/19 at 5:15pm revealed:
-She was unaware of the discrepancy with Resident #5's Miralax.
-The MAs had been trained to compare the medication labels with the MAR 3 times when administering medications.
-If the label and the MAR did not match, the MAs were not supposed to administer the medication until the discrepancy was resolved.
-She would contact Resident #5's PCP regarding the Miralax.

Interview with Resident #5 on 02/19/19 at 1:50pm revealed:
-He was not sure if he was receiving any Miralax.
-He had problems with constipation "sometimes but not often".
-He was not currently having any issues with constipation.

Attempted telephone interview with Resident #5's PCP and pharmacy on 02/20/19 at 5:58pm was not successful.

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The facility failed to administer medications as ordered for 5 of 7 residents observed during the medication passes resulting in a 28% medication error rate with 7 errors out of 25 opportunities. The medication aide used improper technique when administering insulin with an insulin pen to Resident #10. Resident #8 and Resident #9 missed doses of supplements due to the medications being unavailable. Resident #11 was administered another resident's Fish Oil supplement that was the wrong strength and had another supplement in the capsule not ordered for Resident #11 to receive. Two of 7 residents sampled did not receive medications as ordered including Resident #7 who did not receive the correct eye drops resulting in the resident's eyes

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and eyelids being red and irritated for at least two months. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/15/19 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 6, 2019.

D 406 — 10A NCAC 13F .1009(b) Pharmaceutical Care — D 406

10A NCAC 13F .1009 Pharmaceutical Care
(b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to follow-up on medication review recommendations for 3 of 4 sampled residents (#2, #5, #7) related to medications for constipation and pain and inflammation (#7), allergies (#2), and getting updated signed six month physicians orders (#5).

The findings are:

1. Review of Resident #7's current FL-2 dated 08/08/18 revealed:
-Diagnoses included dementia, breast cancer, secondary lung cancer, and neuromuscular

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dysfunction of the bladder.
-There was an order for Miralax 17mg daily. (Miralax is a laxative used to treat and prevent constipation.)

Review of Resident #7's physician's orders dated 08/29/18 revealed an order for Ibuprofen 200mg 2 tablets every 6 hours as needed for pain. (Ibuprofen is for pain and inflammation.)

Review of Resident #7's medication review dated 12/04/18 revealed:
-The pharmacist recommended to add "mix in 4 - 8 ounces of liquid" to the instructions for Miralax.
-The pharmacist noted the resident had not used prn (as needed) Ibuprofen in 60 - 90 days and recommended the order be discontinued due to non-use.
-The section for the physician's response and signature was blank.

Review of Resident #7's February 2019 medication administration record (MAR) revealed:
-There was an entry for Miralax give 17gm in liquid once a day for constipation.
-There were no instructions on the MAR to mix in 4 to 8 ounces of liquid.
-There was an entry for Ibuprofen 200mg 2 tablets every 6 hours as needed for pain.
-No Ibuprofen was documented as administered and the order had not been discontinued.

Review of Resident #7's physician's orders revealed there was no documentation the pharmacist's recommendations had been forwarded to the physician.

Interview with the Health and Wellness Director (HWD) on 02/18/19 at 4:15pm revealed if there was no documentation of Resident #7's

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recommendations being forwarded the physician, then it had not been done.

Refer to interview with the HWD on 02/18/19 at 4:15pm.

2. Review of Resident #5's current FL-2 dated 06/29/18 revealed diagnoses included stroke, Parkinson's disease, chronic obstructive pulmonary disease, congestive heart failure, hypertension, hyperlipidemia, and gastroesophageal reflux disease.

Review of Resident #5's medication review dated 12/04/18 revealed the pharmacist recommended to file updated signed 6 month physician orders.

Review of Resident #5's six month physician orders sheet dated 07/09/18 revealed:
-The order sheet listed 16 different medications.
-The order sheet had not been signed by a physician.
-There was no documentation the form had been forwarded to the physician for signing.

Review of Resident #5's physician's order revealed there were no other six month physician order sheets in the resident's record.

Interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:15pm revealed she was unaware Resident #5's six month physician order sheets had not been signed.

Refer to interview with the HWD on 02/18/19 at 4:15pm.

3. Review of Resident #2's current FL-2s dated 08/11/18 revealed her diagnoses included acute cardiovascular accident, altered mental status,

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chronic pain, gastroesophageal reflux disease and hypertension.

Review of Resident #2's medication review dated 12/03/18 revealed:
-The resident had an order for routine Allegra and Allegra D prn (as needed). (Allegra is for allergies. Allegra D is also for allergies but also contains a decongestant.)
-The pharmacist noted the resident had not used the prn Allegra D.
-The pharmacist recommended the physician discontinue the prn Allegra D due to non-use.
-The area on the form for the physician to respond was blank.
-There was no documentation the recommendation had been forwarded to the physician.

Review of Resident #2's December 2018 - February 2019 medication administration records (MARs) revealed:
-There was a computerized entry for Allegra 180mg once a day for allergies and it was documented as administered daily at 8:00 a.m.
-There was a computerized entry for Allegra D, 1 tablet twice a day as needed for allergies and none was documented as administered from December 2018 - February 2019.

Interview with the Health and Wellness Director (HWD) on 02/19/19 at 4:05 p.m. revealed:
-The pharmacist's recommendation for Resident #2 may have been sent to the resident's former physician instead of the resident's current primary physician.
-She would follow-up on the medication review recommendation for Resident #2 with the current physician.
-She would make sure that a system was put in

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place to keep track of follow-ups to the pharmacist's recommendations.

Refer to interview with the HWD on 02/18/19 at 4:15pm.

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Interview with the HWD on 02/18/19 at 4:15pm revealed:
-She usually received the pharmacist's recommendations electronically and she would print them and pass them to the Resident Care Coordinator / Licensed Practical Nurse (RCC/LPN) and the RCC.
-The RCC/LPN and the RCC were responsible for following up on the recommendations.
-One of them would follow up on the nursing recommendations and the other RCC would follow up on the recommendations that needed sending to the physicians.
-The medication reviews completed in December 2018 would have been the responsibility of the former RCC who no longer worked at the facility.
-The new RCCs were currently in the process of working on the December 2018 recommendations but they had not completed them.

D 451 | D 451

10A NCAC 13F .1212(a) Reporting of Accidents and Incidents

10A NCAC 13F .1212 Reporting of Accidents and Incidents
(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.

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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 was notified of all accidents and incidents which resulted in injury to 4 of 4 sampled residents (#1, #3, #5, #6) who required referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.

The findings are:

1. Review of Resident #3's current FL-2 dated 12/12/18 revealed diagnoses included hypertension, hyperlipidemia, diabetes mellitus, arthritis, and Parkinson's disease.

Review of "Progress Notes" for Resident #3 revealed:
-There was documentation on 01/01/19 at 2:51am Resident #3 fell at approximately 1:10am while using restroom, she attempted to use walker but fell and hit her head on the walker.
-Resident #3 was not able to answer simple questions such as name, date of birth and was sent to the emergency room (ER).
-There was documentation on 02/10/19 at 2:06pm Resident #3 fell that morning, bumped her head and had a knot on the back of her head.
-Resident #3 was sent out to the ER.

Review of Resident #3's record revealed:
-An ER visit on 01/01/19 had Resident #3's chief complaint was a fall.

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-ER visit found Resident #3 had no new injuries and was discharged back to facility.
-An ER visit on 02/10/19 had Resident #3's chief complaint being a fall with complaint of back and shoulder pain.
-There was a history of recent rib fractures per family member at bedside.
-Resident #3 had no new injuries and was discharged back to facility.
-An ER visit on 02/13/19 had Resident #3's chief complaint being a fall.
-The x-rays of Resident #3's bilateral shoulders showed possible rotator cuff tear on the right based on superior migration of the humeral head.
-Resident #3 was deemed stable by ER and was discharged back to the facility.

Review of Resident #3's record revealed there were no completed Incident/Accident Reports for Resident #3 available for review.

Refer to interviews with the Health and Wellness Director (HWD) on 02/13/19 at 11:28am and 02/19/19 at 4:05pm.

Refer to interview with a medication aide (MA) on 02/13/19 at 11:59am.

Refer to telephone interview with the county DSS Supervisor on 02/15/19 at 11:06am.

Refer to interview with Executive Director (ED) on 02/20/19 at 1:42pm.

2. Review of Resident #1's current FL-2 dated 12/20/18 revealed diagnoses included pneumonia, disorder of prostate, sepsis, unsteadiness on feet, type 2 diabetes, hypoglycemia, cognitive communication deficit, hyperlipidemia, sensorineural hearing loss,

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essential (primary) hypertension, allergic rhinitis due to pollen, and muscle weakness.

Review of "Progress Notes" for Resident #1 revealed:
-On 11/15/18 at 9:38pm, a facility staff and Resident #1's family member entered resident's room around 6:30pm and found Resident #1 sitting in his recliner chair with his head slumped to the left with a streak of blood that ran from his mouth.
-Facility staff shook Resident #1 to wake him but got no response, could not feel a strong pulse, emergency medical services (EMS) was called and the resident was sent to the emergency room (ER).
-On 02/04/19 at 7:32am, Resident #1 was trying to get off bed and fell between bed and dresser, hitting his head on dresser, right leg and arm also had major skin tear that was bleeding uncontrollably and Resident #1 was sent to ER.

Review of Resident #1's hospital records revealed:
-An ER visit on 11/15/18 had Resident #3's chief complaint being altered mental status due to unresponsiveness when EMS arrived and found resident slumped over with sonorous breathing, with an initial fasting blood sugar of 54.
-An ER visit on 02/04/19 had Resident #3's chief complaint being a fall with laceration of right arm and multiple skin tears.

Review of Resident #1's record revealed there were no completed Incident/Accident Reports for Resident #1 available for review.

Refer to interviews with the Health and Wellness Director (HWD) on 02/13/19 at 11:28am and 02/19/19 at 4:05pm.

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Refer to interview with a medication aide (MA) on 02/13/19 at 11:59 a.m.

Refer to telephone interview with the county DSS Supervisor on 02/15/19 at 11:06 a.m.

Refer to interview with Executive Director (ED) on 02/20/19 at 1:42 p.m.

3. Review of Resident #6's current FL-2 dated 01/16/19 revealed diagnoses included fracture of right pubis-pelvic fracture, hypertension, hyperlipidemia, fatigue, dementia, depression, and tricuspid regurgitation.

Review of Resident #6's Resident Register revealed there was an admission date of 07/09/18.

Review of Resident #6's Care Plan dated 08/14/18 revealed:
-The resident required limited assistance from staff for toileting and eating.
-The resident required extensive assistance from staff for ambulation, bathing, dressing/undressing, personal hygiene/grooming, and transferring.

Review of emergency department provider notes dated 01/13/19 revealed Resident #6 had been seen at the emergency room for a fall that warranted Resident #6 being admitted to the hospital for a right pubis-pelvic fracture.

Interview with Health and Wellness Director (HWD) on 02/20/19 at 12:42pm revealed from her recollection, no incident or accident reports were faxed to the local county Department of Social Services (DSS) for Resident #6.

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Interview with Executive Director (ED) on 02/20/19 at 1:42pm revealed she was not aware that an incident/accident report was not faxed to the local county DSS for Resident #6.

Refer to interviews with the HWD on 02/13/19 at 11:28am and 02/19/19 at 4:05pm.

Refer to interview with a MA on 02/13/19 at 11:59am.

Refer to telephone interview with the county DSS Supervisor on 02/15/19 at 11:06am.

Refer to interview with ED on 02/20/19 at 1:42pm.

4. Review of Resident #5's current FL-2 dated 06/29/18 revealed diagnoses included stroke, Parkinson's disease, chronic obstructive pulmonary disease, congestive heart failure, hypertension, hyperlipidemia, and gastroesophageal reflux disease.

Review of Resident #5's Resident Register dated 06/01/18 revealed:
-The resident required assistance with dressing, bathing, and toileting.
-The resident used a walker, wheelchair, and electric scooter.

Review of Resident #5's assessment and care plan dated 07/06/18 revealed the resident required extensive assistance with all activities of daily living, including ambulation, toileting, and transferring.

Review of Resident #5's progress notes revealed:
-On 02/09/19 (3:35pm), the resident fell in his bathroom this afternoon, had a bad skin tear on

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his right arm, called 911 and resident was transferred to the emergency room (ER).
-On 02/09/19 (11:53pm), the resident fell today and went to the ER, no breaks on right arm just a big skin tear.

Review of Resident #5's hospital discharge note dated 02/09/19 revealed:
-The resident reported he fell in the bathroom and scraped his right arm on the rail and tore his skin.
-The resident had two large skin tears to posterior upper arm.

Review of Resident #5's incident/accident reports revealed no documentation of an incident/accident report for the fall on 02/09/19 and no documentation a report was forwarded to the county Department of Social Services (DSS).

Interview with the Health and Wellness Director (HWD) on 02/19/19 at 3:15pm revealed:
-She could not locate an incident/accident report for Resident #5's fall on 02/09/19.
-If there was no report completed, then no report would have been sent to DSS.
-They would check to see if they could find a post fall evaluation form for the incident.

Interview with the Resident Care Coordinator/Licensed Practical Nurse (RCC/LPN) on 02/19/19 at 3:15pm revealed she could not find a post fall evaluation report for Resident #5's fall on 02/09/19.

Refer to interviews with the HWD on 02/13/19 at 11:28am and 02/19/19 at 4:05pm.

Refer to interview with a medication aide (MA) on 02/13/19 at 11:59am.

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Refer to telephone interview with the county DSS Supervisor on 02/15/19 at 11:06am.

Refer to interview with Executive Director (ED) on 02/20/19 at 1:42pm.

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Interviews with the HWD on 02/13/19 at 11:28am and 02/19/19 at 4:05pm revealed:
-The MA on duty at the time an incident/accident occurred were responsible for completing an incident/accident report.
-An incident/accident report should be completed for falls, elopements, and medication errors.
-She thought incidents/accidents that were required to be sent to DSS included any head injuries or complaints of pain.
-The MAs were supposed to fax a copy to the local county DSS and staple a copy of the fax confirmation to it.
-The MAs were supposed give a copy of the report and confirmation to the HWD.
-The HWD would enter the information into the facility electronic system in the computer and then she would shred the reports.
-That was how she was trained to do it by a staff person at a sister facility.
-She did not know she needed to keep copies of the reports or confirmation to show it was sent to DSS.
-She was not aware the MAs were not faxing the incident/accident reports to DSS.

Interview with a MA on 02/13/19 at 11:59am revealed:
-The MAs were responsible for completing incident/accident reports and faxing them to the local county DSS.
-The MAs called the HWD, the resident's family, and faxed the resident's physician to notify them of the incident/accident.

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-The MA then put the incident/accident report in the HWD's box.
-The MAs used to fax the incident/accident report to the local county DSS and staple the fax confirmation to the report.
-The MAs were supposed to fax all incident/accident reports to DSS even if the resident did not go to the hospital.
-The MAs stopped faxing reports to DSS a few months ago because the fax number to DSS was no longer posted near the fax machine in the medication room.
-She assumed they no longer had to fax to DSS since the number was no longer posted.
-The HWD told the MAs last week that they were supposed to be faxing incident/accident reports to DSS.
-The DSS fax number was still not posted at the fax machine so she had not faxed any reports to DSS.

Telephone interview with the county DSS Supervisor on 02/15/19 at 11:06am revealed:
-The facility had not faxed an incident/accident report to DSS since 06/25/18 at 10:25am.
-The report was dated 06/23/18 at 9:15am.
-She was in the facility on a follow-up visit on 02/05/19 and told the HWD that DSS had not been receiving incident/accident reports.
-The HWD was not aware DSS had not been receiving the reports.
-The HWD reported the MAs knew they were supposed to fax the reports to DSS.

Interview with the ED on 02/20/19 at 1:42pm revealed:
-The facility's clinical department was responsible for faxing incident/accident reports to the local county DSS.
-Any incident/accident resulting in injury requiring

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D 451	Continued From page 100 more than first aid or being sent to the emergency department should be faxed to DSS. -She expected the incident/accident reports to be faxed to DSS in a timely manner. -She was not aware that incident/accident reports were not being faxed to DSS as required. -She would be meeting with the clinical department regarding submitting incident/accident reports timely.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to training on cardio-pulmonary resuscitation, personal care and other staffing, personal care and supervision, medication administration, adult care home infection prevention requirements, and adult care home medication aides training and competency evaluation requirements. The findings are:	D912		

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1. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times who had completed a course on cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months on third shift for 9 of 11 days sampled in January 2019 and February 2019. [Refer to Tag D167, 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to assure aide hours met the minimum requirements on 14 of 33 shifts for 11 days sampled from January 2019 - February 2019 resulting in inadequate staff to meet the supervision and personal care needs of residents. [Refer to Tag D188, 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type A2 Violation)].

3. Based on observations, interviews, and record reviews, the facility failed to assure adequate supervision was provided for 1 of 7 residents sampled (#3) who had multiple falls requiring multiple visits to the emergency room resulting in rib fractures and head injuries. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].

4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 5 of 7 residents (#8, #9, #10, #11, #12) observed during the medication passes, including errors with insulin (#10), a thyroid medication (#9), a medication for digestive tract spasms (#12), a supplement used to lower triglycerides (#11), a medication for acid reflux

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D912	Continued From page 102 (#8), a vitamin B supplement (#8), and a calcium with vitamin D supplement (#9); and for 2 of 7 residents sampled (#5, #7) for record review including errors with eye drops for redness and dryness (#7), and a laxative for treating and preventing constipation (#5, #7). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 13 of 13 diabetic residents (#3, #8, #10, #13, #14, #15, #17, #18, #19, #20, #21, #22, #24) whose blood sugars were checked by staff and resulted in the shared use of glucometers. [Refer to Tag D932, G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 5 staff sampled (A, C) who administered medications had passed the written medication aide exam within 60 days of hire. [Refer to Tag D935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides Training and Competency Evaluation Requirements (Type B Violation)].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne	D932		

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

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

Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 13 of 13 diabetic residents (#3, #8, #10, #13, #14, #15, #17, #18, #19, #20, #21, #22, #24) whose blood sugars were checked by staff and resulted in the shared use of glucometers.

The findings are:

Review of the Center for Disease Control (CDC) and Prevention guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents.

Review of the owner's manual for Brand A glucometer revealed:
-The glucometer "is intended to be used by a single person and not to be shared".
-The glucometer is for "one person use ONLY, DO NOT share your meter" with anyone.

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-"Do not use on multiple patients!"
-All parts of the blood glucose monitoring system could carry blood-borne pathogens after use, even after cleaning and disinfecting.
-Cleaning and disinfecting the meter destroys most, but not necessarily all, blood-borne pathogens.
-Wash your hands thoroughly with soap and warm water before and after handling the meter, lancing device, lancets, or test strips as contact with blood presents an infection risk.
-Clean and disinfect immediately after getting any blood on the meter or if meter is dirty.
-Clean and disinfect the meter at least once a week.
-If the meter is being operated by a second person who provides testing assistance, the meter and lancet device should be disinfected prior to use by the second person.
-Clean and disinfect the meter with "ONLY PDI Super Sani Cloth Wipes".

Review of the owner's manual for Brand B glucometer revealed:
-The glucometer is for "single patient use only".
-Do not share the meter with anyone.
-"Do not use on multiple patients".
-The meter should be cleaned whenever it is visibly dirty by wiping the outside of the meter using a cloth dampened with either mild detergent mixed with water or 70% isopropyl alcohol.
-Do not use bleach or other harsh abrasives to clean the meter.
-If the meter is being operated by a second person who is providing testing assistance to the user, the meter should be decontaminated prior to use by the second person.
-There were no further instructions on how to disinfect the meter.

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Review of the owner's manual for Brand C glucometer revealed:
-The meter is not intended for multi-patient use in a health care setting.
-The meter is for use by a single person.
-The meter must not be used on more than one person including other family members due to the risk of spreading infection.
-All parts of the meter are considered biohazardous and can potentially transmit infectious diseases, even after performing the cleaning procedure.
-For cleaning, wipe the outside surfaces of the meter with a disinfectant wipe until the meter is visibly clean.
-For disinfection, select "new bleach wipe" and remove excess liquid from the wipe.
-Wipe the outer surfaces of the meter with the wipe.

Review of the owner's manual for Brand D glucometer revealed:
-The glucometer is for single patient use only and should not be shared.
-To clean the meter, wipe the outside with a soft cloth dampened with water and mild detergent.
-Do not use alcohol or another solvent to clean the meter.
-No instructions were provided on how to disinfect the meter.

Confidential interview with staff revealed:
-The facility ran out of glucometer test strips for the residents for over a month.
-The facility shared a glucometer to check the residents' blood sugars when they were out of strips.
-The shared glucometer was kept in a medication cart on the B-side of the facility.
-The shared glucometer was a Brand D

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glucometer and was in a grey box.
-The shared glucometer was wiped off with alcohol wipes.
-At least one resident had their own glucometer.

Interview with a medication aide (MA) on 02/20/19 at 11:17am revealed:
-The facility ran out of test strips for Brand A glucometer in the beginning of January 2019.
-They were out of strips for about a month.
-Some residents had a different brand glucometer and did not run out of strips.
-The Resident Care Coordinator (RCC) usually ordered the test strips so she let the RCC know they were out of strips.
-They got a back-up glucometer that appeared to be brand new (Brand D) to use while they were out of strips.
-The Brand D glucometer was shared between at least 7 different residents when she worked.
-The Brand D glucometer was used for residents on the B-side and the C-side of the facility.
-She used disinfectant wipes to "wipe down" the Brand D glucometer after each use.
-They just started back using the residents' individual glucometers about 1 to 2 weeks ago.
-That was the only time they had shared a glucometer to her knowledge.
-The MAs were trained that each resident was supposed to have their own glucometer.

Interview with a second MA on 02/20/19 at 12:25pm revealed:
-Most of the diabetic residents had the same brand of glucometer.
-The facility ran out of strips for the Brand A glucometers about 1 to 2 months ago.
-There was a back-up glucometer (Brand D) stored on the B-side of the facility that was used to check the residents' blood sugars for about 1

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to 2 weeks.
-Some of the residents on the C-side of the facility had different brands of glucometers and did not run out of strips.
-The MA was not sure where the back-up glucometer came from or who put it on the medication cart.
-The MA heard that facility management (not named) had gotten the Brand D glucometer.
-The MAs passed information along to each other to use the Brand D glucometer for residents without strips and use alcohol wipes to clean the glucometer after each use.
-The MAs had always been taught not to share glucometers and that everyone was supposed to have their own glucometer.
-They had disposable safety lancets and lancets were never shared.

Interview with a third MA on 02/20/19 at 2:56pm revealed:
-About a 3 weeks ago, the facility ran out of test strips for the Brand A glucometers.
-Most of the diabetic residents used Brand A glucometers but a few had Brand B or Brand C.
-There was a back-up glucometer (Brand D) that she thought the other MAs used and shared between residents while they were out of strips.
-She did not use the back-up glucometer.
-They were never supposed to share a glucometer.
-The facility had ran out of strips about a year ago so the MA ordered 2 bottles on-line with her personal money.
-The MA used the strips that she had previously ordered when they ran out of strips this time so she would not have to use a shared glucometer.
-The MA took her strips home with her when she left her shift so she would have them with her each time she worked.

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Review of the memory data for Brand D glucometer on 02/19/19 at 5:29pm revealed:
-The glucometer was in a locked storage room in the nurses' office.
-The glucometer was in the manufacturer's box with no resident's name labeled on the box.
-The pouch and the glucometer were not labeled with any resident's name.
-The date and time on the glucometer reflected the current date and time.
-The memory of the glucometer had 207 readings from 01/06/19 at 4:31pm - 02/12/19 at 6:15am.
-There were multiple days in the memory of the glucometer that had several blood sugars checked within the same time period either in the morning or afternoon.
-For example, on 02/12/19, there were 5 readings checked from 4:32am - 6:15am and ranged from 117 - 145.
-For example, on 02/02/19, there were 7 readings checked from 5:11am - 7:59am and ranged from 107 - 183.

1. Review of Resident #24's current FL-2 dated 06/16/18 revealed diagnoses included Parkinson's disease, paroxysmal atrial fibrillation, mood disorder, hypokalemia, polypharmacy, syncope, fall, head injury, and scalp hematoma.

Review of Resident #24's physician's order dated 06/19/18 revealed an order for fingerstick blood sugars (FSBS) to be checked every morning, notify physician if FSBS was less than 60 or greater than 200.

Observation of all medication carts in the facility on 02/20/19 revealed there was no glucometer in the medication carts for Resident #24.

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Interview with a medication aide (MA) on 02/20/19 at 6:25pm revealed:
-She did not know if Resident #24 had a glucometer and she did not see one in the medication cart.
-She did not usually check the resident's blood sugar because it was scheduled to be checked by third shift at 5:30am.

Interviews with Resident #24 on 02/20/19 at 5:25pm and 6:30pm revealed:
-She had her own glucometer that she kept in her room but staff did not use it.
-Staff checked her blood sugar every day at 6:00am with a glucometer staff kept in the medication cart.
-Her name was not on the glucometer that staff used to check her blood sugar.
-She was not sure if staff always used the same glucometer each time they checked her blood sugar.

Interview with the Health and Wellness Director (HWD) on 02/20/19 at 6:30pm revealed:
-She was not aware Resident #24 did not have a glucometer in the medication cart.
-Resident #24 should have her own glucometer in the medication cart.
-Staff had not reported there was no glucometer for Resident #24 in the medication cart.

Telephone interview with a third shift MA on 02/20/19 at 6:35pm revealed:
-Resident #24 did not have glucometer in the medication cart.
-The MA used a "blank" glucometer or the one with no name (referring to Brand D glucometer) to check the resident's blood sugar.
-She last saw that glucometer in the medication cart on the B-side of the facility.

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Review of Resident #24's February 2019 medication administration record (MAR) revealed:
-There was an entry for blood sugar to be checked once daily at 5:30am.
-The resident's blood sugar ranged from 87 - 205 from 02/01/19 - 02/19/19.

Review of the memory data for the Brand D glucometer on 02/20/19 revealed:
-The date and time on the glucometer reflected the current date and time.
-There were 8 of 12 readings in the memory that matched blood sugars documented for Resident #24 from 02/01/19 - 02/12/19.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

2. Review of Resident #17's current FL-2 dated 10/19/18 revealed diagnoses included diabetes mellitus - diet controlled, hypertension, gastroesophageal reflux disease, transient ischemic attack, and hyperlipidemia.

Review of Resident #17's physician's order dated 11/19/18 revealed an order for fingerstick blood sugar (FSBS) to be checked once a week.

Observation of all medication carts in the facility on 02/20/19 revealed there was no glucometer in the medication carts for Resident #17.

Interview with Resident #17 on 02/20/19 at

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5:10pm revealed:
-The facility staff checked her blood sugar with a glucometer that was kept in the medication cart.
-She did not know if the glucometer staff used belonged to her or if it had her name on it.
-She did not notice if the staff always used the same glucometer each time they checked her blood sugar.

Interview with the Health and Wellness Director (HWD) on 02/20/19 at 6:10pm revealed:
-She could not locate a glucometer in the medication carts for Resident #17.
-She did not know what the medication aides (MAs) used to check the resident's blood sugar.

A second interview with the HWD on 02/20/19 at 6:30pm revealed:
-She contacted Resident #17's family member about a glucometer.
-The family member did not think they brought a glucometer to the facility when the resident was admitted.
-The HWD did not recall ordering a glucometer when the resident was admitted.

Telephone interview with a third shift MA on 02/20/19 at 6:35pm revealed:
-Resident #17 did not have glucometer in the medication cart.
-The MA used a "blank" glucometer or the one with no name (referring to Brand D glucometer) to check the resident's blood sugar.
-She last saw that glucometer in the medication cart on the B-side of the facility.

Review of Resident #17's February 2019 medication administration record (MAR) revealed:
-There was an entry for blood sugar to be checked once a week on Mondays.

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-There were only two documented blood sugars: 107 on 02/11/19 and 107 on 02/18/19.

Review of the memory data for the Brand D glucometer on 02/20/19 revealed:
-The date and time on the glucometer reflected the current date and time.
-There was only one reading in the memory for 02/11/19 and it did not match the resident's documented blood sugar of 107.
-There was no reading in the memory for any blood sugars being checked on 02/18/19.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

3. Review of Resident #21's current FL-2 dated 06/08/18 revealed:
-Diagnoses included diabetes, hypertension, hyperlipidemia, glaucoma, and osteoporosis.
-There was an order for fingerstick blood sugar (FSBS) to be checked twice a day.

Observation of Resident #21's Brand A glucometer on 02/20/19 at 2:25pm revealed:
-The glucometer was stored in the top drawer of the B-down hall medication cart.
-The glucometer pouch was labeled with the resident's name but the glucometer was not labeled with any name.
-There was a supply of single-use disposable safety lancets in the drawer.

Review of the memory data for Resident #21's

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Brand A glucometer on 02/20/19 at 2:25pm revealed:
-The date and time on the glucometer did not reflect the current date and time.
-There were 21 readings in the memory of the glucometer for February 2019 that ranged from 76 - 173.
-There were 18 of 21 readings that did not match blood sugars on the resident's February 2019 medication administration record (MAR).
-There were 5 days in February 2019 that had multiple readings taken within a few minutes of each other.
-For example, on 02/18/19, there were 5 readings in the morning taken within a 1 hour and 26 minute time frame.
-There were no blood sugar readings in the memory for 02/01/19 - 02/12/19.

Review of Resident #21's February 2019 MAR revealed:
-The resident's FSBS was checked twice daily at 5:30am and 4:30pm.
-There were 31 blood sugars documented from 02/01/19 - 2/18/19 but only 21 readings in the memory of the glucometer.
-The FSBS readings ranged from 103 - 207, which did not match the range in the resident's glucometer.
-For example, the resident's blood sugar was 103 on the morning of 02/18/19.
-There were 5 morning readings in the glucometer on 02/18/19 but none of the readings matched the resident's blood sugar of 103.

Interview with Resident #21 on 02/20/19 at 5:00pm revealed:
-She had three glucometers in the medication cart with her name on them.
-The facility staff checked her blood sugar every

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day at 5:00am with one of the glucometers staff kept in the medication cart.
-Staff used a glucometer that talked one day last week that read her blood sugar reading as running high.
-She could not remember the reading, just that it was high.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

4. Review of Resident #3's current FL-2 dated 12/12/18 revealed diagnoses included diabetes mellitus, Parkinson's disease, hypertension, hyperlipidemia, and arthritis.

Review of Resident #3's physician's orders revealed:
-There was an order dated 01/05/19 to check fingerstick blood sugars (FSBS) in the morning.
-There was an order dated 02/04/19 to discontinue FSBS checks.

Observation of Resident #3's Brand A glucometer on 02/20/19 at 1:49pm revealed:
-The glucometer was stored in the top drawer of the B-down hall medication cart.
-The glucometer pouch was labeled with the resident's last name but there was no name labeled on the glucometer.
-There was a supply of single-use disposable safety lancets in the drawer.

Review of the memory data for Resident #3's

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Brand A glucometer on 02/20/19 revealed:
-The date on the glucometer reflected the current date of 02/20/19.
-The time on the glucometer was 2:13pm which was 24 minutes after the current time of 1:49pm.
-There were no readings in the memory for February 2019.
-There were 23 readings in the memory for January 2019 that ranged from 107 - 184.
-There were 10 of the 23 readings in the memory that did not match the resident's blood sugars documented on the January 2019 medication administration record (MAR).
-There were no readings in the memory for 01/14/19, 01/17/19, 01/22/19, and 01/28/19 - 01/31/19 but readings were documented on these 7 days on the MAR.
-There were 3 days that had 2 readings each day but the resident was supposed to get her blood sugar checked once a day.

Review of Resident #3's January 2019 and February 2019 MARs revealed:
-The resident's blood sugar was checked once daily at 6:00am until 02/04/19 when the order was discontinued.
-There were 4 blood sugars documented from 02/01/19 - 02/04/19 that ranged from 174 - 225 but none of the readings were in the glucometer.
-There were 27 blood sugars documented from 01/05/19 - 01/31/19 that ranged from 97 - 216 but there were only 23 readings in the glucometer.
-There were 10 documented blood sugars that did not match the readings in the glucometer.
-For example, the blood sugar was documented as 152 on 01/23/19 on the MAR but the reading in the glucometer was 144.

Interview with Resident #3 and her family member on 02/20/19 at 4:45 p.m. revealed:

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-The facility staff checked her blood sugar every morning.
-The glucometer that staff used from the medication cart had her name on the case but not on the glucometer.
-They thought the glucometer the facility kept on the cart was one the resident's family brought from home.
-The resident did not notice if staff always used the same glucometer each time they checked her blood sugar.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

5. Review of Resident #14's current FL-2 dated 10/11/18 revealed diagnoses included type II diabetes mellitus, hypertension, hyperlipidemia, atrial fibrillation with rapid ventricular rate, and anxiety disorder.

Review of Resident #14's physician's order dated 11/07/18 revealed an order to check fingerstick blood sugars (FSBS) once a day.

Observation of Resident #14's Brand A glucometer on 02/20/19 at 2:14pm revealed:
-The glucometer was stored in the top drawer of the B-up hall medication cart.
-The glucometer pouch was labeled with the resident's name and room number and the glucometer was labeled with the room number only.
-There was a supply of single-use disposable

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safety lancets in the drawer.

Review of the memory data for Resident #14's Brand A glucometer on 02/20/19 revealed:
-The date on the glucometer reflected the current date of 02/20/19.
-The time on the glucometer was 1:56pm which was 18 minutes prior to the current time of 2:14pm.
-There were 15 readings in the memory for from 02/01/19 - 02/19/19 that ranged from 140 - 204.
-There were 5 of the 15 readings that did not match the blood sugars on the resident's February 2019 medication administration record (MAR).
-There were no readings in the memory for 02/02/19, 02/03/19, 02/05/19, and 02/15/19 but readings were documented on these 4 days on the MAR.
-There were 23 readings in the memory for 01/01/19 - 01/31/19 that ranged from 107 - 177.
-There were 8 of the 23 readings in the memory that did not match the resident's blood sugars documented on the January 2019 MAR.
-There were no readings in the memory for 01/05/19, 01/10/19, 01/12/19, 01/15/19, 01/19/19, 01/20/19, 01/23/19, and 01/30/19 but readings were documented on these 8 days on the MAR.

Review of Resident #14's January 2019 and February 2019 MARs revealed:
-The resident's blood sugar was checked once daily at 8:00am.
-There were 19 blood sugars documented from 02/01/19 - 02/19/19 that ranged from 140 - 204 but there were only 16 readings in the glucometer.
-There were 30 blood sugars documented from 01/01/19 - 01/31/19 that ranged from 107 - 177 but there were only 23 readings in the

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glucometer.

Interview with Resident #14 on 02/20/19 at 4:55pm revealed:
-The facility staff checked her blood sugar every morning on her way to breakfast.
-Staff used a glucometer in the medication cart to check her blood sugar.
-She thought the glucometer had her name on it.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

6. Review of Resident #13's current FL-2 dated 12/26/18 revealed:
-Diagnoses included diabetes mellitus type II, hypertension, hyperlipidemia, Alzheimer's disease, and unspecified asthma with acute exacerbation.
-There was an order to check fingerstick blood sugars (FSBS) every morning.

Observation of Resident #13's Brand A glucometer on 02/20/19 at 1:53pm revealed:
-The glucometer was stored in the top drawer of the B-down hall medication cart.
-The glucometer pouch was labeled with the resident's name and room number but the glucometer was not labeled.
-There was a supply of single-use disposable safety lancets in the drawer.

Review of the memory data for Resident #13's Brand A glucometer on 02/20/19 revealed:

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-The date and time on the glucometer did not reflect the current date and time.
-There were 2 readings in the memory for February 2019, one on 02/11/19 and the other on 02/14/19 (corrected dates).
-Both readings matched the February 2019 medication administration record (MAR) for those 2 days but there were no readings in the memory for 17 of 19 days from 02/01/19 - 02/19/19.
-There were 4 readings in the memory for 01/01/19 - 01/31/19 that ranged from 123 - 162.
-None of the 4 readings in the memory matched the blood sugars documented on the January 2019 MAR.
-There were no readings in the memory for 01/04/19 and 01/06/19 - 1/31/19 but readings were documented on these days on the MAR.

Review of Resident #13's January 2019 and February 2019 MARs revealed:
-The resident's blood sugar was checked once daily at 6:00am.
-There were 17 blood sugars documented from 02/01/19 - 02/19/19 that ranged from 107 - 216 but there were only 2 readings in the glucometer and they did not match.
-There were 29 blood sugars documented from 01/01/19 - 01/31/19 that ranged from 96 - 224 but there were only 4 readings in the glucometer and they did not match.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

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7. Review of Resident #15's current FL-2 dated 05/17/18 revealed:
-Diagnoses included diabetes mellitus, hypertension, acquired hemolytic anemia, Alzheimer's disease, hypothyroidism, urinary tract infection, dehydration, chest pain, generalized anxiety disorder, major depressive disorder, and aphasia cerebral infarction.
-There was an order to check fingerstick blood sugars (FSBS) once a day.

Observation of Resident #15's Brand A glucometer on 02/20/19 at 2:02pm revealed:
-The glucometer was stored in the top drawer of the B-up medication cart.
-The glucometer pouch was labeled with the resident's name and room number and the glucometer was labeled with the resident's last name.
-There was a supply of single-use disposable safety lancets in the drawer.

Review of the memory data for Resident #15's Brand A glucometer on 02/20/19 revealed:
-The date on the glucometer reflected the current date of 02/20/19.
-The time on the glucometer was 2:26pm which was 24 minutes beyond the current time of 2:02pm.
-There was 1 reading in the memory from 02/01/19 - 02/19/19 and it was 90 on 02/11/19 but the February 2019 medication administration record (MAR) was documented as 91.
-There were no readings in the memory for 18 of 19 days from 02/01/19 - 02/19/19.
-There were only 2 readings in the memory for 01/01/19 - 01/31/19, including 99 on 01/02/19 and 91 on 01/05/19 and they matched the MAR.
-There were no readings in the memory for 01/01/19, 01/03/19, 01/04/19, and 01/06/19 -

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1/31/19 but readings were documented on these days on the MAR.

Review of Resident #15's January 2019 and February 2019 MARs revealed:
-The resident's blood sugar was checked once daily at 5:30am.
-There were 16 blood sugars documented from 02/01/19 - 02/19/19 that ranged from 76 - 150 but there was only 1 reading in the glucometer and it did not match.
-There were 28 blood sugars documented from 01/01/19 - 01/31/19 that ranged from 70 - 154 but there were only 2 readings in the glucometer for that time frame.

Interview with Resident #15 on 02/20/19 at 4:44pm revealed:
-She thought the facility staff checked her blood sugar 3 times a day.
-Staff used a glucometer that was kept in the medication cart.
-She did not know if the glucometer had her name on it.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

8. Review of Resident #8's current FL-2 dated 10/16/18 revealed diagnoses included diabetes mellitus type II, coronary artery disease, hypertension, anxiety with depression, urinary tract infection - complicated, status post placement of ureteral stent, and obstruction of

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right ureteropelvic junction due to kidney stone.

Review of Resident #8's physician's order dated 01/28/19 revealed an order to check fingerstick blood sugars (FSBS) once per week.

Observation of Resident #8's Brand A glucometer on 02/20/19 at 1:59pm revealed:
-The glucometer was stored in the top drawer of the B-down hall medication cart.
-The glucometer pouch was labeled with the resident's name but the glucometer was not labeled.
-There was a supply of single-use disposable safety lancets in the drawer.

Review of the memory data for Resident #8's Brand A glucometer on 02/20/19 revealed:
-The date and time on the glucometer did not reflect the current date and time.
-There were 2 readings in the memory for February 2019.
-The reading in the memory was 116 on 02/11/19 at 6:42am which matched the February 2019 medication administration record (MAR).
-The reading was 207 on 02/17/19 at 4:14pm but there was no weekly blood sugar due to be checked on the MAR on that date.
-There were no readings in the memory for 02/04/19 and 02/18/19 but weekly blood sugars were documented on the MAR for both days.
-There were 3 readings in the memory for January 2019 that ranged from 22 - 99 but none were documented on the MAR.

Review of Resident #8's January 2019 and February 2019 MARs revealed:
-There was no entry for blood sugars to be checked on the January 2019 MAR.
-The resident's blood sugar was checked once

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D932	Continued From page 124 weekly at 6:00am starting on 02/04/19. -There were 3 blood sugars ranging from 116 - 138 documented on the February 2019 MAR but there were only 2 readings in the memory of the glucometer for February 2019. Interview with Resident #8 on 02/20/19 at 4:55pm revealed: -The facility staff checked her blood sugar every Monday at 6:00am with a glucometer that staff kept in the medication cart. -She was not sure if her name was on the glucometer staff used from the medication cart. -She thought staff always used the same glucometer each time they checked her blood sugar. Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm. Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm. Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm. 9. Review of Resident #18's current FL-2 dated 11/13/18 revealed diagnoses included diabetes, atrial fibrillation, hypertension, congestive heart failure, transient ischemic attack, hypothyroidism, cataract, heartburn, hyperlipidemia, and osteoporosis. Review of Resident #18's physician's orders revealed: -There was an order dated 10/23/18 to check fingerstick blood sugars (FSBS) once a day. -There was an order dated 02/04/19 to discontinue FSBS checks.	D932		

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Observation of Resident #18's Brand A glucometer on 02/20/19 at 2:52pm revealed:
-The glucometer was stored in the top drawer of the C-up hall medication cart.
-The glucometer pouch was labeled with the resident's name and the glucometer was labeled with the resident's room number.
-There was a supply of single-use disposable safety lancets in the drawer.

Review of the memory data for Resident #18's Brand A glucometer on 02/20/19 revealed:
-The date and time on the glucometer did not reflect the current date and time.
-There was 1 reading in the memory for February 2019 and it was 156 on 02/16/19 but this resident's blood sugars were discontinued on 02/04/19.
-There were 9 readings in the memory from 01/15/19 - 01/31/19 that ranged from 86 - 108.
-Two of the 9 readings in the memory did not match the blood sugars documented on the January 2019 medication administration record (MAR).

Review of Resident #18's January 2019 and February 2019 MARs revealed:
-There was an entry for blood sugars to be checked daily at 6:00am until it was discontinued on 02/04/19.
-There were 3 blood sugars documented from 02/01/19 - 02/03/19 that ranged from 104 - 107.
-There were 16 blood sugars documented from 01/15/19 - 01/31/19 but 9 readings were in the memory of the glucometer for that time frame.
-The resident's blood sugar ranged from 86 - 115 from 01/15/19 - 01/31/19.

Interview with Resident #18 on 02/20/19 at 5:13pm revealed:

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-The facility staff checked her blood sugar but she was not sure how often.
-The resident had a glucometer with her name on it that was kept in the medication cart.
-She was not sure if staff used the same glucometer each time they checked her blood sugar.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

10. Review of Resident #20's current FL-2 dated 07/18/18 revealed diagnoses included diabetes mellitus type II, multiple myeloma, hyperkalemia, status post acute renal failure, and history of anxiety and depression.

Review of Resident #20's physician's order dated 12/04/18 revealed an order to check fingerstick blood sugars (FSBS) once a day.

Observation of Resident #20's Brand C glucometer on 02/20/19 at 2:10pm revealed:
-The glucometer was stored in the top drawer of the B-up hall medication cart.
-The glucometer pouch was labeled with the resident's name but the glucometer was not labeled.
-There was a supply of single-use disposable safety lancets in the drawer.

Review of the memory data for Resident #20's Brand C glucometer on 02/20/19 revealed:
-The date on the glucometer reflected the current

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date.
-The time on the glucometer was 2:03pm which was 7 minutes prior to the current time of 2:10pm.
-There were 10 readings in the memory of the glucometer from 02/08/19 - 02/19/19 that ranged from 151 - 214.
-Three of the 10 readings did not match the blood sugars documented on the February 2019 medication administration record (MAR).

Review of Resident #20's February 2019 MAR revealed:
-There was an entry for blood sugars to be checked daily at 6:00am.
-There were 11 blood sugarsdocumented in February 2019 that ranged from 151 - 214 but there were only 10 readings in the memory of the glucometer.
-The resident's blood sugar was documented as 188 on 02/13/19 but there was no reading in the memory of the glucometer for that day.

Interview with Resident #20 on 02/20/19 at 4:50pm revealed:
-The facility staff checked her blood sugar every morning and it ran about 100.
-Her family brought a glucometer from home and gave it to the facility staff to use.
-Staff also took the glucometer strips that she had kept in her room at one time and put in the medication cart.
-She did not remember if her name was on the glucometer.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

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Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

11. Review of Resident #22's current FL-2 dated 02/23/18 revealed:
-Diagnoses included diabetes mellitus type II, hypertension, constipation, acute kidney failure, heart failure, post hemorrhagic anemia, hyperlipidemia, benign prostatic hyperplasia, gastroesophageal reflux disease, bladder neck obstruction, and abnormalities of gait and mobility.
-There was an order to check fingerstick blood sugars (FSBS) every morning.

Observation of Resident #22's Brand A glucometer on 02/20/19 at 2:50pm revealed:
-The glucometer was stored in the top drawer of the C-down hall medication cart.
-The glucometer pouch was labeled with the resident's room number but the glucometer was labeled with a different room number (a currently vacant room).
-There was a supply of single-use disposable safety lancets in the drawer.

Interview with the medication aide (MA) on 02/20/19 at 2:50pm revealed:
-He had not noticed the room number on the pouch did not match the room number labeled on the glucometer in the pouch.
-The room number on the pouch was the correct room number for Resident #22.
-Resident #22 had not lived in the other room labeled on the glucometer.
-The other room number was currently a vacant room.
-He did not recall who used to live in the other room or if it was a diabetic resident.

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Review of the memory data for Resident #22's Brand A glucometer on 02/20/19 revealed:
-The date on the glucometer reflected the current date of 02/20/19.
-The time on the glucometer was 2:36pm which was 14 minutes prior to the current time of 2:50pm.
-There were 8 readings in the memory from 02/01/19 - 02/19/19 that ranged from 79 - 112.
-Six of the 8 readings in the memory did not match the blood sugars documented on the February 2019 medication administration record (MAR).
-There were no readings for 02/01/19 - 02/10/19, 02/12/19, 02/13/19, 02/16/19, and 02/19/19.
-There were 3 days in February 2019 when the memory of the glucometer had 2 blood sugars on the same day but the resident only had orders for once daily checks.
-There were 9 readings in the memory for January 2019 that ranged from 83 - 114.
-There were 8 of the 9 readings in the memory that did not match the resident's blood sugars documented on the January 2019 MAR.
-There were no readings in the memory for 01/01/19, 01/06/19 - 01/13/19, 01/15/19, 01/16/19, and 01/18/19 - 01/31/19 14/19, 01/17/19, 01/22/19, and 01/28/19 - 01/31/19 but readings were documented on these days on the MAR.
-There were 3 days that had 2 readings each day in the memory but the resident only had orders for once daily checks.

Review of Resident #22's January 2019 and February 2019 MARs revealed:
-The resident's blood sugar was checked once daily at 6:00am.
-There were 14 blood sugars documented from 02/01/19 - 02/19/19 that ranged from 106 - 136

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174 - 225 but there were only 8 readings in the memory of the glucometer.
-There were 24 blood sugars documented in January 2019 that ranged from 105 - 152 but there were only 9 readings in the glucometer.
-There were 8 documented blood sugars that did not match the readings in the glucometer.
-For example, the blood sugar was documented as 110 on 01/17/19 on the MAR but the reading in the glucometer was 83.

Interview with Resident #22 on 02/20/19 at 5:24pm revealed:
-Staff checked his blood sugar every morning around 6:00am.
-His blood sugars were usually between 110 - 120 and at times, 130.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

12. Review of Resident #10's current FL-2 dated 02/21/18 revealed:
-Diagnoses included diabetes, hypercholesterolemia, coronary artery disease, left breast cancer, anemia, atherosclerotic heart disease, and osteoarthritis.
-There was an order to check fingerstick blood sugars (FSBS) before breakfast and every evening after dinner.

Review of Resident #10's physician order dated 11/19/18 revealed an order to check FSBS before breakfast.

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Observation of Resident #10's Brand B glucometer on 02/20/19 at 1:00pm revealed:
-The glucometer was stored in the top drawer of the C-up hall medication cart.
-The glucometer pouch was labeled with the resident's name and the glucometer was labeled with the resident's name and room number.
-There was a supply of single-use disposable safety lancets in the drawer.

Review of the memory data for Resident #10's Brand B glucometer on 02/20/19 revealed:
-The date and time on the glucometer did not reflect the current date and time.
-There were 14 readings in the memory from 02/06/19 - 02/19/19.
-Two of the 14 readings in the memory did not match the blood sugars documented on the February 2019 medication administration record (MAR).

Review of Resident #10's February 2019 MAR revealed:
-There was an entry for blood sugars to be checked every morning before breakfast.
-There were 12 blood sugars documented on the MAR from 02/06/19 - 02/19/19 but 14 readings were in the memory of the glucometer.
-The resident's blood sugar ranged from 201 - 324.

Interview with Resident #10 on 02/20/19 at 5:00pm revealed:
-The facility staff checked her blood sugar every morning about 5:35am.
-She had her own glucometer that staff kept in the medication cart.
-She kept her own glucometer strips in her room so staff got the strips from her each time they

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checked her blood sugar.
-About 3 or 4 months ago, one of the medication aides (MAs) tried to use a different glucometer that did not belong to the resident so the strips would not fit.
-The MA had to go back to the medication cart and get the resident's glucometer.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

13. Review of Resident #19's current FL-2 dated 02/13/19 revealed:
-Diagnoses included type 2 diabetes mellitus, hyperlipidemia, unspecified dementia without behavior, stenosis of bilateral carotid arteries, essential hypertension, non-rheumatic valve stenosis, cerebral infarction, and atherosclerosis of renal artery.
-There was an order for fingerstick blood sugars (FSBS) to be checked twice a day.

Observation of Resident #19's Brand B glucometer on 02/20/19 at 1:05pm revealed:
-The glucometer was stored in the top drawer of the C-down hall medication cart.
-The glucometer pouch was labeled with the resident's name and room number but the glucometer was not labeled.
-There was a supply of single-use disposable safety lancets in the drawer.

Review of the memory data for Resident #19's Brand B glucometer on 02/20/19 revealed:

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-The date and time on the glucometer did not reflect the current date and time.
-There were 4 readings in the memory of the glucometer through 02/19/19 that ranged from 100 - 174.
-One of the 4 readings did not match the blood sugars documented on the February 2019 medication administration record (MAR).

Review of Resident #19's February 2019 MAR revealed:
-There was an entry for blood sugars to be checked twice daily at 6:00am and 8:00pm.
-There were 3 blood sugars documented in February 2019 that ranged from 100 - 174 but there were 4 readings in the memory of the glucometer.

Interview with Resident #19 on 02/20/19 at 5:27pm revealed:
-The facility staff checked her blood sugar twice a day.
-Staff used a glucometer that was kept in the medication cart.
-She thought staff used the same glucometer every day.
-She did not know if the glucometer was labeled with her name.

Refer to interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm.

Refer to interview with the Executive Director (ED) on 02/19/19 at 6:04pm.

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Interview with the Health and Wellness Director (HWD) on 02/19/19 at 5:16pm revealed:

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-All diabetic residents had their own glucometer and it should only be used for that resident.
-The glucometers should be labeled with the residents' names.
-Around the end of January 2019 or early February 2019, the facility ran out of test strips.
-The supply company told the facility it was too early to refill the test strips.
-They had a back-up glucometer that was new and still in the manufacturer's box.
-The facility's policy was to not share glucometers.
-They had no choice but to use the back-up glucometer because they had no strips.
-All residents had the same glucometer (Brand A) to her knowledge.
-She told the MAs to use the back-up glucometer (Brand D) and to use disinfecting wipes to clean the glucometer after each use.
-She thought it would be okay to do this based on past training as a registered nurse when she worked at a hospital.

Interview with the Resident Care Coordinator (RCC) on 02/19/19 at 5:35pm revealed:
-She usually ordered diabetic supplies including test strips from a supply company out of state.
-She had contacted the company to reorder strips but there some issues with billing and she was told it was too early to refill the strips.
-She could not recall when she contacted the supply company or if she documented it.
-The facility ran out of test strips for the Brand A glucometer, which most residents used.
-They ran out for about 1 ½ weeks and just got the strips on hand about 2 weeks ago.
-The facility used a back-up glucometer (Brand D) to the residents' blood sugars when they were out of strips for Brand A glucometer.
-She thought 2 or 3 diabetic residents had their

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own glucometers that were different brands and did not run out of strips.

Interview with the Executive Director (ED) on 02/19/19 at 6:04pm revealed:
-She was not aware the facility had ran out of test strips.
-She was not aware staff had used and shared a back-up glucometer for multiple residents.
-The facility's policy was they "don't share glucometers".
-She should have been notified by staff.
-The facility could have purchased some strips to use for Brand A glucometers until the strips could be delivered from the supply company.

The facility shared glucometers for 13 of 13 diabetic residents whose fingerstick blood sugars (FSBS) were checked by staff. A back-up glucometer with 207 readings from 01/06/19 - 02/12/19 was shared between multiple residents when the facility ran out of test strips. There were multiple FSBS readings recorded in the memory of the 13 residents' glucometers that did not match FSBS readings documented on their medication administration records (MARs). There were two residents who had no individual glucometer and staff was using the back-up glucometer to check their blood sugars. The failure of the facility to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines was detrimental to the health and welfare of the residents due to possible exposure of blood borne pathogens by the sharing of glucometers and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/20/19 for this violation.

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D932	Continued From page 136 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 6, 2019.	D932		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration.	D935		

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2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

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

Based on observations, interviews, and record reviews, the facility failed to assure 2 of 5 staff sampled (A, C) who administered medications had passed the written medication aide exam within 60 days of hire.

The findings are:

1. Review of Staff A's personnel record revealed:
-Staff A was hired as a nurses' aide on 02/15/18.
-Staff A's position changed and she was hired as a medication aide (MA) on 10/14/18.
-Staff A completed the 15 hour MA training course on 10/17/18.
-Staff A completed a medication clinical skills checklist on 11/27/18.
-There was no documentation of Staff A passing the written MA exam (due within 60 days of hire as a MA on 10/14/18).

Review of the residents' December 2018 - February 2018 medication administration records

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D935	Continued From page 138 (MARs) revealed: -Staff A documented administration of medications beyond the 60 day timeframe ending on 12/13/18. -Staff A documented administration of medications on 12/18/18, 12/20/18, 12/22/18, 12/23/18, and 12/25/18. -Staff A documented administration of medications on 01/03/19, 01/05/19, 01/06/19, 01/08/19, 01/10/19, 01/15/19, 01/17/19, 01/19/19, 01/20/19, 01/22/19, 01/24/19, and 01/31/19. -Staff A documented administration of medications on 02/02/19, 02/03/19, 02/05/19, 02/07/19, 02/14/19, 02/16/19, and 02/17/19. Observation of the 1:00pm medication pass on 02/14/19 revealed: -Staff A dialed the dosage on a Humalog KwikPen to 4 units but she had not put a needle on the pen. (Humalog is rapid-acting insulin used to lower blood sugar. The manufacturer instructs a new needle should be pushed and twisted onto the pen prior to each use. The Humalog KwikPen should be primed after the needle is attached with a 2 unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.) -Staff A then pushed and twisted the needle onto the pen and administered Humalog to a resident. -Staff A did not perform a 2 unit air shot after applying the needle to the pen and she had already dialed the dose prior to applying the needle. -For a second resident, Staff A retrieved a large over-the-counter manufacturer bottle from the medication cart that was not labeled with any resident's name. -Staff A stated the bottle belonged to Resident #11 and she got 1 gel capsule from the bottle and put in a medication cup.	D935		

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-The manufacturer label was Fish Oil 1200mg with Vitamin D3 2000units.
-The MA administered 1 of the Fish Oil 1200mg with Vitamin D3 capsules to Resident #11 instead of Fish Oil 1000mg as ordered.
-Staff A reported after the medication pass that she made an error and the bottle of Fish Oil did not belong to Resident #11.

Interview with Staff A on 02/19/19 at 12:15pm revealed:
-She had been working as a MA at the facility for about 2 months.
-She was told she had 90 days to pass the written MA exam.
-She was supposed to take the written MA exam this month but she had to change the exam date due to personal reasons.
-She was now supposed to take the exam on 03/06/19.

Interview with the Executive Director (ED) on 02/19/19 at 8:50am revealed:
-Staff A had not taken the written MA exam.
-The Business Office Coordinator (BOC) had flagged Staff A's personnel file for the exam to be completed within 90 days of the medication clinical skills checklist.
-Staff A had continued to administer medications even though she had not passed the exam.
-Staff A had been reassigned to work as a resident care aide today instead of administering medications.
-Staff A would not be allowed to administer medications again until she passed the written MA exam.

Refer to interview with the ED on 02/19/19 at 8:50am.

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Refer to interview with the BOC on 02/19/19 at 2:24pm.

2. Review of Staff C's personnel record revealed:
-Staff C was hired as a nurses' aide on 09/07/18.
-Staff C's position changed and she was hired as a medication aide (MA) on 10/14/18.
-Staff C completed the 15 hour MA training course on 10/17/18.
-Staff C completed a medication clinical skills checklist on 10/26/18.
-Staff C did not pass the written MA exam until 01/17/19, more than 60 days from hire as a MA.

Review of the residents' December 2018 - February 2018 medication administration records (MARs) revealed:
-Staff C documented administration of medications beyond the 60 day timeframe ending on 12/13/18 and prior to passing the written MA exam on 01/17/19.
-Staff C documented administration of medications on 12/14/18, 12/17/18 - 12/20/18, 12/22/18, 12/23/18, 12/25/18, 12/26/18, and 12/31/18.
-Staff C documented administration of medications on 01/01/19, 01/02/19, 01/05/19 - 01/11/19, 01/15/19, and 01/16/19.

Interview with Staff C on 02/19/19 at 10:40am revealed:
-She started administering medications in October 2018.
-She scheduled and took the written MA exam in January 2019.
-She was told to take the written MA exam within 90 days from taking the medication training class.

Interview with the Executive Director (ED) on 02/19/19 at 8:50am revealed:

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-Staff C did not pass the written MA exam within 60 days of hire as a MA.
-The Business Office Coordinator (BOC) thought the MAs had 90 days to pass the written MA exam.
-Staff C administered medications beyond the 60 day timeframe and prior to passing the written exam.

Refer to interview with the ED on 02/19/19 at 8:50am.

Refer to interview with the BOC on 02/19/19 at 2:24pm.

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Interview with the ED on 02/19/19 at 8:50am revealed:
-The BOC was unaware the rule had changed and the written MA exam should be completed within 60 days of hire.
-The BOC thought MAs had 90 days to pass the written exam.
-The BOC was responsible for making sure the MAs were qualified and the documentation was on file in the personnel records.
-The BOC used a compliance tracker tool to keep up with the personnel files.

Interview with the BOC on 02/19/19 at 2:24pm revealed:
-She started working as the BOC in December 2018.
-She had made an excel spreadsheet on the computer for a tracking system for the personnel files.
-She had started working on a complete audit of the personnel files but she had only completed about a third of the audit.
-She thought MAs had 90 days from completing the medication clinical skills checklist to pass the

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written exam.
-She was not aware the rule had changed to 60 days from hire.
-The MAs were responsible for setting up their own exam date and they would let her know once it was completed.
-She then printed a medication exam certificate from the medication testing website and file in the personnel record.

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The facility failed to assure 2 of 5 sampled medication aides, who were administering medications, including insulin, to residents in the facility, passed the written medication aide exam in the required timeframe. Staff A was observed during medication pass and made errors with 2 out of 2 medications administered, including an insulin error and administering a medication to one resident that belonged to a different resident. The facility's failure to have qualified medication aides administering medications was detrimental to the health, safety and welfare of the residents, which constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/19/19 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 6, 2019.