STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: _____ B. WING _____	07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(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 07/24/19 through 07/26/19.	D 000	Responses to sited deficiencies does not constitute an admission or agreement by the facility of the truth of alleged or conclusions set fort in this statement of deficiencies of Corrective Action Report; the plan is solely as a matter of compliance with state law.	
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 4 sampled staff (Staff A and Staff F) were competency validated by a Registered Nurse (RN) for Licensed Health Professional Support (LHPS) tasks of ambulation, transferring, nebulizer, Thromboembolism-Deterrent (TED) Hose, oxygen, finger stick blood sugars and insulin administration. The findings are: 1. Review of Staff A's, Personal Care Aide (PCA)	D 161	10A NCAC 13F .0504 (LHPS Tasks) Executive Director (ED) and Business Office Manager (BOM) will conduct staff file audits to ensure LHPS competency and compliance.Any identified areas will be addressed immediately. BOM will utilize a perpetual staff log to monitor staff requirements. ED and/or BOM will notify RN when staff are in need of competency validation. ED and BOM will perform monthly audits of staff files to ensure compliance.	9/9/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 9/13/19

Reviewed and accepted 09/17/19 KHH

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D 161	Continued From page 1 personnel record revealed: -Staff A was hired on 03/19/19. -There was no documentation Staff A had completed LHPS competency validation. Interview with Staff A on 07/26/19 at 2:00pm revealed: -She started working at the facility earlier this year. -When she was hired, she started training with a nurse, but the nurse quit. -She was supposed to complete the training, but had not been scheduled for LHPS training. -When she worked, she assisted residents with ambulation, transfers and putting on TED Hose. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -Staff A was a PCA and was responsible for assisting residents with ambulation and transfers. -Staff A assisted residents with dressing, which included putting on stockings (including TED hose). -The Business Office Manager (BOM) was responsible to ensure staff completed all training. -Earlier this year the BOM was on leave from work and the previous Administrator was responsible for ensuring staff completed training. Interview with the BOM on 07/26/19 at 6:06pm revealed: -She did not schedule LHPS training for Staff A because she was on leave from work. -The previous Administrator should have scheduled the staff for the training. 2. Review of Staff F's, Medication Aide (MA) personnel record revealed: -Staff F was hired on 02/18/19. -There was no documentation Staff F had	D 161		

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D 161	Continued From page 2 completed a LHPS competency validation. Review of the July 2019 electronic Medication Administration Record (eMARs) of three diabetic residents' records with orders for fingerstick blood sugars and insulin injections revealed documentation Staff F administered insulin and checked fingerstick blood sugars on 07/14/19, 07/18/19, 07/19/10, 07/20/19, 07/21/19, and 07/22/19. Attempted interview with Staff F on 07/26/19 at 11:47am was unsuccessful. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -Staff F was a MA and was responsible for administering medications including fingerstick blood sugars, insulin injections, nebulizer treatments, and ensuring oxygen administration. -She was unaware Staff F had not completed the LHPS training. -The Business Office Manager (BOM) was responsible to ensure staff completed all training. -Earlier this year the BOM was on leave from work and the previous Administrator was responsible for ensuring staff completed training. -The BOM should have checked personnel records to ensure the required training had been completed. Interview with the BOM on 07/26/19 at 6:06pm revealed: -She had not scheduled Staff F for LHPS training. -She did not know that Staff F did not have the required LHPS training prior to working on the floor. -She was on leave from work shortly after Staff F was hired, therefore the previous Administrator should have scheduled Staff F for the LHPS	D 161		

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D 161	Continued From page 3 training. -When she returned back to work she did not check Staff F's record to ensure the LHPS training had been completed.	D 161		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 4 of 6 staff sampled (Staff C, D, E and F) who administered	D 164	10A NCAC 13F .0505 (Training on Care of Diabetic Resident) ED and BOM will conduct staff file audits to ensure Diabetic Care Training is completed as required. Any identied areas will be addressed immediately.BOM will utilize a perpetual staff log to monitor staff training. All Medication Aides (MAs) will complete required training prior to working as a MA and annually thereafter. Registered Nurse (RN) will conduct Diabetic Training for current MAs. ED and BOM will perform monthly staff file audits to ensure compliance.	9/9/2019

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D 164	Continued From page 4 insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic resident prior to the administration of insulin. The findings are: 1. Review of Staff C's, Medication Aide (MA) personnel record revealed: -Staff C was hired in January 2008. -There was no documentation Staff C had completed training on care of the diabetic resident. Review of residents' May 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff C obtained finger stick blood sugars and administered insulin forty-one times. Review of residents' June 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff C obtained finger stick blood sugars and administered insulin thirty-eight times. Review of residents' July 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff C obtained finger stick blood sugars and administered insulin twenty-eight times. Interview with Staff C on 07/26/19 at 9:58am revealed: -She had worked at the facility since 2008 as a MA. -She had worked at the facility for over ten years and was sure that she had diabetic care training. -The certification for training on care of the diabetic resident may have gotten lost because	D 164		

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D 164	Continued From page 5 she had worked at the facility since 2008. -When she worked she checked fingerstick blood sugars, and administered insulin injections. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -The Business Office Manager (BOM) was responsible to schedule training's for all staff and ensure training's were current. -The BOM should have checked Staff C's personnel record to ensure the training was completed. Interview with the BOM on 07/26/19 at 6:06pm revealed: -She was unaware Staff C did not have documentation of completing training on care of the diabetic resident. -The BOM and the Administrator were responsible for scheduling staff for training including training on care of the diabetic resident. 2. Review of Staff D's, Medication Aide (MA) personnel record revealed: -Staff D was hired on 04/11/18 as a Personal Care Aide. -Staff D was moved into the MA position on 07/09/18. -There was no documentation Staff D had completed training on care of the diabetic resident. Review of residents' May 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff D obtained finger stick blood sugars and administered insulin thirty-two times. Review of residents' June 2019 electronic Medication Administration Records (eMARs)	D 164		

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D 164	Continued From page 6 revealed there was documentation Staff D obtained finger stick blood sugars and administered insulin twenty-six times. Review of residents' July 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff D obtained finger stick blood sugars and administered insulin thirty-four times. Interview with Staff D on 07/26/19 at 11:55am revealed: -She had worked at the facility for a little over one year. -She had not received training on care of the diabetic residents. -She was worked as a MA administering medications such as: checked fingerstick blood sugars, and administered insulin injections. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -She did not know Staff D had not completed the required diabetic care training. -The Business Office Manager (BOM) should have scheduled Staff D for training on care of the diabetic resident. -The BOM should have checked Staff D's personnel record to ensure the training was completed. Interview with the BOM on 07/26/19 at 6:06pm revealed: -She had not scheduled Staff D for the diabetic care training. -The Administrator and her were both responsible for ensuring staff completed required training including training on the care of the diabetic resident.	D 164		

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D 164	Continued From page 7 3. Review of Staff E's, Medication Aide (MA) personnel record revealed: -Staff D was hired on 03/22/11. -There was no documentation Staff E had training on care of the diabetic resident. Review of residents' May 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff E obtained finger stick blood sugars and administered insulin twenty-four times. Review of residents' June 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff E obtained finger stick blood sugars and administered insulin thirty times. Review of residents' July 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff E obtained finger stick blood sugars and administered fourteen times. Attempted interview with Staff E on 07/26/19 at 11:48am was unsuccessful. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -Staff E was a MA and was responsible for checking blood sugars and administering insulin. -She did not know Staff E had not completed the training on care of the diabetic resident. -The BOM should have scheduled Staff E for the diabetic care training. -The Business Office Manager (BOM) was responsible for ensuring staff had all the required training. -The BOM should have checked Staff E's personnel record to ensure the diabetic training	D 164		

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D 164	Continued From page 8 was completed. Interview with the BOM on 07/26/19 at 6:06pm revealed: -She had not scheduled Staff E for training on care of the diabetic resident. -She did not know Staff E had not completed diabetic training. -The BOM and the Administrator were responsible for scheduling staff for training, including training on care of the diabetic resident. 4. Review of Staff F's, Medication Aide (MA) personnel record revealed: -Staff F was hired on 02/18/19. -There was no documentation Staff F had completed training on care of the diabetic resident. Review of residents' May 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff F obtained finger stick blood sugars and administered insulin ten times. Review of residents' June 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff F obtained finger stick blood sugars and administered insulin five times. Review of residents' July 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff F obtained finger stick blood sugars and administered fourteen times. Attempted interview with Staff F on 07/26/19 at 11:47am was unsuccessful.	D 164		

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D 164	Continued From page 9 Interview with the Administrator on 07/26/19 at 5:15pm revealed: -Staff F worked as a MA and was responsible for checking finger stick blood sugars and administering insulin injections. -She was unaware Staff F had not completed training on care of the diabetic resident. -The Business Office Manager (BOM) was responsible to ensure Staff F completed required training. -The BOM should have checked Staff F's personnel record to ensure the required training had been completed. Interview with the BOM on 07/26/19 at 6:06pm revealed: -She had not scheduled Staff F for training on care of the diabetic resident. -She was unaware Staff F had not received diabetic care training. -The BOM and the Administrator were responsible to ensure staff had required training. -She did not check staff personnel records to ensure all training had been completed, including training on the care of the diabetic resident.	D 164		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 3 of 6	D 338		

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D 338	Continued From page 10 sampled residents (Residents #8, #9 and #10) in the Special Care Unit (SCU) were free of physical abuse and neglect by three staff (Staff A, Staff B, and Staff C) encouraging the residents to fight each other, resulting in one resident being strangled with her face turning red (Resident #8) while staff recorded and shared the video through social media; a staff (Staff A) pushed a resident into a room, turned off the light and yelled to the resident to go to sleep, and then closed the door leaving the resident in the dark room (Resident #8); and a resident being left on the floor while staff recorded a second video and shared the video through social media (Resident #10). The findings are: A. Review of Video #1 on 07/26/19 at 2:43pm revealed: -The video involved three staff and two residents in the SCU. -The incident appeared to have occurred in a resident's room because a bed and part of a bedside table were observed in the video. -The camera showed two staff [Staff A (Personal Care Aide/PCA) and Staff B (PCA)] observed in the room while two residents were engaged in a physical altercation. -The third staff's [Staff C (PCA)] voice could be heard, but her face was not seen. -There were two residents in the video, identified as Resident #8 and Resident #9. -Review of the video revealed the residents were involved in an altercation. -The residents were standing in front of the side of a bed. -Resident #9 started hitting and kicking at Resident #8 while they were standing. -Resident #9 put her left arm around the back of Resident #8's neck and continued to hit Resident	D 338	10A NCAC 13F .0909 (Resident RIghts) 8/26/2019 ED to conduct "Resident Rights Training" to all staff. ED to educate staff on the importance of reporting abuse and/or neglect to management immediately. Home Health Agency and County Ombudsmen to complete "Resident Rights Training" to all staff. All staff received a copy of the "Declaration of Resident Rights." All staff signed acknowledging receipt and agreement and a copy was placed in staff file. All new employees will complete "Resident Rights Training" upon hire and annually. BOM will utilize a perpetual staff log to ensure training is complete upon hire and annually. ED will conduct training to current employees regarding the company's cell phone policy. All new employees will be given a copy of cell phone policy and a signed copy will be placed in staff file. ED and/or designee will monitor for ongoing compliance through observations and resident council meetings. ED, DRC and/or RCC will conduct visits to the community on all shifts at a minimum of three times per month, with a primary focus on second and/or third shift.	

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D 338	Continued From page 11 #8. -Resident #8 had something in her right hand, and Resident #9 was yelling at Resident #8 saying "give it back." -Resident #8 yelled "let go, let go, let go....." -Resident #8 fell on the bed and Resident #9 fell on bed beside her and continued to hit Resident #8. -Resident #8 was still yelling "let go, help me, help me, let go....." -One staff told Resident #8 "stop screaming, [curse word]" -Staff continued to video record the incident and did not intervene, but allowed Resident #9 to continue hitting Resident #8. -One staff was heard saying "take it out of her hand." -Someone (unable to see staff face) took the item out of Resident #8's hand. -The staff continued to allow the residents to fight and did not intervene. -Resident #9 used her right hand and started to strangle Resident #8. -No staff intervened, but allowed Resident #9 to continue using her right hand to strangle Resident #8. -One of the staff was heard telling Resident #9 to "punch her in the face." -Another staff asked; "Are you recording?" "You gonna send it to send me?" -From the video all three staff could be heard talking, laughing and commenting as Resident #9 and Resident #8 were fighting. -Resident #8 was trying to push Resident #9 off of her. -This altercation continued with no staff intervention to stop the residents from fighting. -Resident #8 attempted to bite Resident #9's arm. -The voice of one staff was heard in the background commenting "you making her turn	D 338		

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D 338	Continued From page 12 red." -The staff still did not intervene to stop the physical altercation, but continued to allow the residents to fight. -One of the staff was heard yelling for the Medication Aide/Supervisor (MA) to come to the room. -The staff allowed the residents to continue hitting each other. -Resident #9 yelled at Resident #8 "why are you doing this." -Resident #8 struggled to get off the bed and away from Resident #9. -Resident #9 grabbed Resident #8 by her shirt and pulled her back down to the bed. -A staff (Staff A) was heard again yelling for the MA. -Staff A yelled to the MA "you moving too slow, you moving too damn slow." -Both residents got up off the bed with Resident #9 still motioning with both arms and hands to hit Resident #8. -Resident #8 attempted to push Resident #9 out of the room, and then attempted to close the door. Staff are heard yelling at Resident #8,"Don't you push her". -The MA came to the door smiling and did not inquire regarding the incident, but pointed her finger at Resident #8 saying, "Stop you better sit down and stop, go to bed." -Resident #8 sat on the bed. -The video ended. 1. Review of Resident #8's current FL2 dated 05/29/19 revealed diagnoses of dementia. -The recommended level of care was Special Care Unit (SCU). -The resident was constantly disoriented. -The profile data for cognitive impairment assessed the resident as being constantly	D 338		

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D 338	Continued From page 13 disoriented. -The interventions that were required by staff included supervision. Review of Resident #8's record revealed there was no documentation related to the incident (fight) that occurred on 06/19/19. Interview with Resident #8's family member on 7/26/19 at 6:05pm revealed: -A Detective from the local police department called and told the family member that Resident #8 was involved in a physical altercation with another resident. -The Detective informed her that the physical altercation was recorded on a cell phone by a staff at the facility, and the video was shared through social media. -The Detective also informed her there were two separate recordings that involved Resident #8. -The Detective told her that the recording showed staff shoving Resident #8 into her room and onto the bed. -The second recording showed Resident #8 engaged in a physical altercation with another resident, while staff observed and did not intervene, but encouraged the behavior. -She was also contacted by the supervisor, "someone from the corporate office", about the incident and was told that the facility would be doing an investigation. -No one at the facility had contacted her since June 2019, when the incident first occurred. Based on record review, observation and interviews, it was determined that Resident #8 was not interviewable. Refer to interview the Detective from the local city police department on 07/26/19.	D 338		

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	HAL034093	A. BUILDING: _____ B. WING _____	07/26/2019

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D 338	Continued From page 14 Refer to interview with the Regional Vice President of Operations on 07/25/19 at 3:38pm. Refer to interview with the Medication Aide/Supervisor (MA) on 07/25/19 at 4:01pm. Refer to interview with a Personal Care Aide (PCA) in the Special Care Unit (SCU) on 07/26/19 at 4:05pm. Refer to interview with Staff C, PCA on 07/26/19 at 1:40pm. 2. Review of Resident #9's current FL2 dated 05/29/19 record revealed a diagnosis of dementia. -The recommended level of care was Special Care Unit (SCU). -The resident was intermittently disoriented. Review of Resident #9's SCU profile and assessment form dated 06/26/19 revealed: - The profile data for cognitive impairment assessed the resident as being constantly disoriented. -The interventions that were required by staff included supervision. Review of Resident #9's record revealed no documentation related to the incident (fight) that occurred on 06/19/19. Interview with Resident # 9's family member on 07/26/19 at 5:50 pm revealed: -She received a telephone call from a police detective, who informed her about the incident with Resident #9 and another resident. -The Detective made her aware that Resident #9 and another resident were engaged in a physical	D 338		

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D 338	Continued From page 15 altercation. -He also made her aware the incident was recorded on a cell phone, and that the recording was shared through social media. -After the phone call from the detective she went to the facility to check on Resident #9, and she was fine. -She had not seen the video, but was aware it was recorded and shared through social media. -Someone from the facility's corporate office had also contacted her regarding the incident. -The corporate person informed her the facility would be doing an investigation of the incident. -As far as she knew, there had been no other videos or incidents that occurred with Resident #9 and staff video recording. -She was told the incident occurred because another resident came into Resident #9's room and Resident #9 was telling the resident to get out. -The other resident would not leave, so they started to fight. -Resident #9 grabbed the other lady by the neck and put her down on the bed. -She was told that one of the staff got out a cell phone and recorded the fight between them. -She was told that the staff present in the room could be heard on video saying, "Get her.... [#9]." -She usually visited Resident #9 at least once weekly, but it's usually in the evenings or on Saturdays. Based on record review, observation and interviews, it was determined that Resident #9 was not interviewable. Refer to interview the Detective from the local city police department on 07/26/19. Refer to interview with the Regional Vice	D 338		

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D 338	Continued From page 16 President of Operations on 07/25/19 at 3:38pm. Refer to interview with the Medication Aide/Supervisor (MA) on 07/25/19 at 4:01pm. Refer to interview with a Personal Care Aide (PCA) in the Special Care Unit (SCU) on 07/26/19 at 4:05pm. Refer to interview with Staff C, PCA on 07/26/19 at 1:40pm. Interview with the Detective from the local city police department on 07/26/19 at 2:30pm revealed: -On 06/21/19, the police department received a phone call from a person desiring to remain anonymous. -The caller stated she received two videos via social media messenger that were disturbing. -The videos involved staff at an assisted living facility and residents in the SCU. -The caller stated she did not work at the assisted living facility and did not know the staff at the facility. -The caller stated a friend sent her the video. -The friend told her that she got the video from an employee that worked at the assisted living facility. -The caller stated the incident happened three days prior to her calling the police department. -On 06/21/19, the officer went to the facility to investigate, but did not get much information. -On 06/22/19, the detective went back to the facility to observe if the residents that were involved in the physical altercation had scars or bruises. -The Detective did not observe any scars or bruises on the residents. -The Detective did identify the staff and residents	D 338		

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D 338	Continued From page 17 in Video #1. -The two residents fighting in the video were identified as Residents #8 and #9. -The fight occurred in Resident #8's room, which was not Resident #9's room. -There were three staff present when the video was recorded. -One of the three staff (Staff C) recorded Video #1. -A second staff was heard asking, "Are you recording this, send me a copy?" -Staff A (Personal Care Aide/PCA) observed the fight, Staff B (PCA) also observed the fight and asked to be sent a copy of the video, and Staff C (PCA) recorded the video using her personal cell phone. -Staff C also encouraged Resident #9 to hit Resident #8 in the face. -Staff C told the Detective that Resident #8 often screamed at her roommate and other residents. -Staff C told the Detective on the date that she recorded the video Resident #8 was in a disturbance with her roommate and the roommate was on the floor. -When staff went to the room to see what was happening Resident #9 followed staff to the room. -When in the room Resident #8 started to yell and scream at Resident #9. -Resident #9 got upset and started hitting Resident #8. -She decided to record the video because Resident #8 was a "Pain in the butt." -Staff B told the officer that she sent the video to a friend that did not work at the facility. -Staff B told the Detective she sent the video because the friend wanted to work at the facility, and she wanted to warn the friend of the type of environment at the facility. -The Detective also found out who the staff and residents were in Video #2.	D 338		

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D 338	Continued From page 18 -In video #2, the resident on the floor in the hallway was identified as Resident #10. -In video #2, the resident that Staff A pushed in the room, turned the light off, told to go to sleep and closed the door was Resident #8. -Staff B (PCA) was the staff who recorded Video #2. Interview with the Regional Vice President of Operations on 07/25/19 at 3:38pm revealed: -She found out about one video via text message on 06/20/19 after 7pm. -In the text message a former employee informed her that she had received a video regarding residents in the SCU fighting. -On Friday, 06/21/19 during a staff meeting she asked all of the staff about a video. -No staff admitted to knowing about the video. -Later, Staff A called the regional office and said she wanted to talk about the video. -Staff A told her the name of the two residents that were fighting. -Staff A told her the video was recorded on 06/19/19. -Staff A admitted she was in the video. -Staff A stated that Resident #8 was having a bad night. -The resident had spit on her three times, and she walked away. -She called the Medication Aide/Supervisor (MA) to break-up the fight between the two residents. -Staff A informed her that Staff C had video recorded the incident, and Staff B asked to get a copy of the video. -The police came to the facility on 06/24/19, and informed her that there were two videos. -After watching both videos, Staff A, B, and C were put on probation pending termination. -She did an investigation and talked with the staff that were in the SCU on the date of the incident.	D 338		

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D 338	Continued From page 19 -The Medication Aide (MA) on duty was the supervisor in charge and staff should have reported the incidents to the MA. -They had informed staff that if anyone knew about a video circulating they should tell what they knew. -The MA denied knowing about a video and denied knowing about a physical altercation with Resident #8 and Resident #9. -Based on the MA's denial of the physical altercation and the video no actions were taken against the MA. -All staff were trained on residents' rights, confidentiality and reporting resident abuse and neglect. -It was the facility's policy that their staff were to report incidents of resident abuse and neglect right away. -Staff should have reported the incident to any manager because all of their telephone numbers were posted for staff to view. Interview with the Medication Aide/Supervisor (MA) on 07/25/19 at 4:01pm revealed: -On 06/19/19, she worked in the SCU as the MA. -She was the supervisor and staff were to report all incidents to her. -She was completing the evening medication pass after 7:00pm and heard Resident #8 and Resident #9 yelling at each other. -She did not know at what moment the residents got into a confrontation, but the yelling could be heard. -She also heard staff yelling for her to come to Resident #8's room. -When she got to the room she noticed Resident #9 was in Resident #8's room. -It appeared that Resident #9 was harassing Resident #8. -She told the PCAs not to "Entice" the residents	D 338		

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D 338	Continued From page 20 to argue, but to calm everyone down and put the residents in their rooms. -To her knowledge no staff had encouraged a fight between Resident #8 and Resident #9. -She did not know that staff recorded a video. -She found out there was a video during a staff meeting on 06/21/19. -When she came to the room, she did not notice staff using the phone. -It was the facility's policy not to have a phone with you or out when on the clock. -She did not assess Resident #8 or Resident #9 on 06/19/19 because she did not know that they had been fighting. Interview with a Personal Care Aide (PCA) on 07/26/19 at 4:05pm revealed: -On 06/19/19, she was working as a PCA on the second shift. -Close to 7:00pm she heard another staff say that Resident #8 pushed her roommate onto the floor. -The MA did an incident report regarding Resident #8's roommate being on the floor. -No one mentioned that Residents #8 and #9 were fighting. Interview with Staff C, PCA on 07/26/19 at 1:40pm revealed: -She had worked at the facility since May 2019, as a PCA. -When she was hired she was required to watch videos regarding residents' rights, and confidentiality. -She knew that she was required to immediately report any form of abuse or neglect of a resident -On 06/19/19, she worked at the facility on the second shift in the SCU. -Around 7:00pm she heard Resident #8 yelling at her roommate, which was common for Resident #8.	D 338		

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D 338	Continued From page 21 -Staff went to Resident #8's room and Resident #9 followed staff, which was common for Resident #9. -While staff was talking to Resident #8, Resident #9 started to repeat what staff was saying. -Resident #8 started yelling at Resident #9 in a loud voice. -Resident #9 got upset and started hitting Resident #8. -The staff (Staff A and Staff B) asked her to use her cell phone to record the fight between residents #8 and #9. -The staff asked her to use her cell phone because their cell phones were charging. -She recorded the fight between Resident #8 and Resident #9 and forwarded the video to Staff A and Staff B. -She did not send the video to anyone else. -The MA on duty was aware that she was recording the video because the MA came to the room and could see her phone recording. -Also, the MA was seen in the video standing in the doorway of Resident #8's room, which was where the incident took place. -She knew recording and sending the video was against the facility's residents' rights policy. -She sent the video because Staff A and Staff B asked her to record and to send them the video. -She knew that she was required to immediately report the incident, but she did not. -She had no reason or excuse why she allowed the residents to fight and did not intervene. -It was the facility's policy for staff to immediately intervene and stop residents from fighting. -They (staff) allowed the residents' to fight because Resident #8 always caused problems. -Resident #8 screamed and yelled at other residents with a loud voice. -On 06/19/19, Resident #8 was causing problems with everyone.	D 338		

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D 338	Continued From page 22 -Resident #8 pushed Resident #10 down on the floor in the hallway. -Resident #8 had also been into it with her roommate and other residents in the SCU. -They (Staff A, B and C) had their fill of Resident #8's behaviors. -Staff A told Resident #8 to go to her room. -Staff A followed Resident #8 to her room, turned off the light and shut the door. -She helped Resident #10 off the hallway floor. -She did not assess Resident #10 for injuries, but informed the MA. -She did not know if the MA assessed Resident #10 for bruises or injuries. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -All facility staff were trained how to intervene with residents with behaviors, especially SCU residents. -The facility's confidentially policy did not allow the recording of residents for social media. -Staff should not be using their cell phones when they were on duty. -She learned of the video from the Regional Vice President of Operations, who got the video from someone that did not work at the facility. -She did not know any details until 06/24/19 when the Detective from the local police department came to the facility. -The Detective also informed her that there were two videos. -Since she learned about and observed the videos Staff A, B, and C were terminated from the facility. -The incident and all three staff (Staff A, Staff B and Staff C) were reported to the health care personal registry on 06/28/19. Staff A and Staff B were not available for	D 338		

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D 338	Continued From page 23 interview. B. Review of Video #2 on 07/26/19 at 3:10pm revealed: -The video started with the view of the main hallway in the SCU. -The staff (Staff B) was recording the video as she walked down the hallway. -Staff B appeared to be following another staff person (Staff A/Personal Care Aide) down the hallway. -Staff A was walking hurriedly towards Resident #8's bedroom. -The video showed a resident (Resident #10) lying on the floor. -The staff that was walking down the hallway walked past the resident that was on the floor and left the resident on the floor. -The staff that was recording the video also walked past the resident that was lying on the floor and got a full body and face view of the resident. -There was a third staff (Staff C) in view of the resident lying on the floor in the hallway. -Out of the three staff no one stopped to assist the resident that was lying on the floor. -Resident #8 is seen standing in her bedroom doorway yelling. -In the video Staff A was seen verbally telling a resident (Resident #8), as Staff A was walking hurriedly toward Resident #8, she is seen making hand gestures and pointing at Resident #8, and is heard telling her sharply "Get in there, get in there." -In the doorway of the room was another staff (Staff C), who stood behind Resident #8. -Staff A approached Resident #8 abruptly, shoved her forcefully into the room, turned off the light, shut the bedroom door and yelled, "Go to sleep!". -Staff C moved from the doorway entrance a few	D 338		

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D 338	Continued From page 24 inches further into the hallway. -The video ended. 1. Review of Resident #8's current FL2 dated 05/29/19 record revealed diagnoses of dementia. -The recommended level of care was special care unit. -The resident was constantly disoriented. Review of Resident #8's Special Care Unit (SCU) profile and assessment form dated 06/26/19 revealed: -The profile data for cognitive impairment assessed the resident was being constantly disoriented. -The interventions that were required by staff included supervision. Based on record review, observation, and interviews, it was determined that Resident #8 was not interviewable. 2. Review of Resident #10's current FL2 dated 05/29/19 revealed diagnoses included dementia. -The resident was constantly disoriented. -The recommended level of care was SCU. There was no SCU profile and assessment form in Resident #10's record. Based on record review, observation, and interviews, it was determined that Resident #10 was not interviewable. Interview with the Detective from the local city police department on 07/26/19 at 2:30pm revealed: -On 06/21/19, the police department received a phone call from a person desiring to remain anonymous.	D 338		

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D 338	Continued From page 25 -The caller stated she received two videos through social media messenger that were disturbing. -The videos involved staff at an assisted living facility and residents in the SCU. -The caller stated she did not work at the assisted living facility and did not know the staff at the facility. -The caller stated a friend sent her the video. -The friend told her that she got the video from an employee that worked at the assisted living facility. -The caller stated the incident happened three days prior to her calling the police department. -The Detective went to the facility on 06/21/19, 06/22/19, and 06/24/19, and was able to identify the staff and residents in Video #2. -The resident on the floor in the hallway was identified as Resident #10. -The resident that staff pushed in the room, turned the light off, told to go to bed and closed the door was Resident #8. -The staff that pushed Resident #8 into the room, turned off the light, told to go to bed and closed the door was Staff A (PCA). -Staff B (PCA) was the staff who recorded the Video #2. Interview with the Regional Vice President of Operations on 07/25/19 at 3:38pm revealed: -She found out about one video via text message on 06/20/19 after 7:00pm. -In the text message a former employee informed she received a video regarding to memory care unit residents fighting. -On Friday, 06/21/19 during a staff meeting she asked all staff about a video. -No staff admitted to knowing about the video prior to the police showing her the video. -The police detective came to the facility on	D 338		

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D 338	Continued From page 26 06/24/19, and informed there were two videos. -After watching the second video, she informed Staff A not to return back to work. -All staff were trained on residents' rights, confidentiality and reporting resident abuse and neglect. -It was the facility's policy that staff were to report incidents right away. -Staff should have reported the incident to any manager because all of their telephone numbers were posted for staff to view. -The facility had investigated the incident involving Resident #8 and Staff A. -During their investigation they talked with the MA that was the supervisor on duty the date of the incident. -The MA denied knowing Staff A had shoved Resident #8 into her room. -Resident #10 being left on the floor was not addressed. -No actions were taken against the MA because she denied having knowledge of the incident. Interview with the Medication Aide/Supervisor (MA) on 07/25/19 at 4:01pm revealed: -One 06/19/19, she worked in the SCU as the MA. -She was the supervisor and staff were to report all incidents to her. -She was completing the evening medication pass after 7:00pm and heard two residents yelling. -She also heard staff yelling for her to come to Resident #8's room. -She told the PCAs to calm everyone down and put the residents in their room. -She did not know that staff recorded a video. -She found out there was a video during a staff meeting on 06/21/19. -She had not seen staff recording videos.	D 338		

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	HAL034093	A. BUILDING: _____ B. WING _____	07/26/2019

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D 338	Continued From page 27 -It was the facility's policy for staff not to have their cell phones out when on the clock. -She did not know that Staff A had pushed Resident #8 in her room. -She did not know that Resident #10 had been pushed to the floor or had fallen to the floor. Interview with Staff C, PCA on 07/26/19 at 1:40pm revealed: -On 06/19/19, Resident #8 was causing problems with everyone. -Resident #8 pushed Resident #10 down on the floor in the hallway. -Resident #8 was also causing problems with her roommate. -They (Staff A, B and C) had their fill of Resident #8's behaviors. -The MA had told staff to try to keep residents calm and put the residents in their room. -Staff A told Resident #8 to go to her room. -Staff A followed Resident #8 to her room, turned off the light and shut the door. -She helped Resident #10 off the floor. -She did not assess Resident #10 for injuries, but informed the MA. -She did not know if the MA assessed Resident #10 for bruises or injuries. -Staff B recorded Staff A's actions and Resident #10 lying on the floor. Staff A and Staff B were not available for Interviews. The facility failed to protect three residents (Residents #8, #9, and #10) from abuse and neglect. Residents #8, #9, and #10 were residents of the facility's special care unit. Residents #8 and #9 began fighting in a resident's room while facility staff watched and encouraged the fight, failing to intervene. During	D 338		

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D 338	Continued From page 28 the altercation, Resident #9 strangled Resident #8 until Resident #8 became red in the face while Staff C recorded the incident and later shared the video through social media. After Resident #8 pushed Resident #10 down in the hall, Staff A followed Resident #8 down to the resident's room, yelling at Resident #8 and then shoved Resident #8 into her room, while Resident #10 was lying on the floor unable to get up. Staff B recorded Staff A's actions and Resident #10 lying on the floor and later shared the video through social media. The failure of the facility to assure that the rights of all residents guaranteed under the Declaration of Residents' Rights were maintained resulted in the serious abuse and serious neglect of residents and constitutes a Type A1 Violation. The facility provided a Plan of Protection on 07/26/19 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 26, 2019.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 29 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 6 of 7 sampled residents (#1, #2, #4, #5, #6 and #7) including a resident who did not receive a medication for fluid build up, thyroid hormone deficiency, neuropathic pain, depression, and allergies (Resident #7), a resident who did not receive medications for high blood pressure, neuropathic pain, overactive bladder and pain (Resident #2), a resident who did not receive medications for chronic pain, fluid retention and anxiety (Resident #1), a resident who did not receive medications for depression and Alzheimer's disease(Resident #5) a resident who did not receive two medications for depression (Resident #6); and a resident with orders for Clonidine (used to treat high blood pressure) as needed for systolic blood pressures greater than 160 (Resident #4). The findings are: 1. Review of Resident #7's current FL2 dated 05/21/19 revealed the diagnosis of schizoaffective bipolar disorder. a. Review of Resident #7's current FL2 dated 05/21/19 revealed a physician's order for spiranolactone 50 mg (used to treat fluid build up)	D 358	10A NCAC 13F .1004(a) Medication Administration Director of Resident Care (DRC) and Residen Care Coordinator (RCC) will conduct resident chart audits and cart audits. Any identified areas will be addressed immediately. ED, DRC and RCC will conduct training to MAs regarding medication administration related to medications not in facility and administration of meds. MAs will notify DRC and/or RCC when medications are not available for administration. DRC and/or RCC will contact pharmacy immediately to have the medications delivered in a timely manner. DRC and RCC will conduct weekly chart audits and cart audits to ensure compliance. ED will monitor compliance through random audits and observations.	9/9/2019

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D 358	Continued From page 30 twice daily. Review of Resident #7's May 2019 electronic Medication Administration Record (eMAR) revealed: -An entry for spironolactone 50 mg, once daily. -The entry included "special instructions" take one tablet (50 mg total) by mouth 2 times daily. -There was documentation of administration of spironolactone 50 mg once daily from 05/01/19 through 05/31/19. Review of Resident #7's June 2019 eMAR revealed: -An entry for spironolactone 50 mg, once daily. -The entry for spironolactone included "special instructions" take one tablet (50 mg total) by mouth 2 times daily. -There was documentation of administration of spironolactone 50 mg once daily on 06/01/19, 06/02/19 and from 06/21/19 through 06/30/19. -There was documentation of spironolactone 50 mg, once daily "not administered: drug/item unavailable" from 06/03/19 through 06/20/19. Review of Resident #7's July eMAR revealed: -An entry for spironolactone 50 mg, once daily. -The entry for spironolactone included "special instructions" take one tablet (50 mg total) by mouth 2 times daily. -There was documentation of administration of spironolactone 50 mg once daily from 07/01/19 through 07/24/19. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #7 revealed spironolactone 50 mg was available for administration. Interview with a contracted pharmacy	D 358		

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D 358	Continued From page 31 representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #7. -The order on file at the pharmacy was spironolactone 50 mg one tablet by mouth 2 times daily. -She did not know why the electronic entry for spironolactone 50 mg included "special instructions" to take one tablet by mouth 2 times daily, which was the same as the order. -The pharmacy sent 30 tablets of spironolactone 50 mg on 05/09/19, 06/20/19, 07/05/19 and 07/23/19. Interview with a Medication Aide (MA) on 07/26/19 at 10:40 am revealed: -She did not know why the spironolactone 50 mg was unavailable for administration for Resident #7 in June 2019. -She had never noticed the "special instructions" for the spironolactone entry on the eMARs. -"I guess it should be given twice every day". Interview with Resident #7's physician on 07/26/19 at 12:20 pm revealed: -She expected medications to be administered as ordered. -She had ordered the spironolactone 50 mg to be administered twice daily. -She was unaware the spironolactone 50 mg was being administered once daily, instead of twice daily. -Resident #7 had no adverse effect from receiving the spironolactone once daily, instead of twice daily. -Resident #7's edema had improved; there was no negative outcome of the spironolactone being administered once daily, instead of twice daily. Interview with Resident #7 on 07/26/19 at 3:30	D 358		

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D 358	Continued From page 32 pm revealed as far as she knew the facility administered her medications as ordered. Refer to interview with the Resident Care Coordinator (RCC) on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 07/26/19 at 2:15 pm. b. Review of Resident #7's current FL2 dated 05/21/19 revealed a a physician's order for levothyroxine 150 mcg (used to treat thyroid hormone deficiency) daily. Review of Resident #7's June 2019 eMAR revealed: -An entry for levothyroxine 150 mcg daily. -Levothyroxine was documented as administered for 27 of 30 opportunities from 06/01/19 through 06/30. -Levothyroxine 150 mcg was documented as "not administered: drug/item unavailable" for 3 of 30 opportunities during the month of June. Review of Resident #7's July 2019 eMAR revealed: -An entry for levothyroxine 150 mcg daily. -Levothyroxine 150 mcg was documented as administered for 13 of 24 opportunities from 07/01/19 through 07/24/19. -Levothyroxine 150 mcg was documented as"not administered: drug/item unavailable" for 11 of 24 opportunities during the month of July. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #7 revealed levothyroxine 150 mcg was available for administration. Interview with a contracted pharmacy	D 358		

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D 358	Continued From page 33 representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #7. -The pharmacy sent 30 tablets of levothyroxine 150 mcg on 04/23/19. -The pharmacy sent 30 tablets of levothyroxine 150 mcg on 05/06/19, and the facility staff returned it to the pharmacy. -She did not know why the facility staff returned the levothyroxine 150 mg to the pharmacy. -The pharmacy sent 14 tablets of levothyroxine 150 mcg on 07/14/19. Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the levothyroxine 150 mcg was unavailable for administration for Resident #7 in June and July 2019. Interview with Resident #7's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered. -The facility staff had not informed her of the missed doses of levothyroxine 150 mcg for Resident #7. -The missed doses of levothyroxine 150 mcg were "unacceptable". -She would order a thyroid stimulating hormone (TSH) lab to be drawn on Resident #7 as soon as possible. Interview with Resident #7 on 07/26/19 at 3:30 pm revealed as far as she knew the facility administered her medications as ordered. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 07/26/19 at 2:15 pm.	D 358		

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D 358	Continued From page 34 c. Review of Resident #7's current FL2 dated 05/21/19 revealed a physician's order for levothyroxine 50 mcg, (used to treat thyroid hormone deficiency) every Wednesday and Sunday, given with the levothyroxine 150 mcg. Review of Resident #7's May 2019 eMAR revealed: -An entry for levothyroxine 50 mcg on Wednesday and Sunday, along with the levothyroxine 150 mg daily dose. -Levothyroxine 50 mcg was documented as administered on Wednesdays and Sundays for 8 of 9 opportunities from 05/01/19 to 05/31/19. -Levothyroxine 50 mcg was documented as "not administered: other, 3rd shift" on Sunday, 05/05/19 for 1 of 9 opportunities during the month of May. Review of Resident #7's June 2019 eMAR revealed: -An entry for levothyroxine 50 mcg on Wednesday and Sunday, along with the levothyroxine 150 mg daily dose. -Levothyroxine 50 mcg was documented as administered on Wednesdays and Sundays for 5 of 9 opportunities from 06/01/19 to 06/30/19. -Levothyroxine 50 mcg was documented as "not administered: drug/item unavailable" on Sunday 06/05/19 and Sunday 06/26/19 for 2 of 9 opportunities from 06/01/19 to 06/30/19. -Levothyroxine 50 mcg was documented as "not administered: resident refused" on Sunday 06/19/19 and Wednesday 06/12/19 for 2 of 9 opportunities from 06/01/19 to 06/30/19. Review of Resident #7's July 2019 eMAR revealed: -An entry for levothyroxine 50 mcg on	D 358		

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D 358	Continued From page 35 Wednesday and Sunday, along with the levothyroxine 150 mg daily dose. -Levothyroxine 50 mcg was documented as administered on Wednesday 07/03/19 and Wednesday 07/17/19 for 2 of 7 opportunities. -Levothyroxine 50 mcg was documented as "not administered: drug/item unavailable" on Sunday 07/07/19, Wednesday 07/10/19 and Sunday 07/14/19 for 3 of 7 opportunities. -Levothyroxine 50 mcg was documented as "not administered: other comment: duplicate" on Sunday 07/21/19 and Wednesday 07/24/19 for 2 of 7 opportunities. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #7 revealed levothyroxine 50 mcg was available for administration. Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #7. -The pharmacy sent 9 tablets of levothyroxine 50 mcg on 04/23/19. -The pharmacy sent 5 tablets of levothyroxine 50 mcg on 07/14/19. Interview with a MA on 07/26/19 at 10:40 am revealed: -"Maybe the 3rd shift gave the medicine" in reference to the documentation of the missed dose of levothyroxine on Sunday 05/05/19. -She did not know why the levothyroxine 50 mcg was unavailable for administration for Resident #7 in June and July 2019. Interview with Resident #7's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be	D 358		

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D 358	Continued From page 36 administered as ordered. -The facility staff had not informed her of the missed doses of levothyroxine 50 mcg for Resident #7. -The missed doses of levothyroxine 50 mcg were "unacceptable". -She would order a TSH lab to be drawn on Resident #7 as soon as possible. Interview with Resident #7 on 07/26/19 at 3:30 pm revealed as far as she knew the facility administered her medications as ordered. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 07/26/19 at 2:15 pm. d. Review of Resident #7's current FL2 dated 05/21/19 revealed a physician's order for gabapentin 100 mg (used to treat neuropathic pain) two tablets every evening. Review of Resident #7's June 2019 eMAR revealed: -An entry for gabapentin 100 mg two tablets daily. -Gabapentin 100 mg two tablets was documented as administered for 25 of 30 opportunities from 06/01/19 to 06/30/19. -Gabapentin 100 mg two tablets was documented as "not administered: drug/item unavailable" for 5 of 30 opportunities during the month of June. Review of Resident #7's July 2019 eMAR revealed: -An entry for gabapentin 100 mg two tablets daily. -Gabapentin 100 mg two tablets was documented as administered for 18 of 23 opportunities from 07/01/19 to 07/24/19.	D 358		

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D 358	Continued From page 37 -Gabapentin 100 mg two tablets was documented as "not administered: drug/item unavailable" for 5 of 23 opportunities during the month of July. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #7 revealed gabapentin 100 mg was available for administration. Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #7. -The pharmacy sent 60 tablets of gabapentin 100 mg on 05/07/19 and 30 tablets on 07/02/19 and on 07/24/19. Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the gabapentin 100 mg was unavailable for administration for 5 days in June 2019 for Resident #7. Interview with Resident #7's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered. -The facility staff had not informed her of the missed doses of gabapentin 100 mg for Resident #7. -If the missed doses of gabapentin 100 mg had a negative outcome, the negative outcome would be pain. -Resident #7 had not complained of pain. Interview with Resident #7 on 07/26/19 at 3:30 pm revealed as far as she knew the facility administered her medications as ordered. Refer to interview with the RCC on 07/26/19 at 11:35 am.	D 358		

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D 358	Continued From page 38 Refer to interview with the Administrator on 07/26/19 at 2:15 pm. e. Review of Resident #7's current FL2 dated 05/21/19 revealed a physician's order for bupropion HCL 150 mg (used to treat depression) daily. Review of Resident #7's May 2019 eMAR revealed: -An entry for bupropion HCL 150 mg daily. -Bupropion HCL 150 mg was documented as administered for 12 of 31 opportunities from 05/01/19 to 05/31/19. -Bupropion HCL 150 mg was documented as "not administered: on hold" for 13 of 31 opportunities from 05/01/19 to 05/31/19. -Bupropion HCL 150 mg was documented as "not administered: drug/item unavailable" for 6 of 31 opportunities. Review of Resident #7's June 2019 eMAR revealed: -An entry for bupropion HCL 150 mg. -Bupropion HCL 150 mg was documented as administered for 10 of 30 opportunities from 06/01/19 to 06/30/19. -Bupropion HCL 150 mg was documented as "not administered: drug/item unavailable" for 20 of 30 opportunities from 06/01/19 to 06/30/19. Review of Resident #7's July 2019 eMAR revealed: -An entry for bupropion HCL 150 mg. -Bupropion HCL 150 mg was documented as administered for 16 of 24 opportunities from 07/01/19 to 07/24/19. -Bupropion HCL 150 mg was documented as "not administered: drug/item unavailable" for 8 of 24	D 358		

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D 358	Continued From page 39 opportunities from 07/01/19 to 07/24/19. Review of Resident #7's physician's orders revealed there was no order to holf bupropion HCL 150 mg. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #7 revealed bupropion HCL 150 mg was available for administration. Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #7. -The pharmacy sent 15 tablets of bupropion HCL 150 mg on 04/09/19, 19 tablets on 05/20/19 and 15 tablets 07/04/19 and on 07/24/19. Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the bupropion HCL 150 mg was unavailable for administration for Resident #7 on some dates in May, June or July 2019. Interview with the physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered, and the bupropion HCL 150 mg was not on hold. -The facility staff had not informed her of the missed doses of bupropion HCL 150 mg for Resident #7. -If the missed doses of bupropion HCL 150 mg had a negative outcome, the negative outcome would be increased depression. -Resident #7 had not displayed increased depression. Interview with Resident #7 on 07/26/19 at 3:30	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: _____ B. WING _____	07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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D 358	Continued From page 40 pm revealed as far as she knew the facility administered her medications as ordered. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 07/26/19 at 2:15 pm. f. Review of Resident #7's current FL2 dated 05/21/19 revealed a physician's order for loratadine 10 mg (used to treat allergies) twice daily. Review of Resident #7's May 2019 eMAR revealed: -An entry for loratadine 10 mg twice daily. -Loratadine 10 mg was documented as administered twice daily for 61 of 62 opportunities from 05/01/19 to 05/31/19. -Loratadine 10 mg was documented as "not administered: drug/item unavailable" for 1 of 62 opportunities from 05/01/19 to 05/31/19. Review of Resident #7's June eMAR revealed: -An entry for loratadine 10 mg twice daily. -Loratidine 10 mg was documented as administered twice daily for 48 of 60 opportunities from 06/01/19 to 06/30/19. -Loratadine 10 mg was documented as "not administered: drug/item unavailable" for 12 of 60 opportunities from 06/01/19 to 06/30/19. Review of Resident #7's July eMAR revealed: -An entry for loratadine 10 mg twice daily. -Loratadine 10 mg was documented as administered twice daily for 44 of 47 opportunities from 07/01/19 to 07/24/19. -Loratadine 10 mg was documented as "not administered: drug/item unavailable" for 3 of 47	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 41 opportunities from 07/01/19 to 07/24/19. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #7 revealed loratadine 10 mg was available for administration. Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #7. -The pharmacy sent 60 tablets of loratadine 10 mg on 05/01/19 and 05/23/19, 30 tablets on 05/30/19 and 06/20/19, 16 tablets on 07/05/19 and 07/17/19, and 30 tablets 07/26/19. Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the loratadine 10 mg was unavailable for administration for Resident #7 in May, June and July 2019. Interview with Resident #7's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered. -The facility staff had not informed her of the missed doses of loratidine 10 mg for Resident #7. -If the missed doses of loratidine 10 mg had a negative outcome, the negative outcome would be increased allergy symptoms. -Resident #7 had not displayed increased allergy symptoms. Interview with Resident #7 on 07/26/19 at 3:30 pm revealed as far as she knew the facility administered her medications as ordered. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on	D 358		

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D 358	Continued From page 42 07/26/19 at 2:15 pm. 2. Review of Resident #2's current FL2 dated 05/21/19 revealed diagnoses included acute kidney failure, diabetes mellitus, hematuria, chronic kidney disease, and hypertension. a. Review of Resident #2's current FL2 dated 05/21/19 revealed a physician's order for amlodipine 10 mg (used to treat high blood pressure) daily at bedtime. Review of Resident #2's May 2019 electronic Medication Administration Record (eMAR) revealed: -An entry for amlodipine 10 mg daily at 9:00 pm. -Amlodipine 10 mg was documented as administered daily for 25 of 31 opportunities from 05/01/19 to 05/31/19. -Amlodipine 10 mg was documented as "not administered/drug/item not available" for 6 of 31 opportunities from 05/01/19 to 05/31/19. Review of Resident #2's June 2019 eMAR revealed: -An entry for amlodipine 10 mg daily at 9:00 pm. -Amlodipine 10 mg was documented as administered daily for 28 of 30 opportunities from 06/01/19 to 06/30/19. -Amlodipine 10 mg was documented as "not administered: drug/item unavailable" for 2 of 30 opportunities from 06/01/19 through 06/31/19. Review of Resident #2's July eMAR revealed: -An entry for amlodipine 10 mg daily at 9:00 pm. -Amlodipine 10 mg was documented as administered for 18 of 23 opportunities from 07/01/19 through 07/23/19. -Amlodipine 10 mg was documented as "not administered: drug/item unavailable" for 5 of 23	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 43 opportunities from 07/01/19 to 07/23/19. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #2 revealed amlodipine 10 mg was available for administration. Review of Resident #2's "Vitals Report" revealed: -Resident #2's blood pressure in May (no date was provided) was 122/72. -Resident #2's blood pressure on 07/26/19 was 130/78. Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #2. -The pharmacy sent 30 tablets of amlodipine 10 mg on 04/17/19, 29 tablets on 05/10/19, 30 tablets 06/04/19 and 07/04/19. Interview with a Medication Aide (MA) on 07/26/19 at 10:40 am revealed she did not know why the amlodipine 10 mg was unavailable for administration for Resident #2 in May, June or July 2019. Interview with Resident #2's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered. -The facility staff had not informed her of the missed doses of amlodipine 10 mg for Resident #2. -If the missed doses of amlodipine 10 mg had a negative outcome, the negative outcome would be increased blood pressure. -Resident #7 had not displayed increased blood pressure.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 44 Interview with Resident #2 on 07/26/19 at 2:52 pm revealed she did not know what medications the facility administered to her. Refer to the interview with the RCC on 07/26/19 at 11:35 am. Refer to the interview with the Administrator on 07/26/19 at 2:15 pm. b. Review of Resident #2's current FL2 dated 05/21/19 revealed a physician's order for lisinopril 10 mg (used to treat high blood pressure) every day. Review of Resident #2's May 2019 eMAR revealed: -An entry for lisinopril 10 mg daily. -Lisinopril 10 mg was documented as administered for 14 of 31 opportunities from 05/01/19 to 05/31/19. -Lisinopril 10 mg was documented as "not administered: drug/item unavailable" for 12 of 31 opportunities from 05/01/19 to 05/31/19. -Lisinopril 10 mg was documented as "not administered: on hold" for 5 of 31 opportunities from 05/01/19 to 05/31/19. Review of Resident #2's physician's orders revealed there was no order to hold lisinopril 10 mg. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #2 revealed lisinopril 10 mg was available for administration. Review of Resident #2's "Vitals Report" revealed: -Resident #2's blood pressure in May (no date was provided) was 122/72. -Resident #2's blood pressure on 07/26/19 was	D 358		

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D 358	Continued From page 45 130/78. Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility had to request refills for Resident #2. -The pharmacy sent 14 tablets of lisinopril 10 mg on 05/25/19, 30 tablets on 06/05/19 and 07/04/19. Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the lisinopril 10 mg was unavailable for administration for Resident #2 in May 2019. Interview with Resident #2's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered, and the lisinopril 10 mg was not on hold. -The facility staff had not informed her of the missed doses of lisinopril 10 mg for Resident #2. -If the missed doses of lisinopril 10 mg had a negative outcome, the negative outcome would be increased blood pressure. -Resident #7 had not displayed increased blood pressure. Interview with Resident #2 on 07/26/19 at 2:52 pm revealed she did not know what medications the facility administered to her. Refer to the interview with the RCC on 07/26/19 at 11:35 am. Refer to the interview with the Administrator on 07/26/19 at 2:15 pm. c. Review of Resident #2's current FL2 dated 05/21/19 revealed a physician's order for gabapentin 300 mg (used to treat neuropathic	D 358		

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D 358	Continued From page 46 pain) three times daily. Review of Resident #2's May 2019 eMAR revealed: -An entry for gabapentin 300 mg three times daily. -Gabapentin 300 mg was documented as administrated three times daily for 77 of 93 opportunities from 05/01/19 to 05/31/19. -Gabapentin 300 mg was documented as "not administered: on hold" for 16 of 93 opportunities from 05/01/19 to 05/31/19. Review of Resident #2's physician's orders revealed there was no order to hold gabapentin 300 mg. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #2 revealed gabapentin 300 mg was available for administration. Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #2. -The pharmacy sent 90 tablets of gabapentin 300 mg on 04/30/19, 48 tablets on 05/23/19, 90 tablets on 06/04/19, and 90 tablets on 07/05/19. Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the gabapentin 300 mg was unavailable for administration for Resident #2 in May 2019. Interview with Resident #2's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered, and the gabapentin 300 mg was not on hold.	D 358		

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D 358	Continued From page 47 -The facility staff had not informed her of the missed doses of gabapentin 300 mg for Resident #2. -If the missed doses of gabapentin 300 mg had a negative outcome, the negative outcome would be increased pain. -Resident #7 had not complained of pain. Interview with Resident #2 on 07/26/19 at 2:52 pm revealed: -She did not know what medications the facility administered to her. -She denied having increased pain. Refer to the interview with the RCC on 07/26/19 at 11:35 am. Refer to the interview with the Administrator on 07/26/19 at 2:15 pm. d. Review of Resident #2's current FL2 dated 05/21/19 revealed a physician's order for myrbetriq 50 mg (used to treat overactive bladder) daily. Review of Resident #2's May 2019 eMAR revealed: -An entry for myrbetriq 50 mg daily. -Myrbetriq 50 mg daily was documented as administrated for 28 of 31 opportunities from 05/01/19 to 05/31/19. -Myrbetriq 50 mg was documented as "not administered: drug/item unavailable" for 3 of 31 opportunities from 05/01/19 to 05/31/19. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #2 revealed myrbetriq 50 mg was available for administration. Interview with a contracted pharmacy	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 48 representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #2. -The pharmacy sent 30 tablets of myrbetriq 50 mg on 04/17/19, 29 tablets on 05/10/19, 30 tablets on 06/04/19 and 07/04/19. Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the myrbetriq 50 mg was unavailable for administration for Resident #2 in May 2019. Interview with Resident #2's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered. -The facility staff had not informed her of the missed doses of myrbetriq 50 mg for Resident #2. -If the missed doses of myrbetriq 50 mg had a negative outcome, the negative outcome would be increased frequency of urination. -Resident #7 had not displayed or complained of increased frequency of urination. Interview with Resident #2 on 07/26/19 at 3:30 pm revealed as far as she knew the facility administered her medications as ordered. Refer to the interview with the RCC on 07/26/19 at 11:35 am. Refer to the interview with the Administrator on 07/26/19 at 2:15 pm. e. Review of Resident #2's current FL2 dated 05/21/19 revealed a physician's order for tramadol 50 mg (used to treat pain) two tablets three times daily.	D 358		

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D 358	Continued From page 49 Review of Resident #2's May 2019 eMAR revealed: -An entry for tramadol 50 mg, two tablets, three times daily. -Tramadol 50 mg, two tablets, three times daily was documented as administered for 59 of 93 opportunities from 05/01/19 to 05/31/19. -Tramadol 50 mg, two tablets, three times daily was documented as "not administered: drug/item unavailable" for 34 of 93 opportunities from 05/01/19 to 05/31/19. Review of Resident #2's June 2019 eMAR revealed: -An entry for tramadol 50 mg, two tablets, three times daily. -Tramadol 50 mg, two tablets, three times daily was documented as administered for 34 of 90 opportunities from 06/01/19 to 06/30/19. -Tramadol 50 mg, two tablets, three times daily was documented as "not administered: drug/item unavailable" for 51 of 90 opportunities from 06/01/19 to 06/30/19. -Tramadol 50 mg, two tablets, three times daily was documented as "not administered: other, waiting on pharmacy" for 3 of 90 opportunities from 06/01/19 to 06/30/19. -Tramadol 50 mg, two tablets, three times daily was documented as "not administered; on hold" for 2 of 90 opportunities from 06/01/19 to 06/30/19. Review of Resident #2's physician's orders revealed there was no order to hold tramadol 50 mg. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #2 revealed tramadol 50 mg was available for administration.	D 358		

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D 358	Continued From page 50 Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility had to request refills for Resident #2. -The pharmacy sent 180 tablets of tramadol 50 mg on 04/19/19, 06/19/19 and 07/16/19. Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the tramadol 50 mg was unavailable for administration for Resident #2 in May and June 2019. Interview with Resident #2's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered. -The facility staff had not informed her of the missed doses of tramadol 50 mg for Resident #2. -If the missed doses of tramadol 50 mg had a negative outcome, the negative outcome would be increased pain. -Resident #2 had not complained of increased pain. -She planned to complete an assessment on Resident #2 on the next office visit day at the facility. Interview on with Resident #2 on 07/26/19 at 2:52 pm revealed: -She did not know what medications the facility administered to her. -She denied having increased pain. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 07/26/19 at 2:15 pm. 3. Review of Resident #1's current FL-2 dated	D 358		

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D 358	Continued From page 51 05/21/19 revealed diagnoses included chronic obstructive pulmonary disease, Type II diabetes and epilepsy. a. Review of Resident #1's current FL-2 dated 05/21/19 revealed a physician's order for hydrocodone acetaminophen 7.5-325 mg one tablet (used to treat chronic pain) three times daily. Review of Resident #1's May 2019 electronic Medication Administration Record (eMAR) revealed: -An entry for hydrocodone acetaminophen 7.5-325 mg three times daily. -Hydrocodone acetaminophen 7.5-325 three times daily was documented as administered for 71 of 93 opportunities from 05/01/19 to 05/31/19. -Hydrocodone acetaminophen 7.5-325 mg three times daily was documented as "not administered: drug/item unavailable" for 6 of 93 opportunities from 05/01/19 to 05/31/19. -Hydrocodone acetaminophen 7.5-325 three times daily was documented as "not administered: on hold" for 16 of 93 opportunities from 05/01/19 to 05/31. Review of Resident #1's June 2019 eMAR revealed: -An entry for hydrocodone acetaminophen 7.5-325 mg three times daily. -Hydrocodone acetaminophen 7.5-325 three times daily was documented as administered for 55 of 90 opportunities from 06/01/19 to 06/15/19. -Hydrocodone acetaminophen 7.5-325 mg three times daily was documented as "not administered: drug/item unavailable" for 31 of 90 opportunities from 06/01/19 to 06/30/19. -Hydrocodone acetaminophen 7.5-325 mg three times daily was documented as "not	D 358		

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D 358	Continued From page 52 administered: on hold" for 2 of 90 opportunities from 06/01/19 to 06/30/19. Review of Residents #1's July eMAR revealed: -An entry for hydrocodone acetaminophen 7.5-325 mg three times daily. -Hydrocodone acetaminophen 7.5-325 three times daily was documented as administered for 46 of 71 opportunities from 07/01/19 to 07/24/19. -Hydrocodone acetaminophen 7.5-325 mg three times daily was documented as"not administered: drug/item unavailable" for 23 of 71 opportunities from 07/01/19 to 07/24/19. Review of Resident #1's physician's orders revealed there was no order to hold hydrocodone acetaminophen 7.5-325 mg Observation on 7/25/19 at 10:15 am of medication on hand for Resident #1 revealed hydrocodone acetaminophen 7.5-325 mg was available for administration. Interview with the Medication Aide (MA) on 07/26/19 at 10:40 am revealed: -She did not know why the hydrocodone acetaminophen 7.5-325 mg was not ordered. -When the medication was out or was getting low, the MA should fax the request to the pharmacy. Interview with the contracted pharmacy representative on 7/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #1. -The pharmacy sent 45 tablets of hydrocodone acetaminophen 7.5-325 on 5/15/19, 45 tablets on 5/31/19, 45 tablets on 6/28/19 and 45 tablets 7/23/19. Interview with the primary care physician on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: _____ B. WING _____	07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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D 358	Continued From page 53 07/26/19 at 12:20 pm revealed: -The hydrocodone acetaminophen 7.5-325 mg was used to treat chronic pain and had not been ordered as "hold". -She did not know the medication was not being given as prescribed. -The outcome of Resident #1 not receiving the hydrocodone acetaminophen 7.5-325 mg would be increased pain. Interview with Resident #1 on 07/26/19 at 2:57 pm revealed: -She received a lot of medication. -"I'm assuming they are giving me what I need". Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to the interview with the Administrator on 07/26/19 at 2:15 pm. b. Review of Resident #1's current FL-2 dated 05/21/19 revealed a physician's order for torsemide 10 mg one tablet every other day (used to treat fluid retention). Review of Resident #1's May 2019 eMAR revealed: -An entry for torsemide 10 mg every other day. -Torsemide 10 mg every other day was documented as administered for 7 of 15 opportunities from 05/01/19 to 05/31/19. -Torsemide 10 mg every other day was documented as "not administered: drug/item unavailable" for 3 of 15 opportunities from 5/01/19 to 5/31/19. -Torsemide 10 mg every other day was documented as "not administered: drug on hold" for 3 of 15 opportunities from 05/01/19 to 05/31/19. -Torsemide 10 mg every other day was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 54 documented as "not administered: not given " for 1 of 15 opportunities from 05/01/19 to 05/31/19. -Torsemide 10 mg every other day was not documented at all for 1 of 15 opportunities from 05/01/19 to 05/31/19. Review of Resident #1's June 2019 eMAR revealed: -An entry for torsemide 10 mg every other day. -Torsemide 10 mg every other day was documented as administered for 1 of 15 opportunities from 06/01/19 to 06/30/19. -Torsemide 10 mg every other day was documented as "not administered: drug/item unavailable" for 3 of 16 opportunities from 06/01/19 to 06/30/19. -Torsemide 10 mg every other day was documented as "not administered: drug on hold" for 11 of 15 opportunities from 06/01/19 to 06/30/19. Review of Resident #1's July 2019 eMAR revealed: -An entry for torsemide 10 mg every other day. -Torsemide 10 mg every other day was documented as administered for 4 of 12 opportunities from 7/01/19 through 7/24/19. -Torsemide 10 mg every other day was documented as "not administered: drug on hold" for 8 of 12 opportunities from 07/01/19 to 07/24/19. Review of Resident #1's physician's orders revealed the was no order to hold torsemide 10 mg. Observation on 7/25/19 at 10:15 am of medication on hand for Resident #1 revealed torsemide 10 mg was available for administration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 55 Interview with the MA on 7/26/19 at 10:40 am revealed: -The facility has not been able to get the torsemide 10 mg for Resident #1. -She did not know why the medication was unavailable, but the medication had been out over a month. -When the medication was out or was getting low, the MA on duty should fax the request to pharmacy. Interview with the contracted pharmacy representative on 7/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #1. -The pharmacy dispensed 8 tablets of torsemide 10 mg on 5/19/19 and 8 tablets 7/16/19. -The medication was on back order from the medical supplier and the pharmacy was unable to fill the prescription until the middle of July. Interview with the primary care physician on 7/26/19 at 12:20 pm revealed: -Torsemide 10 mg was prescribed to treat edema of the lower extremities. -Resident #1 would sometimes refuse because of the side effects. -She was unaware of the medication not being given as prescribed. -She was concerned Resident #1 was not receiving medications as ordered. -She did not place an order to hold the torsemide 10 mg. -She was not aware the torsemide 10 mg was on back order from the pharmacy. Interview with Resident #1 on 07/26/19 at 2:57 pm revealed she took so many medications and was unsure of what she took.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 56 Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 7/26/19 at 2:15 pm. c. Review of Resident #1's current FL-2 dated 05/21/19 revealed a physician's order for lorazepam 1 mg one tablet at bedtime (used to treat anxiety). Review of Resident #1's June 2019 electronic Medication Administration Record (eMAR) revealed: -An entry for lorazepam 1 mg daily at bedtime. -Lorazepam 1 mg daily at bedtime was documented as administered for 21 of 30 opportunities from 06/01/19 to 06/30/19. -Lorazepam 1 mg daily at bedtime was documented as "not administered: drug/item unavailable" for 9 of 30 opportunities from 06/01/19 to 06/30/19. Review of Resident #1's July 2019 eMAR revealed: -An entry for Lorazepam 1 mg daily at bedtime. -Lorazepam 1 mg daily at bedtime was documented as administered for 14 of 22 opportunities from 07/01/19 to 07/22/19. -Lorazepam 1 mg daily at bedtime was documented as "not administered: drug/item unavailable" for 8 of 22 opportunities from 07/01/19 to 07/22/19. Observation on 7/25/19 at 10:15 am of medication on hand for Resident #1 revealed lorazepam 1 mg was available for administration. Interview with the MA on 7/26/19 at 10:40 am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 57 -She did not know why the lorazepam 1 mg was not ordered. -When the medication was out or was getting low, the MA should fax the request to pharmacy. Interview with the contracted pharmacy representative on 7/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #1. -The pharmacy sent 15 tablets of lorazepam 1 mg on 5/30/19, 16 tablets on 7/9/19 and 30 tablets on 7/23/19. Interview with Resident #1's primary care physician on 7/26/19 at 12:20 pm revealed: -The medication was prescribed to treat anxiety. -She was unaware of the medication not being given as prescribed. Interview with Resident #1 on 07/26/19 at 2:57 pm revealed: -She received a lot of medication. -She had so many medications and was unsure of what she took. -"I am assuming they are giving me what I need". Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 7/26/19 at 2:15 pm. 4. Review of Resident #5's current FL2 dated 05/23/19 revealed diagnoses included dementia with behaviors, constipation, hyperlipedemia, hypertension, anemia, Vitamin D deficiency, Vitamin B 12 deficiency and Type II Diabetes without insulin. a. Review of Resident #5's current FL-2 dated	D 358		

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D 358	Continued From page 58 05/23/19 revealed a physician's order for trazadone 100 mg one tablet at bedtime (used to treat depression). Review of Resident #5's May 2019 electronic Medication Administration Record (eMAR) revealed: -An entry for trazadone 100 mg one time daily. -Trazadone 100 mg one time daily was documented as administered for 17 of 31 opportunities from 05/01/19 to 05/31/19. -Trazadone 100 mg one time daily was documented as "not administered: drug/item unavailable" for 7 of 31 opportunities from 05/01/19 to 05/31/19. -Trazadone 50 mg one time daily was documented as "not administered: on order" for 5 of 31 opportunities for 05/01/19 to 05/31/19. -Trazadone 50 mg one time daily was not documented at all, the documentation spaces were blank for 2 of 31 opportunities from 05/01/19 to 05/31/19. Review of Resident #5's June 2019 eMAR revealed: -An entry for trazadone 100 mg one time daily. -Trazadone 100 mg one time daily was documented as administered for 23 of 30 opportunities from 06/01/19 to 06/30/19. -Trazadone 100 mg one time daily was documented as "not administered: drug/item unavailable" for 1 of 30 opportunities from 06/01/19 to 06/30/19. -Trazadone 100 mg one time daily was documented as "not administered: on order" for 6 of 30 opportunities from 06/01/19 to 06/30/19. Observation on 7/25/19 at 10:15 am of medication on hand for Resident #5 revealed trazadone 100 mg was available for	D 358		

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D 358	Continued From page 59 administration. Interview with the contracted pharmacy representative on 7/26/19 at 9:35 am revealed: -Refills for trazadone 100 mg for Resident #5 were automatic. -The pharmacy sent 30 tablets of trazadone 100 mg on 4/9/19, 6/4/19, and 7/4/19. Interview with the Medication Aide (MA) on 7/26/19 at 10:40 am revealed: -She did not know why the medication was not available. -When the medication was out or was getting low, the MA should fax the request to pharmacy. Interview with Resident #5's primary care physician on 7/26/19 at 12:20 pm revealed: -She was unaware of the medication not being given as prescribed. -She was concerned Resident #5 was not receiving medications as ordered. Based on observations, interviews and record reviews it was determined Resident #5 was not interviewable. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 7/26/19 at 2:15 pm. b. Review of Resident #5's current FL-2 dated 05/23/19 revealed a physician's order for donepezil 5 mg two tablets daily (used to treat Alzheimer's dementia). Review of Resident #5's record revealed a physician's order dated 06/17/19 for donepezil 10	D 358		

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D 358	Continued From page 60 mg daily. Review of Resident #5's May 2019 eMAR revealed: -An entry for donepezil 5 mg two tablets daily. -Donepezil 5 mg two tablets daily was documented as administered for 22 of 31 opportunities from 05/01/19 to 05/31/19. -Donepezil 5 mg two tablets daily was documented as "not administered: drug/item unavailable" for 2 of 31 opportunities from 05/01/19 to 05/31/19. -Donepezil 5 mg two tablets daily was documented as "not administered: on order" for 7 of 31 opportunities from 05/01/19 to 05/31/19. Review of Resident #5's June 2019 eMAR revealed: -An entry for donepezil 5 mg two tablets daily. -Donepezil 5 mg two tablets daily was documented as administered for 1 of 17 opportunities from 06/01/19 to 06/30/19. -Donepezil 5 mg two tablets every day was documented as "not administered: on order" for 16 of 17 opportunities from 06/01/19 to 06/17/19. -There was no entry for donepezil 10 mg daily. -Donepezil 10 mg daily was not documented as administered for 13 of 13 opportunities from 06/18/19 to 06/30/19. Review of Resident #5's July 2019 eMAR revealed: -An entry for donepezil 10 mg two tablets daily. -Donepezil 10 mg was documented as administrated for 12 of 24 opportunities from 07/01/19 to 07/24/19. -Donepezil 10 mg daily was documented as "not administered: drug/item unavailable/on order" for 12 of 24 opportunities.	D 358		

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D 358	Continued From page 61 Observation on 7/25/19 at 10:15 am of medication on hand for Resident #5 revealed donepezil 10 mg was not available for administration. Interview with the contracted pharmacy representative on 7/26/19 at 9:35 am revealed: -Refills for donepezil 5 mg and 10 mg for Resident #5 was on automatic refill. -The medication was not covered by insurance for the month of May. -The order changed from donepezil 5 mg 2 tablets daily to donepezil 10 mg daily on 06/17/19. -The medication was not covered by insurance until 6/17/19. -The pharmacy sent 21 tablets of donepezil 10 mg on 6/17/19. Interview with the MA on 7/26/19 at 10:40 am revealed: -She did not know why the donepezil had not been filled. -When the medication was out or was getting low, the MA should fax the request to pharmacy. Interview with Resident #5's primary care physician on 7/26/19 at 12:20 pm revealed: -She was unaware of the medication not being given as prescribed. -She was concerned that Resident #5 was not receiving medications as ordered. -She was not aware donepezil 5 mg was not covered by Resident #5's insurance. Based on observations, interviews and record reviews it was determined Resident #5 was not interviewable. Refer to interview with the RCC on 07/26/19 at 11:35 am.	D 358		

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D 358	Continued From page 62 Refer to interview with the Administrator on 7/26/19 at 2:15 pm. 5. Review of Resident #6's current FL-2 dated 05/29/19 revealed diagnoses included bipolar disorder, schizophrenia, hypertension, post traumatic stress disorder, and anxiety disorder. a. Review of Resident #6's current FL-2 dated 05/29/19 revealed a physician's order for mirtazapine 15 mg one tablet at bedtime (used to treat depression). Review of Resident #6's May 2019 electronic Medication Administration Record (eMAR) revealed: -An entry for mirtazapine 15 mg one time daily at bedtime. -Mirtazapine 15 mg one time daily was documented as administered for 19 of 31 opportunities from 05/01/19 to 05/31/19. -Mirtazapine 15 mg was documented as "not administered: drug/item unavailable" for 12 of 31 opportunities from 05/01/19 to 05/31/19. Review of Resident #6's June 2019 eMAR revealed: -An entry for mirtazapine 15 mg one time daily at bedtime. -Mirtazapine 15 mg one time daily was documented as administered for 11 of 30 opportunities from 06/01/19 to 06/30/19. -Mirtazapine 15 mg one time daily was documented as "not administered: drug/item unavailable" for 19 opportunities from 6/1/19 through 6/30/19. Observation on 7/25/19 at 10:15 am of medication on hand for Resident #6 revealed	D 358		

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D 358	Continued From page 63 mirtazapine 15 mg was available for administration. Interview with the contracted pharmacy representative on 7/26/19 at 9:35 am revealed: -The mirtazapine 15 mg for Resident #6 was on automatic refills. -The pharmacy sent 18 tablets on 6/20/19. -No refills remained for the mirtazapine 15 mg for Resident #6 after 6/20/19. Interview with the Medication Aide (MA) on 7/26/19 at 10:40 am revealed: -She did not know why the mirtazapine 15 mg had not been filled. -When the medication is out or getting low, the MA should fax the request to pharmacy. Interview with the primary care physician on 7/26/19 at 12:20 pm revealed: -She was unaware of the medication not being given as prescribed. -She was concerned that Resident #6 was not receiving medications as ordered. Interview with Resident #6 on 07/26/19 at 2:52 pm revealed: -She did not know all of her prescribed medications. -She did get medications every day, but did not know the times, usually morning and bedtime. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 07/26/19 at 2:15 pm. b. Review of Resident #6's current FL-2 dated 05/29/19 revealed a physician's order for	D 358		

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D 358	Continued From page 64 sertraline 50 mg one tablet daily (used to treat depression). Review of Resident #6's May 2019 eMAR revealed: -An entry for sertraline 50 mg one time daily. -Sertraline 50 mg one time daily was documented as administered for 11 of 31 opportunities from 05/01/19 to 05/31/19. -Sertraline 50 mg one time daily was documented as "not administered: drug/item unavailable" 5 of 31 opportunities from 05/01/19 to 05/31/19. -Sertraline 50 mg one time daily was documented as "not administered: on hold for 15 of 31 opportunities from 05/01/19 to 05/31/19. Review of Resident #6's June 2019 eMAR revealed: -An entry for sertraline 50 mg one time daily. -Sertraline 50 mg one time daily was documented as "not administered: drug/item unavailable" for 30 of 30 opportunities from 6/1/19 to 6/30/19. Review of Resident #6's July 2019 eMAR revealed: -An entry for sertraline 50 mg one time daily. -Sertraline 50 mg one time daily was documented as "not administered: drug/item unavailable for 5 of 24 opportunities from 07/01/19 to 07/24/19. -Sertraline 50 mg one time daily was documented as "not administered: on hold" for 19 of 24 opportunities from 07/01/19 to 07/24/19. Review of Resident #6's physician's orders revealed the was no order to hold sertraline 50 mg. Observation on 7/25/19 at 10:15 am of medication on hand for Resident #6 revealed sertraline 50 mg was not available for	D 358		

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D 358	Continued From page 65 administration. Interview with the MA on 7/26/19 at 10:40 am revealed: -She did not know why the sertraline 50 mg had not been filled. -When the medication was out or getting low, the MA should fax the request to pharmacy. Interview with the contracted pharmacy representative on 7/26/19 at 9:35 am revealed: -A renewal request was sent to the provider in May. -The pharmacy sent 30 tablets of sertraline 50 mg on 04/09/19. Interview with the primary care physician on 7/26/19 at 12:20 pm revealed: -Sertraline 50 mg was not on hold. -She was unaware of the medication not being given as prescribed. -She was concerned that Resident #6 was not receiving medications as ordered. Interview with Resident #6 on 07/26/19 at 2:52 pm revealed: -She did not know all of her prescribed medications. -She depended on the facility staff to administer her medications as prescribed. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with Administrator on 7/26/19 at 2:15 pm. 6. Review of Resident #4's previous FL2 dated 01/17/19 revealed: -Diagnoses included dementia, hypertension,	D 358		

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D 358	Continued From page 66 multiple strokes, type II diabetes mellitus, metabolic encephalopathy, hypoglycemia, and stage IV chronic kidney disease. -A physician's order for Clonidine 0.3mg daily as needed for systolic blood pressure greater 160. -A physician's order to check the resident's blood pressure (BP) daily and record. Review of signed physician's orders for Resident #4 revealed: -A signed physician's order sheet dated 05/14/19, with orders to administer Clonidine 0.3mg daily as needed for systolic blood pressures greater than 160, and an order to check Resident #4's blood pressure daily and record. -A signed physician's order dated 06/18/19 to check Resident #4's blood pressure twice daily and record. Review of Resident #4's May 2019 electronic Medication Administration Record (eMARs) revealed: -There was an entry for Clonidine HCl 0.3mg one tablet every day as needed for systolic blood pressure greater than 160. -There was no documentation Clonidine was administered for systolic blood pressures greater than 160. -There was an entry for blood pressures daily between 7:00am - 3:00pm (no specific time was documented). -There were four BPs documented on the May 2019 eMAR. -Three of the four documented BPs had systolic BPs that were greater than 160 and in range to administer Clonidine as follows: -On 05/29 the systolic BP was 186. -On 05/30 the systolic BP was 178. -On 05/31 the systolic BP was 166.	D 358		

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D 358	Continued From page 67 Review of Resident #4's June 2019 eMARs revealed: -There was an entry for Clonidine HCl 0.3mg one tablet every day as needed for systolic blood pressure greater than 160. -There was no documentation Clonidine was administered for systolic blood pressures greater than 160. -There was an entry for blood pressures daily between 7:00am - 3:00pm (no specific time was documented) from 06/01/19 through 06/19/19. -There was a second entry for blood pressures twice daily at 8:00am and 8:00pm. -There were thirty-eight BPs documented on the June 2019 eMAR. -Twenty-three of thirty-eight blood pressures had systolic blood pressures that were greater than 160 and within range to administer Clonidine as follows: -On 06/01 the systolic BP was 190. -On 06/02 the systolic BP was 184. -On 06/03 the systolic BP was 175. -On 06/04 the systolic BP was 182. -On 06/05 the systolic BP was 168. -On 06/06 the systolic BP was 174. -On 06/07 the systolic BP was 164. -On 06/09 the systolic BP was 166. -On 06/10 the systolic BP was 180. -On 06/11 the systolic BP was 186. -On 06/15 the systolic BP was 182. -On 06/16 the systolic BP was 174. -On 06/17 the systolic BP was 166. -On 06/21 at 8:00am the systolic BP was 182. -On 06/24 at 8:00am the systolic BP was 192. -On 06/24 at 8:00pm the systolic BP was 178. -On 06/25 at 8:00am the systolic BP was 182. -On 06/26 at 8:00am the systolic BP was 186. -On 06/26 at 8:00pm the systolic BP was 178. -On 06/27 at 8:00am the systolic BP was 182. -On 06/28 at 8:00am the systolic BP was 194.	D 358		

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D 358	Continued From page 68 -On 06/29 at 8:00am the systolic BP was 184. -On 06/30 at 8:00am the systolic BP was 190. Review of Resident #4's July 2019 eMARs revealed: -There was an entry for Clonidine HCl 0.3mg one tablet every day as needed for systolic blood pressure greater than 160. -There was no documentation Clonidine was administered for systolic blood pressures greater than 160. -There was an entry for blood pressures twice daily at 8:00am and 8:00pm. -There were forty-seven BPs documented on the July 2019 eMAR from 07/01/19 through 07/24/19. -Nineteen of the forty-seven blood pressures had systolic blood pressures that were greater than 160 and within range to administer Clonidine as follows: -On 07/01 at 8:00am the systolic BP was 162. -On 07/01 at 8:00pm the systolic BP was 173. -On 07/02 at 8:00am the systolic BP was 188. -On 07/02 at 8:00pm the systolic BP was 172. -On 07/04 at 8:00am the systolic BP was 166. -On 07/04 at 8:00pm the systolic BP was 162. -On 07/05 at 8:00am the systolic BP was 184. -On 07/05 at 8:00pm the systolic BP was 161. -On 07/07 at 8:00am the systolic BP was 182. -On 07/07 at 8:00pm the systolic BP was 173. -On 07/08 at 8:00am the systolic BP was 174. -On 07/10 at 8:00am the systolic BP was 162. -On 07/12 at 8:00pm the systolic BP was 162. -On 07/16 at 8:00am the systolic BP was 202. -On 07/16 at 8:00pm the systolic BP was 167. -On 07/22 at 8:00am the systolic BP was 184. -On 07/22 at 8:00pm the systolic BP was 167. -On 07/23 at 8:00am the systolic BP was 170. -On 07/23 at 8:00pm the systolic BP was 168. Interview with Resident #4's Primary Care	D 358		

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D 358	Continued From page 69 Provider (PCP) on 07/26/19 at 12:28pm revealed: -Resident #4 sometimes had high blood pressures. -She wanted the resident's blood pressure monitored and Clonidine administered because the resident had a history of strokes. -She wanted Clonidine administered when the resident's systolic blood pressures was greater than 160. -She had last seen Resident #4 in July 2019, for another issue, but did not know Clonidine was not administered as ordered. Interview with the first shift Medication Aide (MA) on 07/26/19 at 11:58am revealed: -She administered medications to Resident #4. -The resident's BP was checked daily on her shift. -She did not know there was an order for as needed Clonidine. -She did medication cart audits weekly and checked the eMARs with the medications on the cart. -She did not check the as needed medications. -Clonidine was an as needed medication, and reminders did not pop-up on the eMAR as the scheduled medications. -Because the system did not remind her to administer the as needed Clonidine it was not administered. -The Resident Care Coordinator (RCC) checked behind the MAs, but the facility had been without an RCC since May 2019. Interview with a second shift MA on 07/26/19 at 6:45pm revealed: -She checked Resident #4's BP on her shift. -She did not know the resident had an as needed order for Clonidine when her BPs were greater than 160. -She had worked at the facility since March 2019,	D 358		

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D 358	Continued From page 70 and had not administered Clonidine to Resident #4 when her systolic blood pressure was greater than 160. Based on record review, observation and interviews, it was determined that Resident #4 was not interviewable. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with Administrator on 7/26/19 at 2:15 pm. Interview with the RCC on 07/26/19 at 11:35 am revealed: -MAs were responsible for ordering medications when needed. -MAs can order medications by peeling the reorder sticker from the medication bubble pack and faxing the order sheet to the pharmacy or by calling the pharmacy and requesting the refill. -Medication refills should be requested 3 to 5 days prior to the medication running out. -MAs audit the medication carts on a weekly basis to determine if medications need to be ordered, and then order medications from the pharmacy then if needed. -Sometimes a resident's insurance company didn't cover the specific medication ordered and that can cause a delay in the refill of the medication. Interview with the Administrator on 07/26/19 at 2:15 pm revealed: -MAs were responsible for ordering medications when needed. -MAs should request refills when 3 to 5 doses of medication remain. -Medications should be ordered from the	D 358		

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D 358	Continued From page 71 pharmacy before the resident ran out of the medication. The facility failed to administer medications as ordered for 6 of 7 sampled residents (#1, #2, #4, #5, #6 and #7) including an antidepressant to Resident #7, who had a history of schizoaffective bipolar disorder; blood pressure medications to Resident #2, who had a history of hypertension and kidney failure; a medication for fluid retention to Resident #1, who had a history of COPD; a medication for dementia to Resident #5; and as needed blood pressure medication to Resident #4, who had a history of multiple strokes and hypertension. This failure placed the residents at risk due to medication mismanagement and was detrimental to the health, safety and welfare of the residents and constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/26/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 9, 2019.	D 358		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing	D 464	10A NCAC 13F .1307 (Special Care Unit Resident Profile and Care Plan) DRC and RCC will audit resident charts. Any identified issues will be addressed immediately.Upon admission to SCU, all required documentation will be completed and placed in resident chart. Quarterly Reviews will be completed by DRC within thirty days of admission and quarterly thereafter. DRC and RCC will utilize resident tickler to ensure Quarterly Reviews are completed in a timely manner. ED and DRC will conduct monthly chart audits to ensure compliance.	9/9/2019

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D 464	Continued From page 72 assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to complete quarterly Resident Profiles for 1 of 6 residents sampled (Residents #10) in the Special Care Unit (SCU). The Findings are: Review of Resident #10's current FL2 dated 05/29/19 revealed diagnoses included dementia and hypertension. -The resident was constantly disoriented. -The recommended level of care was Special Care Unit (SCU). Review of Resident #10's Resident Register revealed the resident was admitted to the facility on 10/13/16. Review of Resident #10's record for SCU required documents and assessment revealed: -There was no SCU profile and assessment form. -The most current quarterly review was dated 03/31/17. -There were no more quarterly reviews in	D 464		

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D 464	Continued From page 73 Resident #10's record. Interview with the Administrator on 07/26/19 at 5:35pm revealed: -Resident #10 had dementia and resided in the SCU. -She searched their records and was unable to find a profile and screening assessment form for Resident #10. -She was unable to find quarterly reviews more current than 03/31/17. The document should have been completed every ninety days. -She did not know why there were no current quarterly assessments for Resident #10. -The profile and assessment form should have been completed upon the resident's admission to the SCU. -The nurse was responsible for completing the SCU profile and assessment form and the quarterly reviews. -The nurse that is at the facility now is not the same nurse that was at the facility 2016. -She could not say why the profile was not completed.	D 464		
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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D912	Continued From page 74 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate and in compliance with relevent state laws and rules related to medication administration. The findings are: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 6 of 7 sampled residents (#1, #2, #4, #5, #6 and #7) including a resident who did not receive a medication for fluid build up, thyroid hormone deficiency, neuropathic pain, depression, and allergies (Resident #7), a resident who did not receive medications for high blood pressure, neuropathic pain, overactive bladder and pain (Resident #2), a resident who did not receive medications for chronic pain, fluid retention and anxiety (Resident #1), a resident who did not receive medications for depression and Alzheimer's disease(Resident #5) a resident who did not receive two medications for depression (Resident #6); and a resident with orders for Clonidine (used to treat high blood pressure) as needed for systolic blood pressures greater than 160 (Resident #4). [Refer to Tag 0358 10A NCAC 13F .1004(a). Medication Administration (Type B Violation)].	D912	GS 131D-21(2) Resident Rights Residents will have the right to receive care and services which are adequate, appropriate and in compliance with relevant federal & state laws and rules & regulations. ED to complete "Resident Rights Training" to all staff regarding care and services. All staff received a copy of the "Declaration of Resident Rights". All staff signed acknowledging receipt and agreement and a copy was placed in staff file. All new employees will complete "Resident Rights Training" upon hire and annually.BOM will utilize a perpetual staff log to ensure "Resident Rights Training" is completed upon hire and annually. Home Health Agency and County Ombudsmen to complete "Resident Rights Training" to staff. ED and/or designee will monitor for ongoing compliance through observations and resident council meetings.	9/9/2019
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 75 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all residents were free from physical abuse and neglect . The findings are: Based on observations, interviews and record reviews, the facility failed to assure 3 of 6 sampled residents (Residents #8, #9 and #10) in the Special Care Unit (SCU) were free of physical abuse and neglect by three staff (Staff A, Staff B, and Staff C) encouraging the residents to fight each other, resulting in one resident being strangled with her face turning red (Resident #8) while staff recorded and shared the video through social media; a staff (Staff A) pushed a resident into a room, turned off the light and yelled to the resident to go to sleep, and then closed the door leaving the resident in the dark room (Resident #8); and a resident being left on the floor while staff recorded a second video and shared the video through social media (Resident #10). [Refer to Tag 338, 10A NCAC 13F .0909 of Residents' Rights (Type A1 Violation).	D914	GS1314 D21(4) Resident Rights Residents will have the right to be free from physical abuse and neglect. ED to complete "Resident Rights Training" to all staff. Home Health Agency and County Ombudsmen to complete training regarding "Resident Rights." All staff received a copy of the "Declaration of Resident Rights." All staff signed acknowledging receipt and agreement and a copy was placed in staff file. All new employees will complete "Resident Rights Training" upon hire and annually. BOM will utilize a perpetual staff log to ensure training is completed upon hire and annually. ED and/or designee will monitor for ongoing compliance through observations and resident council meetings.	9/9/2019
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe	D934		

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D934	Continued From page 76 practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 4 staff sampled (Staff C, D and E) had completed the mandatory annual infection control training. The findings are: 1. Review of Staff C's Medication Aide (MA) personnel record revealed: -Staff C was hired in January 2008 as a MA. -Staff C had completed the annual infection control training on 03/25/18. -There was no documentation Staff C had completed infection control training in 2019. Interview with Staff C on 07/26/19 at 9:58am revealed: -She worked at the facility since 2008 as a MA. -She administered medications, checked fingerstick blood sugars, gave insulin injections, and administered eye drops. -She had the infection control training last year,	D934	GS 131 D-4.5B (a) Infection Control All current staff will have completed Infection Control Training taught by a Registered Nurse. All new staff will complete infection control training prior to working in their perspective departments which will be reviewed with a Registered Nurse. All ongoing training will be completed annually thereafter. Trainings will be reviewed by the BOM and periodically spot checked by the ED.	

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D934	Continued From page 77 but did not have the training this year. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -The Business Office Manager (BOM) was responsible to schedule training for all staff and ensure training were current. -The BOM should have checked Staff C's personnel record to ensure the training was completed. Interview with the BOM on 07/26/19 at 6:06pm revealed: -She had not scheduled Staff C for the annual infection control training. -She had not scheduled Staff C for the training because she did not know it was due. -The Administrator and her were responsibility for scheduling staff for training. 2. Review of Staff D's Medication Aide (MA) personnel record revealed: -Staff D was hired on 04/11/18 as a Personal Care Aide. -Staff D was moved into the MA position on 07/09/18. -There was no documentation Staff D had completed infection control training. Interview with Staff D on 07/26/19 at 11:55am revealed: -She had worked at the facility for a little over one year. -She had not completed infection control training. -She was worked as a MA administering medications such as: checked fingerstick blood sugars, gave insulin injections, and eye drops. Interview with the Administrator on 07/26/19 at 5:15pm revealed:	D934		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3160 BURKE MILL ROAD WINSTON SALEM, NC 27103

(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
D934	Continued From page 78 -She did not know that Staff D had not completed the required infection control training. -Staff D should have been scheduled for the annual infection control training. -The Business Office Manager (BOM) was responsible for ensuring all staff training's were current. -The BOM should have checked Staff D's personnel record to ensure the training was completed. Interview with the BOM on 07/26/19 at 6:06pm revealed: -She had not scheduled Staff D for the infection control training. -She did not have a reason why she had not scheduled Staff D for the training. 3. Review of Staff E's Medication Aide (MA) personnel record revealed: -Staff D was hired on 03/22/11. -There was documentation Staff E had completed the annual infection control training on 06/11/15. -There was no documentation Staff E had completed infection control training since 06/11/15. Attempt interview with Staff E on 07/26/19 at 11:48am was unsuccessful. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -She did not know Staff E had not completed the required infection control training. -The BOM should have scheduled Staff E for the annual infection control training. -The Business Office Manager (BOM) was responsible for ensuring all staff training were current. -The BOM should have checked Staff E's	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: _____ B. WING _____	07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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D934	Continued From page 79 personnel record to ensure the training was completed. Interview with the BOM on 07/26/19 at 6:06pm revealed: -She had not scheduled Staff E for the infection control training. -She did not have a reason why she had not scheduled Staff E for the infection control training.	D934	GS 131D-4.5B(b)	
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:	D935	All Medication Aide files will be audited immediatly for verification of 5/10,15 hour or verification letter. All new Medication Aides will have a 5/10, 15 hour or verification letter present prior to working independantly as a Medication Aide.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: _____ B. WING _____	07/26/2019

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DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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D935	Continued From page 80 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 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 interviews and record reviews, the facility failed to ensure 1 of 4 sampled medication aides (Staff F) completed the 5, 10 or 15 hour state approved medication aide training. The findings are: Review of Staff F's Medication Aide (MA) personnel record revealed: -Staff F was hired on 02/18/19. -There was documentation Staff F completed the clinical skills checklist on 04/01/19. -There was documentation Staff F had passed the written medication examination on 03/20/19. -There was no documentation Staff F had completed the 5, 10, or 15 hour MA training. Observation on 07/24/19 at various times from	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D935	Continued From page 81 3:30 pm through 5:00pm revealed: -Staff F worked independently on the medication cart. -Staff F administered medications to residents. Attempted interview with Staff F on 07/26/19 at 11:47am was unsuccessful. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -Staff F worked as a medication aide, and was responsible for administering medications to residents. -She was unaware Staff F had not completed the required 5, 10, or 15 hour MA training. -The BOM should have checked Staff F's personnel record to ensure the required training had been completed. Interview with the BOM on 07/26/19 at 6:06pm revealed: -She did not know Staff F was not scheduled for the medication aide training. -The Administrator and her were both responsible to ensure staff completed required training. -She had not checked Staff F's personnel record to ensure the MA training had been completed.	D935		