STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064032	A. BUILDING: _____ B. WING _____	05/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILL SENIOR LIVING	891 NOELL LANE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on May 15-17, 2019 and May 20-22, 2019 with an exit conference via telephone on May 22, 2019.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 6 of 6 exit doors accessible for residents' use had an alarm that activated for safety for 1 of 1 sampled resident (Resident #13) with dementia and assessed to be intermittently and constantly disoriented, known to wander and had exited from the facility without staff knowledge. The findings are:	D 067		

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Observation, upon entrance to the facility, on 05/15/19 at 10:00am revealed there was no sounding device when the front door was opened.

Observation of the exit door at the end of the hall close to the laundry room on 05/15/19 at 10:55am during the initial tour revealed there was no audible sounding device when the exit door was opened.

Observations during the initial tour of the facility on 05/15/19 from 10:30am until 11:55am revealed:
-The alarm on the women's hall exit door was detached from the door and hanging from a wire.
-When the women's hall exit door was opened no alarm was heard and no staff responded to the open door.

Observation of the exit door in the television room on 05/15/19 at 1:17pm revealed there was no audible sounding devices when the exit door was opened.

Observation of the exit door in the activity room on 05/15/19 at 1:45pm revealed there was no audible sounding device when the exit door was opened.

Observation on 05/15/19 at 4:43pm revealed alarms were not actively working on exit doors when opened on the women's hall.

Observation on 05/15/19 at 4:48pm revealed alarms were not actively working on exit doors when opened on the men's hall.

Review of Resident #13's current FL-2 dated 05/14/19 revealed:
-Diagnoses included Alzheimer's, dementia,

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coronary artery disease, and seizure disorder.
-Constantly disoriented was checked for the resident's orientation status on page 1 of the FL-2.
-Intermittently disoriented was checked for the resident's orientation status on page 2 of the FL-2.

Review of a previous FL-2 for Resident #13 dated 09/26/18 revealed:
-Diagnoses included Alzheimer's, dementia, cerebrovascular accident, coronary artery disease, other acute pulmonary embolism, seizure disorder, hypertension, psoriasis, and depression.
-Intermittently disoriented was checked for the resident's orientation status.

Review of Resident #13's Care Plan dated 09/11/18 revealed the resident was assessed as sometimes disoriented, forgetful, and needed reminders.

Review of a progress note for Resident #13 dated 04/08/19 revealed:
-Resident #13 was found walking outside the facility toward the mailbox when the staff arrived at the facility.
-Resident #13 was assisted back into the facility.
-Resident #13 was later seen behind the back of the facility, was redirected from going toward the road, and another staff came to assist.

Confidential interviews with two staff revealed:
-There was a resident who staff had been instructed to "keep an eye on" a month or so ago because the resident went out.
-The resident acted confused sometimes.
-She did not know if the resident had ever left the facility.

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-There were no alarms on any doors in the facility.

A second confidential interview revealed:
-Resident #13 had left the facility and it wasn't discovered until staff was performing their 2 hour checks.
-The resident was found walking, alone, down a busy highway approximately one quarter of a mile from the facility.
-The confidential interviewee thought this occurred the last of March or the first of April 2019.
-Floor staff was heard discussing the need to "keep an extra eye" on Resident #13 after she was returned to the facility.

Interview with the Administrative Assistant on 05/15/19 at 4:50pm revealed:
-Resident #13 got upset one day about three weeks ago.
-Resident #13 walked out the front door and staff (named) were walking with her.
-She and the Administrator rode in the car behind the resident to keep an eye on the resident.

Second interview with the Administrative Assistant on 05/15/19 at 5:55pm revealed door alarms had never been required at the facility.

Interview with the Administrative Assistant on 05/17/19 at 10:16am revealed:
-After the incident with Resident #13 (no date for incident provided) her instructions to staff included to "watch exits".
-If Resident #13 had exited the facility before, then staff had not informed her.

Attempted interview with the Administrator during the survey [05/15/19 through 05/22/19] was

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D 067	Continued From page 4 unsuccessful. Based on observations, interviews, and record review, it was determined Resident #13 was not interviewable. _____ The facility failed to assure 6 of 6 exit doors were equipped with a sounding device that activated when doors were opened with a resident residing at the facility who were intermittently disoriented. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/15/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 067		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION	D 113		

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D 113	Continued From page 5 Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures were maintained between 100 - 116 degrees Fahrenheit (F) for 14 of 17 sampled fixtures on the men's hall with hot water temperatures of 120 degrees F to 128.2 degrees F. The findings are: Observations during the initial tour of the facility on 04/15/19 between 11:20am and 12:32pm revealed: -At 11:24am, the hot water temperature at the bathroom sink in room 121 was 127.4 degrees F. -At 11:34am, the hot water temperature at the bathroom sink in room 121 was 128.2 degrees F. -At 11:46am, the hot water temperature at the bathroom sink in room 122 was 120.2 degrees F. -At 11:52am, the hot water temperature at the bathroom shower in room 122 was 122.3 degrees F. -At 12:03pm, the hot water temperature at the bathroom sink in room 123 was 126.5 degrees F. -At 12:07pm, the hot water temperature at the bathroom sink in room 124 was 125.4 degrees F. -At 12:14pm, the hot water temperature in room 129 was 120 degrees F. -At 12:16pm, the hot water temperature at the bathroom sink in the common bathroom on the right side of the hall, and next to the unlocked water heater room, was 127 degrees F. -At 12:22pm, the hot water temperature at the bathroom shower in the common bathroom on the right side of the hall, and next to the unlocked water heater room, was 122 degrees F. -At 12:17pm, the hot water temperature in room 135 was 122 degrees F. -At 12:20pm,the hot water temperature in the	D 113		

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second common restroom on the left sink was 122 degrees F.
-At 12:23pm, the hot water temperature in the second common restroom on the left shower was 120 degrees F.
-At 12:27pm, the hot water temperature at the bathroom sink in the common bathroom next to room 136, was 127.9 degrees F.
-At 12:32pm, the hot water temperature at the bathroom shower in the common bathroom next to room 136, was 122.3 degrees F.

Interview with a resident who lived on the men's hall on 05/15/19 at 11:28am revealed:
-The water temperature at the bathroom sink got hot.
-He could not wash his hands in the sink because the water was too hot.
-Someone had come around and checked in the bathroom, but he did not know what was checked and did not remember when the bathroom check was done.
-The staff that gave him a bath said the water was hot.
-He did not remember the name of the staff who gave him a bath.

Interview with the Quality Assurance Director/Resident Care Coordinator (QAD/RCC) on 05/15/19 at 11:34am revealed:
-She could see the steam coming from the hot water at the bathroom sink in room 121 on 05/15/19.
-The water was "super hot."
-She instructed the resident in room 121 to be careful when using the water and to mix some cold water with the hot water.
-She would post signs cautioning residents and staff of the hot water.

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Interview with a housekeeping staff on 05/15/19 at 11:53am revealed:
-The Housekeeping/Maintenance Supervisor (HMS) checked water temperatures.
-She did not know how often the HMS checked the hot water temperatures.
-It might have been a "few months ago" when she had seen the HMS check hot water temperatures.
-No one had ever complained to her about the water temperature being too hot.

Second interview the housekeeping staff on 05/15/19 at 12:14pm revealed:
-She had not known the recommended range for hot water temperatures since employment at the facility.
-She had seen staff who performed personal care for residents turn on the hot water and adjust it for residents.

Interview with a second housekeeping staff on 05/15/19 at 12:38pm revealed:
-She had noticed the water temperatures were hot on the men's hall on 05/14/19.
-She put a note in the maintenance book at the desk about the hot water.

Interview with a second resident who lived on the men's hall on 05/15/19 at 11:55am revealed:
-The resident knew how to adjust the water temperature.
-The water temperature was "good."
-Staff were present when the resident bathed in the room shower.

Interview with a third resident who lived on the men's hall on 05/15/19 at 11:59am revealed:
-If the water ran long enough it would get too hot.
-The resident would mix cold water with the hot water.

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D 113	Continued From page 8 -The resident had not told anyone about the water temperature being too hot. -The resident had not seen anyone checking water temperatures. Observation of the QAD/RCC on 05/15/19 at 12:56pm revealed hot water caution signs were being posted at the fixtures on the men's hall. Interview with the QAD/RCC on 05/15/19 at 1:05pm revealed: -The Administrative Assistant had spoken to the HMS about the hot water temperatures. -The HMS told her where the facility thermometer was kept. -The Co-Owner would be the next person to be contacted,but could not be contacted because the Co-Owner was out of the country on vacation. -There was a part time maintenance staff who could be contacted about the hot water temperatures. Interview with the Activity Director on 05/15/19 at 1:55pm revealed: -He had checked water temperatures in rooms 121 and 137 today. -The water temperatures ranged from 118 to 120 degrees F. -He had adjusted the thermostat on the two hot water tanks on the men's hall, and had just adjusted it again about 10-15 minutes ago. -The thermostats on the hot water tanks were sat "closer to 125 but not on it, both hot water tanks were set about the same." -The thermostat settings on the hot water tanks were 90-125-150. Interview with the Administrative Assistant on 05/15/19 at 2:00pm revealed: -The previous maintenance supervisor (HMS)	D 113		

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checked the hot water temperatures weekly.
-She did not know where the hot water temperature log was.
-She would call the HMS and ask about the logs.

Observation of the water temperatures on the men's hall on 05/16/19 between 4:50am and 5:03am revealed:
-At 4:50am, the hot water temperature in room 121 was 86 degrees F.
-At 4:53am, the hot water temperature in room 132 was 86 degrees F.
-At 5:00am, the hot water temperature in the second common restroom on the left sink 86 degrees F.
-At 5:03am, the hot water temperature in the second common restroom on the left shower was 84 degrees F.

Rechecks of facility hot water temperatures on 05/16/19 between 1:05pm and 1:27pm with the Activity Director revealed:
-At 1:11pm, the hot water temperature at the bathroom sink in room 121 was 106.1 degrees F.
-At 1:15pm, the hot water temperature at the bathroom shower in room 121 was 104.5 degrees F.
-At 1:38pm, the hot water temperature at the bathroom shower in room 122 was 103.2 degrees F.
-At 1:40pm, the hot water temperature at the bathroom sink in room 122 was 103.2 degrees F.
-At 1:32pm, the hot water temperature at the bathroom sink in room 123 was 105.5 degrees F.
-At 1:34pm, the hot water temperature at the bathroom sink in room 124 was 105.4 degrees F.
-At 1:20pm, the hot water temperature at the bathroom sink in the common bathroom on the right side of the hall was 106.3 degrees F.
-At 1:23pm, the hot water temperature at the

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D 113	Continued From page 10 bathroom shower in the common bathroom on the right side of the hall was 101.3 degrees F. -At 1:25pm, the hot water temperature at the bathroom sink in the common bathroom next to room 136, was 106.5 degrees F. -At 1:26pm, the hot water temperature at the bathroom shower in the common bathroom next to room 136, was 105 degrees F. -At 1:29pm, the hot water temperature at the bathroom sink in room 137 was 106.6 degrees F. There were no hot water temperature logs available for review by the end of the survey. Attempted interview with the Administrator during the survey [05/15/19 through 05/22/19] was unsuccessful._____ The facility's failure to ensure hot water temperatures were maintained between 100 and 116 degrees Fahrenheit at the sinks and showers on the men's hall, with hot water temperatures of 128 degrees F placed the residents at risk for burns, and was detrimental to the health, safety, and welfare of the residents. This constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/15/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 113		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for	D 131		

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tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to assure 1of 4 staff (Staff B) had been tested upon hire for tuberculosis disease using a two-step tuberculosis (TB) skin test according to the control measures adopted by the Commission for Health Services.

The findings are:

Review of Staff B's personnel record revealed:
-She was hired as a personal care aide (PCA) on 09/28/18.
-There was documentation for one tuberculosis (TB) skin test placed on 12/14/18 and read as 0mm (negative) on 12/17/18.
-There was no additional documentation for TB skin test in Staff B's personnel record.

Interview with Staff B on 05/15/19 at 11:48am revealed:
-She had been employed at the facility since September 2018.
-She assisted residents with activities of daily living.

Interview with the Administrative Assistant on 05/17/19 at 1:05pm revealed:
-The Business Office Manager (BOM) was responsible for ensuring information required was maintained in the employee personnel record,

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D 131	Continued From page 12 including TB skin test results. -The BOM position was currently vacant and the previous BOM was currently working as a medication aide at the facility. -There was no second step TB skin test for Staff B. Second interview with the Administrative Assistant on 05/20/19 at 12:20pm revealed: -There was not a second step TB skin test for Staff B. -There was a tuberculosis questionnaire for Staff B. -Whoever put Staff B's personnel record together must have overlooked that the questionnaire did not include a TB skin test. Interview with Staff B on 05/20/19 at 5:30pm revealed: -When she started working at the facility she provided TB skin test information from her previous employer to the Resident Care Coordinator (RCC). -She did not know what the RCC did with the TB skin test information she had provided. -She was not sure if she had or could get any documentation of her TB skin test performed. -She remembered having a TB skin test in January 2019. No additional information for tuberculosis skin testing for Staff B was available for review by the end of the survey.	D 131		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency	D 150		

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D 150	Continued From page 13 (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure the 80-hour personal care training and competency evaluation required for 2 of 2 staff sampled (Staff A and D) was completed within six months of hire. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 04/19/2018 as a medication aide. -There was no documented certification of personal care training and competency evaluation for an 80-hour training course. Observation of Staff A on 05/16/19 at 4:02am	D 150		

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revealed he checked a resident for incontinent care with another employee.

Interview with Staff A on 05/16/19 at 5:04am revealed:
-He had been employed at the facility for one year and six months.
-He was a medication aide/supervisor.
-His responsibilities included reviewing the personal care aides documentation to ensure the documentation was completed.

Interview with the Administrative Assistant on 05/17/19 at 12:18pm revealed:
-Staff A had not completed an 80-hour personal care training course.
-Anyone who had taken the personal care aide training course would have gone to the community college.
-The Business Office Manager would be responsible to ensure the training was completed.
-Staff A's 80-hour personal care aide training "got looked over."

2. Review of Staff D's personnel record revealed:
-Staff D was hired on 01/23/2018 as a medication aide.
-There was no documented certification of personal care training and competency evaluation for an 80-hour training course.

Interview with Staff D on 05/15/19 at 10:50am revealed:
-She had been employed at the facility since February 2018.
-She was a medication aide.

Interview with the Administrative Assistant on 05/17/19 at 12:18pm revealed:
-Staff D had not completed an 80-hour personal

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D 150	Continued From page 15 care training course. -Staff D had worked at another facility but that facility would not release any information. -Anyone who had taken the personal care aide training course would have gone to the community college. -The Business Office Manager would be responsible to ensure the training was completed. -Staff D's 80-hour personal care aide training "got looked over." Second interview with Staff D on 05/20/19 at 11:25am revealed: -She was not a nursing assistant. -She had personal care aide training at the facility. -She thought the personal care aide training was done by a nurse. -She believed she got a certificate when the personal care training course was completed. -The personal care aide training course "took a couple hours", and there was not a classroom environment. -She had never been in a classroom for personal care aide training. Attempted interview with the Administrator during the survey [05/15/19 through 05/22/19] was unsuccessful.	D 150		
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	D 167		

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management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

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

Based on record review and interviews, the facility failed to assure at least one staff person was on the premises at all times who had completed a course in Cardio-Pulmonary Resuscitation (CPR) and choking management within the last 24 months.

The findings are:

1. Review of the Staff A's personnel record revealed:
-Staff A was hired on 04/19/18 as a Medication Aide.
-There was no documentation of successfully completing a CPR.

Interview with Staff A on 05/16/19 at 5:04am revealed:
-He was working as the Medication Aide/Supervisor for the 11pm - 7am shift.
-He normally worked on the 3pm - 11pm shift.
-He worked a lot because he was the first one called when there was a staff call out.

Interview with the Administrative Assistant on

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D 167	Continued From page 17 05/17/19 at 1:05pm revealed there should be documentation of CPR training for Staff A in the personnel record. Interview with Staff A on 05/17/19 at 3:00pm revealed: -He thought it was October 2018 when he last completed a CPR course. -The facility should have a copy of the CPR certification card. -He did not have a copy of the CPR card. -He had completed the CPR course at the facility. Attempted interview with the Administrator on 05/22/19 at 9:37am was unsuccessful. Refer to interview with the Administrative Assistant on 05/17/19 at 1:05pm. Refer to interview with the Administrative Assistant on 05/17/19 at 2:55pm. Refer to interview with the Administrative Assistant on 05/20/19 at 9:40am. 2. Interview with Staff C on 05/15/19 at 10:00am revealed: -She worked at the facility as a Medication Aide/Resident Care Coordinator (MA/RCC). -She had been employed at the facility since 2015. -She was the Supervisor-in-Charge. Review of the Staff C's personnel record revealed: -Staff C was hired on 06/24/15. -There was no position title listed. -There was documentation for completing a CPR training class on 07/06/15 that was valid for 2 years.	D 167		

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D 167	Continued From page 18 -There was no documentation of successfully completing a CPR training course in the last 24 months. Interview with the Administrative Assistant on 05/17/19 at 1:05pm revealed: -There should be documentation of CPR training for Staff C in the personnel record. -Staff C had completed a CPR training course at the facility with a group of other staff. Interview with Staff C on 05/20/19 at 9:47am revealed: -She worked the 11pm - 7am shift on 05/17/19. -There was no staff in the facility with CPR training, according to information she had. Second interview with Staff C on 05/20/19 at 10:05am revealed: -She had completed a CPR course at the facility. -She completed a two-hour CPR class. -She did not complete a written test when she took the CPR powerpoint presentation. -She remembered taking a CPR training course prior to employment at the facility. Attempted interview with the Administrator on 05/22/19 at 9:37am was unsuccessful. Refer to interview with the Administrative Assistant on 05/17/19 at 1:05pm. Refer to interview with the Administrative Assistant on 05/17/19 at 2:55pm. Refer to interview with the Administrative Assistant on 05/20/19 at 9:40am. _____ Interview with the Administrative Assistant on 05/17/19 at 1:05pm revealed:	D 167		

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D 167	Continued From page 19 -There should be documentation of CPR training for Staff A in the personnel record. -The Business Office Manager (BOM) was responsible for ensuring everything that needed to be in the personnel record was there. -The facility did not currently have a BOM because the previous BOM recently went back into the position of medication aide at the facility. Interview with the Administrative Assistant on 05/17/19 at 2:55pm revealed: -She could not find any documentation showing Staff A had completed a CR course in the past 24 months. -She could not contact the CPR instructor because the instructor was on vacation out of the country. Interview with the Administrative Assistant on 05/20/19 at 9:40am revealed: -She had auditied all staff records and had only found one additional staff with CPR training. -She had not found any documentation for CPR training completed for Staff's A and C. -She had not found any additional CPR training certification cards for any facility staff. -She knew she had breached the 05/17/19 plan of protection but could not go out and hire a bunch of new staff and could not work the ones who have CPR training all the time because that would be against labor law and she was not going to break the labor law. -She had been informed on February 2019 by a county employee that the facility needed to get staff trained in CPR. The facility failed to assure there was one staff member on duty in the facility at all times who had completed a course on CPR and choking management within the last 24 months. The	D 167		

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D 167	Continued From page 20 facility's failure was detrimental to the health and safety of the resident in the event of an emergency requiring CPR or management of a choking resident. This non-compliance constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/17/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 167		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record review and interviews, the facility failed to assure supervision was provided for 1 of 5 (Resident #13) resident, who walked away from the facility, with the diagnosis of Alzheimer's and was deemed constantly disoriented by her primary care provider (PCP).	D 270		

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D 270	Continued From page 21 The findings are: Review of Resident #13's Resident Register revealed an admission date of 09/11/18. Review of Resident #13's current FL-2 dated 05/14/19 on 05/15/19 at 4:51pm revealed: -Diagnoses included Alzheimer's, dementia and hypertension. -The FL-2 indicated the resident wandered and was constantly disoriented. Observations during initial tour of facility on 05/15/19 from 10:30am until 11:55am revealed: -The alarm on the women's hall exit door was detached and hanging from a wire. -When the women's hall exit door was opened no alarm was heard. -While the women's hall exit door was held open, no staff responded to the open door. -Resident #13's room was the closest room on the left to the women's hall exit door. A confidential interview revealed: -Resident #13 had left the facility and it wasn't discovered until staff was performing their 2-hour checks. -The resident was found walking, alone, down a busy highway approximately one quarter of a mile from the facility. -The Interviewee could not understand why the resident had been placed in a room next to an exit without an alarm. -The confidential interviewee thought this occurred the last of March or the first of April 2019. -Staff was heard discussing the need to "keep an extra eye" on Resident #13. -Resident #13 had resided in the room closest to	D 270		

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the exit door since she was admitted.

Based on observations, interviews, and record reviews it was determined Resident #13 was not interviewable.
Confidential interview with a staff revealed:
-There was a resident who staff had been instructed to "keep an eye on" a month or so ago because the resident went out.
-The resident acted confused sometimes.
-The resident had "good days and bad days".
-She did not know if the resident had ever left the facility.

Interview with the Administrative Assistant on 05/15/19 at 4:50pm revealed:
-Resident #13 got upset one day about three weeks ago.
-The Quality Assurance Director/Resident Care Coordinator (QAD/RCC) and another staff were walking with the resident
-Resident #13 walked out the front door and staff (named) were walking with her.
-She and the Administrator rode in the car behind the resident to keep an eye on the resident.
-She called Resident #13's family member and emergency medical services (EMS).
-The family member arrived before EMS and called off EMS.
-Door alarms had never been required at the facility.

Second interview with the Administrative Assistant on 05/17/19 at 10:16am revealed:
-Resident #13 was "having a bad day [exact date not provided], decided she wanted to take a walk".
-She did not know and did not want to over-estimate or under estimate the distance Resident #13 was from the facility when she

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(Administrative Assistant) and the Administrator caught up to the resident and the staff that were with her.
-This was the first incident of wandering out of the facility that had occurred.
-She alerted staff and let staff know Resident #13 wandered (exact date not provided).
-She instructed staff to "keep closer set of eyes" on Resident #13 (exact date of instructions not provided).
-The family member was contacted.
-She discussed with the family member alternate placement on the same day as the incident.
-Her focus was to help the family member find somewhere for placement.
-Resident #13 told the family member she was going home.
-She contacted another facility and faxed information to that facility but did not remember the date.
-The only time she could think of Resident #13 being outside the facility was when the resident was in the courtyard participating in activities.
-If there had been any other occasions when Resident #13 had exited the facility without staff knowledge, she (Administrative Assistant) had not been informed.
-She wanted to say the QAD/RCC contacted Resident #13's physician.
-She did not know all the instructions the QAD/RCC had given to staff regarding supervision for Resident #13.

Interview with Quality Assurance Director/Resident Care Coordinator (QAD/RCC) on 05/17/19 at 10:23am revealed:
-A staff member came and got me, Resident #13 started walking towards the highway. It was on first shift.
-Both staff got Resident #13 to come back, she

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was upset, she had been doing well but her husband died, and she got worse. Her daughter told her, her husband passed and took her to his funeral. Since returning from his funeral she has gotten more upset saying "this is not my home."
-She thought Resident #13's dementia had progressed more. That was the first and only time she walked off.
-The staff got her to come back to the front of the building. She tried to get her to come back. We walked to the grocery store, an area neighborhood, and fire department.
-The Maintenance Director (MD) came and walked with them.
-Two staff members followed them in the car. They called Resident #13's daughter, doctor, and sent referral for the mental health provider to see her.
-Resident #13's daughter was able to get her in the car and ride with her. They returned to the building 30-45 minutes later. Resident #13 was calm.
-Resident #13's daughter came into the facility and signed consent for the mental health provider.
-She was not sure when the mental health provider came, but she knew the provider normally came monthly.
-She acknowledged Resident #13 was seen by a mental health provider on 05/09/19 for the elopement incident in early April 2019.
-The staff reported no abnormal behaviors that night in early April 2019.
-Resident #13's family, QAD/RCC, Administrative Assistant (AA) were working together to find a secured facility and believed it was time, because of Resident #13 walking away incident, it would be safer for her.
-The staff were advised to do hourly checks and to make sure they knew where Resident #13 was

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always. We normally do 15 to 30 minutes.
-She told staff to check on her more the same day of the elopement. Document on forms, medication aides (MA) to report off on each shift.
-The staff "here sometimes, things go missing. Some staff disliked us and would try to sabotage because we wanted them to follow the regulations."
-She stressed the importance of the need to always document, "this is why we have these in place".
-The Resident Care Coordinator (RCC) would check the notebook and they would report any changes.
-There were no elopement incidents since that day, Resident #13's daughter came to visit often.

Telephone interview with PCA on 05/17/19 at 11:15am revealed:
-On 04/08/2019, she noticed Resident #13 coming from side of the building were her room is located.
-Resident #13 was walking down the sidewalk.
-Resident #13 attempted to stop a car.
-She walked with Resident #13 to a grocery store parking lot.
-She saw the Quality Assurance Director and waved for her to come over where she and Resident #13 were.
-She heard Resident #13 attempted to leave facility before.
-She completed a progress note.

_____

Based on observations, interviews and record reviews, the facility failed to provide the needed level of supervison required by Resident #13 even after an increase in her agitation and wandering was observed by staff. The facilty's failure to provide any measureable interventions

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D 270	Continued From page 26 was detrimental to the health and safety of the resident and constitures a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/15/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to assure health care referral and follow up was completed for 4 of 7 sampled resident (Residents #1, #3, #6, #11) as evidenced by over 300 medication refusals not reported to the primary care provider (#1), diabetic nail care (#3), a fall resulting in a fractured hip not sent to the hospital until four days later (#6), and medical care not provided for a sinus infection until 10 days after care was requested by the resident (#11).	D 273		

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D 273	Continued From page 27 The findings are: 1. Review of Resident #1's current FL-2 dated 07/17/18 revealed diagnoses included alcohol induced persisting dementia, bruit, depression with anxiety, hypothyroidism, insomnia, leukocytosis, memory loss, obsessive compulsive, peripheral vascular disease, and Parkinson's. Review of the March 2019, April 2019, and May 2019 electronic medication administration records (eMARs) for Resident #1 revealed seven of fifteen routinely prescribed medications were documented as refused in March 2019, April 2019, and May 2019. Interview with a Medication Aide (MA) on 05/16/19 at 10:20am revealed: -A circle around initials on the eMARs meant the medication was withheld for some reason. -When a medication was refused, the resident's physician was supposed to be contacted. -The facility medication refusal policy was "after three times, three doses of same med." -The hospice agency was notified of medication refusals by "word of mouth" for a resident receiving hospice services. -The physician provider agency was notified of medication refusal during their weekly visits or a fax was sent to the provider office. -The faxes were placed in a green book and the RCC collected them. -After "so many refusals", the facility would "push to have med discontinued." -The RCC should be contacting the physician because the MA's did not have time. -The MAs usually did a chart note that was attached to the eMAR orders or wrote a progress note.	D 273		

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-She had recently just returned to working on the medication cart.
-She had not contacted a doctor about medication refusals since being back on the medication cart.

Interview with a second MA on 05/16/19 at 5:15pm revealed:
-She documented medication refusals on the eMARs.
-She let the supervisor know about residents who refused medications and the supervisor "took it from there."
-Resident #1 refused medications a couple times."
-She had not contacted the physician about any residents refusing medications.
-She was trying to think if she had seen a written policy on medication refusals and was given a lot of paperwork when she started working at the facility, so was sure there was a written policy on medication refusals.

Interview with the MA/RCC on 05/20/19 at 3:10pm revealed:
-The physician was supposed to be faxed after there were three medication refusals.
-She did not know where the faxed reports were.
-Resident #1 had "never really refused" medications for her.
-She had never faxed the physician for any medication refusals for Resident #1.
-If there was no medication refusal sheet in the resident's record, more than likely it wasn't done, and the only documentation of medication refusals would be on the eMAR.

a. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Hydralazine 50mg (used to treat

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hypertension) one tablet three times a day.

Review of the March 2019 electronic medication administration records (eMARs) for Resident #1 revealed:
-There was an entry for Hydralazine HCL 50mg tablet three times a day and scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation Resident #1 refused the Hydralazine 29 of the 93 opportunities.

Review of the April 2019 eMARs for Resident #1 revealed:
-There was an entry for Hydralazine HCL 50mg tablet three times a day and scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation the Hydralazine was documented as refused 24 of the 90 opportunities.

Review of the May 2019 eMARs for Resident #1 revealed:
-There was an entry for Hydralazine HCL 50mg tablet three times a day and scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation Resident #1 refused the Hydralazine 7 of the 46 opportunities.

Observation of the medication on hand on 05/20/19 at 4:00pm revealed there were four blister packs of Hydralazine 50mg tablets totaling 75 tablets on hand.

Interview with the consultant Pharmacist on 05/22/19 at 8:30am revealed:
-Hydralazine 50mg one tablet three times a day was dispensed on 03/12/19, 04/03/19, and 05/05/19 for a quantity of 45 tablets for a 15-day supply.
-The residents blood pressure could be elevated

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and uncontrolled with missed dosages.
-If the blood pressure was elevated for an extended time, there could be more serious effects such as heart attack or stroke.

b. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Amlodipine (used to treat hypertension) 10mg tablet every day.

Review of the March 2019 electronic medication administration records (eMARs) for Resident #1 revealed:
-There was an entry for Amlodipine 10mg tablet every day and scheduled at 8:00am.
-There was documentation Resident #1 refused the Amlodipine 3 out of 31 opportunities.

Review of the April 2019 eMARs for Resident #1 revealed:
-There was an entry for Amlodipine 10mg tablet every day and scheduled at 8:00am.
-There was documentation Resident #1 refused 5 out of 30 opportunities.

Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was a quantity of 15 tablets dispensed on 05/12/19 with 11 tablets remaining on hand.

Interview with the consultant Pharmacist on 05/22/19 at 8:30am revealed:
-The pharmacy dispensed a 15-day supply quantity of 15 tablets of Amlodipine 10mg tablets on 03/03/19, 03/20/19, 04/03/19, 04/46/19/ and 05/12/19.
-An effect of high blood pressure with missed doses of Amlodipine would not be present as much because Amlodipine was a longer acting medication.

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D 273	Continued From page 31 c. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Carbidopa/Levodopa (used to treat Parkinson's) 10-100mg tablet three times a day. Review of the March 2019 electronic medication administration records (eMARs) for Resident #1 revealed: -There was an entry for Carbidopa/Levodopa 10-100mg tablet three times a day and scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Resident #1 refused the Carbidopa/Levodopa 28 out of 93 opportunities. Review of the April 2019 eMARs for Resident #1 revealed: -There was an entry for Carbidopa/Levodopa 10-100mg tablet three times a day and scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Resident #1 refused the Carbidopa/Levodopa 24 out of 90 opportunities. Review of the May 2019 eMARs for Resident #1 revealed: -There was an entry for Carbidopa/Levodopa 10-100mg tablet three times a day and scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Resident #1 refused the Carbidopa/Levodopa 7 out of 46 opportunities. Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was a quantity of 30 tablets in one blister pack plus 2 tablets in a second blister pack dispensed on 04/14/19 for a total of 32 tablets remaining on hand.	D 273		

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D 273	Continued From page 32 Interview with the consultant Pharmacist on 05/22/19 at 8:30am revealed: -The pharmacy had dispensed a quantity of 90 tablets, 30-day supply, refills for Carbidopa/Levodopa 10-100mg tablet three times a day on 02/24/19 and 04/14/19. -The 04/14/19 supply of Carbidopa/Levodopa dispensed to the facility should have run out around 5/14/19 or 5/15/19. -The 02/24/19 supply of Carbidopa/Levodopa dispensed to the facility should have run out around 3/26/19 or 3/27/19. -There could be shakiness, twitching, and unsteadiness with lapses in administration of the Carbidopa/Levodopa. d. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Lexapro (used to treat depression) 5mg tablet at bedtime. Review of the March 2019 electronic medication administration records (eMARs) for Resident #1 revealed: -There was an entry for Lexapro 5mg tablet at bedtime and scheduled at 8:00pm. -There was documentation Resident #1 refused the Lexapro 22 out of 31 opportunities. Review of the April 2019 eMARs for Resident #1 revealed: -There was an entry for Lexapro 5mg tablet at bedtime and scheduled at 8:00pm. -There was documentation Resident #1 refused the Lexapro 8 out of 29 opportunities. Review of the May 2019 eMARs for Resident #1 revealed: -There was an entry for Lexapro 5mg tablet at	D 273		

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bedtime and scheduled at 8:00pm.
-There was documentation Resident #1 refused the Lexapro 7 out of 46 opportunities.

Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was a quantity of 15 tablets dispensed on 04/17/19 with 7 tablets remaining on hand.

Interview with the consultant Pharmacist on 05/22/19 at 8:50am revealed:
-The Lexapro 5mg at bedtime was filled on 12/10/18, quantity of 30 tablets for a 30-day supply.
-The Lexapro was not refilled until 04/17/19, a quantity of 14, for a 14-day supply, which was the last time the Lexapro was refilled.
-The effects of missed doses would be symptomatic such as seeing a lot of "refusals" in residents and increased behaviors.
-If Lexapro was started and stopped, there would be worsening of effects.
-Resident #1 was on the lowest dose of Lexapro and it could not be tapered off.

e. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Tramadol HCL (used to treat pain) 50mg two tablets two times a day.

Review of the March 2019 electronic medication administration records (eMARs) for Resident #1 revealed:
-There was an entry for Tramadol HCL 50mg two tablets twice a day and scheduled at 8:00am and 8:00pm.
-There was documentation the Tramadol was not administered 24 out of 62 opportunities with the reason documented as "resident refused."

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Review of the April 2019 eMARs for Resident #1 revealed:
-There was an entry for Tramadol HCL 50mg two tablets twice a day and scheduled at 8:00am and 8:00pm.
-There was documentation Resident #1 refused the Tramadol 18 out of 61 opportunities.

Review of the May 2019 eMARs for Resident #1 revealed:
-There was an entry for Tramadol HCL 50mg two tablets twice a day and scheduled at 8:00am and 8:00pm.
-There was documentation Resident #1 refused the Tramadol 8 out of 22 opportunities.

Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was a quantity 0f 60 tablets dispensed on 05/05/19 with 26 tablets remaining on hand.

Interview with the consultant Pharmacist on 05/22/19 at 8:50am revealed:
-The Tramadol 50mg two tablets twice a day was dispensed on 03/20/19, 04/11/19, and 05/05/19 each for quantity of 60 tablets, a 15-day supply.
-There were some lapses in refills if the Tramadol was supposed to be administered on a routine schedule.
-The resident may have pain as an effect if the medication was not administered as ordered.

f. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Travatan Z eye drops (used to treat glaucoma) instill one drop in both eyes at bedtime.

Review of the March 2019 electronic medication administration records (eMARs) for Resident #1

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revealed:
-There was an entry for Travatan Z 0.0004% eye drops one drop in each eye at bedtime and scheduled at 8:00pm.
-There was documentation Resident #1 refused the Travatan Z eye drops 27 out of 31 opportunities.

Review of the April 2019 eMARs for Resident #1 revealed:
-There was an entry for Travatan Z 0.0004% eye drops one drop in each eye at bedtime and scheduled at 8:00pm.
-There was documentation Resident #1 refused the Travatan Z eye drops 16 out of 39 opportunities.

Review of the May 2019 eMARs for Resident #1 revealed:
-There was an entry for Travatan Z 0.0004% eye drops one drop in each eye at bedtime and scheduled at 8:00pm.
-There was documentation Resident #1 refused the Travatan Z eye drops 10 out of 13 opportunities.

Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was a 2.5ml bottle of Travatan Z dispensed on 09/19/18 with approximately 2/3rd of the bottle remaining on hand.

g. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Nystatin Ointment (used to treat fungal infections) 100000 apply to feet twice a day.

Review of the March 2019 eMARs for Resident #1 revealed:

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-There was an entry for Nystatin Ointment 100000 apply to feet twice a day for fungal infections and scheduled at 8:00am and 8:00pm.
-There was documentation Resident #1 refused the Nystatin Ointment 31 out of 62 opportunities.

Review of the April 2019 eMARs for Resident #1 revealed:
-There was an entry for Nystatin Ointment 100000 apply to feet twice a day for fungal infections and scheduled at 8:00am and 8:00pm.
-There was documentation Resident #1 refused Nystatin Ointment 28 out of 61 opportunities

Review of the May 2019 eMARs for Resident #1 revealed:
-There was an entry for Nystatin Ointment 100000 apply to feet twice a day for fungal infections and scheduled at 8:00am and 8:00pm.

-There was documentation Resident #1 refused the Nystatin Ointment 19 out of 28 opportunities, with 1 of the 28 opportunities.

Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was an unopened 30gm tube of Nystatin Ointment with a dispense date of 02/19/19 on the pharmacy printed label.

Telephone interview with a representative for the physician provider group on 05/21/19 at 8:55am revealed there was no record showing the facility had reported any medication refusals for Resident #1.

2. Review of Resident #6's current FL-2 dated 07/23/18 revealed diagnoses included accelerated hypertension, dementia with behavior disturbances, hypokalemia, and altered mental

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D 273	Continued From page 37 status. Confidential interview revealed: -Resident #6 fell out of bed on a Friday night on the 11:00pm - 7:00am shift. -The resident's family member saw bruising and swelling on Saturday and wanted Resident #6 sent out for evaluation, but staff would not be able to go because they were "short staffed." -A mobile x-ray was done five days later, and one hour after, the resident was transported to the hospital by emergency medical services. Review of an Incident/Accident report for Resident #6 dated 03/30/19 revealed: -The resident was found by two aides (not named) on the floor with covers wrapped around the resident. -The resident stated she was "fine". -In the section for "seen by physician" staff documented "no". -In the section for "sent to hospital" staff documented "none". -In the section for "witnessed" staff documented "none". -The report time was 5:28am. -There was documentation a fax was sent to the provider physician group at 7:24am. There was no date documented for the fax sent. -There was a nursing follow up documented (no date provided) of "resident had some pain and was given Tylenol. X-rays were ordered for lower back pain and right hip as well. X-rays came back and she has a fractured femur. Dr [doctor] advised we send her out to ER [emergency room]". Review of a physician's order for Resident #6 dated 04/02/19 revealed: -Resident #6's assessment included an	D 273		

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assessment for "age-related physical debility" and complaints of pain from the facility and the Power of Attorney (POA).
-The resident would need ongoing assistance with her activities of daily living.
-The facility staff denied any acute falls/trauma.
-X-rays of the spine and hip were ordered.

Review of a mobile imaging report for Resident #6's hip dated 04/03/19 revealed:
-There was an acute right femoral neck fracture.
-There was 75% shaft with cephalad displacement femoral neck relative to the head remnant.
-The femoral head was situated within the acetabulum with moderate hip joint degenerative changes.

Interview with Resident #6's POA on 05/21/19 at 9:20am revealed:
-She went to the facility on 03/30/19 and "something was wrong" with the resident.
-The resident complained of right hip pain when the family member removed the resident's socks.
-The resident's feet were swollen and a purple dark red color.
-She went to get staff, which took her a few minutes to find someone.
-Resident #6 kept saying she was hurting.
-The family member went back on 03/31/19 and the resident was asleep.
-The family member went back on 04/01/19 and could tell something was wrong because Resident #6 would not talk.
-The family member requested x-rays be done of the resident's hip and agreed for the resident to be seen by the primary care provider (PCP) on Tuesday (04/02/19).
-The family member went back to the facility on 04/02/19 and x-rays were ordered and

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completed.
-The resident was administered two Tylenols that night for pain.
-On 04/03/19 she was notified by the PCP that Resident #6 had a fractured hip and Resident #6 was transported to the hospital.
-Resident #6 had surgery for the fractured right hip on 04/05/19.
-She was told by the surgeon that Resident #6's hip "wasn't just broken but it was crushed, had a very hard fall".
-A staff member told her on 04/01/19 that Resident #6 had not wanted to sit in the chair but she did not remember who the staff was.
-She had not been contacted about Resident #6 falling.

Confidential interview with a staff revealed:
-A former staff told her Resident #6 had fallen.
-Resident #6 kept favoring her right side and would say she was in pain.
-She remembered the resident saying she was in pain the day before she left the facility.
-Resident #6 had been gone from the facility about 2 months.
-She did not remember the day Resident #6 left.
-Resident #6 would say she was in pain.
-The resident did not want to be touched on her right side the day she was sent to the hospital.
-A lot of the staff who worked at the facility when the incident occurred no longer worked at the facility.

Interview with the RCC on 05/21/19 at 11:35am revealed:
-She did not know much but heard Resident #6 had fallen.
-She did not remember which staff told her about Resident #6 falling.
-If there was an unwitnessed fall and the resident

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HUNTER HILL SENIOR LIVING	891 NOELL LANE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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said they were okay, the facility did range of motion and the resident was not sent out to the hospital for evaluation.
-A resident who hit their head was automatically sent out to the hospital for evaluation.

Interview with the Quality Assurance Director/Resident Care Director (QAD/RCC) on 05/21/19 at 12:03pm revealed:
-Resident #6 had a right hip x-ray that showed a fracture.
-Resident #6 had fallen "evidently".
-The PCP was called by Resident #6's family member (POA) because the resident told the POA she was hurting.
-The facility called the PCP on 04/03/19 asking about x-rays and pain medication.
-It looked like the facility's first call to the PCP was 04/03/19.

3. Review of Resident #3's current FL-2 dated 04/20/18 revealed diagnoses included history of urinary tract infection, hyperkalemia, hyperlipidemia, essential hypertension, anemia, and diabetes mellitus.

Review of Resident #3's current assessment and care plan dated 04/18/19 revealed:
-The resident required limited assistance with bathing, dressing, grooming, and transferring.

Review of Resident #3's record revealed:
-There was documentation of Licensed Health Professional Support (LHPS) reviews and evaluations dated 08/27/18.
-Resident #3 toenails were long.
-Resident #3 skin to feet dry but intact.
-There was a recommendation for Resident #3's toenails to be trimmed.

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Review of Resident #3's record revealed:
-There was documentation of Licensed Health Professional Support (LHPS) reviews and evaluations dated 04/18/18.
-Resident #3, some toenails were getting long, jagged.
-There was a recommendation for Resident #3's toenails to be trimmed.

Interview with Resident #3 on 05/15/19 at 11:22am revealed:
-The staff would not cut her fingernails or toenails because she was diabetic.
- The "footman cut toenails here when he comes around, but it's been a long time when he was here. He didn't get to me. He worked out of the utility room."
-It had been a very long time since she had her toenails cut. She had asked the staff, but they only filed her fingernails, because she was diabetic.
-It had been a long time since the staff washed her feet. "When I first came here they washed my feet, legs, thighs, my back, but now they don't do that."

Observation of Resident #3's feet on 05/15/19 at 11:36am revealed:
-She had deep white scaled cracks between all 10 of her toes.
-Her left big toenail was thick, yellowish colored, long, curved left, jagged and 2.5 -3 inches in length.
-Her left second, third, fourth, and fifth digit toenails were thick, yellowish colored, long, jagged and curved right and 2 inches in length.
-Her right big toenail was thick, yellowish, brown colored, curved right, jagged and was 3-3.25 inches in length.
-Her right second, third, fourth, and fifth digit

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toenails were thick, yellowish, brown colored, jagged, curved left and was 2.5 inches in length.

Interview with the Administrative Assistant on 05/15/19 at 4:54pm revealed:
-No one ever asked to have nail care services.
-The podiatry provider came to the facility every 3 months.
-She did not remember the last time Resident #3 had her feet assessed.
-On shower days, when they are assisting residents, especially diabetic residents, staff were supposed to do a full body assessment.
-The staff were supposed to inform the Resident Care Coordinator (RCC) if residents' toenail or fingernails needed to be cut.
-A lot of the diabetic residents' names were placed on the podiatry provider list for services.
-She did not remember if Resident #3 was placed on the podiatry provider list for services.
-Private pay residents must be willing to pay the cost for podiatry services.
-She was not aware of the feet and skin condition of the toenails for Resident #3.
-She never looked at Resident #3's feet.
- "My girls cannot touch or cut her fingernails and toenails!"
-The RCC was responsible for coordinating the foot clinic.

Interview with personal care aide on 05/15/19 at 4:07pm revealed:
-She had not provided nail care services for Resident #3. She had never seen Resident #3 toenails before.

Interview with Quality Assurance Director/Resident Care Coordinator on 05/16/19 at 11:12am revealed:
-She called the podiatry provider on 05/16/19 and

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scheduled her toenails to be trimmed.
-Resident #3 was scheduled an appointment on 06/5/19 at 8:30am with the provider and scheduled to see the podiatrist on 05/24/19 at 9:45am.

Telephone interview with the podiatry provider representative on 05/21/19 at 9:43am revealed:
-The provider saw Resident #3 on 01/23/18 prior to her admittance to the facility.
-She was scheduled to be seen on 04/24/18 after her admission to the facility, but that appointment was missed and canceled.
-She is scheduled to be seen on 05/24/19 at 9:45am.
-The facility called on 05/16/19 at 8:41am and scheduled her toenails to be trimmed.
4. Review of Resident #11's current FL-2 dated 08/13/18 revealed diagnoses included multiple sclerosis, anxiety generalized muscle weakness.

Interview with Resident #11 on 05/17/19 at 11:27am revealed:
-On 04/14/19 resident woke up with facial pain and a dark green nasal discharge.
-The resident told a medication aid (MA) about her symptoms and was told that she would be put on the list to see the facility's primary care provider (PCP) on 04/16/19.
-On 04/16/19, her symptoms included dizziness, lack of appetite, nausea and a cough.
-The PCP did not visit the facility on 04/16/19.
-She continued to report her symptoms and was given Tylenol by staff for her discomfort.
-She was concerned about her low immunity because of her multiple sclerosis.
-She was seen by the PCP on 04/23/19 and was diagnosed with a sinus infection and prescribed an antibiotic.
-She received her first dose of antibiotic at

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D 273	Continued From page 44 9:00am on 04/24/19. Interview with the facility's PCP on 05/21/19 at 10:50am revealed: -This was her first visit to the facility [on 05/21/19]. -The only knowledge she had of Resident #11 was the previous PCP's notes. -Normally, an untreated sinus infection would not be considered a serious issue but with a compromised immune system it could have developed into a more serious condition. Attempted interview with the Administrator during the survey [05/15/19 through 05/22/19] was unsuccessful. The facility failed to assure 4 of 7 sampled residents (#1, #3, #6 and #11) received health referral and follow in a timely manner. The facility failed to assure multiple medication refusals were reported to the PCP (#1), a resident received diabetic nail care (#3), a fall resulted in a hip fracture not sent to the hospital until four days later (#6), and a resident waited 10 days to be treated for a sinus infection (#11).This failure was detrimental to the health and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/15/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support	D 280		

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D 280	Continued From page 45 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 licensed health professional support (LHPS) evaluation was completed for 4 of 5 sampled resident (Residents #1, #2, #3, #5) who required transfer assistance (#1,2), finger stick blood glucose (FSBS) testing (#3, #5), and extensive assistance with toileting (#2). The findings are:	D 280		

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1. Review of Resident #1's current FL-2 dated 07/17/18 revealed diagnoses included alcohol induced persisting dementia, bruit, depression with anxiety, hypothyroidism, insomnia, leukocytosis, memory loss, peripheral vascular disease, Parkinson's, and obsessive compulsive.

Review of Resident #1's current assessment and care plan dated 07/17/18 revealed:
-The resident was assessed on 07/10/18 to require assistance of a walker for ambulation.
-The resident was assessed to require stand by assistance and some redirection with ambulation.
-The resident required limited assistance with transferring.

Review of Resident #1's record revealed:
-There was documentation of Licensed Health Professional Support (LHPS) reviews dated 06/18/18 and 09/30/18 for LHPS tasks of transfers with the use of a cane, and invasive activities such as enemas and suppositories.
-There was no documentation for quarterly LHPS reviews and evaluations for 12/2018 through 05/2019.

Interview with the Quality Assurance Director/Resident Care Director (QAD/RCC) on 05/16/19 at 12:50pm revealed:
-The provider pharmacy did the LHPS reviews.
-The facility contracted with a registered nurse to do LHPS reviews.
-LHPS reviews were done quarterly.
-The completed LHPS reviews were "typically" in the resident record.
-The provider pharmacy filed their reports in the resident record and did an exit review with facility staff.

Refer to interview with the Director of Pharmacy

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D 280	Continued From page 47 Consultants on 05/22/19 at 9:02am. Refer to interview with the Pharmacy Provider Lead Pharmacist on 05/22/19 at 9:32am. 2. Review of Resident #5's current FL-2 dated 04/30/19 revealed diagnoses included chronic allergic rhinitis, hypertension, hyperlipidemia, schizophrenia, and type 2 diabetes mellitus. Review of physician's order for Resident #5 revealed there was a physician's order for finger stick blood sugar (FSBS) checks four times a day. Review of Resident #5's record revealed: -There was documentation of LHPS reviews dated 04/18/18 (admission), 05/10/18 and 08/27/18 for the LHPS tasks of FSBS checks and subcutaneous injections. -There was no documentation for quarterly LHPS reviews and evaluations for 11/2018 through 05/2019. Interview with the Quality Assurance Director/Resident Care Coordinator (QAD/RCC) on 05/16/19 at 12:50pm revealed: -The provider pharmacy did LHPS reviews. -The facility contracted with a registered nurse to do LHPS reviews. -LHPS reviews were done quarterly. -The completed LHPS reviews were "typically" in the resident record. -The provider pharmacy filed their reports in the resident record and did an exit review with facility staff. Refer to interview with the Director of Pharmacy Consultants on 05/22/19 at 9:02am.	D 280		

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D 280	Continued From page 48 Refer to interview with the Pharmacy Provider Lead Pharmacist on 05/22/19 at 9:32am. 3. Review of Resident #2 current FL-2 dated 04/30/18 revealed diagnoses of dementia, hypertension and allergies. Review of the resident's record on 05/20/19 revealed there were no Licensed Health Professional Support (LHPS) found. Review of Resident #2's current assessment and care plan dated 05/15/18 revealed she required extensive assistance with transfers and toileting. Interview with the Quality Assurance Director/Resident Care Coordinator (QAD /RCC) on 05/16/19 at 10:58am revealed: -The current providing pharmacy was hired "at the end of last year" 2018. -LHPS task reviews have not been done since the new pharmacy was hired. -She does not know why the new pharmacy does not do the quarterly reviews. Refer to interview with the Director of Pharmacy Consultants on 05/22/19 at 9:02am. Refer to interview with the Pharmacy Provider Lead Pharmacist on 05/22/19 at 9:32am. 4. Review of Resident #3's current FL-2 dated 04/20/18 revealed diagnoses included history of urinary tract infection, hyperkalemia, hyperlipidemia, essential hypertension, anemia, and diabetes mellitus. Review of Resident #3's current assessment and care plan dated 04/18/19 revealed: -The resident required limited assistance with bathing, dressing, grooming, and transferring.	D 280		

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D 280	Continued From page 49 Review of Resident #3's record revealed: -There was documentation of Licensed Health Professional Support (LHPS) reviews dated 08/27/18 for the LHPS task of finger stick blood sugar (FSBS) testing. -There was no documentation for quarterly LHPS reviews for 8/27/18 through 5/2019. Interview with the Quality Assurance Director/Resident Care Coordinator (QAD/RCC) on 05/16/19 at 11:12am and 05/17/19 at 10:20am revealed: -The LHPS reviews were done by the Provider pharmacy. -LHPS reviews were being done every three months. -The facility changed pharmacy providers in the fall of 2018. -The LHPS quarterly reviews had not been done since the fall of 2018. -She could not explain why the LHPS reviews had not been done since the fall of 2018. -She did not have the contact information for the LHPS nurse who completed the last LHPS reviews for Resident #3, she only knew her first name. -The Administrator had the LHPS nurse contact information. The Administrator was not available to be interviewed. Refer to interview with the Director of Pharmacy Consultants on 05/22/19 at 9:02am. Refer to interview with the Pharmacy Provider Lead Pharmacist on 05/22/19 at 9:32am. Interview with consulting pharmacy provider, Director of Pharmacy Consultants on 5/22/19 at	D 280		

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D 280	Continued From page 50 9:02am revealed: -The pharmacy provider lost the facility account the end of October 2018, it was taken over by another pharmacy provider. -The pharmacy provider was scheduled to resume the facility account on 06/01/19. Interview with another pharmacy provider, lead pharmacist on 05/22/19 at 9:32am revealed: -They began pharmacy services with the facility on 11/01/18. -They were only contracted to provide medication services to the facility. -The consulting services were reviewed and offered to the facility, but it was up to the facility to select that service.	D 280		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure foods stored and served to residents were protected from contamination as relates to a build-up of food debris and spillage in the freezer. The findings are: Observations of the freezer on 05/15/19 between 1:19pm and 1:41pm revealed: -There were several dried puddles of dark red,	D 282		

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dark brownish and pinkish colored substances beneath the three-tiered opened metal shelved racks.
-The third metal shelf held several separate brown boxes labeled with chicken, hamburger, and other meats, etc.

Interview with the Dietary Manager on 05/15/19 at 1:20pm revealed:
-He went into the freezer several times throughout the day.
-He did not know how long the spillage in the bottom of the freezer had been there.
-The spillage should have been cleaned.
-He was not given any formal training by anyone he performed the dietary cleaning task, the best way he knew.
-He was responsible for cleaning the freezer.
-There was no cleaning schedule, or written cleaning duties for anyone in the kitchen.
-A cleaning schedule needed to be created.

Interview with the Administrative Assistant on 05/15/19 at 1:45pm revealed:
-She was not aware of any spills in the freezer, and dietary was not her area to supervise.
-The administrator was responsible for overseeing the cleanliness, food supply, and any other task related to dietary.

Attempted interview with the Administrator during the survey [05/15/19 through 05/22/19] was unsuccessful.
Observation of the walk-in cooler on 05/15/19 at 2:11pm revealed:
-At the entrance of the walk-in cooler, the floor was unsturdy and seemed to be sunken with dark brown stained areas.
-There was an empty box on the floor.

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D 282	Continued From page 52 Observation of the walk-in freezer on 05/15/19 at 2:11pm revealed: -The floor of the walk-in freezer had several dark brown, black stained areas in the corner. -There were 2 (garlic bread and an unnamed product) boxes on the floor. Interview with Dietary Manager on 05/15/19 at 1:43pm revealed: -There were no cleaning schedules or cleaning assignments for staff. -He has inquired about taking the ServSafe class at the local community college. Attempted interview with the Administrator during the survey [05/15/19 through 05/22/19] was unsuccessful.	D 282		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure an adequate three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. . The findings are: Interview with the Resident Care Coordinator on	D 285		

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D 285	Continued From page 53 05/15/19 at 10:00am revealed the facility census was 49. Review of the facility's dinner menu for 05/15/19 and breakfast menu on 05/16/19 revealed breakfast and dinner all residents were to receive one cup (8 ounces) of milk. Observation of the milk inventory on 05/15/19 at 2:11pm revealed 2 gallons of two percent milk in the refrigerator. To have 2 cups of milk available to each resident as a beverage for both days, the facility needed to have 8 gallons on hand. Further review of the facility menus revealed 8 ounces of milk was to be offered to all residents twice daily. The facility would need to purchase 12 gallons of milk on hand to offer 8 ounces of milk twice daily for three days. Interview with a resident on 05/16/19 at 12:02pm revealed: -The facility rarely had second helpings to serve. -He believed the facility did not have enough food. -He would like a second serving, but second servings of food were not available. -They were served three meals per day. Confidential interview with a staff member on 05/15/19 revealed: -The facility recently had been running out of food and milk. -The menu was posted in the facility, the residents did not get fed that same meal. -The residents request second servings, but do not get them. -Staff members go to the area grocery store and purchase food and drinks for the residents with their own money.	D 285		

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D 285	Continued From page 54 Review of the lunch menu for 5/16/19 revealed: Open faced turkey sandwich with gravy, stewed potatoes, Tuscan blend vegetables, and pumpkin mousse for desert. Observation of the lunch meal served on 05/16/19 at 12:02pm revealed: -Residents were served a slice of cubed steak 1 ounces (oz.) in size (with 1 spoonful of brown gravy, egg noodles and mixed vegetables). -All residents were served one vanilla ice cream sandwiches. -No second servings were given. Interview with the Dietary Manager on 05/15/19 at 1:43 pm revealed: -He has had no training related to supervising a kitchen. -He had to teach himself on how to purchase orders for food in the kitchen. -He had not seen the menu spreadsheet for the facility. -If he did not have the foods indicated on the menu, he had to create a different item or meal. -He tried to go by the menu, but it depended on what was available in the pantry and freezer to prepare for the meals. -He and other staff members would purchase food supplies at the local grocery store using their own money. -He was responsible to make sure an adequate amount of food was in the facility for the residents. He recalled telling the Administrator about running low on food and drinks for the resident's meals roughly a week ago. -There was no three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both	D 285		

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D 285	Continued From page 55 regular and therapeutic diets. -He was not aware that he was supposed to have at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. Interview with the Administrative Assistant on 05/15/19 at 1:45pm revealed: -She was not aware of any food shortage, and dietary was not her area to supervise. -The administrator was responsible for food supply needs and any other task related to dietary. -The Administrator was not present, nor available for an interview.	D 285		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure residents were provided a non-disposable place setting consisting of a knife, spoon, and fork at each meal.	D 287		

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D 287	Continued From page 56 The findings are: Observation of the lunch meal service on 05/15/19 at 12:20pm revealed all residents were eating from disposable plates. Observation of the lunch meal served on 05/16/19 at 12:02pm revealed: -The residents were served a slice of cubed steak, brown gravy, egg noodles, mixed vegetable and vanilla ice cream sandwiches. -There were 47 residents eating the lunch meal in the dining room. -All the residents received only a fork and spoon as an eating utensil. -No residents received a knife to eat their lunch meal. -Some residents had trouble cutting there cubed steak with a spoon. Interview with the Dietary Manager on 05/15/19 at 1:20pm revealed: -He told the Administrator a week ago about running low on utensils for the resident's meals. -The Administrator was responsible for ordering facility utensils. -There was not enough plates or utensils to cover the meals for the current facility census. -He was not aware that table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. -He said no one taught him this rule. Interview with the Administrative Assistant on 05/15/19 at 1:45pm revealed: -She was not aware of any utensil's shortage, and dietary was not her area to supervise. -The administrator was responsible for utensils needed and any other task related to dietary.	D 287		

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D 287	Continued From page 57 Attempted interview with the Administrator during the survey [05/15/19 through 05/22/19] was unsuccessful. Observation of the dinner meal on 05/15/19 at 5:00pm revealed table setting with a fork, spoon and napkin but without a knife. Observation of the dinner meal on 05/15/19 at 5:30pm revealed some residents were being served food on disposable plates. Interview with cook on 05/15/19 at 5:40pm revealed: -She used non disposable plates for dinner. -If the facility ran out of non disposable plates they used disposable plates. -All sandwiches were served on disposable plates regardless of the circumstance. -She used disposable plates this evening because she ran out of non disposable plates. Interview with Dietary Manager on 05/16/19 at 12:44pm revealed: -The facilty did not have enough non disposable plates to serve meals. -The facility staff used disposable plates when non disposable plates ran out daily. The Administrator was not available for an interview.	D 287		
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,	D 358		

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D 358	Continued From page 58 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 ensure medications were administered as ordered for 1 of 5 residents (Resident #1) sampled for record review including errors in medications used to control high blood pressure, treat anxiety and depression, treat symptoms of Parkinson's disease, glaucoma, and pain; and failed to ensure medications were administered as ordered and in accordance with the facility's policies for 2 of 33 residents observed during the medication pass. The findings are: 1. The medication error rate was 6% as evidenced by 2 errors out of 33 opportunities during the 8:30am medication pass on 05/16/19. Review of Resident #14's current FL-2 dated 07/23/19 revealed diagnoses that included chronic obstructive pulmonary disease (COPD),	D 358		

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history of cerebrovascular accident (CVA) and left sided weakness.

a. Review of a Physician's Order Form dated 02/21/19 revealed an order for Combivent Respimat AER Inhaler 1 puff four times a day.

Review of the electronic medication administration record (eMAR) for May 2019 revealed an entry for Combivent Respimat AER Inhaler 1 puff four times a day.

Observations during medication pass on 05/16/19 at 8:30am revealed:
-Resident #14 approached the medication cart while still chewing food from the breakfast meal.
-Staff B assisted the resident administered the Combivent Respimat AER Inhaler 1 puff.
-Staff B replaced the cap on the inhaler without wiping the mouth piece to remove food particles.

Interview with Staff B at 8:35am on 05/16/19 revealed:
-She has been a MA for 12 years and has worked at the facility for 1 year.
-She did not think to clean the mouth pieces of Resident #14's inhalers to remove the food particles.
-She usually remembered to have Resident #14 rinse his mouth after the use of the steroid inhaler but just forgot today.
-She would remind him to rinse his mouth out with water as soon as possible.

b. Review of a Physician's Order Form dated 09/22/18 revealed an order for Symbicort AER Inhaler 2 puffs twice a day.

Review of the electronic medication administration record (eMAR) for May 2019

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revealed an entry for Symbicort AER 2 puffs twice a day with instructions to rinse mouth after use.

Observations during medication pass on 05/16/19 at 8:30am revealed:
-Staff B assisted the resident with the administration of Symbicort AER 2 puffs.
-Resident #14 walked away from the medication cart without being prompted to rinse his mouth.

Interview with Staff B at 8:35am on 05/16/19 revealed:
-She usually remembered to have Resident #14 rinse his mouth after the use of the steroid inhaler but just forgot today.
-She would remind him to rinse his mouth out with water as soon as possible.

Interview with the Quality Assurance Director/Resident Care Coordinator on 05/16/19 at 10:53am revealed:
-In the past she had monitored the MA's as the administered medications, but she had not done so recently.
-She would review proper inhaler usage with all MA's as soon as possible.

2. Review of Resident #1's current FL-2 dated 07/17/18 revealed diagnoses included alcohol induced persisting dementia, bruit, depression with anxiety, hypothyroidism, insomnia, leukocytosis, memory loss, obsessive compulsive, peripheral vascular disease, and Parkinson's.

Review of subsequent physician orders for Resident #1 dated 10/02/18 revealed there were no changes to the medications prescribed on the FL-2 dated 07/17/18.

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Review of the March 2019, April 2019, and May 2019 electronic medication administration records (eMARs) for Resident #1 revealed seven routinely prescribed medications were not documented as administered as ordered.

a.Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Hydralazine 50mg (used to treat hypertension) one tablet three times a day.

Review of the March 2019 electronic medication administration records (eMARs) for Resident #1 revealed:
-There was an entry for Hydralazine HCL 50mg tablet three times a day and scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation the Hydralazine was not administered 32 out of 93 opportunities, with 3 of the 32 opportunities documented as "physically unable to take", and 29 of the 32 opportunities documented as "resident refused."

Review of the April 2019 eMARs for Resident #1 revealed:
-There was an entry for Hydralazine HCL 50mg tablet three times a day and scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation the Hydralazine was not administered 1 out of 90 opportunities, with reason documented as "physically unable to take, resident has been in a deep sleep today."

Review of the May 2019 eMARs for Resident #1 revealed:
-There was an entry for Hydralazine HCL 50mg tablet three times a day and scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation the Hydralazine was not administered 21 out of 46 opportunities, with

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reason documented as "physically unable to take".

Observation of the medication on hand on 05/20/19 at 4:00pm revealed there were four blister packs of Hydralazine 50mg tablets totaling 75 tablets on hand.

Interview with the consultant Pharmacist on 05/22/19 at 8:30am revealed:
-Hydralazine 50mg one tablet three times a day was dispensed on 03/12/19, 04/03/19, and 05/05/19 for a quantity of 45 tablets for a 15-day supply.
-There had been sporadic lapses in refilling Resident #1's medications.
-The residents blood pressure could be elevated and uncontrolled with missed dosages.
-If the blood pressure was elevated for an extended time, there could be more serious effects such as heart attack or stroke.

b. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Amlodipine (used to treat hypertension) 10mg tablet every day.

Review of the March 2019

Review of the April 2019 electronic medication administration records (eMARs) for Resident #1 revealed:

-There was an entry for Amlodipine 10mg tablet every day scheduled at 8:00am.
-There was documentation the Amlodipine was not administered 2 out of 30 opportunities with the reason documented as "physically unable to take."

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Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was a quantity of 15 tablets dispensed on 05/12/19 with 11 tablets remaining on hand.

Interview with the consultant Pharmacist on 05/22/19 at 8:30am revealed:
-The pharmacy dispensed a 15-day supply quantity of 15 tablets of Amlodipine 10mg tablets on 03/03/19, 03/20/19, 04/03/19, 04/46/19/ and 05/12/19.
-An effect of high blood pressure with missed doses of Amlodipine would not be present as much because Amlodipine was a longer acting medication.

c. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Carbidopa/Levodopa (used to treat Parkinson's) 10-100mg tablet three times a day.

Review of the April 2019 electronic medication administration records (eMARs) for Resident #1 revealed:
-There was an entry for Carbidopa/Levodopa 10-100mg tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation the Carbidopa/Levodopa was not administered 6 out of 90 opportunities, documented as "physically unable to take."

Review of the May 2019 eMARs for Resident #1 revealed:
-There was an entry for Carbidopa/Levodopa 10-100mg tablet three times a day and scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation the Carbidopa/Levodopa was not administered 3 out

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D 358	Continued From page 64 of 46 opportunities, with a reason documented as "physically unable to take". Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was a quantity of 30 tablets in one blister pack plus 2 tablets in a second blister pack dispensed on 04/14/19 for a total of 32 tablets remaining on hand. Interview with the consultant Pharmacist on 05/22/19 at 8:30am revealed: -The pharmacy had dispensed refills for Carbidopa/Levodopa 10-100mg tablet three times a day on 02/24/19 and 04/14/19. -The 02/24/19 supply of Carbidopa/Levodopa dispensed to the facility should have run out around 3/26/19 or 3/27/19. -A 30-day supply of 90 tablets were dispensed on 04/14/19 which should have lasted until 5/14/19 or 5/15/19. -There could be shakiness, twitching, and unsteadiness with lapses in administration of the Carbidopa/Levodopa. d. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Lexapro (used to treat depression) 5mg tablet at bedtime. Review of the April 2019 electronic medication administration records (eMARs) for Resident #1 revealed: -There was an entry for Lexapro 5mg tablet at bedtime scheduled at 8:00pm. -There was documentation the Lexapro was not administered 1 out of 29 opportunities, with a reason documented as "physically unable to take." Review of the May 2019 eMARs for Resident #1	D 358		

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revealed:
-There was an entry for Lexapro 5mg tablet at bedtime and scheduled at 8:00pm.
-There was documentation the Lexapro was not administered 3 out of 46 opportunities, with a reason documented as "physically unable to take."

Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was a quantity of 15 tablets dispensed on 04/17/19 with 7 tablets remaining on hand.

Interview with the consultant Pharmacist on 05/22/19 at 8:50am revealed:
-The Lexapro 5mg at bedtime was filled on 12/10/18, quantity of 30 tablets for a 30-day supply.
-The Lexapro was not refilled until 04/17/19 quantity of 14, for a 14-day supply, which was last time the Lexapro was refilled.
-The effects of missed doses would be symptomatic such as seeing a lot of refusals in residents and increased behaviors.
-If Lexapro was started and stopped, there would be worsening of effects.
-Resident #1 was on the lowest dose of Lexapro and it could not be tapered off.

e. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Tramadol HCL (used to treat pain) 50mg two tablets two times a day.

Review of the May 2019 electronic medication administration records (eMARs) for Resident #1 revealed:
-There was an entry for Tramadol HCL 50mg two tablets twice a day and scheduled at 8:00am and 8:00pm.

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-There was documentation the Tramadol was not administered 1 out of 22 opportunities, documented as "physically unable to take."

Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was a quantity 0f 60 tablets dispensed on 05/05/19 with 26 tablets remaining on hand.

Interview with the consultant Pharmacist on 05/22/19 at 8:50am revealed:
-The Tramadol 50mg two tablets twice a day was dispensed on 03/20/19, 04/11/19, and 05/05/19 each for quantity of 60 tablets, a 15-day supply.
-There were some lapses in refills if the Tramadol was supposed to be administered on a routine schedule.
-The resident may have pain as an effect if the medication was not administered as ordered.

f. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Travatan Z eye drops (used to treat glaucoma) instill one drop in both eyes at bedtime.

Review of the May 2019 electronic medication administration records (eMARs) for Resident #1 revealed:
-There was an entry for Travatan Z 0.0004% eye drops one drop in each eye at bedtime and scheduled at 8:00pm.

-There was documentation the Travatan Z was not administered 1 out of 13 opportunities documented as "physically unable to take."

Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was a 2.5ml

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bottle of Travatan Z dispensed on 09/19/18 with approximately 2/3rd of the bottle remaining on hand.

Interview with the consultant Pharmacist on 05/22/19 at 8:50am revealed:
-The Travatan Z had not been dispensed to the facility since 11/14/18.
-A supply dispensed to the facility would only last about one month.
-The 09/19/18 supply dispensed was not from the current provider pharmacy.
-She would expect the facility to call the pharmacy and ask for a refill when medication refills were needed.
-The pharmacy had to have a refill request from the facility, patient, or physician in order to refill a medication.

g. Review of a signed physician order sheet for Resident #1 dated 10/02/18 revealed the resident was prescribed Nystatin Ointment (used to treat fungal infections) 100000 apply to feet twice a day.

Review of the May 2019 eMARs for Resident #1 revealed:
-There was an entry for Nystatin Ointment 100000 apply to feet twice a day for fungal infections and scheduled at 8:00am and 8:00pm.

-There was documentation the Nystatin Ointment was not administered 1 out of 28 opportunities, with a reason documented as "physically unable to take."
Observation of the medication on hand on 05/20/19 at 4:00pm revealed there was an unopened 30gm tube of Nystatin Ointment with a dispense date of 02/19/19 on the pharmacy printed label.

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D 358	Continued From page 68 Interview with the consultant Pharmacist on 05/22/19 at 8:30am revealed a tube of Nystatin Ointment could last six months or until the tube expired depending on frequency of administration. Interview with a Medication Aide (MA) on 05/16/19 at 10:20am revealed: -A circle around initials on the eMARs meant the medication was withheld for some reason. -Resident #1 got combative. Interview with the Quality Assurance Director/Resident Care Coordinator (QAD/RCC) on 05/16/19 at 12:40pm revealed: -Medications were delivered to the facility every night if needed. -There was a backup pharmacy if needed. -When new medication orders were received, the RCC or Mas were responsible to approve the new order, so the medication instructions would populate to the eMARs and be accessible for the Mas to immediately view for administration. Interview with the QAD/RCC on 05/17/19 at 1:30pm revealed: -Medications were batch delivered to the facility on the 10th or 12th of the month. -The MA working on the 11:00pm - 7:00am was responsible for checking in the batch delivered medications. -If the MA did not get the batch delivered medications checked in, the RCC checked them in the next day. -Whoever checked in the batch delivered medications wrote a list of those medications that were not delivered with the batch delivery. Interview with the Administrative Assistant on	D 358		

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D 358	Continued From page 69 05/17/19 at 1:35pm revealed: -Some of the medication problems had to do with outside doctors. -There were problems like getting medication refill orders and prescriptions. -The MAs were responsible for getting medications refilled through the eMAR system. -If there was a need for a prescription, the pharmacy would send for the prescription. -The RCC was responsible for getting a prescription from the physician. -The physicians might fax a prescription to the pharmacy or the facility, or the facility would pick the prescription up from the physician's office. -The pharmacy only sent a 15-day supply of medication for residents who were Hospice. -Resident #1 was receiving hospice services. Interview with the Medication Aide/Resident Care Coordinator (MA/RCC) on 05/20/19 at 3:00pm revealed: -When she did not administer a medication to a resident her initials were circled on the eMAR. -When she selected "physically unable to take" as a reason for the medication not administered, it meant the medication was not in the facility. -Sometimes she chose "awaiting" or would leave a blank on the eMAR if the medication was not in the facility. -Any of the MAs working on the medication cart could reorder resident medications. -Routine medications should not have to be re-ordered unless the resident is receiving hospice services because some hospice resident medications are sent only for a 15-day supply. -Eye drops and ointments were medications that had to be re-ordered. -There was no written medication re-order policy. -When a medication supply was down to the last column on the bubble pack, the medication could	D 358		

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be re-ordered by clicking re-order through the eMAR system.
-Batch delivered medications were delivered to the facility around the 12th of the month.
-Usually the 11:00pm - 7:00am shift MA checked in the batch medications delivered.

Interview with a third MA on 05/20/19 at 4:40pm revealed:
-She documented on the eMAR when Resident #1's medications were not administered due to resident refusing medications.
-She selected "physically unable to give or awaiting pharmacy" when medications were not administered because the medication was not in the facility.

Interview with the Hospice Nurse on 05/21/19 at 10:30am revealed:
-Resident #1 should not have been out of medications for any extended amount of time.
-The staff reordered the resident's medication through the eMAR by clicking reorder.
-The staff was instructed to click reorder when Resident #1 was down to 4 or 5 doses of medication.
-If the staff was reordering Resident #1's medication from the pharmacy and was not getting the medication, the facility should have been following up with the RCC, Administrator, and Hospice agency.
-The facility should have been checking with the pharmacy and she thought the RCC would need to know if Resident #1 was missing medications.
-The facility reported to her in the past that Resident #1 had agitation.
Interview with the Nurse Practitioner (FNP) on 05/21/19 at 11:54 am revealed:
-Resident #1 was seen on 03/19/19 at the facility.
-The resident's blood pressure was 146/52 which

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D 358	Continued From page 71 was a little high. -Previous blood pressures were 124/70 and 128/60. -It was concerning if Resident 31 missed blood pressure medications. -If the resident's blood pressure was consistently above 170 or 180, it would place the resident at risk for a light stroke or heart attack. The facility failed to assure medications were administered as ordered related to multiple medications used to treat high blood pressure for Resident #1. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of correction on 05/17/19 in accordance with G.S. 131D-24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 6, 2019.	D 358		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's	D 400		

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record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and
(B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and
(C) documenting the results of the medication review in the resident's record.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to have medication reviews completed at least quarterly for 5 of 5 sampled resident (#1, #2, #3, #4, #5).

The findings are:

1. Review of Resident #1's current FL-2 dated 07/17/18 revealed:
-The resident's diagnoses included alcohol induced persisting dementia, bruit, depression with anxiety, hypothyroidism, insomnia, leukocytosis, memory loss, peripheral vascular disease, Parkinson's disease, and obsessive compulsive.
-Routine medications listed on the FL-2 for Resident #1 included Allopurinol (used to treat gout), Amlodipine (used to treat hypertension),

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D 400	Continued From page 73 Aspirin low chew (used to treat heart disorders). Carb/Levo (used to treat Parkinson's), Docusate Sodium (used to treat constipation), Lexapro (used to treat behavior), Hydralazine (used to treat hypertension), Isosorbide (used to treat heart disorders), Synthroid (used to treat hypothyroidism), Senna (used to treat constipation), Tamsulosin (used to treat urinary disorders), Tramadol (used to treat pain), and Travatan eye drops (used to treat glaucoma), Review of March 2019, April 2019, and May 2019 Medication Administration Records (MARs) for Resident #1 revealed there were opportunities when the resident's medications were not administered. Review of Resident #1's pharmacy reviews revealed: -The last pharmacy review was completed on 09/30/18 by a pharmacist with a consulting pharmacy provider. -There were no quarterly pharmacy reviews available for review between 09/30/18 - 05/15/19 in order to identify medication related problems. Refer to interview with the Quality Assurance Director/Resident Care Coordinator (QAD /RCC) on 05/16/19 at 10:58am. Refer to interview with the Quality Assurance Director/Resident Care Coordinator on 05/16/19 at 12:45pm. Refer to interview with the Director of Pharmacy Consultants on 05/22/19 at 9:02am. Refer to interview with the Pharmacy Provider Lead Pharmacist on 05/22/19 at 9:32am.	D 400		

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D 400	Continued From page 74 2. Review of Resident #5's current FL-2 dated 04/30/19 revealed: -The resident's diagnoses included chronic allergic rhinitis, hypertension, hyperlipidemia, schizophrenia, and type 2 diabetes mellitus. -Routine medications listed on the current FL-2 included Amlodipine (used to treat hypertension), Atorvastatin (used to treat high cholesterol), Buspirone (used to treat schizophrenia), Candesartan (used to treat hypertension), Fluticasone Spray (used to treat allergies), Lantus Insulin and Novolog Insulin (used to treat diabetes), Metformin (used to treat diabetes), and Metoprolol (used to treat hypertension). Review of Resident #5's pharmacy reviews revealed: -The last pharmacy review was completed on 10/17/18 by a pharmacist with a consulting pharmacy provider. -There were no quarterly pharmacy reviews available for review between 10/17/18 - 05/15/19 in order to identify medication related problems. Refer to interview with the Quality Assurance Director/Resident Care Coordinator (QAD /RCC) on 05/16/19 at 10:58am. Refer to interview with the Quality Assurance Director/Resident Care Coordinator on 05/16/19 at 12:45pm. Refer to interview with the Director of Pharmacy Consultants on 05/22/19 at 9:02am. Refer to interview with the Pharmacy Provider Lead Pharmacist on 05/22/19 at 9:32am. 3. Review of Resident #2 current FL-2 dated 04/30/18 revealed:	D 400		

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-Diagnoses included dementia, hypertension and allergies.
-Medication listed included All Day Relief (an over the counter pain medication), Alprazolam (a sedative), Amlodipine (used to treat hypertension), Azelastine (antihistamine used to treat allergies), Cetrizine (antihistamine used to treat allergies), Clopidogrel (a blood thinner), Fluticasone (a steroid used to treat allergies), Lasix (a diuretic), Linzess (used to treat chronic constipation), Myrabetriq (used to treat overactive bladder syndrome), Oxycodone (an narcotic used to treat pain), Potassium Chloride (a electrolyte), Sertraline (used to treat depression) and a stool softener.

Review of Resident #2's pharmacy reviews revealed:
-The last pharmacy review was completed on 10/17/18 by a pharmacist with a consulting pharmacy provider.
-There were no quarterly pharmacy reviews available for review between 10/17/18 - 05/20/19.

Refer to interview with the Quality Assurance Director/Resident Care Coordinator (QAD /RCC) on 05/16/19 at 10:58am.

Refer to interview with the Quality Assurance Director/Resident Care Coordinator on 05/16/19 at 12:45pm.

Refer to interview with the Director of Pharmacy Consultants on 05/22/19 at 9:02am.

Refer to interview with the Pharmacy Provider Lead Pharmacist on 05/22/19 at 9:32am.

Attempted interview with the Administrator during the survey [05/15/19 through 05/22/19] was

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unsuccessful.
4. Review of Resident #4's current FL-2 dated 07/23/18 revealed:
-Diagnoses included End Stage Renal Disease, Diabetes Mellitus, Acute ischemic Stroke, Anemia, Multi Infarction Dementia, Hypercholesterol, Carotid Stenosis s/p left Carotid Endorectery, Essential Hypertension and Syncope.
-Medications listed were Alfuzosin (used to treat signs of enlarged prostate), Amlodopine (used to treat hypertension), Aspirin (used to help prevent recurrent heart attack and ischemic stroke), Atorvastin (prevent cardiovascular disease), Clopidogrel (used to reduce the risk of heart disease and stroke), Flucticosone (used to treat pain, itching and swelling), Probiotic (used to improve or restore gut flora), Sertraline (used to treat major depressive disorder, post-traumatic stress disorder or anxiety), Sevelamer (used to treat hyperphosphatemia), Gabapentin (used to treat partial seizures, neuropathic pain or restless legs syndrome), Lemeir (used to treat diabetes), Lido/Priloen cre (used to prevent pain), Lisinopril (used to treat high blood pressure, heart failure and after heart attack), Metoprolol tart (used to treat high blood pressure, chest pain and heart failure), Nepro (help to minimize blood sugar spikes).

Review of Resident #4's quarterly pharmacy reviews revealed the last pharmacy review completed for Resident #4 was on 10/16/18.

Refer to interview with the Quality Assurance Director/Resident Care Coordinator (QAD /RCC) on 05/16/19 at 10:58am.

Refer to interview with the Quality Assurance Director/Resident Care Coordinator on 05/16/19

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D 400	Continued From page 77 at 12:45pm. Refer to interview with the Director of Pharmacy Consultants on 05/22/19 at 9:02am. Refer to interview with the Pharmacy Provider Lead Pharmacist on 05/22/19 at 9:32am. 5. Review of Resident #3's current FL-2 dated 04/20/18 revealed: -The resident's diagnoses included history of urinary tract infection, hyperkalemia, hyperlipidemia, essential hypertension, anemia, and diabetes mellitus. -Routine medications listed on the FL-2 for Resident #3 included Amlodipine (used to treat hypertension), Ferrous Sulfate (used to treat iron deficiency), Glipizine (used to treat diabetes), Lisinopril (used to treat high blood pressure), Simvastatin (used to treat high cholesterol), Levothyroxine Sodium (used to treat hypothyroidism), and Metformin HCL ER (used to treat diabetes). Review of Resident #3's pharmacy reviews revealed: -The last pharmacy review was completed on 10/17/18 by a pharmacist with a consulting pharmacy provider. -There was no documentation for quarterly pharmacy reviews available for review between 10/17/18 through 5/15/19. Refer to interview with the Quality Assurance Director/Resident Care Coordinator (QAD /RCC) on 05/16/19 at 10:58am. Refer to interview with the Quality Assurance Director/Resident Care Coordinator on 05/16/19 at 12:45pm.	D 400		

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D 400	Continued From page 78 Refer to interview with the Director of Pharmacy Consultants on 05/22/19 at 9:02am. Refer to interview with the Pharmacy Provider Lead Pharmacist on 05/22/19 at 9:32am. Interview with the Quality Assurance Director/Resident Care Coordinator (QAD /RCC) on 05/16/19 at 10:58am revealed: -The QAD/RCC had returned to work in January 2019 after an extended leave. -The current providing pharmacy was hired "at the end of last year" 2018. -Pharmacy reviews have not been done since the new pharmacy was hired. -She does not know why the new pharmacy does not do the quarterly reviews. -The facility changed pharmacy providers fall 2018. -She acknowledged that the pharmacy reviews were not done since fall 2018. -She could not explain why the pharmacy reviews were not done since fall 2018. Interview with the Quality Assurance Director/Resident Care Coordinator (QAD/RCC) on 05/16/19 at 12:45pm revealed: -Pharmacy reviews were done by the Provider Pharmacy. -The pharmacy representative coordinated with the facility when they were coming to perform the pharmacy reviews. -Pharmacy reviews were being done every three months, but she thought since the facility had changed pharmacy providers there had not been any pharmacy reviews completed. -She could not tell when the change in pharmacy providers occurred.	D 400		

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D 400	Continued From page 79 Interview with consulting pharmacy provider, Director of Pharmacy Consultants on 5/22/19 at 9:02am revealed: -The pharmacy provider lost the facility account the end of October 2018, it was taken over by another pharmacy provider. -The pharmacy provider is scheduled to resume the facility account on 06/01/19. -The pharmacy provider was informed that no quarterly pharmacy reviews have been done, since they left in October 2018. -He did not know or understand why no quarterly pharmacy reviews were not done since October 2018. -He could only convey to the quarterly pharmacy reviews were done up to October 2018. Interview with another pharmacy provider, lead pharmacist on 05/22/19 at 9:32am revealed: -They began pharmacy services with the facility on 11/01/18. -They are only contracted to provide medication services to the facility. -The pharmacy provider does provide consulting services (pharmacy quarterly reviews, etc.) -The consulting services were reviewed and offered to the facility, but it was up to the facility to select the services they wanted.	D 400		
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.	D912		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to other requirements, physical environment, supervision, health care, training on cardio-pulmonary resuscitation, and medication administration.

The findings are:

1. Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures were maintained between 100 - 116 degrees Fahrenheit (F) for 14 of 17 sampled fixtures on the men's hall with hot water temperatures of 120 degrees F to 128.2 degrees F. [Refer to Tag 113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)].

2. Based on observations, record review and interviews, the facility failed to assure supervision was provided for 1 of 5 (Resident #13) resident, who walked away from the facility, with the diagnosis of Alzheimer's and was deemed constantly disoriented by her primary care provider (PCP). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].

3. Based on observations, interviews, and record review, the facility failed to assure health care referral and follow up was completed for 4 of 7 sampled resident (Residents #1, #3, # 6, #11)

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	HAL064032	A. BUILDING: _____ B. WING _____	05/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILL SENIOR LIVING	891 NOELL LANE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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who required follow up for medication refusals (#1), diabetic, nail care (#3), a fall resulted in a hip fracture, not sent to hospital until four days later (#6), not treated for a sinus infection until 10 days after care was requested (#11) [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].

4. Based on observations, interviews, and record reviews, the facility failed to assure 6 of 6 exit doors accessible for residents' use had an alarm that activated for safety for 1 of 1 sampled resident (Resident #13) with dementia and assessed to be intermittently and constantly disoriented, known to wander and had exited from the facility without staff knowledge. [Refer to Tag 067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)].

5. Based on record review and interviews, the facility failed to assure at least one staff person was on the premises at all times who had completed a course in Cardio-Pulmonary Resuscitation (CPR) and choking management within the last 24 months.
[Refer to Tag 167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)]

6. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (Resident #1) sampled for record review including errors in medications used to control high blood pressure, treat anxiety and depression, treat symptoms of Parkinson's disease, glaucoma, and pain; and failed to ensure medications were administered as ordered and in accordance with the facility's policies for 2 of 33 residents observed during the medication pass. Refer to

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D912	Continued From page 82 Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		
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. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if	D935		

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D935	Continued From page 83 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: Based on record reviews and interviews, the facility failed to assure 2 of 3 sampled staff (Staff C and D) who administered medications had completed the 10-hour state approved medication administration course within 60 days of completing the 5-hour state approved medication administration course, or completion of the 15 hour state approved medication administration course prior to administering medications. The findings are: 1. Review of Staff C's personnel record revealed: -Staff C was hired on 06/24/15. -There was no documentation for position title at hire. -There was documentation of passing the written medication aide examination on 10/09/18. -There was documentation for completion of the 5-hour state approved medication aide training on 06/21/18. -There was no documentation of the 10-hour, or 15-hour state approved medication aide training course. Interview with Staff C on 05/15/19 at 10:00am	D935		

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revealed:
-She was the Resident Care Coordinator (RCC).
-She was the Supervisor and in charge of the facility at that time.
-She was still in training for the RCC and had not yet been in the RCC role for a month.
-She was a medication aide and was administered medications today (05/15/19).
-She still needed to check resident blood pressures and perform resident finger stick blood sugar checks.
-She had been employed at the facility since 2015.

Review of the March 2019 - May 2019 medication administration records (MARs) revealed Staff C documented administration of medications to residents, and refusals of medications for residents residing at the facility.

Interview with the Administrative Assistant on 05/17/19 at 1:05pm revealed she did not know the status of Staff C's 10-hour or 15-hour state approved medication aide training.

Second interview with Staff C on 05/20/19 at 3:00pm revealed:
-She worked as a medication aide today (05/20/19).
-She administered medications 1-2 times a week.

2. Review of Staff D's personnel record revealed:
-Staff D was hired on 01/23/18 as a medication aide.
-There was documentation of passing the written medication aide examination on 04/19/18.
-There was documentation for completion of the 5-hour state approved medication aide training on 04/12/18.
-There was no documentation of the 10-hour, or

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D935	Continued From page 85 15-hour state approved medication aide training course. Interview with Staff D on 05/15/19 at 10:50am revealed: -She was a medication aide. -She had been employed at the facility since February 2018. Review of the March 2019 - May 2019 medication administration records (MARs) revealed Staff D documented administration of medications to residents, including sliding scale insulin for a resident residing at the facility. Interview with the Administrative Assistant on 05/17/19 at 1:05pm revealed she did not know the status of Staff D's 10-hour or 15-hour state approved medication aide training. Observations of Staff D on 05/20/19 at intervals between 9:45am and 1:00pm revealed she administered medications to residents on the women's hall.	D935		