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ASHE GARDENS	300 WEST ASHE STREET BURGAW, NC 28425

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation from 10/23/18 - 10/26/18, 10/30/18 - 11/02/18, and 11/05/18 - 11/09/18.	D 000		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to complete assessments and care plans for 5 of 7 residents sampled (#2, #4, #5, #8, #18) related to incomplete functional assessments to determine levels of assistance required for 3 residents (#2,	D 254		

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#4, #8) and 2 residents whose assessment and care plans were not done annually (#5, #18).

The findings are:

1. Review of Resident #18's current FL-2 dated 06/04/18 revealed:
-Diagnoses included vascular dementia, anemia, spinal stenosis, hypertension, osteoarthritis, hypothyroidism, depression, anxiety, gastroesophageal reflux disease, and left rotator cuff syndrome.
-The resident was intermittently disoriented and a wanderer.
-The resident was incontinent of bowel and bladder.
-The resident required assistance with bathing and dressing.

Review of Resident #18's most current assessment and care plan dated 02/14/17 revealed:
-The resident wandered and resisted care at times.
-It sometimes took multiple attempts by staff to get the resident to let the staff help her with activities of daily living.
-The resident was ambulatory with a rollator walker.
-The resident had limited range of motion in upper extremities.
-The resident had occasional incontinence of the bowel and daily incontinence of the bladder.
-The resident was sometimes disoriented, had significant memory loss, and must be redirected.
-The resident's assistive device requirements included shower chair, hand held shower, and rollator walker.
-The resident required extensive assistance with bathing, grooming, dressing, and toileting.

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-The resident required limited assistance with transferring and supervision with ambulation.
-The care plan was signed by the primary care provider (PCP) on 03/01/17.
-The care plan was completed over one year ago and a new annual care plan was overdue.

Interviews with the Special Care Coordinator (SCC) on 10/30/18 at 12:14pm and 11/06/18 at 9:27am revealed:
-The February 2017 assessment and care plan completed for Resident #18 was the most current one on file.
-It should have been updated annually.
-The Special Care Manager (SCM) just started working on some resident assessments and care plans a couple of weeks ago so she would check on the status of Resident #18's care plan.

Review of Resident #18's accident/injury reports, charting notes, and hospital records revealed:
-The resident had 8 falls from 02/28/18 - 10/27/18.
-The resident went to the emergency room (ER) for evaluation of injuries for 7 of the 8 falls.
-The resident's injuries included sprain of left wrist; lower back pain; right elbow pain with skin tear; mouth and right shoulder pain; small hematoma to left face; left knee and leg pain, swelling, and discoloration; pain in head, neck, and left shoulder; and right shoulder and leg pain.

Review of Resident #18's licensed health professional support (LHPS) review dated 04/05/18 revealed:
-The resident was able to transfer self independently and ambulated with a rollator walker independently.
-The resident's gait was slow but steady at that time.

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-The resident had a fall since the last review.

Interview with a medication aide (MA) on 10/25/18 at 1:30pm revealed:
-The resident used a rolling walker independently.
-The resident had a history of falls and she had 2 falls today (10/25/18).
-The resident needed assistance with bathing and dressing.

Interview with a second MA on 11/07/18 at 5:00pm revealed:
-Resident #18 used a rolling walker independently.
-The resident tried to be very independent.
-The resident lost her balance and fell at times because she "drags her feet".
-The resident needed assistance with bathing and dressing.

Interview with a personal care aide (PCA) on 11/09/18 at 5:12pm revealed:
-Resident #18 was ambulatory and used a rolling walker.
-Resident #18 fell frequently because her legs would get "wobbly" and she would lose her balance.
-The resident required assistance with bathing and dressing.

Interviews with the Executive Director (ED) on 11/07/18 at 5:18pm and 11/09/18 at 10:47am revealed:
-The ED had worked on the assessments and care plans after the former DON left employment with the facility a few months ago.
-She was not aware Resident #18's care plan was late.
-The interim SCM was currently responsible for doing the assessment and care plans.

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Interview with the SCC on 11/09/18 at 5:15pm revealed:
-Resident #18 had several falls.
-They started 15 minutes checks on Resident #18 today because of her falls.
-Physical therapy was scheduled to come to the facility next week to evaluate the resident.
-The SCM updated the resident's assessment and care plan and the PCP signed it this week.

Interviews with the SCM on 10/30/18 at 4:59pm and 11/09/18 at 5:28pm revealed:
-She had been working on resident assessments and care plans since she started working at the facility 09/07/18.
-She recently completed an assessment and care plan for Resident #18 and it was signed by the PCP this week.

Based on observations, interviews, and record reviews, it was determined Resident #18 was not interviewable.

Refer to the interview with a MA on 11/07/18 at 10:39 a.m.

Refer to the interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53 a.m.

Refer to the interview with the SCC on 10/30/18 at 12:14 p.m.

Refer to the interview with the SCM on 10/30/18 at 4:59 p.m.

2. Review of Resident #8's current FL-2 dated 04/10/18 revealed:
-Diagnoses included Alzheimer's disease, type 2

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diabetes, chronic kidney disease, hyperlipidemia, and idiopathic gout.
-The resident was constantly disoriented.
-The resident was ambulatory and required assistance with bathing.
-The resident was incontinent of bowel and bladder.

Review of Resident #8's Resident Register revealed:
-The resident was admitted to the facility on 04/18/18.
-The resident required assistance for bathing, dressing, nail care, shaving, toileting, mouth care, scheduling appointments, and orientation to time and place.
-The resident was forgetful and needed reminders.

Review of Resident #8's most current assessment and care plan dated 05/11/18 revealed:
-The assessment date on the first page was documented as 05/11/18.
-The assessment and care plan was incomplete.
-There were no assessment entries under the sections titled mental health and social history, ambulation/locomotion, upper extremities, nutrition, respiration, skin, bowel, bladder, orientation, memory, vision, hearing, speech/communication method, licensed health professional support (LHPS), and risk management.
-There was no plan of care related to falls included in the assessment.
-The resident required extensive assistance with bathing, grooming, and dressing.
-The section to indicate the assistance level needed for mobility, including ambulation and transferring, was blank.

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-The resident required limited assistance with toileting and eating.
-The assessment and care plan was signed by the assessor on 08/13/18 and the primary care provider (PCP) on 08/14/18.

Review of Resident #8's accident/injury reports, charting notes, and hospital records revealed:
-The resident had 9 falls from 07/10/18 - 08/22/18.
-The resident went to the emergency room (ER) for evaluation of injuries for 2 of the 9 falls.
-The resident's injuries included right upper extremity pain, skin tear to right elbow, pink spots on right cheek, left wrist sprain, and staples to laceration on top of head.

Interview with a personal care aide (PCA) on 10/31/18 at 1:50pm revealed:
-When Resident #8 first came to the facility, he was mostly independent but required some supervision and limited assistance with activities of daily living (ADLs).
-Toward the last 3 months of Resident #8's life, he had a decline and required total assistance with ADLs and he was more confused.
-The resident had a wheel chair and his feet and legs were swollen.
-The resident had a bed/chair alarm and a fall mat.
-The resident had falls because would try to get up and walk.

Interview with a medication aide (MA) on 11/05/18 at 4:58pm revealed:
-Resident #8 had some falls and staff would find him on the floor.
-She did not recall the resident having injuries from his falls.
-The resident started using a wheel chair about a

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month before he passed away.
-The resident had a fall mat and a chair alarm.

Interview with a second MA on 11/07/18 at 5:00pm revealed:
-Resident #8's condition was "back and forth".
-Sometimes he was up walking around sometimes he was bedbound.
-Resident #8 would fall because he would try to get up and walk by himself.

Interview with a hospice nurse on 11/01/18 at 4:45pm revealed:
-Resident #8 had falls.
-The resident was "all over the place" in his physical ability.
-One day he would be up walking around and the next day, he would bedbound.
-She had gotten an order for a fall mat and for the bed to be in the lowest position.

Interviews with the ED on 11/07/18 at 5:18pm and 11/09/18 at 10:47am revealed:
-She had worked on the assessments and care plans after the former DON left employment with the facility a few months ago.
-She was learning how to do the assessments and care plans when she did Resident #8's care plan in May 2018.
-She must have overlooked the incomplete sections when she did the assessment for Resident #8.
-She thought the date of the assessment and the dates that she and the PCP signed the care plan were different because of billing issues but she could not remember.
-The interim Special Care Manager (SCM) was currently responsible for doing the assessment and care plans.

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Review of a hospice visit note revealed the resident expired on 10/04/18.

Refer to the interview with a MA on 11/07/18 at 10:39 a.m.

Refer to the interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53 a.m.

Refer to the interview with the SCC on 10/30/18 at 12:14 p.m.

Refer to the interview with the SCM on 10/30/18 at 4:59 p.m.

3. Review of Resident #2's current FL-2 dated 03/07/18 revealed diagnoses included Alzheimer's dementia with behaviors, bilateral lower extremity venous stasis wounds, hypertension, schizoaffective disorder, deep vein thrombosis with inferior vena cava filter, major neurocognitive disorder, seizure disorder and history of myocardial infarction.

Review of Resident #2's current assessment and care plan dated 08/13/18 revealed:
-There were no assessment entries under the sections titled mental health and social history, ambulation and locomotion, nutrition, respiration, skin, bowel, bladder, orientation, memory, vision, hearing, speech and communication methods, and licensed health professional support (LHPS).
-There were no entries under the sections marked risk management, plan development and consent.
-There was documentation Resident #2 required extensive assistance with bathing and dressing and supervision with transfers and ambulation.
-There was no documentation on what level of

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assistance Resident #2 required for toileting, eating and other special assistance and monitoring.
-The assessment and care plan was signed by the Executive Director (ED) on 08/13/18 and Resident #2's primary care provider (PCP) on 08/16/18.

Review of an LHPS evaluation for Resident #2 dated 09/07/18 revealed:
-Resident #2's LHPS tasks transfers, ambulation with assistive devices and physical therapy.
-The assessment documented that Resident #2 required two staff for assistance with transfers and had orders for a chair alarm and physical therapy due to a fall in July 2018.
-The assessment documented resident #2 was being followed by home health for lower extremity wounds.

Interview with a medication aide (MA) on 10/30/18 at 4:23pm revealed:
-She had administered medications to residents and assisted with activities of daily living (ADL) such as toileting, ambulation, showering and dressing.
-Resident #2 was ambulatory when he first came to the facility (11/21/17).
-Resident #2 was no longer steady on his feet and was a fall risk.
-Resident #2 would forget that he was not steady on his feet and try to walk.

Review of primary care provider (PCP) visit notes for Resident #2 revealed:
-On 03/01/18, Resident #2 was re-admitted to the facility after hospitalization for psychosis and was to follow up with psychiatry.
-On 06/05/18, Resident #2 was having sexually inappropriate behaviors and was to follow up with

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D 254	Continued From page 10 psychiatry. -On 10/14/18, Resident #2 continued to be aggressive with staff and other residents at times and continued to be followed by psychiatry. Telephone interview with Resident #2's mental health provider (MHP) on 10/26/18 at 11:09am revealed: -She had been working with Resident #2 since February or March 2018. -Prior to September 2018, Resident #2's behavior problems were "sporadic;" taking things that belonged to other residents and reaching out and grabbing people. -Resident #2 started having major problems after the hurricane (September 2018), and she made medication changes for Resident #2. -Resident #2's anger, aggression and sexual behaviors including touching and inappropriate comments were unpredictable and difficult to manage because of Resident #2's dementia diagnosis. -Staff tried to have Resident #2 sit out in the common area or activity room where he could be seen. -Staff reported that they tried redirection and distraction for Resident #2 by taking him outside to look at the gardens and talking to him. Interview with the SCM on 10/30/18 at 4:59pm revealed: -She had been working on each resident's assessment and care plan since she started working at the facility 09/07/18. -Her process was to review the resident's quarterly profile, LHPS evaluation and medication list to develop the assessment and care plan. -She was working her way through each resident in the facility and had not gotten to Resident #2 yet.	D 254		

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Interview with the ED on 11/02/18 at 12:25pm revealed:
-She did not realize there was missing information on Resident #2's assessment.
-Resident #2's assessment and care plan must have been an oversight on her part.
-Things like compression stockings and chair alarms were not usually documented on the assessment and care plan.
-The information for Resident #2's MHP should have been on the assessment and care plan.
-Interventions for behaviors such as redirection and as needed (PRN) medications were not usually documented on the assessment and care plan.

Attempted interview with Resident #2's responsible person on 10/30/18 at 1:32pm was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Refer to the interview with a MA on 11/07/18 at 10:39 a.m.

Refer to the interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53 a.m.

Refer to the interview with the SCC on 10/30/18 at 12:14 p.m.

Refer to the interview with the SCM on 10/30/18 at 4:59 p.m.

4. Review of Resident #5's current FL-2 dated 06/18/18 revealed diagnoses included

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Alzheimer's dementia, coronary artery disease, hearing loss, hyperlipidemia, hypertension, muscular degenerative, and macular degeneration. He was constantly disoriented and a wanderer.

Review of the Resident Assessment Plan revealed:
-The Care Plan assessment was performed on 06/08/17.
-The Care Plan was signed and dated by the physician on 06/19/17.
-Resident #5 was documented as needing assistance with eating (cutting food), toileting, bathing, dressing, grooming, and transfers. He was independent with ambulation.
-Resident #5 wandered, had a history of hallucinations and mental illness, and was forgetful needing reminders.
-Resident #5 was receiving mental health services and the date of referral was 02/01/17.
-There was no other Care Plan created for Resident #5 after 06/08/17.

Review of a Skilled Nurse communication note dated 05/23/18 revealed:
-An evaluation visit was performed for admission to Hospice services with a diagnosis of terminal progressive Alzheimer's dementia for Resident #5.
-Resident #5 had a history of visual hallucinations and weight loss with 3 - 4 falls in the past 6 weeks, sustaining a broken jaw from a fall.
-Staff reported Resident #5 needed prompting for feeding; and that he was unable to dress, bathe, or toilet without assistance.

Interview with Resident #5 on 11/07/18 at 4:10pm revealed:
-Staff helped him with bathing and dressing.

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-He did not need help dressing, but staff dressed him "real quick".

Interview with a medication aide (MA) on 11/06/18 at 11:45am revealed:
-The Care Plan showed what the resident's needs were.
-Resident #5 did not any need assistance.

Interview with the Special Care Coordinator (SCC) on 11/06/18 around 6:15pm revealed:
-She was not aware a yearly Care Plan for Resident #5 was due.
-There was not a 2018 yearly Care Plan for Resident #5.
-A 2018 yearly Care Plan for Resident #5 needed to be done.
-The Supervisor Care Manager (SCM) was responsible for completing resident Care Plans.

Refer to the interview with a MA on 11/07/18 at 10:39 a.m.

Refer to the interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53 a.m.

Refer to the interview with the SCC on 10/30/18 at 12:14 p.m.

Refer to the interview with the SCM on 10/30/18 at 4:59 p.m.

5. Review of Resident #4's hospital generated FL-2 dated 08/01/18 revealed:
-Diagnosis included chronic obstructive pulmonary disease (COPD) exacerbation.
-The resident was intermittently disoriented.

Review of Resident #4's current assessment and

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care plan dated 08/14/18 revealed:
-There were no assessment entries under the sections titled nutrition, respiration, bowel, orientation and vision.
-There were no entries under the sections marked risk management, plan development and consent except staff names that attended the care planning meeting.
-There was documentation the resident required extensive assistance with bathing and there was documentation what level of assistance the resident required to get in the tub/shower.
-There was documentation the resident required extensive assistance and limited assistance to help with fasteners for his clothes and shoes.
-There was no documentation what level of assistance the resident required with mobility.
-The resident's assessment and care plan was signed by the Executive Director (ED) on 08/13/18.

Review of Resident #4's "Interdisciplinary Notes" revealed:
-On 08/06/18, the resident had an evaluation by a Physical Therapist (PT).
-In the subjective section of the note there was an entry the resident had an unsteady gait with complaints of pain in his left foot and a blister on the heel.
-There was documentation by the PT the resident's gait was antalgic (walking with a limp that develops in response to pain).
-The resident was admitted to PT services.
-The resident received scheduled PT services for gait training and fall precaution teaching through 10/01/18.

Review of Resident #4's primary care provider (PCP) visit note dated 08/20/18 revealed:
-There was an entry that the Licensed Health

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Professional Support nurse reported that the resident had "multiple falls" with most occurring when the resident was ambulating without assistance.
-The resident did not request assistance for ambulation.
-The resident could benefit from Physical Therapy services for gait training, endurance, strengthening, and coordination.

Interview with Resident #4 on 10/23/18 at 11:35am revealed:
-He did not need assistance to walk.
-He thought he had fallen twice while living at the facility but unsure when his last fall was.
-Staff assisted him with his bathing and grooming.

Observation of Resident #4 on 10/24/18 at 12:17pm revealed the resident was ambulating in the hallway without an assistance and no assistive device.

Attempted interview with Resident #4's Guardian on 11/08/18 at 12:13pm was unsuccessful.

Refer to the interview with a MA on 11/07/18 at 10:39 a.m.

Refer to the interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53 a.m.

Refer to the interview with the SCC on 10/30/18 at 12:14 p.m.

Refer to the interview with the SCM on 10/30/18 at 4:59 p.m.

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Interview with a MA on 11/07/18 at 10:39am

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revealed:
-Information was gathered from the FL-2's to complete the Care Plans.
-If there was a change in the residents then the care plans were updated.
-The Care Managers completed the Care Plans.
-There was a paper in each resident's closet that let staff know what care that resident needed.

Interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53am revealed:
-The current Special Care Coordinator (SCC) and Special Care Manager (SCM) had been completing assessments and care plans for residents for approximately one to one and half months (August - September 2018).
-Prior to that, the ED might have been completing assessments and care plans for residents.

Interview with the SCC on 10/30/18 at 12:14pm revealed:
-Usually the care manager completed assessments and care plans for residents, but the ED had been completing them.
-The SCM had just started completing resident assessments and care plans a couple of weeks ago (10/15/18).

Interview with the SCM on 10/30/18 at 4:59pm revealed:
-She had been working on each resident's assessment and care plan since she started working at the facility 09/07/18.
-Her process was to review the resident's quarterly profile, LHPS evaluation and medication list to develop the assessment and care plan.
-She was working her way through each resident in the facility.

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D 269 10A NCAC 13F .0901(a) Personal Care and Supervision D 269

10A NCAC 13F .0901 Personal Care and Supervision
(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to provide incontinence care, assistance to the dining room for the lunch meal and assistance with changing clothes for 2 of 7 sampled residents (#2 and #10).

The findings are:

Confidential interview with a staff revealed staff were not able to provide personal care assistance to residents because staff were busy supervising residents with aggressive, violent, sexual and wandering behaviors.

1. Review of Resident #2's current FL-2 dated 03/07/18 revealed diagnoses included Alzheimer's dementia with behaviors, bilateral lower extremity venous stasis wounds, hypertension, schizoaffective disorder, deep vein thrombosis with inferior vena cava filter, major neurocognitive disorder, seizure disorder and history of myocardial infarction.

Review of Resident #2's current assessment and care plan dated 08/13/18 revealed:

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-There were no assessment entries under the sections titled mental health and social history, ambulation and locomotion, nutrition, respiration, skin, bowel, bladder, orientation, memory, vision, hearing, speech and communication methods, and licensed health professional support (LHPS).
-There was documentation Resident #2 required extensive assistance with bathing and dressing and supervision with transfers and ambulation.
-There was no documentation on what level of assistance Resident #2 required for toileting, eating and other special assistance and monitoring.
-The assessment and care plan was signed by the Executive Director (ED) on 08/13/18 and Resident #2's primary care provider (PCP) on 08/16/18.

Observation on 10/23/18 at 10:58am revealed:
-Resident #2 was standing in the middle of his room (#217) with an incontinence brief on and no pants on.
-Resident #2 was holding a pair of blue jean pants in his hands.
-There was no staff present in the room.

Interview with Resident #2 on 10/23/18 at 10:58am revealed "I just have to put my pants on."

Observations on 10/24/18 at 12:48pm revealed Resident #2 was wearing blue jean pants that were unzipped and secured with a fastened belt.

Observations on 10/25/18 from 11:58am until 1:22pm revealed:
-Resident #2 was sitting in a chair in the salon room at 11:58am.
-Resident #2 got up from the chair with verbal prompting from the personal care aide (PCA).

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-Resident #2 was unsteady on his feet and confused about how to step over the salon chair foot rest.
-Once standing, Resident #2's blue jean pants were observed as unfastened with the belt hanging from each side of the resident's waist.
-Upon being asked about Resident #2's pants, the PCA attempted to zip and fasten the resident's blue jean pants, but the waist of the pants were too small to be fastened.
-The PCA said to Resident #2, "Your pants are too small (name of Resident #2)."
-The PCA then fastened the belt and pulled Resident #2's shirt down and instructed Resident #2 to go to the dining room for lunch.
-Resident #2 was not in the dining room for the lunch meal from 12:00pm -12:10pm.
-Resident #2 was sitting on his bed, with his head leaned over onto his pillow and his feet on the floor from 12:11pm through 1:22pm.

Interview with the Dietary Manager (DM) on 10/25/18 at 1:08pm revealed:
-The lunch meal was done and there were no plates set aside.
-Staff usually let her know whenever a resident needed a plate set aside for later.
-She had not been asked to set aside a lunch plate for Resident #2, but she would make the resident a plate.

Interview with a PCA on 10/25/18 at 1:19pm revealed:
-She had seen a medication aide (MA) take Resident #2 down the 200 hall.
-She was in the dining room assisting residents with the lunch mea so she did not know what happened to Resident #2 after the MA took the resident down the 200 hall.

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Interview with the MA on 10/25/18 at 1:20pm revealed Resident #2 had went down to his room to use the bathroom and never returned to the dining room.

Observation on 10/25/18 at 1:40pm revealed Resident #2 was eating lunch in the dining room.

Interview with the MA on 10/25/18 at 3:51pm revealed the PCA normally went back down to Resident #2's room to check on him if had left the dining room at meal time and the resident usually returned to the dining room.

Interview with a second PCA on 10/25/18 at 9:16am revealed:
-It was common for residents to sit in the dining room for 30 minutes before being served the meal.
-Staff usually brought residents to the dining room when staff saw the beverages placed on the tables.
-All of the PCAs were responsible for supervising residents in the dining room.
-Three PCAs stayed in the dining room once residents were in the dining room, and the other three PCAs went down the halls to check other residents and bring residents to the dining room.

Observations on 10/25/18 at 4:43pm revealed:
-The PCA was assisting Resident #2 to put his blue jean pants on.
-The blue jean pants were not large enough to zip and fasten around Resident #2's waist.
-The PCA said to Resident #2, "What's going on with your pants? I'm going to tell them you need some new pants."
-The PCA secured the belt around the unzipped and unfastened blue jean pants.

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Observations on 10/30/18 at 11:26am revealed:
-Resident #2 was laid back on his bed from a sitting position with his feet on the floor and his eyes were closed.
-There were numerous ants crawling on Resident #2's bed, his left arm and around the electrical outlet on the wall behind the resident's bed.
-There were used tissues, wrappers and crumbs on Resident #2's bed, bedside table and floor.
-Resident #2 had a large area of wetness on the front of his dark blue jean pants.
-There was an odor of urine within two feet of Resident #2.
-Resident #2 had shoes on, but did not have socks on and there was swelling to both of his ankles.

Interview with a third PCA on 10/30/18 at 11:30am revealed:
-Resident #2 was tired after breakfast so she and the medication aide (MA) brought him to his room and helped him to his bed "around 10 something."
-Resident #2 was not saturated with urine because his incontinent brief was dry and she had changed his brief just before breakfast (8:00am).
-Resident #2 must have spilt something on his pants.

Interview with a second MA on 10/30/18 at 11:29am revealed:
-It had not been that long since a staff had checked on Resident #2.
-She and the PCA brought Resident #2 to his room and put him in his bed around 9:30am.

Interview with a housekeeper on 10/30/18 at 11:34am revealed she had not noticed ants in Resident #2's room before 10/30/18.

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Interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53am revealed:
-Resident #2 was able to walk, but not very far.
-Resident #2 needed assistance with "buttoning his pants, fixing his britches and/or shirt and help with showering."
-Normally Resident #2 changed his own incontinence brief.

Attempted interview with Resident #2's responsible person on 10/30/18 at 1:32pm was unsuccessful.

Interview with the ED on 10/30/18 at 11:35am revealed:
-Staff were expected to check all residents every 30 minutes and provide toileting assistance every 2 hours.
-Resident #2 often went down to his room and "put stuff on the floor and in his bed."
-If staff had seen Resident #2 "like that (referring to 10/30/18 at 11:26am)" on a 30 minute check, she expected staff to "fix it."

Refer to interview with the Special Care Coordinator (SCC) on 11/07/18 at 3:30pm.

2. Review of Resident #10's current FL-2 dated 07/13/18 revealed diagnoses included major neurocognitive disorder, dementia, dysphagia, hypertension and eczema.

Upon request on 11/02/18, an assessment and care plan for Resident #10 was not available for review.

Review of a Resident Assessment Pre-Screening form for Resident #10 dated 06/18/18 revealed:
-Resident #10 required extensive assistance with

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bathing, dressing, toileting, eating, transfers and ambulating.
-Under the section "Conditions affecting activities of daily living self-performance/assistance time," cognitive impairment was marked yes and gait abnormality was marked yes.
-The form was completed by the Marketing staff person.

Review of an Emergency Room Nurse's Note for Resident #10 dated 07/26/18 revealed:
-On arrival to the emergency room (ER) Resident #10 was noted to have wet clothing with an odor of urine present.
-Resident #10's shorts were wet and the resident's shirt was wet up his back.

Review of an ER Encounter form for Resident #10 dated 07/26/18 revealed:
-Resident #10 was seen in the ER for an unwitnessed fall.
-Staff reported Resident #10 was sleeping sitting up in a chair at 1:00am and fell onto the ground.
-Resident #10 reported hitting his head and had an abrasion on his left elbow.

Attempted interview with the medication aide (MA) on 11/08/18 at 8:01pm was unsuccessful.

Telephone interview with Resident #10's Responsible Person (RP) on 11/04/18 at 6:50pm revealed:
-Resident #10 was only at the facility for two weeks before he died.
-Every time he visited Resident #10 at the facility the resident was wet with urine.
-It looked like someone had went to the bathroom on the floor in the facility and the staff would cover the area with what looked like a doggy pad and just leave it.

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-Staff did not keep the residents or the facility clean.

Based on observations, interviews and record reviews, it was determined Resident #10 was not available for interview.

Interview with the Executive Director (ED) on 11/09/18 at 10:48am revealed:
-She was not aware Resident #10 presented to the ER on 07/26/18 saturated in urine.
-She had told staff to always make sure the residents were clean and dry.

Refer to interview with the Special Care Coordinator (SCC) on 11/07/18 at 3:30pm.

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Interview with the Special Care Coordinator (SCC) on 11/07/18 at 3:30pm revealed:
-The medication aides (MAs) were responsible for making sure personal care aides (PCAs) provided personal care for residents.
-The MAs were expected to report any concerns to the Care Manager (CM) and if the concern was not addressed, then report to the Executive Director (ED).
-In regards to systems implemented since August 2018 for personal care, 3rd shift PCAs had been told what they needed to be doing as far as checking on and assisting residents.
-The 3rd shift staff was responsible for rounding on residents every two hours for incontinence care and toileting.
-The 1st shift had not been getting as many complaints that residents were wet at the change of shift over the last week (10/28/18 - 11/03/18).

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

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to provide supervision for 11 of 16 residents sampled (#1, #2, #6, #8, #9, #13, #14, #17, #18, #25, #26) including 5 residents (#1, #2, #6, #25, #26) with assaultive, aggressive, sexually expressive and wandering behaviors leading to numerous resident to resident altercations; 5 residents (#8, #9, #13, #14, #18) with multiple falls resulting in serious physical injuries to include head laceration requiring staples (#8, #14), traumatic head injury (#13), closed head injury, facial contusion and multiple skin tears (#9), and left wrist sprain (#8, #18); and a resident, who had an order for nectar thick liquids but was allowed to drink another resident's thin liquids resulting in the resident coughing (#17).

The findings are:

Review of the facility's 2018 license from the Division of Health Service Regulation revealed the entire facility was licensed as a special care unit with a capacity of 60 beds.

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Review of the facility's resident roster dated 10/23/18 revealed:
-There were 58 special care unit residents residing in the facility.
-There were 30 residents, male and female, listed as living on the 100 hall.
-There were 28 residents, male and female, listed as living on the 200 hall.

Observation of the layout of the facility throughout the survey from 10/23/18 - 11/09/18 revealed:
-Upon entrance to the facility, there was a common living room on the right.
-There were 3 main hallways, one to the left, right and center of the entrance.
-The 100 hall was a long hallway on the right with two offices, common bathrooms, and residents' rooms.
-The 200 hall was a long hallway on the left with three offices, an entry to the main dining room, a utility room, common bathrooms, and residents' rooms.
-The center hallway was shorter and had a nurses' station on the right across from the main dining room, an entry to the dining room, an entry to the kitchen, a smaller dining room area on the right, common bathrooms, a private dining room, a beauty shop, an activity room, laundry room and a dayroom with vending machines.
-There were no residents' rooms on the center hallway.
-The resident rooms and the 100 and 200 hallway were not visible from behind the nurses station.
-The areas beyond the main dining room on the center hallway were not visible from behind the desk in the nurse's station.

Observations while on facility tour on 10/23/18 from 10:48am until 11:59am revealed:
-At 10:48am, there was a personal care aide

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(PCA) assisting a resident in room # 206 and a second PCA walking down the 200 hall.
-There was a female resident at the end of the 200 hall near the exit door.
-At 10:58am, Resident #2 was standing in his room #217 with a shirt and incontinence briefs on.
-Resident #25 was ambulating in the hallway near room #214.
-There was a second female resident in the hallway near room #212 asking for assistance to leave the facility and for help to locate her dog.
-At 11:14am, Resident #25 was coming out of (his room) #215, into the hallway.
-There was a lamp on the floor with no shade and a broken lightbulb in room #213.
-There was a folded walker between the mattress and the headboard on the bed by the window in room #213.
-At 11:25am, Resident #13 was sitting in a recliner in room #210 with no shoes or socks on and an unused incontinent brief under the resident's left foot and a urine odor was noted within three feet of the resident.
-At 11:27am, Resident #2 was using his feet to propel his wheelchair in the 200 hall going towards the front desk area.
-There was a housekeeper in the hallway.
-A female resident in a wheelchair came out of room #208 using her feet to propel her wheelchair.
-There was another female resident in the hallway in a wheelchair using her feet and the handrail to propel her wheelchair.
-There was a large canvas picture (approximately 24 x 36 inches) fallen from the wall and resting inside the handrail near room #211.
-At 11:40am, a PCA was going room to room on the 200 hall asking, "Are you coming to lunch?"
-At 11:56am, Resident #6 was walking up and down the 200 hall asking, "Is this my room?"

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-The top drawer of the dresser in room #201 was on a chair inside the bathroom in the room.

Observations on the 200 hall on 10/23/18 from 4:18pm until 4:30pm revealed:
-At 4:18pm, Resident #2 was using his feet to propel his wheelchair in the hallway going towards the front desk area.
-At 4:19pm, Resident #27 was walking in the hallway with a large men's slipper on her right foot and a tie up black sneaker on her left foot.
-Resident #27 went into another resident's room #205 and returned to the hallway with personal belongings wrapped in a blanket asking, "Can you get someone to help me to the door?"
-The Business Office Manager (BOM), attempted to assist Resident #27 in returning the belongings saying, "Let's go back down the hall."
-Resident #27 said to the BOM, "I don't want to put it (the belongings) back in there."
-Resident #27 paced the hallway, carrying belongings and asking repeatedly for assistance with getting out of the facility with the BOM until 4:27pm, then with a PCA until 4:30pm.

Observations of the lunch meal on 10/24/18 from 12:00pm until 12:58pm revealed:
-The dining room was noisy and crowded with residents and staff making it difficult to move around.
-At 12:00pm, Resident #2 and Resident #6 were seated at tables in the dining room.
-At 12:05 p.m. some residents were entering the dining room while others were seated at the dining room table while staff were serving beverages to some of the residents seated.
-At 12:06pm, at the end of the 200 hall Resident #6 kissed a female resident on the cheek. A staff went down the hall and assisted Resident #6 back down toward the dining room.

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-At 12:08pm Resident #1 was walking around in the hallway close to the dining room.
-At 12:14pm, staff started serving plates and Resident #6 left the dining room
-There were 6 residents seated in the small dining room and 46 residents seated in the main dining room; there were no more seats available for the remaining 6 residents.
-At 12:17pm, Resident #4 left the dining room and went down the 100 hall.
-At 12:18pm, Resident #1 was at the nurse's station talking with a surveyor.
-At 12:19pm, Resident #4 re-entered to dining room and was served a plated meal.
-From 12:22pm until 12:41pm, there was a male resident walking to and from in all of the hallways until a PCA brought the resident to the dining room.
-At 12:24pm, Resident #2 had not been served a plate; plates were being served 3-4 plates at a time and staff had turn sideways to navigate between tables.
-At 12:25pm, Resident #1 was being assisted by staff to eat her meal.
-At 12:30pm, the Executive Director (ED) brought Resident #6 back to the dining room.
-At 12:31pm, Resident #2 left the table walking and the ED brought the resident his wheelchair.
-The female resident with the men's slipper on her foot on 10/23/18 was not in the dining room.
-At 12:41pm, Resident #1 finished eating and was walking through the dining room then stopped at the table Resident #16 was sitting at and grabbed Resident #16's tea yelling, "Is that your tea? All of it?"
-The PCA that had been assisting Resident #1 with eating was assisting another resident with eating and looked at Resident #1 while she grabbed Resident #16's tea. Other staff took Resident #1 by the hand and assisted her out of

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the dining room.
-At 12:48pm, Resident #2 was in his room on his hands and knees looking under his bed.
-At 12:53pm, the ED went to Resident #2's room and asked the resident why he had not returned to the dining room.
-At 12:58pm, the female resident with the men's slipper on her foot on 10/23/18, was sitting in the living room.

Observations of the lunch meal on 10/25/18 from 12:00pm until 12:43pm revealed:
-The dining room was noisy and crowded with residents and staff making it difficult to move around.
-At 12:00pm, there were beverages on all of the tables in the dining room except the table on the corner between the kitchen door and the hallway entrance.
-At 12:06 pm resident #1 went behind the nurse's station and the ACM in training redirected her from behind the nurse's station.
-At 12:08pm, Resident #1 and Resident #2 were not in the dining room.
-At 12:10pm, Resident #4 was in dining room and had been served tea and water.
-Resident #4 had left the dining room and came back at 12:24pm.
-At 12:11pm, Resident #1 was seated at a table, her plate and beverages were provided and the Assistant Care Manager (ACM) in training was seated next to the resident.
-At 12:15pm, two female residents sitting at the same table were arguing in a raised voice. One of the females told the other female resident "you say all these ugly things to me", "if someone don't get her", "you're stupid about your finger sticking up", "she is enough to make me throw up".
-The ED moved one of the female residents to the next table and the resident told the ED to "just

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shut her up".
-At 12:30pm, an alarm sounded and a personal care aide (PCA) left the dining room and went down to room #213.

Telephone interview with a resident's family member on 11/06/18 at 9:14 a.m. revealed:
-The family member visited at all times during the day.
-When the family member visited, staff stayed busy taking care of the residents but at times saw residents wandering in the halls and there would be no worker on the floor monitoring the halls.

Confidential interview with a family member revealed:
-The staff stayed around the front desk and residents did their own thing.
-Staff were not out where the residents were to watch them and help them.
-It was chaotic inside the facility, especially on weekends.
-It seemed like there was no one in charge to make sure staff were doing what they were supposed to be doing.

Confidential interview with a concerned citizen revealed:
- The concerned citizen did not think staff cared.
-"The residents were in danger"; there had been so many injuries including falls, bruises and fractures that did not make sense.
-Staff sat outside smoking or sitting at desk.

Confidential interview with a staff revealed there were some residents at the facility (named) that needed one on one attention but there was not enough staffing each shift to meet their needs and care for the other residents.

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Confidential interview with a second staff revealed:
-There were several residents at the facility with violent and aggressive behaviors.
-There were no safety interventions or increased supervision for residents with violent and aggressive behaviors.
-The Executive Director (ED) was aware and nothing was done about behavior concerns.

Confidential interview with a third staff revealed:
-Residents were not supervised and did not get the care they needed because the staff were too busy trying to manage residents with violent and aggressive behaviors.
-Staff had not been trained properly and could not handle the residents at the facility because of resident behaviors.
-The ED had been told about concerns for residents with violent behaviors by several staff many times since July 2018.
-The ED did not say much about the concerns and nothing was done.

Interview with a personal care aide (PCA) on 10/26/18 at 1:23pm revealed:
-There were no set times to check residents; "we're here all day watching residents."
-Residents were probably checked every 30 minutes.
-The PCAs were assigned four rooms or eight residents each shift.
-There was not enough staff to care for other residents when Resident #1 needed one to one staff.
-There were two PCAs for the 100 hall, two PCAs for the 200 hall and sometimes a "floater" PCA to float between both halls.
-Since 10/23/18, there were two PCAs for the 100 hall, two PCAs for the 200 hall and two floater

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PCAs.
-It was difficult to work 12 hour shifts from 7:00am until 7:00pm at the facility because that shift was responsible for all three meals and most of the showers.
-The residents were already sleeping when the 7:00pm until 7:00am shift came in.
-The night shift did not have as many showers and was responsible for getting all residents up and dressed before 7:00am.
-They had been working 12 hour shifts for about 1 and ½ months because there were short staffed.

Interview with a second PCA on 11/07/18 at 2:35pm revealed:
-The 3rd shift staff rounded every 2 hours unless a resident was on every 15 or 30 minute checks.
-The PCAs would know which residents needed every 15 or 30 minute checks because a 15 or 30 minute check sheet would be attached to the PCA's assignment sheet.
-Each staff had a folder that had their assignment sheet, shower sheets, end of shift round sheets and any 15 and 30 minute checks for each shift.
-The folder system had been in place for at least the last three months.

Interviews with the Special Care Coordinator (SCC) on 11/07/18 at 3:30pm and 3:54pm revealed:
-On 08/30/18, she informed 3rd shift staff specifically on where they needed to be stationed in the building and what they needed to be doing.
-Two PCAs were in the halls at all times.
-Two PCAs monitored residents who were still awake and ambulating.
-The PCAs checked all residents every two hours.
-There were 15 and 30 minute check sheets for residents on increased supervision and PCAs

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were expected to check those residents every 15 or 30 minutes.
-The medication aides (MAs) were responsible for making sure PCAs provided supervision for residents.
-The MA was expected to report any concerns to the Special Care Manager (SCM) and if the concern was not addressed, then report to the ED.

Telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25pm revealed:
-She had worked at the facility from March - September 2018.
-There were no safety interventions or increased supervision for residents with behavior concerns.
-The ED would always blame the staff for a resident's behavior and not do anything about the behavior.
-It was difficult for staff to manage all of the supervision needs of residents because there was always so much going on in the facility.
-There was a day at the end of July 2018, when Resident #26 knocked Resident #7 down to the floor and then was "fighting with everybody".
-The staff were so involved with Resident #26 they did not check on Resident #9 who had been gotten up and put in her wheelchair by 3rd shift staff then fell and got a head injury.
-At the same time, there was another resident who died sitting in his wheelchair in the hallway after breakfast.
-Resident #26 would get into a rage whenever the grass was cut because he thought they had stolen his lawnmower; the grass was being cut that morning.
-There were no interventions put in place specifically around cutting the grass for Resident #26.
-She was supposed to be responsible for

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completing resident prescreening assessments prior to admission, but she was only allowed to complete one assessment for the entire six months she worked at the facility.
-She did not know what the admission process and criteria was because the Executive Director (ED) and the Marketing Person completed all resident admissions.

Interview with a primary care provider (PCP) on 11/05/18 at 10:35am revealed:
-She was the PCP for approximately half of the residents at the facility.
-She was concerned about the safety of all residents at the facility.
-Residents were not supervised and there was a high percentage of injuries of unknown origin for residents.
-Residents who were unable to give consent were involved in sexual incidents and there were quite a few residents with aggressive behaviors.
-If a resident at the facility had sexual behaviors and/or aggressive behaviors, that resident needed to be watched.
-Staff should not allow the behaviors to continue without intervention.
-A resident with the behaviors should be moved closer to the front desk area so the resident could be watched.

Telephone interview with the mental health provider (MHP) on 11/06/18 at 11:44am revealed:
-Behavior plans were not normally sent with a resident at discharge from the acute psychiatric behavior center.
-Not having a behavior plan was concerning because often behaviors were present and considered stable at the time of discharge, but those behaviors were not safe for a resident going to an assisted living facility with 58 other

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residents who were frail.

Interview with the ED on 10/30/18 at 1:44pm revealed:
-All of the residents were on every 30 minute checks routinely for every shift. Residents were checked by staff, but the 30 minute checks were not documented.
-If residents were checked more frequently, the PCAs documented the checks.
-The 15 minute checks were documented by the PCAs on an increased supervision form.
-The MAs monitored the PCAs throughout the shift and signed off on the increased supervision form each shift.

Interview with the ED on 11/09/18 at 10:48am revealed:
-All residents were checked by staff every 30 minutes routinely for all shifts; every two hour checks were incontinence checks.
-She expected staff to get the aggressive resident away from other residents or get other residents away from the aggressive resident.
-Staff were trained on managing aggressive behaviors upon hire and throughout the year.
-Staff shadowed a PCA on the floor before working on their own after hire.
-Staff were expected to communicate behavior concerns in their shift to shift report because behaviors changed day to day.
-Since October 2018 staff had implemented an at risk board in the medication room to alert staff of falls, behaviors and residents out of the facility.
-The MAs were expected to notify the SCM of behavior concerns and the SCM notified the PCP for medication modification or possible send out to the emergency room.
-Sometimes there was increased supervision for a resident which would be more one staff to one

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resident monitoring.
-The MA decided if one to one staffing of a resident was necessary and notified the SCM.
-At times there was additional staff to cover one to one with a resident and still meet the needs of the other residents.
-The decision to increase supervision for a resident was done on an individual basis.
-She did not recall if there was a plan in place for the safety of other residents at the time of admission with residents being admitted from an acute inpatient psychiatric center.

1. Review of the facility's policy, Guidelines for Supervision of Residents who Exhibit Difficult Behaviors, revealed:
-At risk behaviors included agitation, aggression, assaultive behavior and sexual inappropriate behavior (definitions were given for each).
-Staff shall be trained in methods of recognizing and managing at risk behaviors as agitation, aggression, assaultive behavior, and inappropriate sexual behavior to include use of redirection, recognizing escalating behavior, maintaining safety, using activities, using the intervention list, room change, or as needed (PRN) medication if appropriate and ordered by the physician.
-Upon observation of at-risk behavior, staff shall notify the Supervisor. The Supervisor shall assure the Care Manager is notified who is responsible for also notifying the Executive Director (ED).
-Any resident at risk shall be placed on increased supervision with documentation included on the Medication Administration Record (MAR). The doctor, Guardian or Responsible Party was to be notified.
-A mental health referral shall be considered and discussed with the resident's physician.
-The ED shall assure staff is made aware of any

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resident at risk. The at-risk resident shall be added to the At-Risk Board in the staff lounge and medication room.
-A care planning meeting shall be held to discuss the resident's behavior, proposed interventions and ongoing plan to assure care and safety.
-The resident's care plan shall be updated to include the at-risk behavior and interventions.
-Any behavior which escalates to a threat to the resident or others shall require immediate intervention to assure safety as to move residents out of harm's way and call 911 (Emergency Medical Services/Authorities).
-Notification shall be made to the Supervisor, Care Manager, ED, Regional Director of Operations, DSS (department of social services), physician, Mental Health Provider and Guardian/Responsible Party.
-Notice of immediate discharge with issuance of the discharge/transfer/appeal form shall be discussed.

a. Review of Resident #1's current FL-2 dated 08/09/18 revealed:
-Diagnoses included Alzheimer' disease, frontal dementia, panic disorder and insomnia.
-The resident was constantly disoriented and wandered.
-The resident was ambulatory.

Review of Resident #1's assessment and care plan dated 03/26/18 revealed:
-The resident was always disoriented with significant memory loss requiring direction.
-The resident was receiving mental health services and medications for mental health behaviors.
-The resident was on 30 minute checks as an implemented safety measure.

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Review of Resident #1's special care unit Resident Profile and Care Plan Update Form dated 08/27/18 revealed:
-The resident's behavioral pattern was documented as "wanders" and the interventions were documented as "ensure safety".
-The resident's cognitive impairment was documented as "confused" and the interventions were documented as "reminders".

Review of Resident #1's electronic "Charting Notes" revealed on 09/26/18 at 6:20 p.m., there was documentation by a medication aide (MA) the resident was in an altercation with another resident.

Review of an Accident/Injury report for Resident #1 dated 09/26/18 at 4:45 p.m. revealed:
-The Assistant Care Manager (ACM) in training discovered the incident.
-There was a resident on resident altercation.
-The resident was not taken to the emergency room (ER).

Review of Resident #1's primary care provider's (PCP's) visit note dated 09/26/18 revealed:
-The reason for the visit included follow up on previous reports of "agitation'.
-On 09/10/18, a urinalysis and culture was ordered per staff request for agitation.
-Review of the medication administration records (MARs) indicated that only one dose of as needed Lorazepam had been administered since the previous visit on 09/10/18 for agitation.
-There was an addendum to the PCP's visit note dated 09/26/18 at 5:33 p.m. with documentation that staff had notified the provider that Resident #1 "got into an altercation with another resident". According to staff, neither resident was injured nor felt it was necessary to send either one to the

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ER. Resident #1 would be evaluated at the next facility visit with regards to the reported allegation.

Review of a social worker's mental health attendance notes for Resident #1 revealed on 09/26/18 there was an entry of no tearfulness, improved mood, confused but pleasant, smiling and laughing and pacing halls.

Review of Resident #1's mental health provider (MHP's) visit note dated 09/26/18 revealed:
-The resident was being seen for a follow up visit.
-The resident had increased anxiety and fear as a result of the recent evacuation and occurrences related to the hurricane; however, staff reported as circumstances resumed to a typical daily routine, the resident's mood had improved and she had not needed as needed medication.
-Staff reported fewer behavioral outbursts and no aggressive behaviors; verbal outburst could be redirected and were usually related to cognitive declines.
-On 09/21/18, staff reported increased anxiety/agitation; discontinued Ativan 0.25mg as needed for agitation, added Ativan 0.5 mg twice daily for anxiety/agitation
-Staff reported no behavioral outbursts; at baseline and doing well; mood reported as stable; continue to monitor.
-The resident should continue the current medications with no changes, continue psychotherapy 1 to 4 times per month and follow up within 3 to 6 months or as needed.

The ACM in training, who discovered Resident #1's incident of a resident to resident altercation on 09/26/18 was not available for interview on 11/07/18 and 11/09/18.

Interview with the ED on 11/07/18 at 4:42pm

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revealed:
-A male resident hit Resident #1 on her forehead leaving a red mark which was completely gone the next day (09/27/18).
-After the male resident hit Resident #1 the local police department was notified and the male resident was sent to the ER.

Review of Resident #1's electronic "Charting Notes" revealed:
-On 10/03/18 at 4:00 p.m., there was documentation by the Special Care Manager (SCM) the physician was notified of the resident's mood swings and agitation at times when being directed. When visited by her family member a few days ago, the family member also noticed how the resident responded to questions had changed and her answers would appear to be as if she were agitated. When redirected by staff, she would yell at them as they were calmly redirecting her or swing her arms as if to hit staff.
-On 10/06/18 at 3:59 p.m., there was documentation by a MA the resident was agitated this morning and did not have any medication for this.
-On 10/07/18 at 6:24 a.m., there was documentation by a MA the resident continued to get up and go into another resident's bed but was willing to get up and "go to room".
-On 10/07/18 at 8:47 p.m., there was documentation by a MA the resident had been disruptive to others and agitated most of the day.

Interview with the MA, who documented the electronic note for Resident #1 on 09/26/18 at 6:20 p.m. and 10/07/18 at 6:24 a.m., on 11/06/18 at 11:55 a.m. revealed:
-Resident #1 had behaviors that included getting into other residents' faces (personal space of other residents).

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-Some residents grabbed Resident #1 by the arms to get her out of their face.
-Staff were expected to redirect Resident #1 when she had these behaviors.
-Resident #1 was on 30 minute checks but staff were able to keep closer eyes on her because she was a hall walker.

Interview with the MA, who documented the electronic charting note for Resident #1 on 10/07/18 at 8:47 p.m., on 11/05/18 at 4:55 p.m. revealed
-Resident #1 had not always been the way she was now; her dementia had worsened in the last month or so.
-Resident #1's behaviors included "hovering" over other residents and cursing at them.
-Resident #1 went into other residents' rooms but usually came right back out.
-Resident #1 did not usually take items from other residents' rooms.
-Resident #1 had an as needed medication that was given for behaviors that helped some.
-Resident #1 had been on 15 minute checks since last week and was on every 30 minute checks before then.

Review of Resident #1's PCP's visit note dated 10/08/18 revealed:
-The reason for the visit included reports of agitation.
-On 10/05/18, staff reported that Resident #1 was experiencing "agitation" The as needed Lorazepam was discontinued due to non-use, and Resident #1's Depakote (used to treat psychiatric conditions) was increased to address her agitation. The resident was observed closely on the visit and the resident's agitation appeared to be directly related to a loud, noisy aggressive environment. She was calm and cooperative

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D 270	Continued From page 43 when redirected and placed in a quieter atmosphere. -Review of her recent psychiatric notes indicated that psychiatry was in agreement with regards to her Lorazepam as they had also reduced the scheduled doses as well. Any further reports or concerns of agitation would be deferred to psychiatry to prevent conflicting medication orders. -There was an order to please use redirection as the first line treatment for agitation (i.e. encourage the resident to go to a quieter area, engage in a quieter activity. etc.). -There was another order to notify psychiatry to manage all psychotropic medications going forward. Review of Resident #1's electronic "Charting Notes" revealed: -On 10/11/18 at 6:32 p.m., there was documentation by the MA the resident was still wandering in and out of residents' rooms, taking their stuff and still getting into people's faces. -On 10/13/18 at 5:32 p.m., there was documentation by a MA the resident had behavior issues today with other residents, had been redirected several times and got upset when staff tried to redirect her. -On 10/15/18 at 11:49 a.m., there was documentation by the SCM the resident continued to get up in other residents' faces really upsetting the other residents. Review of a social worker's mental health attendance notes for Resident #1 revealed on 10/12/18, there was an entry the resident was more confused, arguing with another resident, taking other residents' things, talking about a deceased family member a lot; staff reported the resident was cursing and combative during care.	D 270		

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Interview with the MA, who documented the electronic "Charting Note" dated 10/15/18 at 11:49 a.m. for Resident #1, on 11/07/18 at 10:49 a.m. revealed:
-Resident #1's behaviors lately included her getting into other residents' faces a lot.
-Resident #1 started having increased behaviors in September 2018 but was "full blown" in October 2018.
-At one time it was easy to redirect Resident #1, but now it was hard to redirect her at times.
-Resident #1's PCP had been contacted recently about possibly getting a urinalysis because of her behaviors.
-Staff were expected to use redirection, to engage the resident in an activity and perform monitoring checks on her every 30 minutes or sometimes even one on one supervision.
-Resident #1 was in and out of other residents' rooms which caused other residents to fuss and want staff to come and get Resident #1 out of the room.
-Resident #1 could go anywhere when staff were busy assisting other residents.

Review of Resident #1's PCP's visit note dated 10/15/18 revealed:
-The resident was being seen to follow up on reports of an altercation with another resident.
-On 10/09/18, staff reported that Resident #1 had and altercation with another resident. Details about the altercation were not provided. The other resident involved in the altercation was male with whom Resident #1 sat next to and held hands on a daily basis.
-The PCP had never observed any signs of aggression between the two residents before.
-Resident #1 had no recollection of the altercation. She had a large superficial scratch

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along the jawline on the right side of her face and was unaware how the scratch occurred.
-There was an order reminding staff to report all behaviors to psychiatry and to verbally redirect the resident at the first sign of agitation; Resident #1 responded well to redirection.

Review of Resident #1's electronic "Charting Notes" revealed:
-On 10/17/18 at 6:46 p.m., there was documentation by a MA the resident had behavior issues with several residents.
-On 10/18/18 at 10:25 p.m., there was documentation by a MA the resident slapped another resident.
-On 10/18/18 at 11:39 p.m., there was documentation by a MA the resident was resting after an altercation with another resident today.
-On 10/20/18 at 9:56 p.m., there was documentation by a MA the resident was very agitated, her behavior was not nice and had to be redirected several times before having several altercations.

Review of Resident #1's physician's orders revealed an order dated 10/21/18 to implement one or more of the following interventions to prevent future altercations with other residents: attempt to keep the resident separate from other residents with whom she did not get along, increase supervision of the resident to redirect and intervene as needed and use distraction techniques such as activities to diffuse the situation.

Review of Resident #1's PCP's visit note dated 10/22/18 revealed:
-The resident was being seen to follow up on reports of an altercation with another resident.
-On 10/18/18, staff reported that Resident #1

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"slapped another patient in the face"; no further details were provided. Multiple attempts to obtain additional information by telephone were unsuccessful.
-Review of Resident #1's record indicated a history of multiple altercations with other residents.
-Resident #1 had no recollection of the altercation which occurred last week.
-At one point during today's visit, the PCP observed Resident #1 become agitated toward another resident and raised her hands as if she was going to push him. The PCP was able to successfully verbally direct Resident #1 and distract her by handing her a magazine. Resident #1 seemingly forgot what had upset her and began to smile, thanking the PCP for the magazine and walked away.
-There was a reminder to notify psychiatry of all behaviors and to please implement non-pharmacological interventions to prevent future altercations with other patients.

Attempted telephone interview with the MA, who documented the electronic "Charting Note" for Resident #1 on 10/17/18 at 6:46 p.m. and 10/18/18 at 11:39 p.m., on 11/09/18 at 4:43 p.m. was unsuccessful.

Review of Resident #1's care plans and quarterly resident profiles revealed:
-There was no documentation Resident #1's supervision was increased from the 30 minute checks that were documented on the resident's care plan on 03/26/18.
-There was no interventions documented as implemented to prevent future altercations with other residents including attempting to keep the resident separate from other residents with whom she did not get along, increasing supervision of

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the resident to redirect and intervene as needed and using distraction techniques such as activities to diffuse the situation.

Interviews with the Special Care Coordinator (SCC) on 11/07/18 at 3:30pm and 3:54pm revealed there were 15 and 30 minute check sheets for residents on increased supervision and PCAs were expected to check those residents every 15 or 30 minutes.

Review of Resident #1's 30 minute Increased Supervision and Accountability Checks form 09/21/18 through 10/25/18 revealed there was no documentation of 30 minute checks performed from 10/02/18 through 10/15/18.

Interview with the ED on 11/09/18 at 10:48 a.m. revealed:
-She was not aware of an order written by Resident #1's PCP on 10/21/18 to implement one or more interventions to prevent future altercations with other residents.
-The ED reviewed Resident #1's order dated 10/21/18 and stated "That doesn't make any sense" (the order).
-Resident #1 was also being seen by mental health for her behaviors.

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

Interview with a resident on 10/23/18 at 11:35 a.m. revealed:
-Resident #1 came into his room a lot and sometimes tried to get in bed with him.
-Resident #1 would come into the room, walk around or lay down on the bed.
-The resident had to go down the hall and get

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staff to come get Resident #1 out of his room.
-It was a daily occurrence that Resident #1 would come in and out of other residents' rooms and staff had to go and get her out.

Interview with another resident on 10/23/18 at 11:54 a.m. revealed:
-There was a female resident with blonde hair that lived at the facility and staff "better keep her out of my room" because that was their (staff) jobs and not her job.
-If the resident came into her room anymore "she was going to kill her"; "she was a pain in the [expletive].
-Resident #1 went into everybody's space.
-The resident was not sure why Resident #1 bothered her so much.
-Staff would come to her room to get Resident #1 out of the room, but by then Resident #1 had done what she wanted to.
-The resident usually had to get out of bed and go down the hallway to get staff to come to her room and have Resident #1 removed.
-She was not sure if Resident #1 had been back in her room "lately."

Interview with a third resident on 10/25/18 at 11:50 a.m. revealed:
-She knew Resident #1 very well.
-Resident #1 was not "clear headed" now; her mind had gotten worse recently.
-She had observed staff allowing Resident #1 to wander around the dining room of the facility during meals.
-Resident #1 picked up other residents' beverages and food in the dining room which made some of the residents angry.
-Resident #1 did not know what she was doing but some residents did not have sympathy for that.

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-Staff got aggravated with Resident #1 and would tell Resident #1 "to get out of here".
-Staff had been observed pulling Resident #1 by the arm out of the dining room like they were "holding on to a piece of garbage" and "pushing her out" of the dining room.
-She knew that some residents had hit Resident #1 when they got upset with her.

Interview with a personal care aide (PCA) on 10/23/18 at 11:20 a.m. revealed:
-Resident #1 was disoriented and wandered all the time.
-All residents were on every 2 hour checks unless they had a fall, came from the hospital or were sick; then a resident was placed on every 30 minute checks.
-Every 30 minute checks were documented on a sheet but the 2 hour regular checks were not.
-Checks meant staff had to physically see where the resident was and assure the resident was safe.
-The PCAs were responsible for documenting the 30 minute checks.
-Resident #1 was a non-stop walker and was actually seen and checked on by staff more than the every 2 hour checks.

Interview with a second PCA on 10/23/18 at 4:44 p.m. revealed:
-Resident #1 needed someone with her "step by step" because she was into everything.
-Most staff do every 30 minute checks on Resident #1 but she tried to keep an extra watch on the resident because of her going everywhere including going in and out of other residents' rooms.

A second interview with the PCA on 10/30/18 at 11:28 a.m. revealed:

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-Staff had to "stay on top" of Resident #1 because they (staff) did not want Resident #1 in other residents' faces and grabbing at the residents or taking items from them.
-Resident #1 was "everywhere" and staff were unable to keep the resident in site unless staff were hand in hand with her.

Interview with a third PCA on 10/26/18 at 1:23pm revealed:
-Resident #1 was on every 15 minute checks.
-Resident #1 would get into everything; went into other residents' rooms and took things and was aggressive.
-Resident #1 needed constant supervision.
-If staff tried to redirect Resident #1, the resident would pull away and say get away from me and call staff by curse words.
-Staff would keep trying to redirect Resident #1.
-Since 10/23/18, staff had been taking turns being one to one with Resident #1.
-Resident #1 needed one to one supervision because she was getting more aggressive.
-It took two staff to take Resident #1 to the bathroom.
-Each staff would have to take (Resident #1) by her arm and make her sit down and urinate.

Interview with a housekeeper on 10/25/18 at 11:19 a.m. revealed:
-Resident #1 went into other resident rooms.
-Some of the residents did not like for Resident #1 to come into their room but some "don't mind" when Resident #1 went into their rooms.
-She had never been told by management what was expected when Resident #1 was seen in someone else's room; she just knew to redirect Resident #1 out of the room.
-Some days when Resident #1 was seen in residents' rooms she would alert the MA instead

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of redirecting the resident herself.
-Resident #1 went into other residents' rooms daily and would pick up baby dolls or pillows and "tote" the item around with her. Some residents became upset with Resident #1 when she was seen in the hallways with their personal items.

Interview with the laundry staff on 10/24/18 at 9:10 a.m. revealed:
-Resident #1 wandered and went in and out of other resident rooms by walking in and then walking back out.
-She had seen Resident #1 in other rooms when she delivered the residents' laundry.
-She had not been told of any specific interventions for Resident #1 if she saw her in another residents' room but just knew to redirect the resident.

Confidential interview with a staff revealed:
-Resident #1 "is a lot".
-Resident #1 had "gotten worse" by irritating the other residents especially during meals.
-Meal time was a struggle with Resident #1 because she took other residents' drinks and grabbed food.
-Staff thought this was a "hard situation to diffuse".
-At times, Resident #1 would be very irritable, hitting at other residents but staff did not think Resident #1 meant to be harmful, but the other residents would not see it that way and some residents reacted by hitting her back.
-Resident #1 would get into an empty resident's bed but staff had never seen her get in another resident's bed while another resident was in the bed.
-Resident #1 did not take residents' clothes but would take other items such as stuffed animals which was no big deal to some residents.

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However, some residents would try to get back the item that belonged to them from Resident #1 which caused Resident #1 and the other resident to sometime start "swatting and fighting".
-Resident #1 irritated a male resident (named).
-Resident #1 sometimes would go by the male resident and push at him or get in his personal space and the male resident reacted at times when she did this.
-About a month or two ago the male resident struck Resident #1 in the face.

A second confidential staff interview revealed:
-Staff could not supervise Resident #1 as much or as often as needed and take care of all of the other residents at the same time.
-It was hard to manage Resident #1's behavior issues but staff managed the best they could.

A third confidential interview with staff revealed:
-Staff attempted to monitor Resident #1 especially in the dining room but "just blink" and Resident #1 was gone.
-Resident #1 had always been a walker but for about a month, her behaviors had worsened.
-Resident #1 was now taking food from other residents, sticking her hands in other residents' food, taking items from residents and would get into other residents' personal spaces.
-Staff tried to keep Resident #1 safe when other residents reacted toward her behaviors.
-Some of the other residents retaliated by pushing the resident's hand away from them or grabbing her by the arm.
-The staff thought the facility was not the right place for Resident #1 because of her high supervision needs.

A fourth confidential interview with staff revealed:
-Resident #1 had declined for the last three

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months.
-Resident #1 needed someone with her 24/7.
-Resident #1 had always been a walker but gradually worsened going into rooms, putting different things in her mouth such as Styrofoam from decorative pumpkins and would pick up things out of the trash can.
-Resident #1 had never had one on one staff supervision until now.
-Staff did not have time to spend with Resident #1 and take care of the other residents.
-Resident #1 wandered all day.

A fifth confidential interview with staff revealed Resident #1 needed one on one supervision and the facility was not the right setting to meet the resident's supervision needs.

Confidential interview with a concerned citizen revealed:
-The concerned citizen visited the facility often.
-It had been observed that staff "ignored" Resident #1 which left the resident free to wander in and out of resident rooms and up and down the hallways of the facility.
-Resident #1 did not have staff supervision in the dining room which resulted in Resident #1 taking food and beverages out of the hands of other residents.

Observation in the dining room on 10/24/18 at 1:04 p.m. revealed:
-A resident was sitting at a dining room table finishing her lunch.
-Resident #1 walked up to the other resident's table and grabbed at the resident's cup.
-Resident #1 kept trying to pull the cup out of the resident's hand.
-Both residents tugged back and forth on the cup.
-Resident #1 was yelling at the resident, accusing

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her of spitting in the cup.
-The resident kept telling Resident #1 that it was her cup and to let go.
-There were at least two staff across the dining room near the kitchen door but no staff acknowledged the incident or intervened.
-After approximately 15 seconds of arguing and tugging at the cup, Resident #1 let go and walked away, cursing the resident as she walked away.

Observation of Resident #1 on 10/25/18 at 9:05 a.m. revealed:
-Resident #1 walked up to the side of a resident while he was seated in a wheelchair.
-Resident #1 was standing over the resident while he was seated and started patting him on the head with her hand.
-The resident glanced up at Resident #1 and then looked away from her.

Observation of Resident #1 on 10/25/18 from 10:02 a.m. to 10:07 a.m.
-The resident was walking down the 100 hallway.
-The resident entered resident room 103 (assigned to two female residents) while there was a PCA assisting another resident at the medication cart stored on the right side of the 100 hallway located close to the nurse's station.
-The female residents assigned to the room were not in the room.
-Resident #1 walked to the opposite side of the room and began to pick up personal items of the residents assigned to resident room 103.
-At 10:07 a.m., Resident #1 walked out of resident room 103 toward the nurse's station where staff were located.
-A MA asked Resident #1 what she had in her hand and then walked away from the resident and a second MA took a picture from Resident #1.

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Observation of Resident #1 on 10/25/18 at 12:10 p.m. revealed:
-Resident #1 was assisted into the dining room by a MA holding her hand and guiding her to the other end of the dining room between the dining room tables with many of the residents already seated.
-Resident #1 stopped walking and attempted to sit down at a table but was redirected by the MA to sit at another table.
-Resident #1 picked up a stuffed animal from another resident's rollator walker as she was walking by; the resident seated said something to Resident #1 as she picked up the stuffed animal and Resident #1 cursed at the resident.
-Resident #1 stopped at another resident's table as the MA continued to redirect her to a specific table and attempted to pick up food from another resident's plate and started cursing at the resident.

Attempted telephone interview with Resident #1's family member was unsuccessful on 10/26/18 at 4:00 p.m. and 11/05/18 at 5:24 p.m.

Interview with the Executive Director (ED) on 10/25/18 at 12:53pm revealed:
-Resident #1 had not been on increased supervision.
-There was a new plan as of 10/24/18 to monitor Resident #1 on her way into the dining room, throughout the meal and as she left the dining room to keep Resident #1 from grabbing at other residents.
-Staff were expected to monitor Resident #1 and see where the resident was, redirect her, sit with her in the dining room and monitor when she left the dining room so Resident #1 was not grabbing at other residents' food.

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-Resident #1 had some bruises from altercations with other residents.
-She could not remember when Resident #1 last had bruises and where the bruises were.
-Staff were expected to redirect Resident #1 when the resident went into other residents' rooms.
-Most of the time Resident #1 responded to redirection by just walking away and talking about Jesus or her family member.

Interview with the SCM on 10/25/18 at 12:53 p.m. revealed there had been medication changes, a work up to rule out a urinary tract infection and the SCM was working on ideas to manage Resident #1 including involving the resident in activities.

Interview with the Regional Protocol Registered Nurse on 10/25/18 at 12:53 p.m. revealed the facility "probably needed to look at increasing supervision" for Resident #1.

Telephone interview with Resident #1's PCP on 10/25/18 at 3:58 p.m. revealed:
-The PCP had provided services for Resident #1 since February 2018.
-The PCP thought the staff did not provide enough supervision for Resident #1.
-The resident required redirection.
-There had been many reports of the resident having altercations with other residents but the PCP was not always sure what staff meant as altercations and if it was related to hitting, kicking or biting.
-The PCP thought there was not a good explanation for these altercations and staff were not working with the resident to prevent behaviors.
-The PCP saw the resident on 10/22/18 and

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wrote orders to implement one or more interventions that included increasing supervision of the resident, use redirection and intervene as needed and use distraction techniques such as activities to diffuse the situation.

Interview with Resident #1's PCP on 11/05/18 at 10:35 a.m. revealed:
-The PCP had never observed staff with Resident #1 and thought staff supervision seen today was for "show" (done for appearance).
-When the PCP made her visits to the facility, staff were sitting at the desk or outside smoking.

Attempted telephone interview with Resident #1's MHP on 11/09/18 at 4:30 p.m. and 4:37 p.m. was unsuccessful.

b. Review of Resident #6's current FL-2 dated 10/01/18 revealed:
-Diagnoses included Alzheimer's disease.
-The resident was constantly disoriented and ambulatory.

Review of Resident #6's Resident Register revealed:
-The resident was admitted on 10/02/18.
-The resident was forgetful and needed reminders.

Review of Resident #6's record revealed there was no assessment or care plan.

Review of Resident #6's Resident Assessment Tool dated 09/25/18 revealed there was no identifying at risk behavior documented.

Review of Resident #6's electronic "Charting Notes" dated 10/09/18 revealed:
-On 10/09/18 at 5:37 p.m., there was

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documentation by a medication aide (MA) the resident was very aggressive, turning over tables, and "slamming hands at doors" and refused his medications by spitting the medication out of his mouth.
-On 10/09/18 at 5:38 a.m., there was documentation by a MA the resident was going in other resident rooms and disturbing them.
-On 10/09/18 at 10:26 p.m., there was documentation by a MA the resident was going into another residents rooms and had upset one of the residents very badly.

Attempted telephone interview with the MA who documented the electronic "Charting Note" for Resident #6 on 10/09/18 at 10:26 p.m. and 10/23/18 at 5:44 p.m., on 11/09/18 at 4:43 p.m. was unsuccessful.

Review of Resident #6's electronic "Charting Notes" dated 10/20/18 -10/23/18 revealed:
-On 10/20/18 at 10:02 p.m., there was documentation by a MA the resident was very active and going into other residents' rooms; still on 30 minute watch.
- On 10/22/18 at 7:05 a.m., there was documentation by a MA "up going into other rooms, bother people".
-On 10/23/18 at 5:44 p.m. there was documentation the resident had some behavior issues today and was given a "PRN" (as needed).

Interview with Resident #6's family member on 10/25/18 at 10:30 a.m.
-The resident had not lived at the facility long but had two recent incidences.
-On 10/21/18, the family member received a call from the facility (unable to recall the staffs name or title) around 2:00 am and was told that Resident #6 pushed over a women in the

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wheelchair causing the woman to hit her head and had to be sent to the local emergency room for evaluation.
-She was told by staff the female resident was "checked out" and was fine.
-On 10/22/18, around 1:30 a.m., the family member was called by staff and told Resident #6 walked into another resident's room and the other resident hit Resident #6 with a lamp. The family member was not sure what part of Resident #6's body was hit with the lamp, but was told that Resident #6 "Bite" the other resident. The family member did not think either resident was injured.

Review of Resident #6's Supervision & Accountability Check List form (documentation of increased safety checks) for 30 minute checks dated 10/20/18 - 10/24/18 revealed:
-On 10/22/18, 10/23/18 and 10/24/18 there was no documentation of increased 30 minute checks for 11 hours and 30 minutes.
-The resident remained on 30 minute checks with no increased safety checks implemented.

Review of Resident #6's electronic "Charting Notes" dated 10/27/18 revealed:
- On 10/27/18 at 5:05 p.m., there was documentation by a MA Resident #6 was found in another residents room laying in the bed but the other resident was found lying on the floor complaining of pain.
-On 10/27/18 at 5:06 p.m., there was documentation by a MA the resident was put on 30 minute checks.

Interview with the MA, who documented the electronic "Charting Note" for Resident #6 on 10/27/18 at 5:05 p.m. and 10/27/18 at 5:06 p.m., on 11/07/18 at 4:55 p.m. revealed:
-She was the MA that found Resident #6 in the

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female resident's bed on 10/27/18.
-Resident #6 was a "handful".
-Resident #6 had difficulty understanding simple commands.
-Resident #6 required a lot of redirection.
-Resident #6 was on 30 minute checks, but was placed on every 15 minute checks after the incident on 10/27/18 and then was transferred to an inpatient behavioral health unit.
-Resident #6 had behaviors that included hitting staff.
-Resident #6's behaviors would worsen at night.

Interview with the Special Care Coordinator (SCC) on 10/30/18 at 12:10 p.m. revealed:
-The SCC received a call from a MA that a named female resident had a fall on 10/27/18.
-The MA told the SCC Resident #6 pushed the named female resident out of her bed.
-The ED knew about the incident because the MA had called her after the incident occurred.

Interview with the ED on 10/30/18 at 1:44pm revealed staff had been instructed to place Resident #6 on watches which meant staff should have checked Resident #6 more than the usual every 30 minute checks.

Interview with a personal care aide (PCA) on 10/23/18 at 4:08pm revealed:
-Resident #6 wandered.
-Resident #6 usually slept during the day.
-Resident #6 "sun downed (a term used for increased confusion restlessness or delirium that is also known as late-day confusion) really bad" and constantly wandered all night.
-She did not know the details of Resident #6's "sun downing" behaviors because her shift ended at 7:00pm.

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Follow-up interview with the PCA on 10/30/18 at 4:44 p.m. revealed:
-A named female resident had fallen in her room on 10/27/18.
-The PCA did not know what happened but heard yelling from the named female resident's room.
-Resident #6 was in the female resident's bed and the female resident was laying on the floor on her right side beside the bed.

Review of a primary care provider's (PCP's) "Patient Notes" for a female resident dated 10/31/18 revealed:
-In a phone call with the Special Care Manager (SCM) on 10/31/18 at 7:21 p.m., the PCP was informed when the female resident fell, a named male resident (first name of Resident #6) was present in the room.
-The female resident had previously voiced her concern to both the PCP and another outside provider about (first name of Resident #6) coming into her room uninvited multiple times throughout the night and standing by her bed "staring" at her and this behavior reportedly made the resident feel uncomfortable.
-This had been reported verbally to the SCM (most recent report 10/24/18).
-The SCM's response was "we are aware and keeping an eye on the situation".

Review of Resident #6's electronic "Charting Notes" dated 10/29/18 and 10/31/18 revealed:
-On 10/29/18 at 6:17 p.m., there was documentation by a MA the resident's was pushing residents and had an altercation with another resident.
-On 10/29/18 at 10:49 p.m., there was documentation by a MA the resident was agitated, had to call "EMT", gave medication and the resident went to bed and was still resting.

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-On 10/31/18 at 11:05 a.m., there was documentation by the Executive Director (ED) on 10/30/18 Resident #6 was taken to an inpatient behavioral health unit (named) for behaviors and medication modifications.

Review of Resident #6's Supervision & Accountability Check List form (documentation of increased safety checks) for 30 minute checks revealed on 10/27/18, the resident was placed on increased 15 minute checks at "10:00" to "9:45"; there was no documentation of increased 15 minute checks for one hour and 45 minutes from "6:00" to "6:45".

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

Interview with a male resident on 10/23/18 at 11:35 a.m. revealed:
-A resident (Resident #6's name) who was a "tall, ball-headed guy" had been getting into his bed for about a week now.
-He had told a MA and they would come and get the male resident out of his bed but could not remember which MA he had told.

Interview with a female resident on 10/23/18 at 12:20 p.m. revealed:
-She had lived at the facility for about two months.
-The female resident had a recent concern of a male resident who was an "old man, white hair who wears Bermuda shorts" coming into her room. They (staff) had to keep the male resident out of rooms.
-When this male resident came into her room, he mostly just stood in the room.
-She would use her call bell to alert staff that "he" was in her room.

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D 270	Continued From page 63 Observation of Resident #6 on 10/23/18 at 11:56 a.m. revealed: -Resident #6 was walking down the 100 hallway. -Resident #6 was a tall male with white colored hair and was wearing khaki colored Bermuda type shorts. Observation on 10/25/18 at 12:43pm revealed: -Resident #6 and five other residents were sitting in the common area during the lunch meal. -There were no staff present at the front desk area, in the hallway or in the common area. Interview with a PCA on 10/25/18 at 9:16am revealed: -Resident #6 liked to grab people's hands and was sometimes more aggressive. -Aggressive meant someone could have been talking to Resident #6 and he would get loud and swing at the person talking to him. -Resident #6 was aggressive with other residents and his family members. Interview with a MA on 11/07/18 at 10:49 a.m. revealed: -Resident #6 was a "walker"(walked around the facility a lot). -Resident #6 was fine but when "sun downing" occurred she often thought "is that the same one (same resident)" because he wanted to fight residents or whoever was in his sight. -Resident #6 was on 30 minute supervision checks. Interview with a second MA on 11/09/18 at 10:20 a.m. revealed: -Resident #6 was confused but was not combative to residents. -Resident #6 wandered in other residents' room.	D 270		

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-She was not given any specific instructions or aware of a concern that Resident #6 was entering a named female resident's room.
-She knew from past experience to redirect residents as an intervention when they were confused and wandered.

Interview with a housekeeper on 11/07/18 at 4:45 p.m. revealed Resident #6 wandered and it was common for him to get into other residents' beds.

Confidential interview with a staff revealed Resident #6 needed one on one supervision and the facility was not the right setting to meet the resident's supervision needs.

Observation on 10/30/18 at 1:37 p.m. revealed Resident #6 was in the activity room alone without any staff.

Interview with the ED on 10/30/18 at 1:43 p.m. revealed:
-It was "alleged" that Resident #6 pushed the named female resident out her bed.
-The MA called the ED immediately on 10/27/18 when the incident occurred.
-The MA had reported when she entered the named female resident's room, the female resident was on the floor and Resident #6 was in the female resident's bed.
-Resident #6's staff monitoring checks had been increased from every 30 minutes to every 15 minutes since 10/27/18.
-She had not interviewed the female resident's roommate because she was "not coherent".
-The named female resident told local hospital staff that a resident had pushed her out of bed.
-Resident #6 had a separate incident with a second female resident a week or more ago.
-The incident happened in the middle hallway of

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the facility.
-Resident #6 was pushing a female resident in her wheelchair and when the female resident placed her feet on the floor, the wheelchair would stop while Resident #6 was pushing her.
-The female resident placed her feet again on the floor as Resident #6 was pushing her in the chair which caused the chair to stop rolling again.
-Resident #6 attempted to look at the wheel of the wheelchair and caused the female resident to fall out of the chair but was not trying to push her out.
-Resident #6 had behavior issues and could be aggressive with staff.
-It was reported to her a couple of weeks ago, Resident #6 had followed/forced himself in resident room 207 with staff and destroyed the room. However, she was told three different stories involving this incident from staff. It was reported that he threw a lamp and a nightstand against the wall. She observed the room afterward with the SCC and there was no apparent damage to the room and no one was hurt in the incident.
-She had started the process for Resident #6 to go to one of the two named inpatient behavioral units.

A second interview with the ED on 10/31/18 at 10:50 a.m. revealed the Resident #6 was admitted to one of the named inpatient behavioral health units last night (10/30/18).

Interview with the SCM on 11/09/18 at 4:52 p.m. revealed:
-She had never been told there was a concern about Resident #6 going into a named female resident's room; "he wandered" but this was the first she had heard of this.
-If she had known there was a concern about Resident #6 going into a named female resident's

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room, she would have notified the ED, contacted Resident #6's PCP and family and would have "jumped right on it".
-She thought it was possible it could have been a day it was chaotic in the facility and she may not have remembered being told about the female resident's concerns of Resident #6 going into her room, particularly if she didn't document the concern at that time.

Interview with the ED on 11/09/18 at 10:48 a.m. revealed:
-Staff had not made her aware of Resident #6 going into a named female resident's room.
-If this was reported, she would have documented it.
-If she had known, she could have increased Resident #6's supervision and contacted the mental health provider.
-She would have thought about moving Resident #6 to the 100 hall where three male rooms were side by side.
-Resident #6's mental health provider had been contacted previously concerning the resident going from room to room following staff and residents.
-She had instructed staff to always redirect Resident #6 and engage him in conversation of his interest to help divert behaviors.
-Another provider (the named female resident's provider) was in her office recently and they had called Resident #6's PCP to discuss Resident #6 being up more at night and Melatonin (a medication used to aid in sleep) was started but she was not sure if it worked, but thought it did.

Telephone interview with Resident #6's PCP on 11/09/18 at 4:36 p.m. revealed:
-She had only seen the resident twice.
-The resident was pleasantly confused but she

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did not know his "past story".
-Resident #6 was smart and intelligent but required redirection a lot.
-There was a misunderstanding and she was not aware of the resident going into other resident rooms.
-The resident had to be discharged out of the facility and into a mental health inpatient unit because of his behaviors at the facility.
-The resident had not been at the facility long and had not been seen by mental health yet.
-The most she ordered was Benzodiazepines (a group of medications used to treat anxiety) and that medication was not calming the resident down enough.

c. Review of Resident #26's current FL-2 dated 01/26/18 revealed:
-Diagnoses included dementia.
-He was constantly disoriented.

Review of Resident #26's Resident Register signed 01/26/18 revealed he was admitted from a hospital to this facility on 01/29/18.

Review of charting notes for Resident #26 dated 01/29/18 at 11:29 pm revealed:
-That resident was very agitated and became violent, throwing objects in his room.
-Physician was called and order was received for a one time dose of Lorazepam (used for agitation) 0.5 mg topically.

Review of Resident #26's psychiatry visit note dated 02/19/18 revealed:
-This was a new patient visit due to referral from facility staff for resident anxiety and psychiatric medication management.
-Resident #26 reported no past psychiatric history, treatment or hospitalization.

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Review of charting notes for Resident #26 dated 03/28/18 at 6:53 pm revealed:
-That Resident #26 was wearing another resident's shoes, he became upset, began slamming his bedroom door and using foul language.
-It took a few minutes talking to Resident #26 to calm him down and remove the shoes.

Review of Resident #26's psychiatry visit note dated 03/30/18 revealed:
-There was a psychiatry follow-up visit report of continued anxiety and nervousness by facility staff.
-Staff also reported that Resident #26 had been less combative after medication changes that were ordered on 02/19/18.

Confidential interview with a staff revealed:
-Residents were not supervised and did not get the care they needed because the staff were too busy trying to manage residents with violent and aggressive behaviors.
-Staff had not been trained properly and could not handle the residents at the facility because of resident behaviors.
-The Executive Director (ED) had been told about concerns for residents with violent behaviors by several staff many times since July 2018.
-The ED did not say much about the concerns and nothing was done.

Review of Resident #26's accident/ injury report dated 04/20/18 at 3:49 am revealed:
-He tried to physically assault staff and another resident at the nurse's station.
-Resident #26 was sent to the hospital.

Review of charting notes for Resident #26 dated

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04/20/18 at 6:13 am revealed resident was sent to the hospital for combative behavior and altered mental status.

Review of Resident #26's after visit summary from the hospital visit dated 04/20/18 at 4:20 am revealed:
-The reason for the hospital visit was aggressive behavior.
-Resident #26 was reported to have combative behavior by facility staff.
-The MA reported she was called to the common area where the resident was throwing chairs and being combative.

Review of a physician's order request dated 04/20/18 revealed Resident #26 was sent to the hospital for altered mental status and physically combative behavior toward staff and residents.

Confidential interview with another staff revealed:
-Resident #26 flipped out every time the grass was cut because he thought someone stole his lawnmower.
-There were never any interventions for residents with violent behaviors.

Confidential interview with a third staff revealed:
-Resident #26 hit a female resident and a staff member but the staff could not recall when incident took place.
-There had been other incidents before.
-The care would be different if there were not so many residents who were inappropriate for a special care unit (SCU).
-Resident #26 would get very upset when they came to mow the lawn.
-He would say they stole his lawn mower and slam his room door and carried on.
-He was discharged due to his behavior

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sometime toward the end of July.
-Resident #26 should have been discharged long before he was because he was hitting people and throwing things.
-Staff had told the ED many times those residents were not right for the SCU and the ED did not say much about it.

Confidential interview with a fourth staff revealed:
-There were several residents at the facility with violent and aggressive behaviors.
-There were no safety interventions or increased supervision for residents with violent and aggressive behaviors.
-Nothing was done about behavior concerns.

Review of charting notes for Resident #26 dated 05/12/18 at 2:29 pm revealed:
-The resident was upset at lunch and hit another resident in the face.
-Staff broke up the altercation and Resident #26 went down the hall.
-When he came back to lunch, he was okay.

Review of Resident #26's accident/ injury report dated 05/12/18 at 8:45 pm revealed:
-He had an altercation with another resident in the hallway.
-Resident #26 was sent to the hospital at 9:15 pm.

Review of Resident #26's after visit summary from the hospital visit dated 05/12/18 revealed the reason resident was sent to the hospital was for agitation and being combative.

Review of charting notes for Resident #26 dated 05/12/18 at 10:03 pm revealed the resident pushed another resident out of a chair.

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Review of charting notes for Resident #26 dated 05/13/18 at 9:48 pm revealed:
-The resident came to the front at 9:25 pm and asked for something to eat.
-When he was offered a snack, he became combative and started cussing.
-He walked into the dining room tossed a chair and turned a table over.
-He was still "cussing" and finally went to his room.

Interview with a personal care aide (PCA) on 11/7/18 at 2:55 pm revealed:
-That Resident #26 "was off the charts", he was very aggressive and combative.
-When snacks came, if you did not address him first, he would go to his room and keep slamming the door until he got tired and stopped.
-If he did not like the snack, he would go in the dining room and throw chairs.
-Then, it would just escalate to where he would start attacking residents.
-These incidents happened every other night.
-Another PCA said not to go in his room alone.
-He beat a female resident around the face on morning shift in July, the EMS and police came, he was taken from the facility and did not come back after that.

Review of Resident #26's accident/ injury report dated 05/15/18 at 6:15 am revealed:
-The resident was observed in the hallway very agitated, throwing equipment and attacking staff and other residents.
-Resident #26 was sent out to the hospital.

Review of Resident #26's after visit summary from the hospital visit dated 05/15/18 revealed the reason the resident was sent to the hospital was for agitation.

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Review of charting notes for Resident #26 dated 05/15/18 at 6:31 am revealed:
-The resident was being sent to the hospital for altered mental status.
-Resident #26 was extremely violent.
-He hit two residents with furniture and attacked staff.

Review of a physician's order request dated 05/15/18 revealed:
-Resident #26 was sent to the hospital for altered mental status and aggression.
-The Physician's response to facility staff was Resident #26 had as needed order for Ativan to be given for agitation that according to the medication administration record had not been given since February 2018.
-The Physician requested that facility staff please use as needed Ativan order before resident was sent out to hospital for agitation/ aggression.

Interview with Resident #26's primary care provider (PCP) on 11/9/18 at 1:06 pm revealed:
-Resident #26 was not at the facility very long.
-The staff would not give as needed Ativan at times when resident could not be redirected.
-Resident #26 attacked other residents.
-The last incident when he attacked a female resident was caught on camera.
-He was sent out multiple times to the hospital due to his behavior.
-The facility staff sometimes sent him to the hospital without telling the PCP.

Review of Resident #26's psychiatry visit note dated 05/29/18 revealed:
-There was a follow-up visit for reports of aggressive behavior by facility staff.
-Staff reported that Resident #26 "punched"

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another resident after a verbal altercation.

Review of charting notes for Resident #26 dated 07/24/18 at 2:11 am revealed:
-The resident assaulted another resident multiple times.
-Staff called 911 and Resident #26 was kept away from the resident he had assaulted until Emergency Medical Services (EMS) arrived.
-When the police confronted the resident in his room, he was still walking around.
-Staff kept a close eye on resident.

Confidential interview with a fifth staff revealed:
-Resident #26 attacked another resident and then knocked a second resident onto the floor.
-Resident #26 punched the second resident and threw the second resident on the floor, the second resident hit her head on the hand rail as she fell to the floor.
-Resident #26 attacked other residents on a regular basis.
-Resident #26 would hitting other residents and slap food out of their hands.
-The ED would just tell staff to send Resident #26 to the emergency room (ER).

Review of charting notes for Resident #26 dated 07/25/18 at 8:00 am revealed the resident assaulted a female resident causing the need for her to be sent out due to bleeding around her head.

Confidential telephone interview with staff revealed:
-There was an incident the staff was asked to change documentation by the ED but the staff refused.
-The staff had documented assault, but the ED told the staff she never got the report and had

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changed the wording on the form and put the staff's name on it.
-The staff reported the concern about the changing of the staff wording in the document to corporate.
-The staff remembered the male resident went off and another resident was punched and thrown to the floor and she hit her head on the handrail.
-Resident #26 was attacking residents on a regular basis.
-The ED constantly told staff to send Resident #26 out and not contact the PCP.
-Resident #26 was sent to an inpatient behavioral health unit after he went to the hospital.

Review of Resident #26's accident/ injury report dated 07/25/18 at 7:00 am revealed:
-There was a resident to resident altercation in the hallway.
-Resident #26 was discharged from the facility due to danger to self and other residents.

Telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25 pm revealed:
-There were no safety interventions or increased supervision for residents with behavior concerns, including Resident #26.
-There was a morning when Resident #26 knocked another resident to the floor in July 2018 and she got a head injury.
-Resident #26 would get in a rage every time the grass was cut, he would say someone stole his lawnmower and slam the door to his room so hard the frame was messed up.
-Resident #26 was a problem because he was so violent.

Review of an Incident/Investigation Report from the local Police Department dated 07/25/18 at 6:54 am revealed:

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-The time of the report was
-The incident was a simple assault.
-There was second crime section with an entry of "Non-Criminal Detainment (Involuntary Commit).
-In the weapon section of the report the personal weapons included hands, fists, feet, teeth, etc.
-A resident was assaulting another resident and staff.
-Resident #26's name was entered in the "Suspect" section of the report.
-A female resident was listed as the victim and the type of injury was documented as severe lacerations.
-On 07/25/18 at 6:54 a.m. the Officer was dispatched to the facility in reference to a resident that had been assaulted by another resident who was actively fighting with a staff.
-Upon arrival, there was female resident lying by the front door, a female lying straight down the hallway and a white male subject fighting a male staff.
-The Officer made his way to the altercation and helped the staff to restrain the resident.
-The Officer asked one staff to provide a wheelchair while the other staff and the Officer continued to hold the resident.
-It was at that time the Officer noticed the resident (Resident #26) was bleeding heavily from both of his arms.
-Once a staff provided the wheelchair they (the Officer and the staff) were able to get the resident to sit in the wheelchair while holding the resident down by his shoulders.
-The resident (Resident #26) at that point started kicking the staff and attempted to bite the Officer's right arm/hand twice.
-Another Officer arrived and helped to get the resident handcuffed to the wheels of the wheelchair to keep the resident from hurting himself or anyone else.

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-The other Officer then continued to restrain the resident (resident #26) who continued to try and head butt and "kick" the other Officer.
-EMS arrived on the scene and started to render aid to the assaulted victim (female resident) as well as the fall victim (a female resident) who had become unresponsive.
-EMS called for two other units to proceed to the facility.
-The other EMS unit arrived and took care of the combative resident who was identified as Resident #26 who at that time had calmed down and EMS was able to render aid and load the resident. The other Officer rode with Resident #26 to the local hospital while the facility staff went to the Magistrate's office for involuntary commitment (IVC) paperwork.
-On arrival, Resident #26 was compliant and non-combative.
-The Officer received the IVC paperwork from the Magistrate for Resident #26 and the Officer was able to serve the the resident.
-The Officer was advised by the ER staff there was no need to sit with Resident #26 under IVC.
-A few hours later the local Sheriff's Department called and stated that Resident #26 was acting out and attempting to assault staff and had to be tased.
-The Officers returned to the ER to check on Resident #26. ER staff had Resident #26 restrained in soft restraints and were medicating him.

Review of the facility's notice of transfer/ discharge for Resident #26 dated 07/25/18 revealed the resident was discharged from the facility because he was a danger to himself and other residents.

Interview with the ED on 11/7/18 at 5:30 pm

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revealed:
-Most of the time Resident #26 stayed to himself.
-He would have an outburst every now and then.
-If something triggered him, he would start slamming doors.
-He would kick trash cans or he may go in the dining room and flip over a table.
-This would happen once per week.
-Resident #26 was going down the hallway in July 2018 and a female resident was walking behind him talking.
-He told her to get away from him and pushed her and hit her in the chest.
-He walked away, then turned back and hit her again.
-EMS and the police were called.
-He was discharged to the hospital and then to a mental health behavior facility.
-Resident #26 was at the hospital for over a month due to aggressive behaviors.
-Resident #26 took a shower rod down and was going to hit someone with it while he was at another facility but he had been at the hospital for a while and exhibited no behaviors, so the ED was not concerned about a similar situation happening while he was at her facility.
-The staff did constant redirecting and monitoring.
-First steps was to redirect the resident.
-Then consult with the physician about medication modification and notify psychiatry.
-Receive guidance from corporate.
-The RCC or the ED now look at patterns of behavior, medications, diagnoses and consult with physician.

d. Review of Resident #25's current FL-2 dated 09/09/18 revealed:
-Diagnoses included dementia, coronary artery bypass graft, coronary artery disease.
-He was intermittently disoriented.

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-He was inappropriate with sexual behaviors.

Review of Resident #25's Resident Register signed 10/31/17 revealed he was admitted from a behavioral health inpatient facility.

Review of Resident #25's initial assessment and care plan signed by physician on 11/07/17 revealed:
-He had a history of mental illness.
-He was currently receiving medication for mental illness/ behavior.
-He was always disoriented.
-He had significant memory loss and must be directed.

Review of Resident #25's Charting Notes dated 08/22/18 at 11:38 am revealed:
-The resident had been masturbating in the wrong places.
-The resident was starting to make advances at other residents and was masturbating in the wrong places like the dining room.

Review of Resident #25's Charting Notes dated 08/22/18 at 4:24 pm and 10:20 pm revealed:
-Resident was sent out to the hospital with altered mental status.
-He returned from the hospital with no new orders.
-Resident #25's mental health physician ordered Ativan gel (used for agitation).
-He was placed on 30 minutes checks for behavior.

Confidential interview with a staff revealed:
-Resident #25 had sexual issues.
-He would do sexual things to himself like masturbating.
-He was sent out for treatment and then came

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back.
-The issues with sexual activity started again.

Review of Resident #25's Charting Notes dated 08/23/18 at 6:58 pm revealed that resident had been masturbating excessively, assessed for jock itch, no redness noted.

Review of Resident #25's Charting Notes dated 08/23/18 at10:08 pm revealed:
-The resident had sexual behaviors and tried to corner another resident.
-The resident was up and down the hall trying to touch other residents.

Interview with the medication aide (MA) on 10/31/18 at 4:00 pm revealed:
-There was talk about Resident #25 acting out sexually.
-She could not remember the date but another MA had went down to the resident's room and another resident was sitting on the bed naked from the waist down.
-Resident #25 was down in front of the other resident looking between her legs in the perineal area.
-The other resident told the other MA to get out.
-The MA called personal care aides (PCAs) to come and help her.

Review of Resident #25's Charting Notes dated 08/24/18 at 2:26 pm revealed that resident would be sent out to a mental health behavioral inpatient facility today.

Review of Resident #25's Charting Notes dated 08/24/18 at 2:54 pm and 2:56 pm revealed that resident had an altercation with another resident at 11:10 am prior to been sent out to a mental health behavioral inpatient facility.

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Interview with a personal care aide (PCA) on 10/26/18 at 1:23pm revealed:
-She had seen another resident "knock (Resident #25) out."
-The other resident did not actually knock Resident #25 out, but he caused a bruise between his lip and nose.
-Resident #25 was not sent to the emergency department for evaluation, staff just put ice on his face.
-The other resident said he punched him because Resident #25 "touched his butt."

Review of Resident #25's Charting Notes dated 09/08/18 at 4:06 pm revealed he continued to touch other female residents. He was asked several times to stop and continued to bother other residents.

Review of Resident #25's Charting Notes dated 09/09/18 at 2:32 pm revealed the resident fondled female residents and refused to cooperate.

Interview with the PCA on 11/07/18 at 2:55 pm revealed:
-Resident #25 always kept to himself.
-In the last 2 to 3 months he had gotten "grabby" (grabbing female breast).
-He had been masturbating in the dining room during meal times and while going down the hall.
-He had been sent out for medication adjustment a few times.
-He would come back and be good for 3 to 4 days, then he would be back doing the same behavior.

Review of Resident #25's Charting Notes dated 09/27/18 at 8:18 pm revealed:
-Resident #25's primary care physician (PCP)

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visited the resident due to his behaviors.
-PCP requested that resident be re-admitted to an acute inpatient psychotic facility due to his behaviors that threaten the wellbeing of other residents.

Interview with Resident #25's PCP on 11/09/16 at 2:00 pm revealed:
-Resident #25 was on an antidepressant for sexual behavior.
-He had to be sent out to an inpatient mental health behavioral facility for a week at the beginning of September.
-He was also sent out for a second time, 10/23/18 for sexual behaviors.
-He was placed on monitoring one on one several times or facility tried to keep him in the common areas.

Review of Resident #25's Charting Notes dated 10/28/18 at 6:12 pm revealed:
-The resident's behavior was starting to change.
-Resident #25 PCP was notified she gave staff instructions that if resident had any of these behaviors (grabbing breast) with any of the other residents, to send him out to the hospital as a danger to residents.
-His PCP instructed staff Resident #25 really needed to go to an outside source for psych.

Interview with the Special Care Coordinator (SCC) on 11/07/18 at 4:00 pm revealed:
-The medication aides (MAs) were responsible for making sure personal care aides (PCAs) provided personal care and supervision for residents.
-The MA was expected to report any concerns to the Care Manager (CM) and if the concern was not addressed, then report to the Executive Director (ED).

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Review of Resident #25's Charting Notes dated 10/28/18 at 8:55 pm revealed that resident was still having behavior issues and was now on 30 minutes checks.

Telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25pm revealed:
-Resident #25 was a problem because of his sexual behavior.
-No interventions were ever put in place, the ED would always blame the staff and instruct staff to redirect the resident.
-They tried medication changes for Resident #25 but that did not work because Resident #25 refused all of his medications.

Interview with the ED on 11/7/18 at 5:30 pm revealed:
-From time to time the facility admitted residents from behavioral facilities.
-Resident #25 was sent out two times because he was making sexual advances and not taking his medications.
-The first time it was due to sexual advances toward residents and staff.
-The staff did constant redirecting and monitored every 30 minutes of residents with behavioral issues.
-First steps was to redirect the resident.
-Consult with physician about medication modification.
-Notify psychiatry.
-Receive guidance from "corporate."

e. Review of Resident #2's current FL-2 dated 03/07/18 revealed diagnoses included Alzheimer's dementia with behaviors, schizoaffective disorder and major neurocognitive disorder.

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Review of a charting note for Resident #2 dated 05/16/18 at 12:01pm revealed Resident #2 had been putting his hands on and touching female residents.

Review of a charting note for Resident #2 dated 05/26/18 at 9:28pm revealed:
-Resident #2 grabbed and hit female residents and cussed at staff when staff told Resident #2 to leave the female residents alone.
-Resident #2 was also going in other residents' rooms and taking items.
-There was no documentation of increased supervision for Resident #2.

Interview on 10/25/18 at 3:51pm with the medication aide (MA) who documented the charting note dated 05/26/18 at 9:28am revealed:
-Resident #2 got "very violent at times."
-She could not remember who Resident #2 was trying to grab on 05/26/18.
-She could not remember any interventions being implemented for Resident #2 following the incident on 05/26/18.

Review of a charting note for Resident #2 dated 07/16/18 at 9:50pm revealed:
-Resident #2 was in another resident's room, sitting in the other resident's chair.
-Staff attempted to assist Resident #2 out of the other resident's chair when the other resident yelled he was going to kill the [explicit] and pushed Resident #2 down by the head.
-The situation was handled and there were no more problems.

Interview on 10/25/18 at 3:51pm with the MA who documented the charting note dated 07/16/18 at 9:50pm revealed:

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-Resident #2 was threatened (the other resident would kill Resident #2) because Resident #2 went in the other resident's room and sat in the resident's chair on 07/16/18.
-Neither resident was injured.
-There was no need for increased supervision for Resident #2 because both residents were calm once the incident was resolved.

Review of a charting note for Resident #2 dated 08/18/18 at 10:19pm revealed Resident #2 was aggressive on 08/18/18, but not had any sexual misconduct.

Interview on 11/07/18 at 5:10pm with the MA who documented the charting note dated 08/18/18 at 10:19pm revealed:
-When Resident #2 was being aggressive, it meant Resident #2 was hitting, cursing and looking at residents in a mean way which meant Resident #2 would have an angry face.
-Resident #2 would have a fight or defensive posture which meant his chest would be puffed up and his fist clenched like he was ready for a physical fight.
-Whenever Resident #2 was being aggressive and/or sexually inappropriate, staff would usually redirect him by taking him outside and sometimes Resident #2 would redirect himself and go down the hall.
-There was no increased monitoring of Resident #2 on 08/18/18.

Review of a charting note for Resident #2 dated 08/23/18 at 6:59pm revealed Resident #2 was redirected and placed on acute charting for sexual aggression.

Telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25pm revealed:

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-She could not recall the specifics of the note she documented on 08/23/18 for Resident #2.
-Resident #2 had a lot of sexual aggression towards other residents, any female.
-Resident #2 would "touch females on their rear end and say sexual things."
-She would talk to Resident #2 and redirect him.
-Acute charting meant staff monitored the resident each shift for three days and documented a follow up note each shift.
-Monitoring the resident meant staff checked the resident throughout the shift for any behaviors.
-There were no specific time frames for how frequently staff checked Resident #2.

Upon request on 11/06/18, there was no acute charting forms for Resident #2 dated 08/23/18 through 08/26/18.

Review of charting notes for Resident #2 dated 08/23/18 through 08/26/18 revealed there were no charting notes for Resident #2 between 08/24/18 at 2:59pm and 08/26/18 at 9:32pm.

Review of a charting note for Resident #2 dated 08/29/18 at 10:27pm revealed:
-Resident #2 had "exhibited sexual misconduct with two residents."
-Resident #2 was "removed from the residents and monitored throughout this shift."

Interview on 10/25/18 at 3:51pm with the MA who documented the charting note dated 08/29/18 at 10:27pm revealed:
-Resident #2 was probably trying to grab another resident on 08/29/18, because the other resident was usually the one Resident #2 "messed with" meaning trying to grab the resident's "butt".
-Staff checked on Resident #2 that shift to make sure there were no further incidents.

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-There were no specific time frames for how frequently staff checked Resident #2.

Review of Resident #2's August 2018 electronic medication administration record (eMAR) revealed:
-There were no doses of as needed (PRN) Haloperidol or Clonazepam documented as administered on 08/18/18 or 08/23/18. (Clonazepam is used to treat anxiety and Haloperidol is used to treat psychosis.)
-There was no documentation of safety checks for Resident #2.

Review of a charting note for Resident #2 dated 09/12/18 at 6:45pm revealed:
-Resident #2 was "very aggressive toward another resident."
-There was no documentation of safety interventions or increased supervision for Resident #2.

Interview on 11/07/18 at 5:10pm with the MA who documented the charting note dated 09/12/18 at 6:45pm revealed:
-She did not remember the resident involved in the incident documented in her note on 09/12/18.
-She did not know when, but Resident #2 had been on every 30 minute checks for a while.

Upon request on 11/06/18, there was no Supervision & Accountability Check List form (documentation of increased checks) for Resident #2 dated 09/12/18.

Review of Resident #2's September 2018 eMAR revealed:
-There were no doses of Haloperidol or Clonazepam documented as administered on 09/12/18.

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-There was no documentation of safety checks for Resident #2.

Review of charting notes for Resident #2 dated 09/26/18 revealed:
-On 09/26/18 at 4:21pm, staff documented Resident #2 "had behavioral issues and Haloperidol was administered at 1:52pm."
-On 09/26/18 at 5:19pm staff documented Resident #2 "had an altercation with another resident again this afternoon."
-There was no documentation of increased supervision for Resident #2.

Review of an accident/injury report for Resident #2 dated 09/26/18 at 10:00am revealed Resident #2 was involved in a resident to resident altercation.

Review of an accident/injury report for Resident #2 dated 09/26/18 at 4:45pm revealed:
-Resident #2 was involved in a resident to resident altercation.
-Resident #2 was taken to the emergency room (ER) by emergency medical services (EMS) at 4:35pm.

Interview on 10/25/18 at 4:27pm with the MA who completed the accident/injury reports on 09/26/18 at 10:00am and 4:45pm revealed:
-On 09/26/18 at 4:45pm, Resident #2 had an altercation with another resident.
-The altercation was "knowing (Resident #2's name), he probably grabbed her (the other resident)."
-At that time (September 2018), Resident #2 would grab whatever other residents had in their hands whenever they walked by.

A second interview on 11/06/18 at 1:23pm with

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the same MA revealed:
-Resident #2 took a watch from another resident's arm on 09/26/18 which was documented on the incident report as an altercation.
-"Basically all of us (staff)" were trying to get the watch back.
-Resident #2 became combative when staff asked for the watch.
-She could not remember the staff involved in the incident or what happened after Resident #2 became combative because she walked away.
-Resident #2 hitting a second resident had to have happened later in the afternoon on 09/26/18.
-Resident #2 had taken the watch in the morning on 09/26/18.
-She did not recall any interventions or increased supervision for Resident #2 being implemented on 09/26/18.

Interview with the ED on 10/25/18 at 10:35am revealed:
-Resident #2 had taken another resident's watch earlier in the day on 09/26/18.
-Safety interventions for Resident #2 included being seen by the mental health provider (MHP) and there were medication changes.
-She had also been looking into transferring Resident #2 to another facility because the resident's family members wanted Resident #2 to be closer to them.
-Staff managed Resident #2's aggressive behaviors by redirecting the resident and taking him outside to smoke cigarettes.
-There was no increased supervision for Resident #2 on 09/26/18.

Review of a MHP order form for Resident #2 dated 09/27/18 revealed:
-There was an order to discontinue Clonazepam

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1mg daily PRN for agitation, take with Haloperidol 1mg daily PRN for severe agitation.
-There was an order for Clonazepam 1mg three times daily (TID) PRN for anxiety.
-There was an order for Haloperidol 1mg TID PRN for severe agitation and take with Clonazepam.

Interview with a personal care aide (PCA) on 10/31/18 at 3:30pm revealed:
-She was present on 09/26/18,when Resident #2 had taken a watch off of a resident's arm and was trying to fight everybody.
-The ED, the Assistant Care Manager (ACM) in training, the Activity Director (AD) and a MA were all present on 09/26/18.
-There were no other residents in the hall, just Resident #2 and the resident that Resident #2 took the watch from.
-The local police department was called because of Resident #2's behaviors.

Telephone interview with a local Police Officer on 10/30/18 at 6:22pm revealed:
-He had responded to the incident involving Resident #2 on 09/26/18.
-The AD was the main staff he interacted with.
-Resident #2 was in his room and there were 4 to 5 staff standing around the door to his room.
-Each staff confirmed the events that occurred which were documented in the police report.

Review of the police report dated 09/26/18 involving Resident #2 revealed:
-The police department responded to a psychiatric call in which one of the residents was combative towards staff and other residents.
-Staff reported Resident #2 had assaulted one resident.
-The AD informed the Officer that Resident #2

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had struck a resident in the head leaving a red mark and had stolen a watch from a second resident.
-The second resident reported Resident #2 had grabbed the watch she was wearing.
-The watch was found in Resident #2's front left pocket and returned to staff.
-Resident #2 reported that he had not hit anyone and the watch was his.
-Emergency medical services (EMS) arrived, evaluated Resident #2 and transported Resident #2 to the emergency room (ER).

Interview with the AD on 11/01/18 at 11:59am revealed:
-Resident #2 grabbed a watch off of a resident's arm.
-The other resident was not injured, just scared.
-The police were called and ultimately got the watch from Resident #2.
-There were no other residents involved in the incident, just Resident #2.
-There was more than one incident on 09/26/18 involving Resident #2.
-Resident #2 was involved in an incident earlier in the day which occurred in front of her office which was right next to the ED's office.
-She could not remember the details, but thought a second resident leaned into Resident #2's personal space and got a little too close.
-Resident #2 just cussed at the other resident and staff separated them.

Interview with a MA on 11/06/18 at 12:38pm revealed:
-She was working on 09/26/18 and witnessed the incident involving Resident #2.
-Resident #2 had taken another resident's watch and the ED and the AD went to get the watch from Resident #2.

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-Resident #2 became agitated, swinging at the ED and the AD and trying to use his wheelchair to run staff over.

A second interview with the AD on 11/07/18 at 4:36pm revealed:
-There was an altercation between Resident #2 and a resident in front of her office right before Resident #2 went down and took the watch from a second resident.
-Resident #2 must have hit the resident, but the resident only had redness and no bruising.
-She did not know if any safety interventions such as increased supervision was implemented for Resident #2 on 09/26/18.

A second interview with the ED on 11/07/18 at 4:42pm revealed:
-On 09/26/18, the first incident Resident #2 had involved taking the watch from a resident.
-The MHP was at the facility on 09/26/18 and spoke with Resident #2 that day.
-The last incident on 09/26/18 for Resident #2 was when he hit a second resident on her forehead leaving a red mark which was completely gone the next day (09/27/18).
-After the incident when Resident #2 hit a resident, the local police department was notified and Resident #2 was sent to the ER.
-Safety measures implemented on 09/26/18 were the staff removed Resident #2 from the situation and he appeared calm after taking the watch from the resident and just prior to Resident #2 hitting the second resident, Resident #2 had been near the wellness station because the Special Care Manager (SCM) had just brought the resident cigarettes.
-There was no increased supervision for Resident #2 on 09/26/18.

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Review of a charting note for Resident #2 dated 09/27/18 at 5:03pm revealed:
-Staff documented Resident #2 had many altercations with residents...was given PRNs (as needed medications) and still had behavior issues.
-There was no documentation of increased supervision for Resident #2.

Interview on 11/05/18 at 4:41pm with the MA who documented the charting note dated 09/27/18 at 5:03pm revealed:
-She was not really sure what the altercations were on 09/27/18 involving Resident #2.
-It was probably over a cigarette and there was more than one altercation that day.
-Resident #2 would frequently grab at residents walking by him.
-The only interventions for Resident #2's behaviors were medication changes and if the resident was hollering for a cigarette staff would take him out to smoke.
-The cigarettes helped calm Resident #2 down, the medications did not do much to help then, but were helping Resident #2 now.
-There was no increased monitoring of Resident #2 on 09/27/18.

Review of a charting note for Resident #2 dated 10/02/18 at 7:09pm revealed:
-Resident #2 was shaking another resident's wheelchair.
-Resident #2 was asked to stop and then became aggressive toward staff and tried to hit a few staff.
-There was no documentation of increased supervision for Resident #2.

Review of an accident/injury report for Resident #2 dated 10/02/18 at 6:00pm revealed:
-Resident #2 was aggressive and highly agitated.

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-Resident #2 was sent to the ER on 10/02/18 at 7:32am.

Interview on 11/06/18 at 1:23pm with the MA who documented the charting note dated 10/02/18 at 7:09pm revealed:
-There were two incidents on 10/02/18 involving Resident #2.
-Resident #2 was just sitting in his wheelchair and just slid to the floor.
-One hour later, Resident #2 had increased agitation.
-Resident #2 was sent to the ER on 10/02/18 for increased agitation.
-There was no increased monitoring of Resident #2 on 10/02/18.

Review of a charting note for Resident #2 dated 10/04/18 at 6:04pm revealed:
-Resident #2 grabbed a visitor's breast when the visitor walked past the resident.
-Staff explained the behavior was inappropriate and redirected Resident #2 to the opposite direction.
-There was no documentation of increased supervision for Resident #2.

Interview on 10/25/18 at 3:51pm with the MA who documented the charting note dated 10/04/18 at 6:04pm revealed:
-Resident #2 grabbed the breast of a family member visiting another resident.
-The family member "laughed it off" and another MA spoke to Resident #2 about inappropriate touching.
-She was not aware of Resident #2 engaging in any inappropriate touching or sexually expressive behaviors in his room with female residents.
-There was no increased monitoring of Resident #2 on 10/04/18.

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Review of charting notes for Resident #2 dated 10/05/18 revealed:
-At 6:34am, staff documented Resident #2 was aggressive with an employee.
-At 3:34pm, staff documented Resident #2 was hitting other residents and snatching stuff away from them.
-There was no documentation of increased supervision for Resident #2.

Interview on 11/07/18 at 5:10pm with the MA who documented the charting note dated 10/05/18 at 6:34am revealed:
-Resident #2 was just angry with everybody, but he went down to the vending machines and calmed down.
-There was no increased monitoring of Resident #2 on 10/05/18.

Review of charting notes for Resident #2 dated 10/09/18 revealed:
-At 7:01am, staff documented Resident #2 had bad behavior, was touching and trying to hit other residents.
-At 2:35pm, staff documented Resident #2 had been mildly aggressive.
-There was no documentation of increased supervision for Resident #2.

Interview on 11/07/18 at 5:10pm with the MA who documented the charting note dated 10/09/18 at 7:01am revealed:
-Resident #2 liked to get up and go to the front about 6:30am every morning, he was up front blocking females from getting by him and touching their arms the morning of 10/09/18.
-Resident #2 was on every 30 minute checks then (10/09/18) and the incident happened first thing in the morning.

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Interview on 10/30/18 at 4:23pm with the MA who documented the charting note dated 10/09/18 at 2:35pm revealed:
-Mildly aggressive meant that Resident #2 was "mouthing off" and did not hit anyone.
-If Resident #2 had hit someone she would have documented that.
-There was no increased monitoring of Resident #2 on 10/09/18.

Review of a charting note for Resident #2 dated 10/12/18 at 5:50pm revealed:
-Resident #2 was asked to move away from the medication cart and became very aggressive.
-Resident #2 started swinging at other residents and staff.
-Resident #2 picked up a wheelchair to throw and was cussing and threatening people.
-Resident #2 was frightening and unpredictable.
-Resident #2 had 4 medication changes in the last two weeks.
-There was a new order to give Resident #2 Haloperidol in the afternoon.
-There was no documentation of increased supervision for Resident #2.

Interview on 10/31/18 at 4:03pm with the MA who documented the charting note dated 10/12/18 at 5:50pm revealed:
-Resident #2 was very unpredictable, staff just never knew what the resident was going to do.
-Resident #2 had tried to charge at staff and other residents.
-Resident #2 was sitting in his wheelchair both in front of and next to the medication cart in the front hall.
-She asked Resident #2 to move up a little twice and then pushed the residents chair up some.
-Resident #2 became aggressive and started

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swinging at staff and other residents.
-Resident #2 then turned around and picked up his wheelchair like he was going to throw it, then he put it down and was swinging at staff.
-The PCAs came up behind Resident #2 and pushed his wheelchair under him and wheeled him down to his room.
-Resident #2 was still swinging at staff and cursing at staff sitting in his wheelchair.
-She notified the MHP on 10/12/18.
-Resident #2 was on 30 minute checks on 10/12/18, but now the resident was on every 15 minute checks.
-She did not know when the every 15 minute checks started for Resident #2, but thought it had been within the last two weeks (10/15/18).
-Resident #2 had also had some medication changes to help decrease the aggressive behaviors.

Review of a MHP order form for Resident #2 dated 10/09/18 revealed:
-There was an order to add Haloperidol 0.5mg TID at 8:00am, 2:00pm and 8:00pm.
-There was an order to continue PRN Haloperidol for severe agitation.

Review of a Physician's Order Request form for Resident #2 dated 10/12/18 revealed:
-Staff documented PRN Haloperidol 1mg, PRN Clonazepam 1mg and routine Clonazepam was 0.5mg.
-There was an order to give PRN at 11:00am and 3:00pm.
-The order did not specify to give Clonazepam, Haloperidol or both.
-The order did not specify for 10/12/18 or daily at 11:00am and 3:00pm.

Review of Resident #2's October 2018 eMAR

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revealed:
-There were no doses of PRN Haloperidol or Clonazepam documented as administered on 10/12/18.
-There was no entry for Haloperidol 1mg or Clonazepam 1mg at 11:00am and 3:00pm.
-There was no documentation of safety checks for Resident #2.

Upon request on 11/06/18, there was no Supervision & Accountability Check List form for Resident #2 dated 10/12/18.

Review of a charting note for Resident #2 dated 10/13/18 at 6:16am revealed:
-Staff had to stop Resident #2 from "trying to get another resident to help take pants off while in the room."
-There was no documentation of increased supervision for Resident #2.

Interview on 11/07/18 at 5:10pm with the MA who documented the charting note dated 10/13/18 at 6:16am revealed:
-On 10/13/18, a resident was in Resident #2's room and Resident #2 "cornered her off" so she could not get by.
-The resident told staff she had to go to the bathroom and Resident #2 was going to help her.
-She did not remember which resident was in Resident #2's room.
-She had come upon Resident #2 and the other resident because she had just come down to Resident #2's room to check on him.
-The other resident still had her pants on and was redirected to use her own bathroom.
-There was no increased monitoring of Resident #2 on 10/13/18.

Review of Increased Supervision & Accountability

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Check List forms for Resident #2 dated 10/16/18 from 12:00pm through 10/24/18 revealed:
-There was no form for 10/17/18.
-There was no am/pm documented for time entries and there was no documentation from 2:30 - 7:30 (5 hours) on 10/18/18.
-There was no documentation between 1:00am on 10/19/18 and 7:00am on 10/20/18 (6 hours).
-There was no documentation between 10:00pm on 10/20/18 and 7:00am on 10/21/18 (9 hours).
-There was no am/pm documented for time entries and there was no documentation from 7:00 - 6:30 (11.5 hours) on 10/22/18, 10/23/18 and 10/24/18.

Interview with a second PCA on 10/25/18 at 9:16am revealed:
-Resident #2 liked to grab other resident's hands and was sometimes aggressive.
-Aggressive meant someone could have been talking to Resident #2 and he would get loud and swing at the person talking him.
-Resident #2 was aggressive with other residents and his family members.

Telephone interview with Resident #2's MHP on 10/26/18 at 11:09am revealed:
-She had been working with Resident #2 since February or March 2018.
-Prior to September 2018, Resident #2's behavior problems were "sporadic."
-Resident #2 had problems with taking things that belonged to other residents and reaching out and grabbing people.
-Resident #2 started having major problems after the hurricane (September 2018).
-After the hurricane, the MHP made some medication changes and sought out a possible inpatient stay.
-Resident #2 was not accepted for inpatient

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psychiatric care.
-Resident #2's anger, aggression and sexual behaviors including touching and inappropriate comments were unpredictable and difficult to manage because of Resident #2's dementia diagnosis.
-Staff tried to keep Resident #2 away from other residents because "he was a big man."
-Staff tried to have Resident #2 sit out in the common area or activity room where he could be seen.
-Staff reported they tried redirection and distraction for Resident #2 by taking him outside to look at the gardens and talking to him.

Observations on 10/25/18 from 12:00pm until 1:22pm revealed:
-Resident #2 was not in the dining room for the lunch meal from 12:00pm -12:10pm.
-Resident #2 was sitting on his bed, with his head leaned over onto his pillow and his feet on the floor from 12:11pm through 1:22pm.
-No staff checked on Resident #2 from 12:11pm through 1:22pm.

Review of an Increased Supervision & Accountability Check List form for Resident #2 dated 10/25/18 revealed:
-Staff documented Resident #2 was in the dining room at 12:00pm and 12:30pm.
-Staff documented Resident #2 was in the hallway at 1:00pm and 1:30pm.

Interview with the ED on 11/02/18 at 12:25pm revealed:
-Staff had been trained to redirect Resident #2 when he was being aggressive or sexually inappropriate.
-Staff had been instructed to tell Resident #2, "That's not appropriate, please don't touch me."

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-Resident #2's MHP had been notified and there had been medication changes.
-There has been improvement in Resident #2's behavior since the medication changes were made.
-It had been since approximately 10/10/18 since an improvement in Resident #2's behavior had been seen.
-Resident #2 should have received PRN medication for episodes of aggression if it was within the ordered timeframe.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

2. Review of the facility's accident/falls/emergency and fire safety policy and fall packet checklist revealed:
-After a resident fall, the medication aide (MA) was to assess the resident, perform range of motion, and obtain vital signs.
-If the resident hit their head it was mandatory they go to the emergency room (ER).
-Call and notify the doctor and responsible party of fall and how it happened.
-Fill out physician order sheet stating fall and how it happened...attach a fax confirmation to the order and place under Special Care Coordinator's (SCC) door.
-Fill out an incident report and put under the SCC's door.
-Start 72 hour falls sheet.
-Place resident's record in "hot box".
-Place in communication book.
-Give report to your staff and oncoming staff.
-Do 30 minute checks.
-Call the on-call person listed on assignment sheet.
-The SCC follow-up included calling the family,

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speak with the primary care provider (PCP) about interventions, scan and fax the incident report to the facility's nurse and social services.
-This sheet should be done and turned in with the 72 hour fall follow-up sheet to the Executive Director (ED) after the 72 hour sheet was completed.

Interview with a MA on 11/05/18 at 4:58pm revealed:
-The 72 hour falls follow-up reports should be completed each shift for 72 hours after each fall.
-The MAs were supposed to document the information on the forms.
-She did not know why the 72 hour forms were not done or incomplete for some of the residents.
-After the 72 hour monitoring was complete, a resident would continue to be on routine 30 minute checks.

Interview with a second MA on 11/07/18 at 2:15pm revealed:
-For unwitnessed falls, the MAs were responsible to check the resident and make sure there was no bleeding and if the resident appeared okay, complete an accident and incident report.
-If the resident appeared to have an injury, the MA called emergency medical services (EMS) and the resident was not moved until EMS arrived and moved the resident.
-The MA was responsible for notifying the resident's PCP and the family member.
-The MA was responsible for completing the accident/incident report and initiating the 72 hour falls sheet.
-The 72 hour monitoring was not started until a resident returned from the hospital if the resident was sent out.
-Completed 72 hour sheets were given to the ED.
-Staff performed 30 minute checks all the time on

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the "walkers," residents that were ambulatory, or the residents staff knew fell a lot.

Interview with the ED on 11/09/18 at 11:48am revealed:
-The current SCC and the Special Care Manager (SCM) were responsible for following the falls protocol since October 2018.
-For the past 1 to 1 ½ months, the SCC and SCM had been implementing the 72 hour falls report forms.
-A 72 hour falls report was supposed to be done for any fall.
-The 72 hour falls sheets were supposed to be completed by the MAs and forwarded to the SCM.
-She usually had a falls meeting with the physical therapy/occupational therapy (PT/OT) group the first week of the month and documented on a form the results of the meeting, including any interventions.
-All residents were on 30 minute routine checks.
-They did not document routine 30 minute checks for residents.
-If a resident's supervision was increased, it would be noted on the medication administration records (MARs) and the MAs would document the checks on the MAR and the charting notes.

Interview with the Corporate Registered Nurse Clinical Instructor on 11/09/18 at 5:20pm revealed:
-The facility was supposed to have a monthly falls management team meeting.
-The meeting was supposed to be attended by the care managers (SCC and SCM), the ED, one direct caregiver, and the therapy group.
-The falls team was supposed to review the incident reports for falls each month and the 72 hour falls monitoring reports.

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-The monthly meetings were occurring but not all suggested participants were attending the meetings.
-The care managers had not been participating in the meetings and she was not sure why.
-The documentation from the monthly falls meetings were considered internal documents and were not available for review.
-The content of the meetings were supposed to include any recommendations for interventions.
-She had reviewed the monthly internal documents for the monthly falls team meetings and the meetings were not being conducted and documented consistently according to the facility's protocol.
-She did not know why the falls meeting were not being conducted according to the facility's protocol.
-They would be retraining staff on the falls team meeting and all suggested participants would be present at the meeting.
-A system would be put in place to assure interventions for falls would be implemented and documented.

Interviews with the SCC on 11/06/18 at 9:27am and 9:42am revealed:
-Staff were supposed to complete the resident 72 hour fall assessment form every shift for 72 hours after any fall.
-Staff were supposed to complete all sections of the 72 hour fall reports but there were some 'holes and gaps" in the documentation.
-She was not sure if there was a system to check to make sure the 72 hour fall reports were completed as required.
-The 72 hour fall reports should be reviewed monthly by the falls team which included the ED, a care manager, and the PT/OT provider.
-She did not know if the monthly fall meetings had

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been done.
-She had not participated in any monthly fall meetings.

Interview with the SCM on 11/09/18 at 5:28pm revealed:
-They were supposed to have falls team meetings every month.
-The care managers (SCC and SCM), the ED, and the therapy group were supposed to participate in the meetings.
-She had not participated in any monthly falls team meetings since she had been at the facility.
-She did not participate in the meeting because she had not been asked to attend the meeting.
-The last falls team meeting was this month (11/2018).

a. Review of Resident #14's current FL-2 dated 04/20/18 revealed diagnoses included vascular dementia, abnormal posture, paroxysmal atrial fibrillation, heart failure, cerebral vascular accident, dysphagia, hemiplegia and hemiparesis.

Review of Resident #14's current care plan dated 04/24/18 revealed:
-Resident #14 was ambulatory with assistance or device.
-Resident #14's right upper extremity was affected.
-Resident #14 was incontinent of bowel and bladder.
-Resident #14 was sometimes disoriented and forgetful.
-Resident #14 was totally dependent on staff for assistance with bathing, dressing, toileting, transfers and mobility.

Review of a Physician's Order Request form for

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Resident #14 dated 04/05/18 revealed:
-Staff documented Resident #14 was found on the floor in her room.
-Resident #14 complained of head and bilateral shoulder pain.
-Resident #14 was sent to the emergency room (ER).
-Resident #14's primary care provider (PCP) signed the form on 05/14/18.

Upon request the ER discharge instructions for 04/05/18, were not available for review.

Review of an Accident/Injury Report for Resident #14 dated 04/05/18 at 4:08am revealed:
-Resident #14 was observed on the floor screaming and complaining of right and left shoulder pain.
-The locations of injury were at the left front of the head, left back of head, right shoulder and left shoulder.
-There were no bruises on Resident #14 prior to emergency medical services (EMS) transport to the ER.
-The ER diagnosed Resident #14 with a closed head injury.

Attempted interview on 11/08/18 at 8:01pm with the medication aide (MA) documented as discovering the incident on the accident/incident report dated 04/05/18 at 4:08am, was unsuccessful.

Review of a Physician's Order Request form for Resident #14 dated 05/01/18 revealed:
-There was a request for a fall mat at bedside.
-There was a line marked through the request and no was written next to the request.
-Resident #14's PCP documented the resident was receiving physical and occupational therapy

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for fall prevention.
-The PCP signed to request on 05/07/18.

Review of a PCP visit note for Resident #14 dated 05/07/18 revealed:
-Staff reported Resident #14 fell in her room and complained of head and bilateral shoulder pain on 05/03/18.
-Staff requested a fall mat, but due to Resident #14's ambulatory status a fall mat might have posed a tripping hazard.

Review of a Physician's Order Request form for Resident #14 dated 05/03/18 revealed:
-The Home Health Nurse (HHN) documented Resident #14 was admitted for home health services.
-There were orders for physical therapy and occupational therapy evaluation and treatment.

Review of ER discharge instructions for Resident #14 dated 05/05/18 revealed Resident #14 was seen for a fall with no obvious injury.

Review of charting notes for Resident #14 revealed there were no charting notes dated 05/03/18 through 05/08/18.

Upon request an Accident/Injury Report for Resident #14 dated 05/04/18 - 05/05/18 was not available for review.

Review of a charting note for Resident #14 dated 05/10/18 at 7:27am revealed Resident #14 was sent to the ER for a fall in her room the morning of 05/10/18 and had a bump on her forehead.

Attempted interview on 11/08/18 at 8:01pm with the MA who documented the charting note dated 05/10/18 at 7:27am, was unsuccessful.

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Review of an Accident/Injury Report for Resident #14 dated 05/10/18 at 12:08am revealed:
-Resident #14 was observed laying on the fall mat with her head under the bed rail.
-Resident #14 had a bump/swelling to her forehead.

Review of an ER discharge summary for Resident #14 dated 05/10/18 revealed:
-Resident #14 was seen for an unwitnessed fall and had vomiting in route to the ER.
-Resident #14 had a right forehead hematoma.
-Resident #14 reported to ER staff that she fell getting out of bed that morning.
-Facility staff reported Resident #14 cried out for help right away.
-Resident #14 had residual left sided deficits from a prior stroke.
-Resident #14 was diagnosed with a closed head injury.

Review of a Physical Therapy note for Resident #14 dated 05/10/18 revealed staff reported Resident #14 rolled out of the bed last night and was sent to the ER.

Review of a Physician's Order Request form for Resident #14 dated 05/10/18 revealed:
-Staff documented Resident #14 was sent to the ER for a fall in her room on her fall mat.
-Resident #14's PCP documented a fall mat was not ordered for Resident #14 and the resident would be seen that day.
-The PCP signed the form on 05/14/18.

Review of a charting note for Resident #14 dated 05/13/18 at 4:01am revealed:
-Resident #14 was sent to the ER for a fall on her fall mat in her room.

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-Resident #14 complained of back and neck pain.
-Resident #14 had an old skin tear on her right arm that reopened.

Attempted interview on 11/08/18 at 8:01pm with the MA who documented the charting note dated 05/13/18 at 4:01am, was unsuccessful.

Review of an Accident/Injury Report for Resident #14 dated 05/13/18 at 3:02am revealed:
-Resident #14 was observed laying on the fall mat in her room.
-Resident #14 had an old skin tear reopen due to the fall.

Review of an ER discharge summary for Resident #14 dated 05/13/18 revealed:
-Resident #14 was seen for a fall.
-Resident #14 had a right elbow skin tear and multiple stages of healing bruises to her face and extremities.
-A computed tomography (CT) scan of Resident #14's head showed a subdural hygroma (a collection of spinal fluid developing after chronic subdural hematomas) and decreasing right forehead scalp hematoma.
-Resident #14 was prescribed dexamethasone (a steroid used to decrease swelling around the brain).

Review of a Physician's Order Request form for Resident #14 dated 05/14/18 revealed there was a PCP order for a personal body alarm to be worn in the wheelchair, chair and bed.

Review of Physician's Orders for Resident #14 dated 05/14/18 revealed there were orders for a low bed with a fall mat, a pressure alarm when in bed or chair and a standard manual wheelchair.

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D 270	Continued From page 109 Review of a charting note for Resident #14 dated 05/22/18 at 10:41am revealed: -Resident #14 fell out of her wheelchair onto the floor on her right side. -Resident #14 hit the right side of her head and complained of right hip pain. -Resident #14 was sent to the ER. The MA who documented the charting note dated 05/22/18 at 10:41am was not available for interview on 11/07/18 and 11/09/18. Review of an Accident/Injury Report for Resident #14 dated 05/22/18 at 10:10am revealed: -Resident #14 fell out of her wheelchair onto the floor on her right side. -The location of injury was at the head. -There was a check mark to document bruising under type of injury. Review of ER discharge instructions for Resident #14 dated 05/22/18 revealed Resident #14 was seen for a fall. Review of a Physical Therapy note for Resident #14 dated 05/22/18 revealed Resident #14 had returned from the ER after a fall from her wheelchair and had a bruise on her face. Review of a Hospice Communication Note for Resident #14 dated 05/23/18 revealed: -Resident #14 was seen for evaluation and admission for hospice services. -Resident #14 was bed bound and required two staff for assistance with transfers to and from bed to a wheelchair due to muscle weakness. -Resident #14 was unable to raise her left arm without assistance. -Resident #14 was frequently confused and disoriented.	D 270		

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-Resident #14 had multiple bruises on her face, both arms and both legs.
-Resident #14 had old skin tears on both elbows and superficial abrasions to both knees.

Review of a 72 Hour Follow Up on Resident Fall forms for Resident #14 dated 05/22/18 through 05/23/18 revealed:
-There was no was no post fall monitoring documentation for 6 of 9 shifts.
-There was partial documentation for 2nd shift on 05/22/18.

Review of a hospice order for Resident #14 dated 05/30/18 revealed orders for a low hospital bed, fall mat and bed alarm due to multiple recent falls and a wheelchair due to decreased ability.

Review of a Nurse's Note for Resident #14 dated 06/21/18 at 5:00am revealed:
-The Hospice Nurse (HN) documented an as needed visit for a fall.
-Staff reported Resident #14 rolled out of bed and there was no obvious signs of trauma.

Telephone interview with the HN on 11/09/18 at 8:51am revealed:
-He could not remember the specifics of the note dated 06/21/18.
-If he had written a note, it meant the facility had notified hospice of a fall and the HN went out to see the resident.
-It was not unusual that incidents were not documented by facility staff.

Review of a PCP visit note for Resident #14 dated 06/25/18 revealed:
-On 06/24/18, the HN reported Resident #14 had been falling a lot lately.
-Staff had not reported any falls to the PCP.

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-Fall interventions in place included a low bed with a fall mat and a pressure mat alarm.

Review of a charting note for Resident #14 dated 08/16/18 at 1:44pm revealed Resident #14 fell out of bed the morning of 08/16/18 and was sent to the ER.

Review of an Accident/Injury Report for Resident #14 dated 08/16/18 at 6:20am revealed:
-Resident #14 was found lying on her back on the floor.
-The location of injury was at the head.
-There was a check mark documenting a laceration under type of injury.

Interview with a personal care aide (PCA) on 11/07/18 at 2:35pm revealed:
-She had found Resident #14 on the morning of 08/16/18 while doing rounds.
-Resident #14 was lying crosswise on the fall mat next to her bed and bleeding from her head.
-Resident #14 fell on the fall mat and must have moved off of the fall mat and hit her head on something.
-She did not know what Resident #14 could have hit her head on because there was no bedside table or dresser near the resident's bed.
-When she found Resident #14 on the morning 08/16/18, the resident was "scooting like she was trying to get on the mat."
-She notified the MA, they put a cloth on Resident #14's head and waited for the EMS.
-Resident #14 was not ambulatory, she needed at least one staff to assist with transfers to and from her wheelchair.
-She was not aware of any new fall prevention interventions put in place for Resident #14 after the fall on 08/16/18.

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Review of ER discharge instructions for Resident #14 dated 08/16/18 revealed:
-Resident #14 was seen for multiple falls.
-Resident #14 sustained a facial laceration requiring sutures, right elbow skin tear and a closed head injury.

The MA who documented the charting note dated 08/16/18 at 1:44pm was not available for interview on 11/09/18.

Interview with Resident #14's PCP on 11/05/18 at 10:35am revealed:
-Resident #14 fell on 08/16/18 and sustained a laceration on her forehead that required sutures.
-The staff reported Resident #14 fell onto the floor mat and injured her forehead.

Review of a Physician's Order for Resident #14 dated 08/16/18 revealed an order to discontinue the fall mat at bedside and remove the fall mat from Resident #14's room.

Review of a charting note for Resident #14 dated 08/17/18 at 4:05pm revealed Resident #14 was found on the floor mat the afternoon of 08/17/18 with no injuries.

The MA who documented the charting note date 08/17/18 at 4:05pm declined interview on 11/09/18 at 3:00pm.

Review of a 72 Hour Follow Up on Resident Fall forms for Resident #14 dated 08/16/18 through 08/19/18 revealed:
-There was no post fall monitoring documentation for 5 of 9 shifts.
-There was partial documentation for 1st shift on 08/16/18.

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Review of a PCP visit note for Resident #14 dated 08/20/18 revealed:
-On 08/16/18, the HN reported Resident #14 had three falls and was increasingly agitated.
-The HN also reported the fall mat was a safety hazard and the falls were caused by Resident #14 attempting to get up and tripping over the mat.
-Under the Plan there was an order for hospice to provide a concave mattress for fall prevention.

Review of a charting note for Resident #14 dated 09/04/18 at 2:48pm revealed Resident #14 had a new right elbow skin tear.

The MA who documented the charting note date 09/04/18 at 2:48pm declined interview on 11/09/18 at 3:00pm.

Review of a 72 Hour Follow Up on Resident Fall forms for Resident #14 dated 09/03/18 through 09/05/18 revealed:
-There was a circle around 2nd, documenting a fall occurred on 2nd shift on 09/03/18.
-There was no post fall monitoring documentation for 3 of 9 shifts.

Review of a PCP visit note for Resident #14 dated 09/10/18 revealed:
-On 09/04/18, the HN notified the PCP that Resident #14 experienced a fall the previous night (09/03/18 - 09/04/18) and sustained skin tears and trauma to both knees.
-The HN reported the fall mat which was ordered to be removed from the room (on 08/16/18) was still tucked under Resident #14's bed.
-It was likely Resident #14's fall reported on 09/04/18, was precipitated by the resident tripping over the fall mat when trying to get out of bed.

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D 270	Continued From page 114 Telephone interview with a second PCA on 11/08/18 at 8:02pm revealed: -Resident #14 did not sit back in her wheelchair and would fall from her wheelchair. -Resident #14 was not able to walk, the resident was "kind of paralyzed on one side." -Resident #14 still tried to do things on her own. Telephone interview with a third PCA on 11/09/18 at 5:04pm revealed: -Resident #14 had a fall mat which was already out when the PCA arrived at work for 3rd shift. -Resident #14 did have an issue with tripping over the fall mat. -Resident #14 would try to get up and walk, loose her balance and fall. -On 08/16/18, another PCA had gotten Resident #14 up out of the bed and put the resident in her wheelchair. -Resident #14 tried to stand up from her wheelchair and fell. **REFER TO TAG 9999 (PAGE 398) FOR CONTINUED FINDINGS FOR TAG 270**	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for acute and routine health care needs were met for 4 of 8 sampled residents (#1, #2, #4, #13) related to failing to send Resident #1 to the emergency room after being found in a male resident's room and failing to notify the primary care provider (PCP) that a urinalysis and culture had not been sent for testing; failing to notify the PCP of a productive cough and cold symptoms and failed to send an x-ray result that was positive for a fracture for Resident #4; failing to notify Resident #13's PCP of the resident drinking liquid body wash; and failing to report Resident #2's rectal bleeding to the PCP.

The findings are:

1. Review of Resident #1's current FL-2 dated 08/09/18 revealed:
-Diagnoses included Alzheimer's disease, frontal dementia, panic disorder, insomnia and history of pituitary adenoma.
-The resident was constantly disoriented and wandered.
-The resident was ambulatory.

Review of Resident #1's assessment and care plan dated 03/26/18 revealed:
-The resident was ambulatory, wandered, disoriented and had significant memory loss requiring direction.
-The resident required extensive assistance from staff to put on her clothing, socks and shoes and limited assistance from staff to remove clothing.

a. Review of Resident #1's primary care provider's (PCP's) visit note dated 10/08/18

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revealed:
-The reason for the visit included allegations of "possible sexual behavior" and a visit to the emergency room, reports of agitation abrasions and bruises to the left arm.
-On 10/03/18, the PCP received a telephone call from the facility, reporting the resident was found in a male resident's bed with her incontinent brief pulled down and bruising between her legs.
-The PCP ordered the caller to notify law enforcement and send Resident #1 to the emergency room (ER) for evaluation. Additional phone calls followed, questioning if Resident #1 "really" needed to go to the ER, and stating that the resident's injuries were "really not as bad" as originally reported.
-Although, the PCP insisted on notifying law enforcement and sending Resident #1 to the ER, facility staff chose to do neither, reportedly on the advice of their Corporate Regional Director.
-On 10/04/18, Resident #1 was reportedly experiencing "altered mental status" for which she was sent to the ER for evaluation. The ER staff were not made aware of the allegations made on the previous day, and therefore did not examine Resident #1 in regards to that concern. Resident #1 was sent back to the facility with no new orders and very limited hospital documentation.

Interview with Resident #1's PCP on 10/25/18 at 3:58 p.m. revealed:
-The resident had vascular dementia.
-On 10/03/18, at 10:58 a.m., Special Care Coordinator (SCC) called stating the facility ED had instructed her to call to report the following: "patient was found in [a male resident's] bed with her incontinent brief down and bruising between her thighs". The ED wanted the PCP to come to the facility immediately and do a "rape kit".

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-The SCC was advised that performing a rape kit was not in her scope of practice and gave orders to send the resident to the ER and to notify local law enforcement.
-The PCP also notified her provider's office.
-On 10/03/18 at 11:12 a.m., the Special Care Manager (SCM) called questioning the orders that were just given to the SCC. The SCM reported that she just did a "full skin check" on the resident and there was no bruising after all.
-The SCM was instructed that due to the conflicting information, previous and recent suspicious bruising on this resident to err on the side of caution and send the resident to the ER as ordered.
-On 10/03/18 at 11:33 a.m., the SCM called again and stated that she "wants to make sure" the resident should be sent to the ER. Again, the PCP reiterated, the resident should be sent to the ER for evaluation.
-At 11:41 a.m., the PCP received a phone call from the facility's Regional Protocol Registered Nurse who informed the PCP that the appropriate procedure for handling situations such as this one was to send the resident to the ER and to notify law enforcement. The facility's Regional Protocol Registered Nurse was told that this order had been given multiple times and to do just that.
-The PCP called the facility to get a status update on the resident from the ER visit on 10/03/18 at 3:03 p.m. The PCP was told by the SCM that the Regional Director of Operations (RDO) had instructed the facility staff not to send the resident to the ER as ordered.
-The SCM reported that the RDO "looked at the cameras" and made the decision that there was no need for the resident to be examined.
-The SCM told the PCP that there were no cameras inside of the residents' rooms and this determination was made based on video

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recordings from cameras in the common areas of the facility.
-On 10/04/18, the PCP received notification from the facility that the resident was sent to the ER for "altered mental status", however, the ER was not made aware of the allegations made on 10/03/18 and an exam was not done in response to the alleged incident on 10/03/18.

Review of Resident #1's electronic "Charting Notes" revealed there were no charting notes that documented the resident was found in a male resident's bed with her incontinent brief pulled down and bruising between her legs.

Interview with the SCC on 10/25/18 at 5:00 p.m. revealed:
-There was an incident on 10/03/18 involving Resident #1.
-A MA had reported Resident #1 had walked into a male resident's room while she was doing her morning medication pass.
-Resident #1 was the last resident found for the morning pass and was found in a male resident's room.
-The MA "directly" reported to the ED Resident #1 was found in the male resident's room.
-There had been no reports made to her that another resident was in the male residents' room except for Resident #1.
-She was told Resident #1 was found lying in a males resident's bed with a shirt on covered with a blanket.
-She knew Resident #1's PCP was notified about the incident on 10/03/18 and it was not ever sure to us (staff) who contacted the provider, "the whole thing exploded fast".

A second interview with the SCC on 11/01/18 at 11:48 a.m. revealed:

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-She remembered that she did call Resident #1's PCP after the MA reported finding Resident #1 in the male resident's bed and told the PCP the ED was going to watch the video footage from the facility's camera and would contact her with further information.
-The PCP told the SCC to let her know if she needed to do anything.
-The RDO said not to send Resident #1 out to the ER.
-When a verbal order was given it was expected that staff wrote down the order and read the order given back to the PCP.
-Resident #1's PCP did not give her an order to send the resident to the ER.
-She did call Resident #1's PCP on 10/03/18 and told the facility was starting an investigation.
-If Resident #1's PCP had given her an order to send the resident to the ER then she would have "overrode" any decision not to send the resident out and would have sent her out anyway.
-She called Resident #1's PCP and told her that Resident #1 was not sent out, the PCP did not say anything, did not ask why the resident was not sent to the ER and the PCP never came out to the facility.

Interview with the SCM on 10/25/18 at 5:25 p.m. revealed:
-She was told about Resident #1 wandering into resident room 217 on 10/03/18 by the ED.
-She was told Resident #1 got into a named male resident's bed.
-On 10/03/18, the first shift PCAs had got all the residents up for breakfast and the PCAs saw Resident #1 in the bed of a named male resident (room 217).
-The MA told the ED when she went into the male resident 's room that Resident #1 was asleep.
-The MA reported Resident #1 had on a shirt and

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incontinent briefs with no pants on and was covered up with a white sheet.
-The ED contacted Resident #1's PCP and family.
-The PCP did not give any orders for Resident #1 that she knew of.

Interview with a personal care aide (PCA) on 10/30/18 at 11:28 a.m. revealed:
-On 10/03/18, she and another PCA (named) were checking their "last rounds" that morning to assure all residents were up before breakfast on the 200 hallway.
-Resident #1 was found in resident room 217 during their last rounds, asleep in a named male resident's bed with a "T-shirt" and an incontinent brief on; there was no other resident in resident room 217 with Resident #1.
-Resident #1 was left in resident room 217 because she was asleep.
-She was not certain how long Resident #1 was in the room and if she and the other PCA were the first staff to find Resident #1 in resident room 217.
-She was questioned about the incident later in the day and spoke with the ED on 10/03/18 about finding Resident #1 in the male residents' room.
-She remembered that someone (staff) said "rape" but she was not sure who that was, "I was confused".
-She didn't know if Resident #1's PCP was contacted.

Interview with a second PCA on 10/30/18 at 4:05 p.m. revealed:
-She was on duty on 10/03/18; her shift started at 7:00 a.m.
-She remembered when she first started her shift that day (10/03/18) she had checked all of the resident rooms from resident rooms 212 to 217 and all the residents were up and out of their

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rooms.
-Just before breakfast on 10/03/18 she and another PCA (named) went looking for Resident #1 and found her in the named male resident's bed, room 217 asleep around 7:30 a.m.
-Resident #1 would not get up so they left her there and went back into the dining room to assist the other residents.
-She assisted one of the named male residents assigned to room 217 out of the dining room after breakfast and back down the hall, left him in the hallway at the door of room 217 and Resident #1 was still asleep in the named male resident's bed.
-She woke Resident #1 up and Resident #1 started cursing at her.
-Resident #1 had on an incontinent brief, shoes, and a shirt with a blanket covering her.
-Resident #1 was "wet" with a bowel movement.
-She took Resident #1 to the bathroom and cleaned the resident.
-Resident #1 did not have any bruises on her thighs, no blood "didn't see nothing" unusual.
-She didn't know if Resident #1's PCP was contacted.

Interview with a MA on 10/31/18 at 4:04 p.m. revealed:
-She worked on 10/03/18.
-She remembered that she was looking for Resident #1 during the morning medication pass and thought the time was between 8:30 a.m. - 9:15 a.m. but could not remember exactly.
-The MA and the Activity Director (AD) went down the 200 hallway and found Resident #1 in the named male resident 's bed.
-Resident #1 was just lying in bed with a shirt, and an incontinent brief on.
-Resident #1 was drowsy when she found her.
-She had Resident #1 to sit on the side of the bed to take her medication.

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-She thought she saw a bruise when Resident #1 sat on the side of the bed on her inner thigh but it was not a bruise because when the resident was cleaned up later on 'the area came right off".
-She let the SCC know where she had found Resident #1 while the AD stayed at the door because she wanted to let someone else know where she had found Resident #1.
-She could not remember if she told the SCC about the area that she thought was a bruise on Resident #1's inner thigh and was not sure if she reported the stained area that she initially thought was a bruise.
-She did not call Resident #1's PCP but the ED might have called because she knew the PCP had been notified.
-She was not sure what was reported to the PCP or if an order was given to send Resident #1 to the ER.
-She remembered the RDO came to the facility before noon on 10/03/18 and told her "you said she was raped" and she replied "oh no, I didn't, don't know who told you that".
-She thought one of the PCAs said that (rape) but did not remember exactly which one.

Review of additional electronic 'Charting Notes" for Resident #1 dated 11/09/18 at 11:40 a.m. as a late entry from 10/03/18 by the SCC revealed:
-On 10/03/18 she notified the resident's PCP that an investigation would be started because the resident was found sleeping in another resident's room.
-The PCP asked to be informed when the investigation had been completed.
-The RDO came in when the investigation had been completed and stated that there was no incident or injury and we did not need to send the resident to the ER.
-The Special Care Manager (SCM) called the

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physician and gave her the updates and told the PCP the resident was not sent out.

Interview with the SCM on 11/07/18 2:27 p.m. revealed
-She normally documented every single thing but didn't document the incident that occurred with Resident #1 on 10/03/18.
-She asked should she document the incident and was told no that there would be a file regarding the incident with Resident #1 on 10/03/18.
-She was not sure why she didn't document any of her own documentation.
-She remembered that day (10/03/18) was chaotic.

Interview with the Regional Protocol Registered Nurse on 11/01/18 at 3:15 p.m. revealed:
-The facility contacted him on 10/03/18 in the morning around 11:00 a.m. and 12 noon and reported Resident #1 was found in a male resident's room and all the resident had on was an incontinent brief and T-shirt.
-He was told the PCP had already been notified.
-He called the PCP himself and explained what had been reported to him.
-He was informed by the PCP if the resident needed to go out then to send her out to the ER.
-He could not make that call because he had not been in the building.
-He called the ED, RCM and SCC and told them the PCP wanted Resident #1 sent to the ER, it was thought if Resident #1 needed to go out to send her if she needed to go.
-The RDO thought it was the staffs' discretion to send Resident #1 to the ER.
-He was not sure if the RDO ever talked to Resident #1's PCP.
-If an order was received to send Resident #1 to

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the ER, staff should have written a verbal order.
-He understood Resident #1's PCP called after 3:00 p.m. on 10/03/18 and spoke with the SCM (he thought) questioning if the resident was sent to the ER and was informed "no" the resident was not sent out. The PCP did not say that Resident #1 should have been sent out, "nothing at all".

Review of additional electronic 'Charting Notes" for Resident #1 dated 11/09/18 at 11:13 a.m. as a late entry by the facility's Regional Protocol Registered Nurse revealed:
-The entry was labeled as a late entry from 10/03/18.
-During a phone conversation with Resident #1's PCP, the PCP stated that she had spoken with the facility to send the resident out for a "wellness check" since the resident was found in another resident's room sleeping.
-He told the PCP follow-up would be done with the facility to assure an investigation was completed to find out what was going on.
-Staff found some dried stool on the resident's inner leg but no other marks or injuries were noted on the body assessment.
-They had contacted the resident's PCP and made her aware of the updated assessment findings.
-When the RDO left he called and stated that it was his understanding when he arrived at the facility that Resident #1's PCP said that it would be at the facilities discretion to send the resident out since there was no sign of any incident or injury.

Interview with the ED on 10/31/18 3:38 p.m. revealed:
-The MA (named) who saw Resident #1 in the male resident's room at first said there was bruising between Resident #1's legs but it was

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"bowel movement" which was discovered when the PCA took Resident #1 to the bathroom and cleaned her up.
The MA and the Assistant MCM in training completed a body assessment and there was no bruising between Resident #1's legs on 10/03/18.
-She did not know an order was given by the PCP to send to the ER.

Interview with the Vice President of Quality Assurance and Regulatory Compliance on 11/09/18 at 5:20 p.m. revealed:
-She was contacted by the Regional Protocol Registered Nurse when he was talking back and forth with the PCP on 10/03/18.
-The PCP did not give an order but instructed staff to use your best judgment if she Resident #1 needed to be sent out.
-The dictated notes from Resident #1's PCP dated 10/08/18 related to the incident on 10/03/18 were not accurate because the incontinent brief was intact and the brown substance on Resident #1 was a small amount of dried stool.
-When incidents occurred, typically the facility would send the resident out for a wellness check; and contact the guardian and call the PCP, but with Resident #1 there was no incident.

Interview with Resident #1's PCP on 10/25/18 at 3:58 p.m. revealed:
-It was the PCP's professional opinion that Resident #1 should have been absolutely examined in the ER given the conflicting reports by staff on 10/03/18.
-No orders were ever given to the facility to disregard the orders to send the resident to the ER.
-Because Resident #1 had not been examined in the ER as ordered on 10/03/18 there was loss of evidence if the resident has been sexually

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assaulted.

Interview with Resident #1's PCP on 11/05/18 at 10:32 a.m. revealed:
-She was contacted by the ED on 11/01/18 at 12:15 p.m. and was placed on the speaker phone with the facility's corporate nurse and the SCM in the room.
-She was asked a series of questions regarding the alleged "rape" on 10/03/18.
-She was never asked if any additional follow-up was needed for Resident #1 regarding the incident that occurred on 10/03/18.
-The Regional Protocol Registered Nurse asked her if at any time was it suggested that Resident #1 did not have to follow-up in the ER or call local law enforcement and she responded "absolutely not", the order given should have been followed.

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

Attempted telephone interview with Resident #1's family member was unsuccessful on 10/26/18 at 4:00 p.m. and 11/05/18 at 5:24 p.m.

b. Review of a physician's order for Resident #1 with a handwritten entry with a faxed date of 09/10/18 on the bottom of the form revealed to collect a clean catch urine specimen and deliver to the hospital for a urinalysis (a test to show bacteria or blood in the urine) with a culture and sensitivity (a test used for urinary tract infections and to identity the bacteria or yeast causing the infection in the urinary tract).

Review of Resident #1's laboratory results revealed there were no results for a urinalysis and culture sensitivity for the order dated 09/10/18.

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Interview with the Special Care Coordinator (SCC) on 10/30/18 9:10 a.m. revealed:
-She thought Resident #1's urine could not be collected on 09/11/18, but she was not sure.
-The medication aides (MAs) or the Assistant Care Manager (ACM) in training would have been responsible to call the PCP if Resident #1's urine could not be collected within a day or two.

Review of Resident #1's primary care provider's (PCP's) "Patient Notes" dated 10/30/18 at 12:45 p.m. revealed:
-The Special Care Manager (SCM) contacted the PCP and stated "remember when you ordered a UA (urinalysis)" on Resident #1 during the hurricane and staff could not "do it" because the hospitals were closed and "everyone was closed and I notified you".
-The SCM was informed that a urinalysis had been ordered on 09/10/18 and she notified the PCP it was not done on 09/22/18.

Review of Resident #1's electronic "Charting Notes" revealed on 09/23/18 at 12:33 a.m., there was documentation by the SCM the resident's PCP was notified that the urinalysis she had requested (ordered) could not be picked up by a local lab provider due to the flooded areas and once the area cleared up the urine would be collected.

Further review of Resident #1's electronic "Charting Notes" revealed there was no other documentation related to the order for the urinalysis with the culture and sensitivity ordered by the PCP on 09/10/18.

Review of Resident #1's electronic "Charting Notes" revealed:

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-On 09/27/18 at 1:16 p.m., there was documentation by the SCM the resident appeared to be lethargic, pale in color and mumbled when she was spoken to which was unusual for her.
-The resident had not voided since first shift yesterday when assisted to the bathroom.
-The resident stated that she felt like she had to void but could not.
-The resident was sitting on the side of her bed feeling too tired to get up to go eat which was unusual for her.
-She was very active last night around 10:00 p.m. prior to going to bed.
-She was shivering stating that she felt cold.
-The PCP was notified and gave a verbal order to send the resident out for further evaluation and to have a urinalysis and culture and sensitivity done while she was at the emergency room (ER).
-The resident was sent out to the local ER.
-On 09/27/18 at 2:12 p.m. there was documentation by the SCM that the local hospital called and gave a report to the medication aide (MA) that Resident #1 had a "raging UTI" and the resident was ready to be picked up.
-The resident would be returning with an order for an antibiotic.

Review of Resident #1's primary care provider's (PCP's) visit note dated 10/01/18 revealed:
-The resident was being seen for a follow-up for a recent visit to the ER.
-The resident was seen on 09/10/18 at the request of facility staff for "agitation", and a urinalysis with culture and sensitivity was ordered.
-After multiple requests for the results, it was discovered on 09/26/18 that the urine specimen had been collected but was never sent to the lab.
-On 09/26/18, an order was given to send a urine specimen to the lab for testing on the next scheduled lab day.

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-On 09/27/18, the Special Care Manager (SCM) reported Resident #1 "appeared to be lethargic, pale in color, and had not voided urine since the morning shift yesterday", which was greater than 36 hours from the time of reporting.
Resident #1 was reportedly "sitting on the side of the bed feeling too tired to get up and feeling cold, shivering at times".
-An order was given to send the resident to the ER for evaluation.
-Approximately two hours later, the SCM reported Resident #1 had been diagnosed with a "raging UTI" and was returning to the facility with oral antibiotics.
-There had been no further reports of agitation or other issues after the diagnosis and treatment from the urinary tract infection.

Review of an "Incident/injury Report" for Resident #1 dated 09/27/18 at 11:35 a.m. revealed:
-There was documentation the resident appeared lethargic, a pale skin color of the face, shivering and complained of being cold and mumbled words when spoken to.
-The resident was unable to void when assisted to the bathroom even though she felt like she had to void.
-The resident was transported by emergency medical services on 09/27/18 at 12:00 p.m. to a local hospital.
-The resident had a "raging UTI" and was returning with antibiotics.

Review of Resident #1's ER visit at local hospital on 09/27/18 revealed:
-The chief complaint was increased altered mental status and lethargy since yesterday. There was a report that the resident had not urinated since yesterday.
-A urinalysis was concerning for infection and a

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urine culture had bee added
-The resident would be treated for a urinary tract infection .

Interview with the SCM on 10/31/18 at 12:19 p.m. revealed:
-Resident #1's urine sample was collected on 09/14/18 but due to the hurricane staff were unable to take the specimen after it was collected.
-The ACM collected the urine but she was not sure if the ACM documented that the urine was collected; documentation should have been done in Resident #1's charting notes.
-She contacted the PCP and informed Resident #1's urine specimen had been collected, but could not be picked up or sent to the lab due to the hurricane.
-She was not sure if anyone had contacted the provider prior to her contact with Resident #1's PCP on 09/23/18.
-Resident #1 was seen in the local ER on 09/27/18, was diagnosed with a UTI and was placed on antibiotics at that time.
-She did not contact Resident #1's PCP the same week the order for the urinalysis with a culture and sensitivity was given because of the the hurricane and evacuating the residents on 09/15/18.
-She could not answer why Resident #1's PCP was not contacted before the residents had to be evacuated on 09/15/18., but thought it may have been because staff had a hard time initially obtaining the sample from the resident.

Interview with a MA on 11/05/18 at 4:55 p.m. revealed:
-She knew about an order written around 09/10/18 to collect a urine sample for Resident #1 but she was sure about the specifics of the order.

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-If there was a delay in collecting a urine specimen, the MA would have been responsible to contact the PCP after a day if the sample could not be collected.
-The MAs were responsible to document when urine specimens were collected and sent to the lab in the residents' charting notes.

Interview with the ED on 11/09/18 at 10:48am revealed she would have expected staff to have contacted Resident #1's PCP if there was a delay in obtaining or delivering a urine specimen and to document it.

Interview with the PCP on 11/05/18 at 10:32 a.m. revealed:
-She expected staff to notify her if there was any delay in obtaining Resident #1's urine sample or sending the sample to the lab for the ordered urinalysis with a culture and sensitivity.
-She expected all orders given to be implemented.

Attempted interview with the ACM was unsuccessful on 11/02/18 at 11:26 a.m.

The ACM in training was not available for interview on 11/07/18 and 11/09/18.

2. Review of Resident #4's hospital generated FL-2 dated 08/01/18 revealed:
-Diagnosis included chronic obstructive pulmonary disease (COPD) exacerbation.
-The resident was intermittently disoriented.

Review of Resident #4's Resident Register revealed an admission date of 05/02/18.

a. Interview with Resident #4 on 10/23/18 at 11:35 a.m. revealed:

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-The resident had a cough and cold for about a month.
-My "spit" was white colored and thick.
-He had not received any medication and had not saw his primary care provider (PCP) for his cough and cold.
-He had told the MAs he had a cold and cough but "they don't pay me no attention", "Think I'm crazy because I am in a mental institution."
-He told a MA today about his cough and cold and said they would give him "something".

Observation of Resident #4 on 10/23/18 at 11:35 a.m. revealed:
-He was lying in bed with a thin white sheet over him.
-He had a rattling sounding cough.
-He coughed up white colored sputum that was thick into the small trash can beside his bed.

Observation of Resident #4 on 10/24/18 at 12:17 p.m. revealed:
-The resident left the dining room and entered into the hallway.
-The resident started coughing and was making sniffling nasal noises.

Interview with a personal care aide (PCA) on 10/25/18 at 9:19 a.m. revealed:
-Resident #4 had not mentioned anything to her about a cold or cough.
-Resident #4 coughed a lot when he ate.
-She had not noticed any difference in Resident #4's cough than what his cough usually sounded like.
-Resident #4 coughed and "spits" all the time and she told him it was because he smoked cigarettes.

Interview with a second PCA on 10/26/18 at

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1:23pm revealed whenever a PCA had a concern about a resident, the PCA reported to a MA and the MA "took it from there."

Interview with a MA on 10/25/18 at 9:35 a.m. revealed Resident #4 had not mentioned to her that he had a cough and a cold.

Interview with a second MA on 10/25/18 at 9:40 a.m. revealed:
-Resident #4 had COPD and would not stop smoking.
-It was normal for him to cough up white phlegm.
-Resident #4 "puts on some" with his illnesses.
-Resident #4 was seen for a cough and cold a few months ago and that was when he was diagnosed with COPD.
-She would follow-up with Resident #4 on the cough and cold complaints.

Interview with Resident #4 on 10/25/18 at 11:45 a.m. revealed he felt "better" and thought staff gave him medicine for his cough and cold.

Interview with Resident #4 on 10/31/18 at 1:54 p.m. revealed:
-The resident thought he still had a cold and felt bad.
-He was coughing and "spitting up stuff" that was yellow.

Interview with a third MA on 10/31/18 at 1:55 p.m. revealed:
-She did not know of Resident #4's complaints of a cold and productive cough with yellow sputum.
-Resident #4 had COPD.
-Resident #4 had as needed medication for a cough and she did not given him any yesterday (10/30/18).
-She would see what needed to be done for

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Resident #4's productive cough and complaints of feeling bad.

Interview with Resident #4 on 11/02/18 at 11:17 a.m. revealed:
-He had been up today (11/02/18) and ate breakfast.
-He felt "alright" but was still coughing.
-He was able to cough up green colored "stuff" but yesterday (11/01/18) he was spitting up white colored "stuff".
-He did not think he was given any medication yesterday for his coughing and cold.
-He was not having any shortness of breath.

Interview with the Special Care Coordinator (SCC) on 11/02/18 at 11:48 a.m. revealed she was not aware and none of the MAs had reported that Resident #4 had a productive cough and complaints of a cold but she would follow up with that immediately.

A second interview with third MA on 11/05/18 at 4:55 p.m. revealed:
-The MA offered Resident #4 an as needed cough medicine on 10/31/18 after receiving report of his productive cough and cold, but he refused the cough medication. She did not document when she offered him the cough medication.
-He only coughed badly when he went out to smoke.
-She told the MA coming on the next shift about his productive cough and cold but did not contact his PCP because she considered that normal for Resident #4.

Review of Resident #4's hospital discharge medication orders dated 08/01/18 revealed there was an order for Robafen (used to relieve coughing, thins and loosens mucous) 100mg/5ml

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take 200 mg by mouth every four hours as needed for cough and congestion.

Review of Resident #4's electronic medication administration records (eMARS) for October 2018 and November 2018 revealed:
-There was an entry for Robafen 100mg/5ml to take 10 mls by mouth every 6 hours as needed for cough, not to exceed 4 doses in 24 hours.
-There was no documentation Robafen 100mg/5ml had been administered in October 2018 and November 2018.

Interview with a MA on 11/07/18 at 2:15pm revealed:
-Whenever the MA had a concern about a resident she would call the resident's PCP.
-The MAs were supposed to document in the charting notes whenever the PCP was contacted.

Review of an Emergency Room (ER) visit summary for Resident #4 dated 11/02/18 revealed:
-The reason for the visit was documented as cough.
-A chest X-ray was done.
-The resident was diagnosed with community acquired pneumonia of the right lung, unspecified part of the lung and COPD.

Review of Resident #4's PCP's "Patient Notes" dated 11/02/18 at 1:37 p.m. revealed a medication aide (named) called and reported that the resident was sent out because he had a bad cough and was spitting up green (sputum). Had the facility notified the PCP before sending the resident to the ER an order would have been given for a portable chest x-ray, preventing any unnecessary visits to the ER.

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Review of Resident #4's "Charting Notes" revealed dated 11/02/18 at 3:53 p.m. revealed an entry by a MA the resident was sent to the ER for cough and diagnosed with acquired pneumonia of the right lung unspecified part of lung and COPD and the resident had new medications.

Interview with the Executive Director (ED) on 11/09/18 at 10:48am revealed the MAs were responsible and should have contacted Resident #4's PCP immediately about the productive cough and cold symptoms Resident #4 was having.

Interview with Resident #4's PCP on 11/05/18 at 10:32 a.m. revealed:
-She expected to be notified when there was a change with the resident in order to provide treatment for the resident.
-Resident #4 had a chronic cough from COPD but not profuse drainage, "pneumonia".

b. Review of Resident #4's "Charting Notes" revealed:
-On 06/28/18 at 1:17 p.m. there was an entry by a medication aide (MA) that the resident was complaining of right shoulder and arm pain. The MA had spoken with the resident's primary care provider (PCP) who ordered an x-ray and the report should be sent to the PCP.

The MA who documented the charting note dated 06/28/18 declined additional interviews on 11/07/18 at 11:41 a.m.

Review of the PCP's "Patient Notes" for Resident #4 on 06/28/18 at 12:44 p.m. revealed:
-There was an entry by the PCP that the facility called reporting the resident was complaining of pain in the right arm and shoulder.
-The PCP could hear the resident on the other

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D 273	Continued From page 137 end of the phone, moaning in pain. Per the facility, the resident had not fallen or had any recent injury. -An order for a portable x-ray of the right arm and shoulder was faxed to the facility (both at the nursing station and administrative office). A copy of the order and fax confirmation pages were uploaded to the chart. Review of a portable radiology report for Resident #4 dated 06/28/18 revealed the findings included there was a mildly displaced fracture of the arm, of indeterminate age. Review of the PCP's "Patient Notes" Resident #4 on 06/30/18 at 10:59 a.m. revealed: -There was an entry by the PCP that the results of the x-ray had not been received. -There had been a faxed request sent to the facility requesting the resident's results today (06/30/18). Review of the PCP's "Patient Notes" Resident #4 on 07/01/18 at 11:46 a.m. revealed: -There was an entry by the PCP there had been no response from the facility re: x-ray results. -A second request for the x-ray results was faxed to both the nursing station and the administrative office this morning. -A copy of the fax and both confirmation pages was uploaded to the chart. Review of a fax cover sheet in Resident #4's record dated 07/01/18 revealed: -The fax cover sheet was related to Resident #4's x-ray results labeled as "second request". -In the cover message section there was an entry, attention MA assigned to Resident #4, please fax the PCP the results of the resident's x-ray of the right arm and shoulder which was	D 273		

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ordered on 06/28/18, "I need these results today, please."

Review of Resident #4's "Charting Notes" revealed on 07/02/18 at 11:39 a.m. there was an entry by a second MA that the resident had x-rays (two view) done on his right shoulder. The resident was doing "OK at this time". X-ray results had been faxed to the PCP.

Review of the Radiology report for Resident #4 filed in the resident's record dated 06/28/18 revealed:
-There was a fax cover page dated 07/02/18 from the facility stapled to the x-ray report labeled with a another residents name, not addressed to Resident #4's PCP and was from the MA who documented in Resident #4's "Charting Notes" on 07/02/18 at 11:39 a.m. indicating the x-ray results had been faxed to the PCP.
-The fax confirmation result was "busy/no response".

Review of the PCP's "Patient Notes" for Resident #4 dated 07/02/18 revealed:
-On 07/02/18 at 8:40 a.m., there was an entry by the PCP there had been no response to either request for the x-ray results over the weekend.
-The PCP found the report in a folder during today's visit.
-The resident had a fractured shoulder.
-The x-ray was done on 06/28/18 and the report was faxed to the facility also on 06/28/18, but the PCP was never notified of the results despite multiple requests.
-The "DON" (Director of Nursing) and the Executive Director (ED) were notified.
-The resident was sent to the emergency room for further evaluation and treatment.
-On 07/02/18 at 8:43 a.m., there was an entry by

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the PCP she found the request for the resident's x-ray results faxed on 07/01/18 sitting on the fax machine this morning.
-On 07/02/18 at 2:53 p.m., there was an entry by the resident's PCP the facility staff had faxed the x-ray report today (07/02/18) at 11:31 a.m. after the PCP had already located the report, evaluated the resident, and sent the resident to the ER for his fracture.

Review of Resident #4's Emergency Room visit on 07/02/18 revealed:
-The chief complaint was shoulder pain for 3-4 months per emergency medical services. An x-ray was performed yesterday; and sent here for a fracture.
-An x-ray of the right shoulder showed an acute, non-displaced fracture of a section of the shoulder bone was seen and the impression revealed an acute fracture of the scapula.
-The resident's pain was controlled with acetaminophen and ibuprofen and he was discharged with a sling for his right arm and follow up at orthopedics later in the week.

Interview with Resident #4 on 11/02/18 at 11:17 a.m. revealed:
-He had "broke" his right shoulder from a fall, however, could not remember when this happened.
-His right shoulder occasionally made a "popping sound" and caused him pain "sometimes".

Interview with the Special Care Coordinator (SCC) on 11/07/18 at 3:30pm revealed:
-The care managers (CM) were responsible for supervising the MAs.
-CMs were responsible for monitoring primary care provider (PCP) orders, follow up with PCPs and documentation of contact with PCPs

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Interview with the ED on 11/06/18 at 12:25 p.m. revealed:
-Resident #4 used to sleep on the couch in the vending room of the facility.
-She remembered Resident #4 fractured his shoulder in June 2018.
-Resident #4 told her he had rolled off the couch after the fracture was recognized in June 2018.
-The x-ray report should have been faxed "immediately" to the PCP when the results of the x-ray were given to the facility by the MA on duty.
-The faxed x-ray report should have the faxed confirmation attached to the x-ray report in the residents chart.
-It was the responsibility of the MA to have documented the x-ray report was sent to the resident's PCP in the resident's "Charting Notes".
-She did not know of any delay in Resident #4's x-ray results being forwarded to the PCP.

Interview with Resident #4's PCP on 11/05/18 at 10:32 a.m. revealed:
-None of the staff bothered to contact the PCP after multiple requests were sent to send the results of the resident's x-ray done on 06/28/18.
-She found the x-ray report for Resident #4 when she visited the facility on 07/02/18 "stuck" in a folder.
-When she visited the facility on 07/02/18, all of the faxed requests she had sent to the facility were found sitting on the fax machine at the nurse's station.
-She expected the facility to have faxed Resident #4's x-ray report immediately after it was performed on 06/28/18.
-The delay in receiving the resident's x-ray report resulted in the Resident #4 having untreated pain for 5 days; she could hear the resident on the other end of the phone, moaning in pain on

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06/28/18 when the facility called.

The ACM in training was not available for interview on 11/07/18 and 11/09/18.

3. Review of Resident #13's current FL-2 dated 10/25/17 revealed diagnoses included Alzheimer's dementia, type II diabetes mellitus, hypertension, stage III chronic kidney disease, and anemia.

Review of a charting note for Resident #13 dated 08/25/18 at 8:20pm revealed:
-Resident #13 was observed in his room drinking liquid body wash.
-Staff took the body wash and was to monitor Resident #13 for vomiting.
-Staff tried to call Resident #13's primary care provider (PCP), but the voicemail was full.

Attempted interview on 11/08/18 at 7:56pm, with the medication aide who documented the charting note dated 08/25/18 at 8:20pm, was unsuccessful.

Review of charting notes for Resident #13 dated 08/25/18 through 08/30/18 revealed there was no further documentation regarding follow up attempts to contact Resident #13's PCP.

Telephone interview with Resident #13's PCP on 11/09/18 at 4:42pm revealed:
-It was possible her voice mailbox was full when the staff tried to contact her on 08/25/18.
-She was not aware of any follow up contact by staff.
-She would have expected staff to have monitored Resident #11 for adverse symptoms after the resident drank the liquid body wash and then send the resident to the emergency room

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(ER) "if need be".

Interview with the Executive Director (ED) on 11/09/18 at 10:48am revealed:
-She was not aware of the charting note dated 08/25/18 which documented Resident #13 drank liquid body wash.
-Staff should have sent Resident #13 to emergency room (ER) for evaluation.
-Staff should have called the PCP and reported the incident to the oncoming MA and the Special Care Manager (SCM).

Attempted interview with Resident #13's Responsible Person on 11/06/18 at 12:15pm was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #13 was not interviewable.

4. Review of Resident #2's current FL-2 dated 03/07/18 revealed diagnoses included Alzheimer's dementia with behaviors, hypertension, deep vein thrombosis with inferior vena cava filter, major neurocognitive disorder, seizure disorder and history of myocardial infarction.

Review of a charting note for Resident #2 dated 08/13/18 at 8:28pm revealed:
-Resident #2 was bleeding from the rectum.
-There was no documentation Resident #2's primary care provider (PCP) was notified.

Interview with a medication aide (MA) on 10/30/18 at 4:23pm revealed:
-She had written the charting note dated 08/13/18.
-Resident #2 had a bowel movement and had a

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"little bleeding from a little tear that he had."
-"From what I can remember, the doctor was notified."
-She could not remember the name of the provider she notified.

Review of PCP visit notes for Resident #2 dated 08/07/18, 08/16/18 and 08/21/18 revealed there was no documentation regarding notification or follow up for Resident #2 having rectal bleeding.

Interview with Resident #2's PCP on 11/06/18 at 12:40pm revealed:
-She could not recall being notified of Resident #2 having rectal bleeding on 08/13/18.
-If she had been notified she would have prescribed hemorrhoid relief suppositories or had Resident #2 sent to the emergency room (ER) for evaluation.
-If there were no verbal orders then she was likely not contacted.
-She expected staff to notify her for a resident experiencing rectal bleeding.
-She was not aware of Resident #2 having any continued rectal bleeding.
-She visited the facility weekly and saw residents based on which residents staff placed on her visit list.
-If the resident was not on her visit list that week, she did not see the resident.

Interview with the Executive Director (ED) on 11/09/18 at 10:48am revealed:
-She was not aware that Resident #2 had rectal bleeding documented in a charting note on 08/13/18.
-She expected staff would have contacted Resident #2's PCP or to have sent the resident to the ER.
-The former Director of Nursing (DON) may have

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contacted the PCP.
-Staff were expected to document contact with the PCP in the charting notes.

Attempted interview with Resident #2's responsible person on 10/30/18 at 1:32pm was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

____

The facility failed to send a resident to the hospital for evaluation and treatment as ordered and failed to notify the PCP of an ordered urine test that was not sent for testing resulting in the resident having to be evaluated in the emergency room and receiving treatment for infection 17 days later (#1); failed to provide an x-ray report that showed a fracture which resulted in the resident going without any treatment for 5 days and failed to notify the PCP of a productive cough and cold symptoms that resulted in the resident having to be evaluated in the emergency room and diagnosed with pneumonia (#4) ; failed to notify the PCP of Resident #13 drinking liquid body wash; and failed to report Resident #2's rectal bleeding to the PCP. The facility's failure to assure referral and follow up for residents resulted in substantial risk of serious physical harm to the residents which constitutes a Type A2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/31/18 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 9, 2018.

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10A NCAC 13F .0902 Health Care
(c) The facility shall assure documentation of the following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

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

Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 3 of 7 sampled residents (#2, #11, #14), which included orders to discontinue and remove a fall mat from the resident's room (Resident #14), orders for a chair alarm and compression stockings (Resident #2), and an order for a thyroid stimulating hormone (TSH) level (Resident #11).

The findings are:

1. Review of Resident #14's current FL-2 dated 04/20/18 revealed diagnoses included vascular dementia, abnormal posture, paroxysmal atrial fibrillation, essential hypertension, heart failure, major depressive disorder, cerebral vascular accident, dysphagia, hemiplegia and hemiparesis.

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Review of physician's orders for Resident #14 dated 05/14/18 revealed there were orders for a low bed with a fall mat, a pressure alarm when in bed or chair and a standard manual wheelchair.

Review of a Physician's Order for Resident #14 dated 08/16/18 revealed an order to discontinue the fall mat at bedside and remove the fall mat from Resident #14's room.

Review of a charting note for Resident #14 dated 08/17/18 at 4:05pm revealed Resident #14 was found on the fall mat with no injuries.

Review of a primary care provider (PCP) visit note for Resident #14 dated 08/20/18 revealed:
-On 08/16/18, the hospice nurse (HN) reported Resident #14 had three falls and was increasingly agitated.
-The HN also reported the fall mat was a safety hazard and the falls were caused by Resident #14 attempting to get up and tripping over the mat.
-An order was faxed to the facility to discontinue the fall mat and remove the mat from Resident #14's room (08/16/18).
-Staff notified the PCP on 08/17/18 that Resident #14 fell over the mat, indicating the order to discontinue the mat was not addressed.
-There was an order for hospice to provide a concave mattress for fall prevention.

Telephone interview with the HN on 11/09/18 at 8:51am revealed:
-Falls should not have been an issue for Resident #14 because the resident was non-ambulatory and required two staff to assist with transfers.
-It was "odd" that Resident #14 had a fall mat (on 08/16/18) and ended up with a laceration on her forehead.

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-He had a concern with facial injuries of residents at the facility.

Review of a PCP visit note for Resident #14 dated 08/27/18 revealed there was an order to discontinue the fall mat and remove from room per faxed order dated 08/20/18 and encounter note dated 08/20/18.

Review of a PCP visit note for Resident #14 dated 09/03/18 revealed there was an order to discontinue the fall mat and remove from room per previous orders dated 08/16/18, 08/20/18 and 08/27/18.

Review of a PCP visit note for Resident #14 dated 09/10/18 revealed:
-On 09/04/18, the HN notified the PCP that Resident #14 experienced a fall the previous night (09/03/18 - 09/04/18) and sustained skin tears and trauma to both knees.
-The HN reported the fall mat, which was ordered to be removed from the room (on 08/16/18), was still tucked under Resident #14's bed.
-It was likely Resident #14's fall reported on 09/04/18, was precipitated by the resident tripping over the fall mat when trying to get out of bed.

Telephone interview with a personal care aide (PCA) on 11/08/18 at 8:02pm revealed:
-Resident #14 did not sit back in her wheelchair and would fall from her wheelchair.
-Resident #14 was not able to walk, the resident was "kind of paralyzed on one side."
-Resident #14 still tried to do things on her own.

Telephone interview with a second PCA on 11/09/18 at 5:04pm revealed:
-Resident #14 had a fall mat which was already placed on the floor by the resident's bed when the

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PCA arrived at work for 3rd shift.
-She was not aware of the fall mat being discontinued.
-Resident #14 had an issue with tripping over the fall mat.
-Resident #14 would try to get up and walk, lose her balance and fall.
-On 08/16/18, another PCA had assisted Resident #14 out of the bed to her wheelchair.
-Resident #14 tried to stand up from her wheelchair and fell.

Interview with Resident #14's PCP on 11/05/18 at 10:35am revealed:
-Resident #14 fell on 08/16/18 and sustained a laceration on her forehead that required sutures.
-The staff reported Resident #14 fell onto the floor mat and injured her forehead.
-She had written an order for the fall mat to be removed because she had been informed by other staff that Resident #14 was getting up and tripping over the fall mat.
-Staff refused to take the fall mat out of Resident #14's room because the staff thought the resident was better off with the floor mat.
-She had written orders several times to discontinue the floor mat; the floor mat remained in place until Resident #14 left the facility on 09/18/18.
-She had concerns about facility staff not implementing provider orders.
-She expected staff to follow through on orders given by the PCP.

Telephone interview with Resident #14's PCP on 11/09/18 at 10:24am revealed:
-She was confused as to how Resident #14 fell onto a floor mat and sustained "such horrible head injuries."
-The HN had informed the PCP Resident #14 got

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up and tripped over the fall mat.
-She had spoken with several PCAs, the Assistant Care Manager (ACM) in training and the Special Care Manager (SCM) about removing the fall mat.
-There was one PCA that said she was not removing the mat.
-The PCP did not remember the name of the PCA.

Interview with the Executive Director (ED) on 11/09/18 at 10:48am revealed:
-Because Resident #14 had a low bed, the resident would roll onto the floor mat.
-Resident #14 would try to get up from her wheelchair unassisted.
-She could not recall the injury Resident #14 sustained form the fall on 08/16/18 onto the fall mat where she had a forehead laceration requiring sutures.
-She was not aware the fall mat had been discontinued.
-She was not aware of an order for a concave mattress.
-She was not aware of staff not carrying out PCP orders.
-She thought the PCP brought printed copies of her visit notes to the facility for filing in the residents' records.
-She had just learned on 11/09/18, that staff were supposed to access the visit notes electronically.
-She did not have access to the PCP's electronic visit notes prior to 11/09/18.
-The PCP would meet with the Care Manager (CM) after seeing residents and discuss new orders in addition to the written orders.

Attempted interview on 11/09/18 at 3:00pm, with the medication aide (MA) who documented the charting note dated 08/17/18 at 4:05pm, was

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unsuccessful.

The ACM was not available for interview on 11/09/18.

Attempted interviews with the SCM on 11/09/18 were unsuccessful.

Attempted interview with Resident #14's Responsible Person on 11/06/18 at 12:17pm was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #14 was not available for interview.

2. Review of Resident #2's current FL-2 dated 03/07/18 revealed diagnoses included Alzheimer's dementia with behaviors, bilateral lower extremity venous stasis wounds, hypertension, schizoaffective disorder, deep vein thrombosis with inferior vena cava filter, major neurocognitive disorder, seizure disorder and history of myocardial infarction.

a. Review of a Physician's Order Request form for Resident #2 dated 08/01/18 revealed order for a chair alarm when the resident was not in his room signed by the primary care provider (PCP) on 08/07/18.

Observation on 10/23/18 at 11:22am revealed there was no alarm device on Resident #2's chair.

Interview with a medication aide (MA) on 10/26/18 at 12:10pm revealed:
-Resident #2 had a chair alarm back in March 2018.
-She did not know anything about the order dated

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8/7/18, for Resident #2 to have a chair alarm.

Review of a charting note for Resident #2 dated 10/02/18 at 6:23pm revealed Resident #2 "slid to the floor this evening."

Interview on 11/06/18 at 1:23pm with the MA who documented the charting note dated 10/02/18 at 6:23pm revealed:
-On 10/02/18, Resident #2 was just sitting in his wheelchair and just slid to the floor.
-Resident #2 did not have a chair alarm on 10/02/18.

Review of a charting note for Resident #2 dated 10/20/18 at 6:50am revealed Resident #2 was pushing (another) resident and slid to the floor with no injuries.

Interview on 10/25/18 at 4:27pm with the MA who documented the charting note dated 10/20/18 at 6:50pm revealed:
-On 10/20/18, Resident #2 was propelling himself in his wheelchair using his feet.
-Resident #2 was leaned back in his wheelchair and sitting on the edge of the seat.
-Resident #2 was pushing another resident in their wheelchair while propelling himself and slid out of his wheelchair.
-Resident #2 did not have any injury from the fall.

Observations on 10/24/18 from 12:31pm until 12:53pm revealed:
-Resident #2 got up from the table before being served the lunch meal and started to leave the dining room walking with an unsteady gait at 12:31pm.
-The Executive Director (ED) brought Resident #2 his wheelchair when he was approximately halfway across the dining room.

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-The ED assisted Resident #2 into his wheelchair and down the 200 hall towards his room #217.
-Resident #2 was in his room on his hands and knees looking under his bed at 12:48pm.
-There no alarm device on Resident #2's chair.

Observation on 10/25/18 at 4:43pm and 10/30/18 at 11:26am revealed there was no alarm device on Resident #2's chair.

Observations on 10/30/18 at 1:13pm revealed:
-Resident #2 was lying on the hallway floor between the main dining room and small dining room.
-Resident #2 was lying on his right side in front of his wheelchair with his head near the front wheels of the wheelchair.
-There were a dime sized and nickel sized area of bright red blood on Resident #2's left knee.
-There was no alarm device on Resident #2's wheelchair.
-Staff assisted Resident #2 to standing and then to sit in his wheelchair.

Interview with a personal care aide (PCA) on 10/30/18 at 1:13pm revealed Resident #2 must have been scooting in his wheelchair and slid out onto the floor.

Review of a charting note for Resident #2 dated 10/31/18 at 11:37am revealed:
-Staff documented a late entry that Resident #2 returned from the ER on 10/31/18 after being sent due to a fall.
-Resident #2 was diagnosed with a fall and left knee abrasion.

Review of ER Discharge instructions for Resident #2 dated 10/30/18 revealed Resident #2 was seen in the ER for a fall and left knee abrasion.

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Interview with a second MA on 10/30/18 at 4:23pm revealed:
-Resident #2 was ambulatory when he first came to the facility (11/21/17).
-Resident #2 was no longer steady on his feet and was a fall risk.
-Resident #2 would forget that he was not steady on his feet and try to walk.
-She did not have anything to do with the order for a chair alarm for Resident #2.

Interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53am revealed she was not aware of an order for a chair alarm for Resident #2.

Interview with the Special Care Coordinator (SCC) on 10/30/18 at 12:14pm revealed:
-She was not aware of an order for a chair alarm for Resident #2.
-She would follow up on whether the order for the chair alarm had been discontinued.

Interview with the SCC on 10/30/18 at 3:54pm revealed:
-She had not known Resident #2 to have had a chair alarm.
-She had interviewed staff who reported Resident #2 did have a chair alarm, but the resident would take the chair alarm off of his chair and hide it.
-She did not know if this had been reported to Resident #2's PCP.

Telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25pm revealed:
-Resident #2 did have a chair alarm because she remembered going to assist the resident at one time when the alarm was going off.
-She could not remember when that was.

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-She did not know of an order to discontinue the chair alarm for Resident #2.

Telephone interview with Resident #2's PCP on 10/26/18 at 11:21am revealed:
-Resident #2 was supposed to have a chair alarm because he was "definitely a fall risk."
-He had a fall approximately one month ago which was "not serious," he usually would "slide out of his chair" and had not had any injury.

Interview with the ACM in training on 11/02/18 at 12:20pm revealed:
-She did not know the status of orders for a chair alarm for Resident #2.
-The SCC and Special Care Manager (SCM) might have been working on the chair alarm issue for Resident #2 on 11/02/18.

Interview with the Executive Director (ED) on 11/02/18 at 12:25pm revealed:
-Chair alarms were not kept in the facility, they needed to be ordered for each resident.
-She would make sure the chair alarm was ordered for Resident #2.
-Resident #2 did remove the chair alarm from his wheelchair and hide it, but she expected to staff to look for the chair alarm and put it back on the resident's wheelchair.

Observation on 11/06/18 at 12:30pm revealed Resident #2 had an alarm device attached to the back of his wheelchair and his shirt.

b. Review of a Physician's Order Request form for Resident #2 dated 05/21/18 revealed:
-There was a request for compression stockings for Resident #2 from the home health nurse (HHN).
-There was no documented response or order

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from the primary care provider (PCP).

Review of a Physician's Order Request form for Resident #2 dated 05/29/18 revealed there was an order for compression stockings on in the morning and off at bedtime.

Observations on 10/24/18 at 12:48pm revealed:
-Resident #2 raised his pant legs to just below his knees and had on black ankle high socks.
-Resident #2 did not have compression stocking on.
-Resident #2's lower legs were swollen, red/brown in color and appeared taut and shiny with areas of peeling skin between the ankle and calf areas.
-There were no compression stockings observed in Resident #2's room.

Observations on 10/25/18 at 4:43pm revealed:
-The personal care aide (PCA) assisted Resident #2 with removing his pants.
-Resident #2's lower legs were swollen, red/brown in color and appeared taut and shiny with areas of peeling skin between the ankle and calf areas.
-There was an indented ring at the ankle area on both legs where the socks had been.
-Resident #2 did not have compression stockings on.

Interview with the PCA on 10/25/18 at 4:43pm revealed Resident #2 did not had compression stockings that she knew of.

Interview with a medication aide (MA) on 10/26/18 at 12:10pm revealed Resident #2's compression stockings should have been discontinued because Resident #2 was getting "leg wraps" by home health.

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Observations on 10/30/18 at 1:20pm revealed:
-Both of Resident #2's lower legs were swollen from the knee to the foot, the right leg was more swollen than the left leg.
-The MA could not get Resident #2's right shoe on all the way and told the resident his right foot and ankle were swollen so she was going to leave his right shoe off.
-Resident #2 did not have compression stockings on.

Interview with the MA on 10/30/18 at 1:20pm revealed:
-The compression stockings were discontinued by home health (HH).
-HH had been applying the compression bandages for a while.
-She did not know when HH had discontinued the compression stockings or stopped applying the compression bandages.

Interview with a second MA on 10/30/18 at 4:23pm revealed:
-She did not have anything to do with the order for compression stockings for Resident #2.
-Resident #2 was wearing compression stockings several months back (Summer 2018).

Observation on 11/06/18 at 12:30pm revealed Resident #2 had on yellow socks and did not have compression stockings on.

Observation on 11/07/18 at 9:34am revealed:
-Resident #2 did not have on compression stockings.
-Resident #2's lower legs were swollen, the right leg having more swelling than the left leg.

Telephone interview with the HH Case Manager

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(CM) on 10/26/18 at 12:50pm revealed:
-Resident #2 was admitted for HH services on 07/19/18 and discharged from HH on 10/23/18.
-Resident #2 was being treated with compression bandages for right lower extremity wounds.
-The HH nurse documented in a visit note dated 10/17/18 for Resident #2 that the lower extremity wounds were healed and the compression bandage was discontinued.
-Usually if the resident removed the compression bandage, the facility staff would place a compression stocking until the next HH nurse visit.
-The PCP's order for compression stockings was not a HH order and there was no order to discontinue the compression stockings.

Interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53am revealed:
-She had not seen an order for compression stockings for Resident #2.
-She only knew the compression bandages from HH had been discontinued because Resident #2's legs were better.
-She had just started taking care of provider orders for residents.
-For the last month or month and half, the Special Care Coordinator (SCC) and the Special Care Manager (SCM) had been taking care of the orders.

Interview with the SCC on 10/30/18 at 12:14pm revealed:
-She was not aware of an order for compression stockings for Resident #2.
-She would follow up on whether the order for compression stockings had been discontinued.

Interview with the SCC on 10/30/18 at 3:54pm and 5:00pm revealed:

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-There was an order for the compression stockings for Resident #2 on the electronic medication administration record (eMAR) on 05/28/18.
-The order was entered and discontinued the same day because the eMAR system required measurements and specific directions for the compression stockings.
-Pharmacy did not have an order for compression stockings for Resident #2.
-She was unable to find an order to discontinue the compression stockings for Resident #2.
-She contacted Resident #2's PCP on 10/31/18.

Telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25pm revealed:
-Resident #2 had an order for compression stockings.
-Before she stopped working at the facility (09/27/18), HH were doing "some kind" of treatment to Resident #2's legs, so he was not wearing the compression stockings.
-She did not recall seeing a discontinue order for Resident #2's compression stockings.

Telephone interview with Resident #2's PCP on 10/26/18 at 11:21am revealed:
-Resident #2 was non-compliant with wearing compression stockings so whenever the resident had any swelling home health would come out to the facility and apply compression gauze bandages.
-The PCP asked if the compression stockings were on Resident #2's eMAR because if the resident had an order for compression stockings it would be documented on the eMAR.
-She thought the compression stockings had been discontinued because Resident #2 did not need them anymore.
-She had not looked at Resident #2's legs in

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several weeks.

Interview with the Executive Director (ED) on 10/30/18 at 11:35am revealed she "wanted say" the compression stockings for Resident #2 had been discontinued because HH was applying bandages to the resident's legs.

Interview with the first MA on 11/06/18 at 1:23pm revealed:
-Residents needs, including the use of compression stockings, should be communicated from the Special Care Manager (SCM) to the MA verbally and the order should have also been on the electronic medication administration record (eMAR).
-The MAs passed the information on verbally to PCAs.
-Usually compression stockings were put on the eMAR to put on residents at 6:00am.
-The 3rd shift MA should have been responsible for putting the compression stockings on.
-If the 3rd shift MA did not have time to put the compression stockings on, then the MA could ask the PCA to put the compression stockings on.

Review of Resident #2's August, September and October 2018 eMAR revealed there was no entry for compression stockings.

Review of a charting note for Resident #2 dated 10/30/18 at 7:02pm revealed a fax notification was sent to the PCP requesting a home health evaluation for Resident #2 having swollen legs.

Interview with the Executive Director (ED) on 11/02/18 at 12:25pm revealed:
-Staff were expected to process and send new orders to the pharmacy upon receipt from the doctor.

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-If the order required ordering equipment and/or supplies, she expected staff to go ahead and place the order.

Attempted interview with Resident #2's responsible person on 10/30/18 at 1:32pm was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

3. Review of Resident #11's current FL-2 dated 05/23/18 revealed diagnoses included vascular dementia, hypothyroidism, vitamin B deficiency, atrial fibrillation, atrial flutter, chronic kidney disease and mild cognitive impairment.

Review of a Physician's Order Request form for Resident #11 dated 05/23/18 revealed:
-There was a notation Resident #11's thyroid stimulating hormone (TSH) was elevated at 5.7 and that the resident was noncompliant with taking Synthroid (a medication used to treat hypothyroidism).
-There was an order to get a TSH level done for Resident #11 in six weeks (week of 07/02/18).

Review of a primary care provider (PCP) visit note for Resident #11 dated 05/23/18 revealed an order to increase Resident #11's Synthroid dosage to 125mcg daily and recheck the TSH level in 6-8 weeks (07/02/18 - 07/13/18).

Upon request, there were no PCP visit notes dated after 06/05/18 for Resident #11 available for review.

Upon request on 11/09/18, there was no TSH level result from the laboratory for Resident #11

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dated after 05/07/18 available for review.

Telephone interview with Resident #11's PCP on 11/08/18 at 8:23pm revealed:
-She remembered ordering the TSH level for Resident #11 because the resident had a high TSH level previously.
-She had started Resident #11 on Synthroid and wanted to monitor the resident's response to the medication.
-She did not recall getting a result for the TSH level ordered on 05/23/18.
-Normally when she ordered a laboratory test, the facility staff contacted home health (HH) to obtain the specimen.
-Laboratory results were always sent to the facility and facility staff placed the result in her folder at the facility.
-She usually brought visit notes to the facility for residents the week following the actual visit.
-She had not been able to print and bring visit notes since September 2018 because she was having printer problems.

Interview with the Executive Director (ED) on 11/09/18 at 10:48am revealed:
-The HH agency would have been contacted by the former Director of Nursing (DON) to obtain the blood sample for the TSH level ordered for Resident #11 on 05/23/18 by the PCP.
-Back in May 2018, when the laboratory results came back to the facility a copy was faxed to the PCP and placed in the PCP's folder at the facility for the PCP to sign.
-The signed copy of the laboratory result was filed in the resident's record.
-There was a new system implemented in October 2018 which the Assistant Care Manager (ACM) in training was responsible for.

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D 276	Continued From page 162 Attempted interview with Resident #11's Responsible Person on 11/06/18 at 12:15pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #11 was not interviewable. ________________________________ The facility failed to implement orders from the primary care provider for the removal of a fall mat for Resident #14 who had a history of falls and was suspected of tripping over the mat resulted in Resident #14 having a fall with skin tears and traumas to both knees; for a chair alarm for Resident #2 who had a history of falls which resulted in Resident #2 experiencing 3 falls from his wheelchair with referral to the emergency department on each occasion; and compression stockings for Resident #2 who had a history of venous stasis ulcers which resulted in untreated lower extremity edema. The failure of the facility to implement orders for the floor mat removal (#14), a chair alarm (#2) and compression stockings (#3) was detrimental to the health and safety of the residents and constitutes a Type B Violation. ________________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/02/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 24, 2018.	D 276		
D 281	10A NCAC 13F .0903 (d) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health	D 281		

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Professional Support

(d) The facility shall assure action is taken in response to the licensed health professional review and documented, and that the physician or appropriate health professional is informed of the recommendations when necessary.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure follow up on recommendations written by the Licensed Health Support Professional (LHPS) nurse for 1 of 5 sampled residents (#2) related to compression stockings and a chair alarm.

The findings are:

Review of Resident #2's current FL-2 dated 03/07/18 revealed diagnoses included Alzheimer's dementia with behaviors, bilateral lower extremity venous stasis wounds, hypertension, schizoaffective disorder, deep vein thrombosis with inferior vena cava filter, major neurocognitive disorder, seizure disorder and history of myocardial infarction.

a. Review of an LHPS evaluation for Resident #2 dated 09/07/18 revealed:
-Resident #2 had an order for compression bandages on both legs, but there was only a compression bandage on the right leg.
-There was a recommendation to clarify the order for the compression bandages.
-There was a recommendation to clarify if the compression bandage was only for the right leg, then an order for a compression stocking for the left leg needed to be obtained.

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Observations on 10/24/18 at 12:48pm revealed:
-Resident #2 raised his pant legs to just below his knees and had on black ankle high socks.
-Resident #2 did not have on compression stockings.
-Resident #2's lower legs were swollen, red/brown in color and appeared taut and shiny with areas of peeling skin between the ankle and calf areas.
-There were no compression stockings observed in Resident #2's room.

Interview with the PCA on 10/25/18 at 4:43pm revealed Resident #2 did not had compression stockings that she knew of.

Review of Physician's Order Request forms for Resident #2 revealed there was no order of clarification or to discontinue the compression stockings.

Interview with a medication aide (MA) on 10/26/18 at 12:10pm revealed:
-Resident #2's compression stockings should have been discontinued because Resident #2 was getting "leg wraps" by home health.
-She did not know anything about the recommendation on the LHPS evaluation dated 09/07/18 for Resident #2 to have an order clarified for compression stockings.

A second interview with the MA on 11/06/18 at 1:23pm revealed:
-Residents needs, including the use of compression stockings, should be communicated from the Special Care Manager (SCM) to the MA verbally and the order should have also been on the electronic medication administration record (eMAR).

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-The MAs passed the information on verbally to PCAs.
-Usually compression stockings were put on the eMAR to put on residents at 6:00am.

Review of Resident #2's August, September and October 2018 eMAR revealed there was no entry for compression stockings.

Interview with the SCC on 10/30/18 at 12:14pm revealed:
-She was not aware of the recommendations by the LHPS Nurse to follow up on the compression stockings for Resident #2.
-She was going to follow up on the order for compression stockings for Resident #2.

Refer to interview with a medication aide (MA) on 10/26/18 at 12:10pm.

Refer to interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53am.

Refer to interview with the Special Care Coordinator (SCC) on 10/30/18 at 12:14pm.

Refer to interview with the Special Care Manager (SCM) on 10/30/18 at 4:59pm.

Refer to telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25pm.

Refer to interview with the Executive Director (ED) on 11/02/18 at 12:25pm.

b. Review of an LHPS evaluation for Resident #2 dated 09/07/18 revealed there was a recommendation to put the chair alarm for Resident #2 on the electronic medication

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administration record (eMAR) and use as ordered.

Observations on 10/24/18 at 12:48pm revealed there was no alarm device on Resident #2's chair.

Review of Physician's Order Request forms for Resident #2 revealed there was no order of clarification or to discontinue the chair alarm.

Interview with a medication aide (MA) on 10/26/18 at 12:10pm revealed:
-Resident #2 had a chair alarm back in March 2018.
-She did not know anything about the recommendation on the LHPS evaluation dated 09/07/18, for Resident #2 to have a chair alarm.

A second interview with the MA on 11/06/18 at 1:23pm revealed:
-Residents needs, including the use of a chair alarm, should be communicated from the Special Care Manager (SCM) to the MA verbally and the order should have also been on the electronic medication administration record (eMAR).
-The MAs passed the information on verbally to PCAs.

Review of Resident #2's August, September and October 2018 eMAR revealed there was no entry for a chair alarm.

Interview with the SCC on 10/30/18 at 12:14pm revealed:
-She was not aware of the recommendations by the LHPS Nurse to follow up on the chair alarm for Resident #2.
-She was going to follow up on the order for the chair alarm for Resident #2.

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Refer to interview with a medication aide (MA) on 10/26/18 at 12:10pm.

Refer to interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53am.

Refer to interview with the Special Care Coordinator (SCC) on 10/30/18 at 12:14pm.

Refer to interview with the Special Care Manager (SCM) on 10/30/18 at 4:59pm.

Refer to telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25pm.

Refer to interview with the Executive Director (ED) on 11/02/18 at 12:25pm.

____

Interview with a medication aide (MA) on 10/26/18 at 12:10pm revealed the Special Care Coordinator (SCC) was responsible for review and follow up on resident LHPS evaluations.

Interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53am revealed:
-The current Special Care Coordinator (SCC) and Special Care Manager (SCM) had been responsible for review and follow up on LHPS evaluations for residents for approximately one to one and half months.
-Prior to that, the Executive Director (ED) might have been responsible for review and follow up on LHPS evaluations for residents.

Interview with the Special Care Coordinator (SCC) on 10/30/18 at 12:14pm revealed:
-She was not working on 09/07/18 when the LHPS evaluation was completed for Resident #2.

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-Once the LHPS Nurse completed the resident assessment and evaluation, a copy was given to the Special Care Manager (SCM) for review and follow up and a second copy was placed in the resident's record.
-There were two copies of the LHPS evaluation in Resident #2's record so it seemed that a copy had not been given to the SCM.
-When she started working at the facility in August 2018, the LHPS evaluations had not been updated.
-Since August 2018, a "tickler" file had been set up to assure LHPS evaluations were completed.
-The Supervisors, MAs or SCM were able to follow up on LHPS evaluation recommendations.

Interview with the Special Care Manager (SCM) on 10/30/18 at 4:59pm revealed:
-She was not aware of the LHPS evaluation and recommendations for Resident #2 dated 09/07/18.
-Normally, when the LHPS evaluations were done, the forms were given to the CM.
-The LHPS evaluations were going to be reviewed during the quarterly review which included updating the residents care plan and profile.

Telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25pm revealed:
-She did not recall seeing an LHPS evaluation dated 09/07/18 for Resident #2.
-Before she left the facility (09/27/18) she was responsible for review and follow up on LHPS evaluations.
-The LHPS Nurse would give the evaluations to the DON and she would give recommendations to the doctor.

Interview with the Executive Director (ED) on

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11/02/18 at 12:25pm revealed:
-She was not aware of the LHPS recommendations for Resident #2 regarding the chair alarm and compression stockings.
-She was not aware that there had not been any follow up on the LHPS recommendations for Resident #2.
-The LHPS Nurse did evaluations on residents and gave the evaluations to the SCC or the SCM.
-Any recommendations should be carried out and documented in the charting notes.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Attempted interview with the facility's LHPS nurse on 11/06/18 at 11:39am was unsuccessful.

D 338 10A NCAC 13F .0909 Resident Rights D 338

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:
Based on observations, interviews and record reviews, the facility failed to assure residents were treated with respect, dignity, consideration, and right to privacy and failed to assure residents

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were in an environment free of verbal, physical, mental, and emotional abuse.

The findings are:

1. Based on observations, record reviews, and interviews, the facility failed to assure residents were treated with respect, dignity, consideration, and right to privacy as related to staff failing to knock on a resident's door before entering (#22); failing to close the bathroom door while toileting a resident (#21); obtaining a urine sample without explanation to the resident (#22); and failed to maintain privacy for residents as related to uninvited residents (#1, #6) entering other residents' rooms. [Refer to Tag D911 G.S. 131D-21(1) Declaration of Resident Rights (Type B Violation)]

2. Based on observations, interviews and record reviews, the facility failed to assure residents were protected from harm and injury from residents with known aggressive behaviors resulting in Resident #7 sustaining a subdural hematoma following an assault by another resident and a hip fracture after being pushed out of the bed by a second resident; failed to protect one resident diagnosed with dementia (#16) from sexual exploitation by a resident with known sexually aggressive behaviors; and mistreatment by staff (#2); and neglected the safety needs of Resident #10 who had a history of violent behavior associated with falls and injuries, was found by a family member on the floor in the hallway during the lunch meal sustaining a pelvic fracture and died one week later. [Refer to Tag D914 G.S. 131D-21(4) Declaration of Resident Rights (Type A1 Violation)]

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D 344	10A NCAC 13F .1002(a) Medication Orders	D 344		

10A NCAC 13F .1002 Medication Orders
(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure as needed (PRN) orders for a psychotropic medication (haloperidol) and a narcotic anti-anxiety medication (clonazepam) were clarified in regards to defined time frames and maximum daily dosage for 1 of 5 sampled residents (#2).

The findings are:

Review of Resident #2's current FL-2 dated 03/07/18 revealed:
-Diagnoses included Alzheimer's dementia with behaviors, bilateral lower extremity venous stasis wounds, hypertension, schizoaffective disorder, deep vein thrombosis with inferior vena cava

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filter, major neurocognitive disorder, seizure disorder and history of myocardial infarction.
-Medication orders included haloperidol 1mg every 24 hours, give with clonazepam 1mg every 24 hours PRN for agitation. (Clonazepam is used to treat anxiety and haloperidol is used to treat psychosis.)

Review of a mental health provider (MHP) order form for Resident #2 dated 03/20/18 revealed there was an order for clonazepam 1mg daily PRN for agitation, take with haloperidol 1mg daily PRN for severe agitation.

Review of a MHP order form for Resident #2 dated 08/17/18 and 09/29/18 revealed there was an order for clonazepam 0.5mg TID (TID) at 8:00am, 2:00pm and 8:00pm.

Review of a MHP order form for Resident #2 dated 09/27/18 revealed:
-There was an order to discontinue clonazepam 1mg daily PRN for agitation, take with haloperidol 1mg daily PRN for severe agitation.
-There was an order for clonazepam 1mg three times daily PRN for anxiety.
-There was an order for haloperidol 1mg three times daily PRN for severe agitation and take with clonazepam.

Observation of medications on hand for Resident #2 on 10/25/18 at 4:05pm revealed:
-There were three bubble packs with pharmacy labels that had Resident #2's name and instructions for clonazepam 0.5mg three times daily.
-The pharmacy labels indicated 90 tablets were dispensed on 10/24/18 and there were 88 tablets remaining.
-There was a bubble pack with pharmacy label

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that had Resident #2's name and instructions for clonazepam 1mg three times daily PRN agitation.
-The pharmacy label indicated 30 tablets were dispensed on 09/27/18 and there were 15 tablets remaining.
-There was no haloperidol 1mg tablets for Resident #2.

Review of Resident #2's August 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 0.5mg TID.
-Staff documented administering clonazepam 0.5mg at 8:00am, 2:00pm and 8:00pm daily 08/01/18 through 08/31/18.
-There was an entry for clonazepam 1mg daily PRN for agitation (take with haloperidol).
-Staff documented administering clonazepam 1mg PRN on 08/16/18 at 8:14pm, 08/17/18 at 9:46am and 08/28/18 at 9:29pm.
-There was an entry for haloperidol 1mg daily PRN for severe agitation (take with clonazepam).
-There were no doses of haloperidol documented as administered 08/01/18 through 08/31/18.
-There was documentation staff administered one PRN dose of clonazepam 1mg within 14 minutes of the scheduled dose of 0.5mg on 08/16/18 and did not administer haloperidol with clonazepam on 08/16/18, 08/17/18 and 08/28/18.

Interview with a medication aide (MA) on 11/06/18 at 1:23pm revealed Resident #2 did not have any scheduled clonazepam 0.5mg on 08/17/18 so she administered the PRN 1mg dose of clonazepam.

Review of Resident #2's September 2018 eMAR revealed:
-There was an entry for clonazepam 0.5mg TID.
-Staff documented administering clonazepam 0.5mg at 8:00am, 2:00pm and 8:00pm daily

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09/01/18 through 09/30/18.
-There was an entry for clonazepam 1mg daily PRN for agitation (take with haloperidol) that was documented as discontinued on 09/27/18.
-Staff documented administering the clonazepam 1mg daily PRN on 09/27/18 at 11:00am.
-There was an entry for haloperidol 1mg daily PRN for severe agitation (take with clonazepam) that was discontinued on 09/27/18.
-Staff documented administering the haloperidol 1mg daily PRN on 09/23/18 at 7:54am, 09/26/18 at 1:52pm and 09/27/18 at 9:02am.
-There was an entry for clonazepam 1mg TID PRN for anxiety.
-Staff documented administering clonazepam 1mg TID PRN on 09/28/18 at 9:16am, 09/29/18 at 8:22am, 09/29/18 at 2:55pm and 09/29/18 at 8:41pm.
-There was an entry for haloperidol 1mg TID PRN for severe agitation and take with clonazepam.
-Staff documented administering haloperidol 1mg TID PRN on 09/28/18 at 9:16am, 09/29/18 at 8:22am, 09/29/18 at 2:55pm, 09/29/18 at 8:41pm and 09/30/18 at 7:30pm.
-There was no documentation staff administered a PRN dose of clonazepam on 09/27/18 at 11:00am with haloperidol.
-There was documentation the PRN doses of haloperidol administered on 09/23/18, 09/26/18, 09/27/18 (at 9:02am) and 09/30/18 were administered within one hour of scheduled clonazepam doses and not with a PRN dose of clonazepam.

Interview with a second MA on 10/30/18 at 4:23pm revealed:
-On 09/23/18, she administered the PRN dose of haloperidol with the scheduled dose of clonazepam (0.5mg) at 8:00am.
-If the haloperidol was administered between the

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scheduled doses of clonazepam, she would have administered the PRN clonazepam (1mg) with the haloperidol.
-"More than likely" all MAs were administering the PRN haloperidol and clonazepam the same way.

Interview with the first MA on 11/06/18 at 1:23pm revealed on 09/28/18 Resident #2 was agitated and that was why she gave him a PRN dose of clonazepam.

Review of a MHP order form for Resident #2 dated 10/09/18 revealed:
-There was an order to add haloperidol 0.5mg TID at 8:00am, 2:00pm and 8:00pm.
-There was an order to continue PRN haloperidol for severe agitation.

Review of a Physician's Order Request form for Resident #2 dated 10/12/18 revealed:
-Staff documented PRN haloperidol 1mg, PRN clonazepam 1mg and routine clonazepam was 0.5mg.
-There was an order to give PRN at 11:00am and 3:00pm.
-The order did not specify to give clonazepam, haloperidol or both.
-The order did not specify for 10/12/18 or daily at 11:00am and 3:00pm.

Review of Resident #2's October 2018 eMAR revealed:
-There was an entry for clonazepam 0.5mg TID.
-Staff documented administering clonazepam 0.5mg at 8:00am, 2:00pm and 8:00pm daily 10/01/18 through 10/23/18 except on 10/02/18 at 8:00pm, 10/18/18 at 8:00am and 10/20/18 at 8:00pm.
-There was an entry for haloperidol 1mg TID.
-Staff documented administering haloperidol 1mg

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at 8:00am, 2:00pm and 8:00pm daily 10/09/18 at 8:00pm through 10/23/18 except on 10/11/18 at 2:00pm and 8:00pm, 10/13/18 at 2:00pm, 10/14/18 at 8:00pm, 10/17/18 at 8:00am and 10/18/18 at 8:00am.
-There was an entry for clonazepam 1mg TID PRN for anxiety.
-Staff documented administering clonazepam 1mg TID PRN on 10/05/18 at 3:42pm, 10/06/18 at 5:15pm, 10/09/18 at 4:36pm, 10/13/18 at 12:45pm, 10/13/18 at 4:54pm, 10/16/18 at 5:07pm, 10/18/18 at 4:02pm, 10/19/18 at 6:00pm, 10/20/18 at 8:55am and 10/20/18 at 9:03pm.
-There was an entry for haloperidol 1mg TID PRN for severe agitation and take with clonazepam.
-Staff documented administering haloperidol 1mg TID PRN on 10/01/18 at 7:52am, 10/03/18 at 7:26pm, 10/04/18 at 7:42pm, 10/05/18 at 3:42pm, 10/05/18 at 7:43pm, 10/06/18 at 8:52am, 10/06/18 at 7:25pm, 10/08/18 at 9:37am, 10/09/18 at 4:36pm, 10/11/18 at 2:31pm, 10/11/18 at 7:50pm, 10/13/18 at 12:45pm, 10/13/18 at 4:54pm, 10/13/18 at 8:23pm, 10/14/18 at 7:18pm, 10/16/18 at 5:07pm, 10/17/18 at 7:49am, 10/18/18 at 4:02pm, 10/19/18 at 8:22am and 10/20/18 at 8:55am.
-There was no entry for haloperidol 1mg or clonazepam 1mg at 11:00am and 3:00pm.
-There was documentation Resident #2 missed three scheduled doses of clonazepam and five scheduled doses of haloperidol.
-Staff documented administering 10 doses of PRN clonazepam, 2 of which were administered within one hour of the scheduled dose of clonazepam.
-Staff documented administering 20 doses of PRN haloperidol, 8 of which were administered within one hour of scheduled clonazepam and the PRN dose of clonazepam was not administered, and 7 of which were administered within one hour

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of scheduled haloperidol and clonazepam.

Review of a Physician's Order form for Resident #2 dated 10/14/18 revealed:
-There was an order for haloperidol 1mg TID PRN for severe agitation and take with clonazepam.
-There was no order for haloperidol 1mg TID at 8:00am, 2:00pm and 8:00pm.

Review of MHP order forms and Physician's Order Request forms for Resident #2 revealed:
-There was no clarification of the PRN orders for clonazepam and haloperidol regarding quantified time frames between dosages and maximum daily dosage amount.
-There was no clarification of time frames between scheduled dosages and PRN dosages of haloperidol and clonazepam.
-There was no clarification of Physician's Orders dated 10/14/18 and the MHP order dated 10/09/18 for haloperidol.

Interview with the first MA on 10/26/18 at 12:10pm revealed:
-The haloperidol and clonazepam should have been given together for Resident #2.
-The haloperidol and clonazepam came up together on the eMAR.
-She always administered the haloperidol and clonazepam together for Resident #2, the medications were scheduled to be given together.
-She had only administered a PRN dose of clonazepam once to Resident #2 on 10/25/18.

Interview with a third MA on 11/02/18 at 4:25pm revealed:
-She administered PRN medication to Resident #2 on 10/13/18 because on 10/12/18 Resident #2 was "real agitated" and the doctor changed his

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medications around.
-The MAs were supposed to give the PRN to see if the changes would work.
-She administered the PRNs on 10/17/18 and 10/18/18 under the same order as directed.
-Resident #2 was getting his scheduled haloperidol and clonazepam and the PRN doses on 10/13/18, 10/17/18 and 10/18/18.
-The order was dated 10/12/18 and was kept on the medication cart with a paper MAR.
-The order was no longer on the medication cart and she was unable to locate the paper MAR.
-The paper MAR was used until the order was entered on eMAR, the paper MAR was not used for more than a day or two.
-The order dated 10/12/18 was not a onetime order, it went on daily.
-She was not sure when the order had been changed.

Interview with the first MA on 11/07/18 at 2:15pm revealed:
-If she administered a PRN or onetime medication to Resident #2, her initials would be documented on the resident's eMAR.
-She did not document administering clonazepam and haloperidol on a MAR for Resident #2 from the 10/12/18 order.

Upon request on 11/02/18 at 4:25pm, a paper MAR for October 2018 for Resident #2 was not available for review.

Telephone interview with a technician at the facility's contracted pharmacy on 10/26/18 at 10:30am revealed:
-Resident #2 had an order for haloperidol 0.5mg TID at 8:00am, 2:00pm and 8:00pm written on 10/09/18.
-The pharmacy had not dispensed haloperidol

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0.5mg for Resident #2 because there was a national shortage of haloperidol 0.5mg and 1mg tablets.
-Prior to 10/09/18, Resident #2 had orders for haloperidol 1mg TID PRN.
-The pharmacy dispensed 30 haloperidol 1mg tablets on 09/27/18 for the PRN order.
-She had spoken with someone at the facility on 10/26/18 regarding the national shortage and informed the facility that a new order was needed for liquid haloperidol.

Telephone interview with a technician at the facility's contracted pharmacy on 11/09/18 at 4:29pm revealed the order dated 10/12/18 for Resident #2 had not been faxed to the pharmacy.

Interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53am revealed:
-She had just started processing provider orders for residents.
-For the last month or month and half, the Special Care Coordinator (SCC) and the Special Care Manager (SCM) had been taking care of the orders.

Interview with the SCC on 10/30/18 at 12:14pm revealed:
-She was not aware of the discrepancy between the orders dated 10/09/18 signed by the MHP and the physician's orders dated 10/14/18 signed by primary care provider (PCP) for haloperidol.
-She would follow up on whether there was a clarification for the haloperidol.

Interview with the SCC on 10/30/18 at 3:54pm revealed:
-The physicians order sheet was printed on 10/09/18 at 3:00pm and the new order for haloperidol was written on 10/09/18 at 6:00pm.

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-She was not sure why the physicians order form was printed on 10/09/18 since the PCP did not visit the facility until 10/14/18.
-The MAs, Supervisors, or the SCM were able to print the physicians order forms.
-The physicians order form was then placed in the PCP's folder for the PCP to review and sign.
-The physicians order form should not have been printed and placed in the PCPs folder until she came to the facility.
-The orders for PRN haloperidol and clonazepam TID should have been clarified by the ACM in training, the SCC or the SCM.
-MAs had been instructed to fax PCP orders to the pharmacy and keep the order on a clip board with the 24 hour reports on the medication cart until the order was completed.
-Once the order had been faxed and entered into the eMAR system, the order was placed in a box in the medication room for ACM in training, SCC or SCM.
-The ACM in training, SCC or SCM went through their boxes daily.
-The ACM in training, SCC, SCM and the Executive Director (ED) were the only staff able to approve orders in the eMAR system.

Interview with the SCM on 10/30/18 at 4:59pm revealed:
-The MAs should have known to clarify the haloperidol and clonazepam orders for Resident #2.
-Once the MAs received an order for scheduled and TID as needed, they should have known to contact the provider and get the orders clarified.
-She thought she may have been the one to approve the haloperidol and clonazepam orders on the eMAR and she should have caught the need for clarification also.

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Telephone interview with Resident #2's MHP on 11/06/18 at 11:44am revealed:
-The orders dated 03/20/18 and 09/27/18 for the PRN haloperidol and PRN clonazepam were written to be administered together PRN.
-Resident #2 was difficult to manage because his behaviors were sporadic and it had been difficult to get Resident #2's medications adjusted.
-The order dated 10/12/18 for haloperidol and clonazepam to be given at 11:00am and 3:00pm was a onetime order for that day because Resident #2's behavior was severe that day.
-Resident #2 had pushed either another resident or a staff.
-She was concerned about the safety of other residents so staff were instructed to administer haloperidol and clonazepam just before lunch and just before dinner that day (10/12/18).
-She had not spoken with staff regarding a clarification of TID PRN order for haloperidol and clonazepam.
-She reviewed Resident #2's for PRN medication usage when she visited the resident at the facility.
-Staff had been instructed to call the MHP if there were concerns about Resident #2 being too sedated.
-She expected that staff administer medications as ordered and contact the MHP with any concerns.

Interview with the Executive Director (ED) on 11/02/18 at 12:25pm revealed:
-She had been made aware since 10/23/18 of the concerns related to PRN psychotropic medication orders and administration.
-She was not sure if MAs, the SCC and SCM were aware of the rules and regulations for PRN psychotropic orders prior to 10/23/18.
-Staff should have been administering the scheduled doses of haloperidol and clonazepam

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for Resident #2 as ordered by the doctor.
-The PRN doses of haloperidol and clonazepam for Resident #2 should have been clarified.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

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10A NCAC 13F .1004(a) Medication Administration

10A NCAC 13F .1004 Medication Administration
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 6 residents (#4, #19, #20) observed during the medication passes including errors with insulin (#20), a topical pain relief patch (#19), and a medication for mild to

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moderate pain (#4); and for 7 of 8 residents sampled (#1, #2, #3, #4, #8, #13, #15) for record review including errors with narcotic pain relievers (#3, #8, #15), antibiotics for infection (#4, #13), medications for breathing problems (#4), narcotics used to treat anxiety and agitation (#1, #2, #3), an antipsychotic (#2), a steroid to treat inflammation (#4) and an eye drop for glaucoma (#2).

The findings are:

1. Review of Resident #4's hospital generated FL-2 dated 08/01/18 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD) exacerbation.
-The resident was intermittently disoriented.

Review of Resident #4's electronic "Charting Notes" dated 07/31/18 at 8:49 a.m. revealed there was an entry by a medication aide (MA) the resident had complaints of shortness of breath and was sent to the local hospital by emergency medical services (EMS).

Review of Resident #4's "Hospitalist Discharge Note" dated 08/01/18 revealed:
-The date of admission was 07/31/18 and the discharge date was 08/01/18.
-The discharge diagnoses included COPD exacerbation, hypokalemia and acute respiratory failure with hypoxia.
-In the Emergency Department (ED) the resident was noted to be hypoxic requiring supplemental oxygen, had rapid breathing and a rapid heart rate.
-In the ED the resident had a chest x-ray and a computerized tomography (CT) scan (a diagnostic medical scan used to take images of organs bones, blood vessels and soft tissue) that

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showed moderate emphysema.
-The resident was placed on supplemental oxygen with improvement and received multiple Duo-neb treatments (an inhaled mediation used to open airway passage in the lungs), intravenous magnesium, fluids, steroids, and a one-time dose of intravenous antibiotics used to treat infection.
-The resident had improvements in his shortness of breath and was admitted to the hospital.
-In the hospital course section, there was an entry that the resident was supplemented with oxygen, given IV fluids and started on antibiotics and steroids.
-The resident also received scheduled and as needed breathing treatments.
-The resident quickly improved overnight and was weaned off oxygen. He was to continue the antibiotic and steroids for a total of five days each.

a. Review of Resident #4's hospital discharge medication orders dated 08/01/18 revealed there was an order to start Doxycycline (an antibiotic used to treat infection) 100mg, take one (100mg) twice daily, take one tablet tonight; then one tablet twice daily for 3 days.

Review of Resident #4's August 2018 through November 2018 electronic medication administration records (eMARs) revealed there was no entry for Doxycycline 100 mg twice daily or documentation of administration.

b. Review of Resident #4's hospital discharge medication orders dated 08/01/18 revealed there was an order to start Advair 250-50mcg/dose (used to treat chronic obstructive pulmonary disease (COPD) symptoms), inhale one puff into the lungs twice daily.

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Review of Resident #4's August 2018 through November 2018 electronic medication administration records (eMARs) revealed there was no entry for Advair 250-50mcg dose, inhale one puff into the lungs twice daily or documentation of administration.

c. Review of Resident #4's hospital discharge medication orders dated 08/01/18 revealed there was an order to start Prednisone 20 mg (used to treat inflammation), take 2 tablets (40 mg) daily with breakfast.

Review of Resident #4's August 2018 through November 2018 electronic medication administration records (eMARs) revealed there was no entry for Prednisone 20 mg, take 2 tablets (40 mg) daily with breakfast or documentation of administration.

d. Review of Resident #4's hospital discharge medication orders dated 08/01/18 revealed there was an order to start Spiriva 18 mcg capsule (used to treat bronchospasms), inhale one capsule into the lungs daily.

Review of Resident #4's August 2018 through November 2018 electronic medication administration records (eMARs) revealed there was no entry for Spiriva 18 mcg capsule, inhale one capsule into the lungs daily or documentation of administration.

Interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:26 a.m. revealed:
-She was not aware Resident #4 had medication orders on a hospital discharge dated 08/01/18.
-The medication aides (MAs) were responsible for faxing all hospital discharge orders to the contracted pharmacy.

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-She was not sure why Resident #4's FL-2 dated 08/01/18 was not sent to the contracted pharmacy.

Interview with the Special Care Coordinator (SCC) on 11/02/18 at 11:48 a.m. revealed:
-She was not aware Resident #4 had an FL-2 dated 08/01/18 along with a discharge summary signed by the physician for new medications and not sure why Resident #4's medication orders were not started from the order dated 08/01/18.
-She "guessed" Resident #4's FL-2 dated 08/01/18 was never sent to the facility's contracted pharmacy.
-"In a normal world" before a resident was brought back to the facility from the hospital, the hospital should fax the discharge summary to the facility so that the orders could be reviewed for changes and to assure the resident was appropriate to come back to the facility.
-The MAs had been trained within the past two months to fax the entire discharge summary to the facility's pharmacy, then the pharmacy placed the orders in the eMAR system.
-Once the resident's medications had been added to the eMAR system, the MA or the ACM were supposed to review the medication orders to assure the orders were correct by comparing the resident's new orders with the eMAR and previous order and approve the order changes in the system.
-When new medication orders were placed into the system by the contracted facility pharmacy, the order was flagged "green" in color and the MA would not be able to click off that certain medication until the medication had been approved.
-Since she had started working at the facility, she and the Special Care Manager (SCM) had been performing resident record audits.

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-She had not yet performed a record audit on Resident #4's record.

Interview with Resident #4 on 11/02/18 at 11:17 a.m. revealed:
-The resident had a cough and cold for about a month.
-He had never received any inhaled medications at the facility but had received inhaled medications in the past when he was in the hospital.
-He had shortness of breath at times, but was not having any currently.

Review of Resident #4's PCP's "Patient Notes' dated 11/03/18 at 2:40 p.m. revealed:
-The resident's PCP received an email from the Executive Director (ED) as follows: The resident had new orders when he was released from (a named local) hospital on 08/01/18 that were not sent to the pharmacy.
-The PCP was questioned what were her recommendations related to the Doxycycline, Advair, Nitroglycerin, Prednisone, and Spiriva inhalation capsules.
-An email response was sent the ED 11/03/18 at 1:53 p.m.

Interview with the ED on 11/09/18 at 10:48am revealed:
-Whenever there was a new order written by the PCP, the order was faxed to the pharmacy by the MA on duty and then forwarded to SCM.
-The SCM reviewed the order on the electronic medication system and the order was filed.
-The completed order was initialed by the MA after it was faxed and by the SCM after it was approved in the electronic medication system.
-She was not able to give a reason why Resident #4's medications orders dated 08/01/18 were not

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started.

Interview with the PCP on 11/05/18 at 10:32 a.m. revealed:
-She expected staff at the facility to implement all orders for residents.
-Going without ordered medications could have caused an exacerbation of COPD for Resident #4.

2. Review of Resident #1's current FL-2 dated 08/09/18 revealed:
-Diagnoses included Alzheimer's disease, frontal dementia, panic disorder, insomnia, lupus erythematosus and history of pituitary adenoma.
-The resident was constantly disoriented and wandered.
-There was an order for Lorazepam 0.5mg (used to treat anxiety) take one twice daily.
-There was an order for Lorazepam 0.5 mg, take 0.5 tablet (0.25mg) every day as needed for agitation.

Review of Resident #1's August 2018 electronic medication administration record (eMAR) revealed:
-There was a computer generated entry for Lorazepam 0.5mg take one twice daily, scheduled to be administered at 6:00 a.m. and 6:00 p.m.
-There was documentation Lorazapam 0.5mg was administered twice daily from 08/01/18 starting at 6:00 a.m. through 08/21/18 at 6:00 a.m.
-There was no documentation Lorazepam 0.5mg was administered at 6:00 p.m. on 08/21/18.
-There was a computer generated entry for Lorazepam 0.5mg, take 0.5 tablet (0.25mg) every day as needed for agitation.
-There was documentation the resident received

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one tablet of Lorazepam 0.5mg (not the ordered dose of a 0.5 tablet) as needed on 08/22/18 at 5:20 p.m. with a quantity of one (0.5mg) for agitation and the result was documented as effective.

Attempted interview with the MA who documented her initials for Lorazepam 0.5mg as needed for Resident #1 on 08/22/18 at 5:20 p.m. was unsuccessful on 11/09/18 at 4:43 p.m.

Review of Resident #1's September 2018 eMAR revealed:
-There was a computer generated entry for Lorazepam 0.5mg, take 0.5 tablet (0.25mg) every day as needed for agitation.
-There was documentation the resident received one tablet of Lorazepam 0.5mg (not the ordered dose of 0.5 tablet) as needed on 09/11/18 at 3:08 p.m. with a quantity of one for agitation (0.5mg) and the result was documented as effective.

Interview with the Assistant Care Manager (ACM) in training on 10/30/18 at 11:53am revealed:
-Medication aides (MAs) did daily audits on the medication carts.
-The MAs were responsible for making sure medications were in the facility for each resident.

Telephone interview with a pharmacy technician with the facility's contracted pharmacy provider on 11/08/18 at 2:30 p.m. revealed the contracted pharmacy had never dispensed any of the as needed prescriptions for Lorazepam 0.5mg, take 0.5 tablet (0.25mg) every day as needed for agitation for Resident #1

Interview with the Special Care Coordinator (SCC) on 11/07/18 at 3:30pm revealed:
-The care manager (CM) was responsible for

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supervising the MAs, assuring medications were administered timely and that medication cart audits were completed.
-The CM supervised MAs by reviewing reports from the electronic medication administrations system which allowed a real time online review of a medication pass in progress.
-CMs were responsible for monitoring primary care provider (PCP) orders.

Interview with the Executive Director (ED) on 11/09/18 at 10:48am revealed:
-When a residents' medication was not administered, the MAs documented their initials with a circle around their initials along with a reason in the exception section of the eMAR why the medication was not administered on that day.
-Resident #1's Lorazepam 0.5mg, take 0.5 tablet (0.25mg) every day as needed for agitation should have been available and administered as ordered.

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

Telephone interview with the primary care provider on 11/09/18 at 4:15 p.m. revealed:
-She was not sure if there would be any outcome if Resident #1 received an increased dose of the as needed Lorazepam because this medication had an opposite effect on the resident.
-She expected for all medications to be administered as ordered.

Attempted telephone interview with Resident #1's mental health provider on 11/09/18 at 4:30 p.m. was unsuccessful.

3. Review of Resident #2's current FL-2 dated

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03/07/18 revealed diagnoses included Alzheimer's dementia with behaviors, schizoaffective disorder, major neurocognitive disorder and seizure disorder.

a. Review of Resident #2's current FL-2 dated 03/07/18 revealed there was a medication order for travoprost 0.004% one drop in each eye daily at bedtime. (Travoprost is used to treat glaucoma.)

Review of Resident #2's August, September and October 2018 electronic medication administration records (eMARs) revealed:
-There was an entry for travoprost 0.004% one drop to both eyes at bedtime.
-There was documentation the travoprost was administered daily 08/01/18 through 10/29/18 at 9:00pm except on 10/02/18 and 10/06/18.
-There was documentation that Resident #2 was in the hospital on 10/02/18 and refused the 10/06/18 dose.

Observation of medications available for administration for Resident #2 on 10/25/18 at 4:05pm revealed there were no travoprost eye drops.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/26/18 at 10:30am revealed:
-Resident #2's travoprost eye drops were not on a monthly automatic cycle refill, the facility needed to request a refill.
-The pharmacy last dispensed travoprost eye drops for Resident #2 on 03/02/18.
-There were 50 drops per 2.5 milliliter (ml) bottle and with an order for one drop in each eye daily at bedtime, one bottle would last 25 days.
-The facility sent a refill request on 10/23/18

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which was declined by the insurance company.
-Resident #2's provider would need to write an order for a different eye drop that would be covered by the resident's insurance.

Interview with a medication aide (MA) on 10/26/18 at 12:10pm revealed:
-MAs ordered refills by clicking on the refill tab on the eMAR.
-She did not know anything about the travoprost eye drops for Resident #2 because the drops were given at bedtime.

Interview with a second MA on 10/30/18 at 4:23pm revealed:
-She worked regularly when 8:00pm medications were administered.
-She had not seen a bottle of the travoprost eye drops for Resident #2 for a while.
-She gave many medications and eye drops and thought it may have been one week since she last saw a bottle of Resident #2's travoprost eye drops.
-She did not always work on the 200 hall medication cart so she was not sure.

Interview with a third MA on 11/07/18 at 5:10pm revealed:
-She worked 2nd shift when Resident #2's travoprost eye drops were scheduled to be administered.
-She had administered the travoprost eye drops to Resident #2 as she had documented on the resident's eMAR.
-There were eye drops on the medication cart for Resident #2.
-She probably had not checked and noticed the eye drops were expired and another MA threw them away when a medication cart audit was done.

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-She did not know when the eye drops had been thrown away.
-She did not have a response for pharmacy dispensing the last bottle on 03/02/18.

Interview with the Special Care Coordinator (SCC) on 10/30/18 at 3:54pm revealed:
-Staff should have seen Resident #2's travoprost eye drops were out of stock during the medication cart audit and sent a refill request to the pharmacy.
-The MAs were expected to perform medication cart audits daily Monday through Thursday.
-The MAs were responsible for making sure there was a minimum of a seven day supply for medications when the medication cart audit was done.

Telephone interview with Resident #2's primary care provider (PCP) on 10/26/18 at 11:21am revealed:
-It was a concern that Resident #2 had not received the travoprost eye drops for approximately 7 months.
-The travoprost eye drops were used to treat glaucoma.
-Resident #2 should have been getting the travoprost eye drops to reduce the pressure in his eyes.

Telephone interview with the Operations Manager at Resident #2's Ophthalmologist's office on 11/06/18 at 12:20pm revealed:
-Resident #2 was last seen on 6/5/18 for glaucoma, the Ophthalmologist visited the facility every six months.
-Resident #2 was prescribed travoprost eye drops one drop in each eye at bedtime to treat the glaucoma by lowing pressure in the eyes.
-The eye drops had not been discontinued and

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the facility had not contacted the Ophthalmologist's office requesting a change in the order.
-Not getting the travoprost eye drops could lead to a loss of vision and increased pressure in the eyes.

Interview with the Executive Director (ED) on 11/02/18 at 12:25pm revealed:
-There was a new system implemented on 10/15/18, where MAs completed inventory audit on the medication carts.
-Staff should have seen Resident #2's travoprost eye drops were out of stock during the medication cart audit and sent a refill request to the pharmacy.
-The SCC and the Special Care Manager (SCM) spot check the medication carts behind the MAs.

b. Review of Resident #2's current FL-2 dated 03/07/18 revealed there was a medication order for clonazepam 1mg daily at 8:00am, 2:00pm. (Clonazepam is used to treat anxiety.)

Review of a mental health provider (MHP) order form for Resident #2 dated 08/17/18 revealed there was an order for clonazepam 0.5mg three times daily.

Review of Resident #2's August 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 0.5mg three times daily.
-There was documentation the clonazepam was administered at 8:00am, 2:00pm and 8:00pm from 8:00am on 08/16/18 through 2:00pm on 08/28/18.

Review of Resident #2's controlled drug Inventory

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History for clonazepam 0.5mg tablets dated 08/16/18 through 08/28/18 revealed:
-On 08/16/18 at 2:05pm, the remaining count was one tablet.
-On 08/17/18 at 9:10pm, there was documentation of a "Delivery" of 15 tablets.
-On 08/27/18 at 1:26pm, the remaining count was zero tablets.
-On 08/28/18 at 11:01pm, there was documentation of a "Delivery" of 90 tablets.

Based on review of Resident #2's August 2018 eMAR and controlled drug Inventory History from 08/16/18 through 08/28/18, there were no clonazepam 0.5mg tablets to administer to Resident #2 on 08/16/18 at 8:00pm, 08/17/18 at 8:00am and 2:00pm, 08/27/18 at 8:00pm and 08/28/18 at 8:00am, 2:00pm and 8:00pm.

Review of Resident #2's September 2018 eMAR revealed:
-There was an entry for clonazepam 0.5mg three times daily.
-There was documentation the clonazepam was administered at 8:00am, 2:00pm and 8:00pm from 8:00am on 09/28/18 through 8:00pm on 09/29/18.

Review of Resident #2's controlled drug Inventory History dated 09/01/18 through 09/30/18 revealed:
-On 09/27/18 at 7:24pm, the remaining count was zero tablets.
-On 09/30/18 at 3:38pm, there was documentation of a "Delivery" of 90 tablets.

Based on review of Resident #2's September 2018 eMAR and controlled drug Inventory History from 09/27/18 through 09/30/18, there were no clonazepam 0.5mg tablets to administer to

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Resident #2 on 09/28/18 and 09/29/18 at 8:00pm, 2:00pm and 8:00pm.

Observation of medications on hand for Resident #2 on 10/25/18 at 4:05pm revealed:
-There were three bubble packs with pharmacy labels that had Resident #2's name and instructions for clonazepam 0.5mg three times daily.
-The pharmacy labels indicated 90 tablets were dispensed on 10/24/18 and there were 88 tablets remaining.

Interview with a medication aide (MA) on 11/05/18 at 5:30pm revealed a resulting count of zero documented on the controlled drug record meant the medication was out of stock.

Interview with the Special Care Coordinator (SCC) on 11/07/18 at 3:54pm revealed:
-She acknoledged her initials were on Resident #2's eMAR for administering six doses of clonazepam on 09/28/18 and 09/29/18.
-She had not worked on the medication cart administering medications to residents at the facility.
-She did not know how her initials got onto Resident #2's eMAR.
-No one would have been able to enter her initials unless they knew her password.

Interview with the Executive Director (ED) on 11/09/18 at 10:48am revealed:
-If the doses of clonazepam were not given, it would have come up on the eMAR with the staff's initials circled.
-The MAs were responsible for auditing the medications of a certain number of residents each day to assure medications were on the medication carts.

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-All residents' medications had to be audited by Friday of each week.
-She did not know where staff had obtained doses of clonazepam 0.5mg to administer to Resident #2 on 08/16/18, 08/17/18, 08/27/18 and 08/28/18, unless the staff borrowed the medication from another resident.
-Medications should not have been borrowed unless it was an emergency.
-Staff were supposed to document what was borrowed and when it was paid back.
-She would check the dates for any documentation on doses that might have been borrowed from another resident.

Upon request, documentation on borrowed doses of clonazepam for Resident #2 were not available for review.

The Director of Nursing (DON), who documented administering clonazepam to Resident #2 on 08/16/18 at 8:00pm and 08/17/18 at 8:00am and 2:00pm, was not available for interview on 11/09/18.

The Assistant Care Manager (ACM) in training, who documented administering clonazepam to Resident #2 on 08/27/18 at 8:00pm and 08/28/18 at 8:00am and 2:00pm, was not available for interview on 11/07/18 and 11/09/18.

c. Review of Resident #2's current FL-2 dated 03/07/18 revealed there was an order for haloperidol 1mg every 24 hours give with clonazepam 1mg every 24 hours as needed (PRN) for agitation. (Clonazepam is used to treat anxiety and haloperidol is used to treat psychosis.)

Review of a mental health provider (MHP) order

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form for Resident #2 dated 03/20/18 revealed there was an order for clonazepam 1mg daily as needed (PRN) for agitation, take with haloperidol 1mg daily PRN for severe agitation.

Review of a MHP order form for Resident #2 dated 09/27/18 revealed:
-There was an order to discontinue clonazepam 1mg daily PRN for agitation, take with haloperidol 1mg daily PRN for severe agitation.
-There was an order for clonazepam 1mg three times daily PRN for anxiety.
-There was an order for haloperidol 1mg three times daily PRN for severe agitation and take with clonazepam.

Review of charting notes for Resident #2 for August 2018 revealed staff documented Resident #2 was aggressive 08/18/18 at 10:19pm, had a sexual incident on 08/19/18 at 10:51pm and was sexually aggressive and cursing on 08/23/18 at 10:12pm.

Review of Resident #2's August 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 1mg daily PRN for agitation (take with haloperidol).
-There was an entry for haloperidol 1mg daily PRN for severe agitation (take with clonazepam).
-There were no doses of haloperidol or cloanzepam documented as administered on 08/18/18, 08/19/18 or 08/23/18.
-There was no entry for clonazepam 1mg three times daily PRN for anxiety.
-There was no entry for haloperidol 1mg three times daily PRN for severe agitation and take with clonazepam.

Interview on 11/07/18 at 5:10pm with the

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medication aide (MA) who documented the charting notes dated 08/18/18 at 10:19pm, 08/19/18 at 10:51pm and 08/23/18 at 10:12pm revealed:
-On 08/18/18, Resident #2 being aggressive meant Resident #2 was hitting, cursing, looking at residents in a mean way and having a fight or defensive posture.
-Whenever Resident #2 was being aggressive and/or sexually inappropriate, staff would usually redirect him by taking him outside and sometimes Resident #2 would redirect himself and go down the hall.

The MA who documented the charting notes dated 08/18/18 at 10:19pm, 08/19/18 at 10:51pm and 08/23/18 at 10:12pm, was not available for re-interview on 11/09/18 regarding the administration of PRN haloperidol and clonazepam.

Telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25pm revealed:
-She could not recall the specifics of the note she documented on 08/23/18 for Resident #2.
-Resident #2 had a lot of sexual aggression towards other residents, any female.
-Resident #2 would "touch females on their rear end and say sexual things."
-She would talk to Resident #2 and redirect him.

Review of charting notes for Resident #2 for September 2018 revealed staff documented Resident #2 was very aggressive toward another resident on 09/12/18 at 6:45pm.

Review of Resident #2's September 2018 eMAR revealed:
-There was an entry for clonazepam 1mg daily PRN for agitation (take with haloperidol).

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-There was an entry for haloperidol 1mg daily PRN for severe agitation (take with clonazepam).
-There was an entry for clonazepam 1mg three times daily PRN for anxiety.
-There was an entry for haloperidol 1mg three times daily PRN for severe agitation and take with clonazepam.
-There were no doses of haolperidol or clonazepam documented as administered on 09/12/18.

Interview on 11/07/18 at 5:10pm with the MA who documented the charting note dated 09/12/18 at 6:45pm revealed she did not remember the staff or the resident involved in the incident documented in her note.

The MA who documented the charting note dated 09/12/18 at 6:45pm, was not available for re-interview on 11/09/18 regarding the administration of PRN haloperidol and clonazepam.

Review of charting notes for Resident #2 for October 2018 revealed staff documented Resident #2 was aggressive, swinging at other residents and staff, picked up a wheelchair to throw and was cussing and "threatening people" on 10/12/18 at 5:50pm.

Review of Resident #2's October 2018 eMAR revealed:
-There was an entry for clonazepam 1mg three times daily PRN for anxiety.
-There was an entry for haloperidol 1mg three times daily PRN for severe agitation and take with clonazepam.
-There were no doses documented as administered on 10/12/18.

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Interview on 10/31/18 at 4:03pm with the MA who documented the charting note dated 10/12/18 at 5:50pm revealed:
-She notified the MHP on 10/12/18.
-Resident #2 had also had some medication changes to help decrease the aggressive behaviors.

Attempted interview on 11/09/18 at 3:00pm, with the MA who documented the charting note dated 10/12/18 at 5:50pm regarding the administration of PRN haloperidol and clonazepam, was unsuccessful.

Observation of medications on hand for Resident #2 on 10/25/18 at 4:05pm revealed:
-There was no haloperidol 1mg tablets available for administration for Resident #2.
-There was a bubble pack with a pharmacy label that had instructions for clonazepam 1mg three times daily PRN agitation.
-The pharmacy labels indicated 30 tablets were dispensed on 09/27/18; there were 15 tablets remaining.

Interview with the Assistant Care Manager (ACM) in training on 11/02/18 at 12:20pm revealed Resident #2 needed haloperidol when he was agitated.

Interview with the Special Care Coordinator (SCC) on 11/05/18 at 5:45pm revealed she absolutely would expect PRN medication to be given to Resident #2 for episodes of agitation and aggression.

Telephone interview with Resident #2's MHP on 10/26/18 at 11:09am revealed:
-She had made changes to Resident #2's haloperidol and clonazepam in late September

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2018 due to the resident having escalating behaviors.
-Prior to the end of September 2018, Resident #2's behaviors were sporadic and included episodes of anger, touching other residents and inappropriate comments towards other residents.
-Resident #2's behaviors had been difficult to manage and get the medications adjusted since approximately

Telephone interview with Resident #2's MHP on 11/06/18 at 11:44am revealed:
-Resident #2 was difficult to manage because his behaviors were sporadic and it had been difficult to get Resident #2's medications adjusted.
-She reviewed Resident #2's eMARs for how often PRN medications were administered when she visited the resident at the facility.
-Staff had been instructed to call the MHP if there were concerns about Resident #2 being too sedated.
-She expected that staff administer medications as ordered and contact the MHP with any concerns.

Interview with the Executive Director (ED) on 11/02/18 at 12:25pm revealed:
-She was not aware there were five incidents of aggression documented in Resident #2's charting notes and there was no PRN medication documented as administered on the eMAR.
-Resident #2 should have received PRN medication for episodes aggression if it was within the ordered timeframe.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

4. Review of Resident #13's current FL-2 dated

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10/25/17 revealed diagnoses included Alzheimer's dementia, type II diabetes mellitus, hypertension, stage III chronic kidney disease, and anemia.

Review of hospital records for Resident #13 dated 04/11/18 through 04/13/18 revealed:
-Resident #13 presented to the hospital on 04/11/18 after a fall with vomiting and diarrhea and was admitted with acute gastroenteritis with dehydration and placed on isolation until a stool specimen was obtained.
-Resident #13 was discharged on 04/13/18 with no further episodes of vomiting and diarrhea.

Review of a Physician's Order Request for Resident #13 dated 04/13/18 (received from the pharmacy on 11/09/18) revealed:
-Staff documented an update that the hospital contacted the facility that Resident #13's stool specimen came back positive for norovirus and clostridium difficile (C-Diff).
-The hospital requested Resident #13's primary care provider (PCP) prescribe antibiotics.
-There was an order for metronidazole 500mg twice daily for seven days signed by the PCP and dated 04/20/18. (Metronidazole is an antibiotic used to treat infections.)

Attempted interview on 11/08/18 at 8:01pm, with the medication aide (MA) who documented the hospital contact on 04/13/18, was unsuccessful.

Review of a charting note for Resident #13 dated 05/04/18 at 8:23pm revealed:
-The metronidazole ordered for Resident #13 had not been received.
-There was no documentation of contact with the pharmacy or PCP.

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The MA who documented the charting note dated 05/04/18 at 8:23pm was not available for interview on 11/09/18.

Review of Resident #13's May 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for metronidazole 500mg twice daily at 8:00am and 8:00pm.
-The first dose was documented as administered at 8:00pm on 05/04/18.
-The caregiver key indicated the initials for the 8:00pm dose on 05/04/18 were the former Director of Nursing's (DON).
-There was documentation Resident #2 refused the 8:00am dose on 05/10/18.

The former DON was not available for interview on 11/09/18.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/09/18 at 4:29pm revealed a seven day supply of metronidazole was dispensed for Resident #13 on 05/03/18.

Telephone interview with Resident #11's PCP on 11/09/18 at 4:42pm revealed:
-Resident #13 was treated for C-Diff when he was on the hospital for gastritis.
-She was not aware she had written the order dated 04/20/18 for metronidazole in response to the notification of a C-Diff positive stool culture for Resident #13.
-She thought the staff was just notifying her of the culture result and that Resident #13 had been treated in the hospital.
-She was not aware the metronidazole ordered on 04/20/18 was not filled by the pharmacy until 05/03/18 and the first dose of metronidazole was

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not administered until 05/04/18 at 8:00pm.
-Resident #13 had not had any further nausea, vomiting or diarrhea.

Interview with the Executive Director (ED) on 11/09/18 at 5:37pm revealed:
-She was not aware Resident #13 had a delay of 14 days in receiving the metronidazole ordered 04/20/18.
-She did not recall staff reporting any issues with obtaining the metronidazole from the pharmacy.

Interview with the Executive Director (ED) on 11/09/18 at 10:48am revealed:
-Whenever there was a new order written by the PCP, the order was faxed to the pharmacy by the MA on duty and then forwarded to the Special Care Manager (SCM).
-The SCM reviewed the order on the electronic medication system and the order was filed in the resident's chart.
-The completed order was initialed by the MA after it was faxed and by the SCM after it was approved in the electronic medication system.
-There was a new process implemented in October 2018.
-The process was reviewed with each MA one on one with the SCM.

Based on observations, interviews and record reviews, it was determined Resident #13 was not interviewable.

5. Review of Resident #3's current FL-2 dated 01/26/18 revealed diagnoses included Alzheimer's disease, hypertension, chronic kidney disease, and history of cerebrovascular accident.

a. Review of Resident #3's primary care provider's (PCP) order dated 07/05/18 revealed

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there was an order for Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours, hold if sleeping. (Morphine Sulfate is a controlled substance used to treat moderate to severe pain.)

Review of Resident #3's PCP's order dated 08/17/18 revealed an order for Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours (scheduled), hold for sedation.

Review of Resident #3's PCP's order dated 08/29/18 revealed an order for Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours.

Review of Resident #3's charting note dated 08/29/18 at 4:11pm revealed they were waiting on a refill of the Morphine from the pharmacy.

Review of Resident #3's pharmacy dispensing records for Morphine Sulfate for August 2018 revealed:
-There was 10.5ml (42 prefilled syringes) of Morphine Sulfate dispensed on 08/07/18.
-There was 15ml (60 prefilled syringes) of Morphine Sulfate dispensed on 08/17/18.
-There was 11.25ml (45 prefilled syringes) of Morphine Sulfate dispensed on 08/29/18.

Review of Resident #3's controlled substance (CS) log dated 08/18/18 - 08/31/18 revealed:
-There were 3 doses of Morphine not administered as ordered.
-The 12:00pm, 4:00pm, and 8:00pm doses on 08/29/18 were not documented as administered due to a balance of 0 Morphine on hand at those times.
-There were 6 doses of Morphine documented as administered late, more than 1 hour after the

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scheduled time.
-The late doses ranged from 1 hour 32 minutes after the scheduled time up to 2 hours 20 minutes after the scheduled time.
-For example, on 08/20/18, the 8:00am dose was documented as administered at 10:20am.
-For example, on 08/25/18, the 4:00am dose was documented as administered at 5:32am.

Review of Resident #3's August 2018 medication administration record (MAR) revealed:
-There was an entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml (5mg) by mouth every 4 hours and it was scheduled for 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The 12:00pm, 4:00pm, and 8:00pm doses on 08/29/18 were documented as administered on the MAR but not on the CS log as there was none on hand to administer.

Attempted interview on 11/08/18 at 7:56pm with a former medication aide (MA) who initialed Morphine doses as administered on the MAR on 08/29/18 but not administered on the CS log was unsuccessful.

Review of Resident #3's PCP orders dated 09/02/18 revealed:
-There was an order to discontinue all current Morphine orders.
-There was an order for Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours (scheduled).
-There was a note to the pharmacy not to fill any controlled substances unless written by the PCP.

Review of Resident #3's PCP order dated 09/24/18 revealed an order for Morphine Sulfate 100mg/5ml take 0.25ml by mouth or sublingually

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every 4 hours.

Review of Resident #3's charting note dated 09/24/18 at 6:49pm revealed the resident had a new refill for Morphine and it would be in from the pharmacy tonight.

Review of Resident #3's pharmacy dispensing records for Morphine Sulfate for September 2018 revealed:
-There was 15ml (60 prefilled syringes) of Morphine Sulfate dispensed on 09/03/18.
-There was 4.5ml (18 prefilled syringes) of Morphine Sulfate dispensed on 09/24/18.
-There was 15ml (60 prefilled syringes) of Morphine Sulfate dispensed on 09/28/18.

Review of Resident #3's September 2018 MAR revealed:
-There were 4 entries for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml (5mg) sublingually and/or by mouth every 4 hours with scheduled administration times of 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Morphine was not documented as administered on the following 9 occasions with no reasons documented.
-Morphine was not documented as administered from 8:00am on 09/24/18 through 8:00pm on 09/24/18.
-Morphine was not documented as administered from 4:00am on 09/28/18 through 4:00pm on 09/28/18.
-Morphine was not documented as administered at 4:00am on 09/29/18.
-The resident refused Morphine on 4 occasions.
-Morphine was "withheld per doctor orders" on 7 occasions but there was no order to hold it.
-If administered as ordered every 4 hours, 180 doses should have been administered from

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09/01/18 - 09/30/18.
-There was a total of 172 doses (43ml) of Morphine Sulfate documented as administered in September 2018.

Review of Resident #3's CS log for September 2018 revealed:
-There was a total of 161 doses of Morphine documented as administered on the CS log but 172 doses were documented as administered on the MAR from 09/01/18 - 09/30/18.
-There were 2 doses documented as administered on 09/03/18 at 4:52am and both were deducted from the balance.
-There were 5 doses not documented or declined from the count on the CS log that were documented as administered on the MAR.
-There were 3 doses not documented as administered on the CS log or the MAR with no reason documented.
-There were 5 doses not administered from 4:00am on 09/24/18 through 8:00pm on 09/24/18 due to no Morphine being on hand with a balance of 0.
-There were 4 doses not administered from 4:00am on 09/28/18 through 4:00pm on 09/28/18 due to no Morphine on hand with a balance of 0.
-There were 15 doses of Morphine documented as administered late, more than 1 hour after the scheduled time.
-The late doses ranged from 1 hour 26 minutes after the scheduled time up to 2 hours 59 minutes after the scheduled time.
-For example, on 09/13/18, the 12:00pm dose was documented as administered at 1:26pm.
-For example, on 09/11/18, the 12:00am dose was documented as administered at 2:59am.

Review of a hospice update report dated 09/25/18 for Resident #3 revealed the resident

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missed 16 doses of Morphine due to facility oversight.

Interview with a hospice nurse on 11/09/18 at 2:40pm revealed:
-Resident #3 had missed doses of Morphine because the medication had ran out.
-The resident was grimacing in pain, had agonal shallow breathing when she missed the Morphine doses.
-The Morphine made the resident more comfortable.

Review of Resident #3's PCP visit note dated 09/26/18 revealed:
-The resident was being seen for follow up on pain management.
-The MAR indicated 3 doses of Morphine were withheld per doctor orders but there was no order to hold this medication.
-This was brought to the attention of the Special Care Coordinator (SCC).

Review of a hospice noted dated 09/27/18 at 8:08pm for Resident #3 revealed the resident had one dose of Morphine left.

Review of Resident #3's charting notes dated 09/28/18 at 2:34pm and 5:35pm revealed they were waiting for medication to come in from pharmacy.

Review of Resident #3's charting note by the Special Care Manager (SCM) dated 09/28/18 at 10:20pm revealed:
-The SCM spoke with the pharmacy to see why the Morphine had not been delivered.
-The SCM let the pharmacy know the PCP had called and faxed the order to the pharmacy.
-The pharmacy said they never received the

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order or a phone call from the PCP.
-The SCM notified the PCP the facility never received the Morphine from the pharmacy and the resident had been out of Morphine for several days.
-The PCP stated she called the pharmacy and faxed the order several times to the pharmacy.
-The PCP faxed the order to the facility and the facility faxed it to the pharmacy.
-The SCM called the pharmacy and they had received the fax but the prefilled syringes could not be sent through the back up pharmacy.
-The pharmacy stated the Morphine would be delivered to the facility the next morning.
-The SCM notified the PCP and the Executive Director (ED).
-They had to borrow a one-time dose until the medication arrived due to the resident feeling restless and in pain.

Interview with the SCM on 11/02/18 at 1:27pm revealed:
-Resident #3 was a hospice resident.
-She was aware Resident #3 ran out of Morphine.
-The MAs should have notified the PCP, pharmacy and hospice if the resident ran out of Morphine.
-The Morphine prescriptions were being faxed to the pharmacy.
-The MAs were supposed to start getting a new prescription when there was about a 10 day supply remaining of any controlled substance.
-The problem with Resident #3 running out of Morphine was caused by the MAs waiting too late to try to get a new prescription.
-She could not recall the specific details when Resident #3 ran out of Morphine but she thought the ED got on the computer and "did something" with the Morphine.
-She could not explain what the ED did but the

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ED took care of the problem with Morphine being unavailable.
-Resident #3 was in pain and more restless towards the end of her life.
-Medications were supposed to be administered on time, within an hour of the scheduled time.
-If the MAs were late administering medications, they should contact the PCP's about the late doses or any missed doses.
-The residents were only displaced from the facility on 1 day due to the hurricane and they stayed at a local school shelter on 09/15/18.
-This would not have affected whether Resident #3's Morphine was available.

Review of Resident #3's PCP order dated 09/28/18 revealed:
-There was an order for Morphine Sulfate 100mg/5ml take 0.25ml by mouth or sublingually every 4 hours.
-There was a handwritten note the order was faxed to the pharmacy and called on 09/28/18 by a MA.

Interview with the MA who faxed and called the pharmacy on 09/28/18 on 11/07/18 at 5:00pm revealed:
-Resident #3 was restless and did a lot of moving around in bed.
-The resident would grimace in pain.
-She did not recall Resident #3 running out of Morphine.

Telephone interview with a manager at the facility's primary pharmacy on 11/09/18 at 4:15pm revealed:
-On 09/28/18, the pharmacy received a prescription for Resident #3 dated 09/28/18 for Morphine from the PCP.
-The pharmacy dispensed Morphine on 09/28/18

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and it was delivered to the facility on 09/29/18.
-Facility staff signed for the Morphine on 09/29/18 at 3:55am.

Review of Resident #3's PCP visit note dated 10/01/18 revealed:
-The resident was being seen for follow up on pain management.
-The resident continued to receive Morphine Sulfate every 4 hours for pain control.
-Review of the MARs indicated 14 doses of Morphine were not administered for reasons including "resident refused" and "withheld by doctor order", or no reason documented at all.
-No orders had been written instructing the staff to withhold the resident's Morphine.
-The resident was non-verbal and cooperative with her medications, especially with Morphine since the prefilled syringe could be placed directly into her mouth and be administered with minimal effort.
-On 09/28/18, the hospice nurse reported the resident was completely out of Morphine.
-A prescription was faxed directly to the facility's primary pharmacy on 09/28/18 with confirmed received at 2:53pm.
-Later that evening (09/28/18), the facility reported the pharmacy never received the prescription.
-They also reported the pharmacy never received a prescription for Morphine on 09/24/18.
-Upon further investigation, the resident had been out of Morphine for the past 4 days and staff did not notify the provider about this problem.
-Staff were either borrowing Morphine from another resident or not administering it at all.
-The family expressed concern about the resident running out of Morphine.
-From now on, the SCC at the facility would monitor the resident's medications and let the

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PCP know before the meds run out.

Review of Resident #3's PCP order dated 10/05/18 at 3:47pm revealed an order to administer the next dose of Morphine at 5:00pm instead of 4:00pm, then resume ordered schedule.

Review of Resident #3's PCP order dated 10/05/18 revealed:
-There was an order to discontinue all Morphine orders.
-There was an order for Morphine Sulfate 100mg/5ml take 0.25ml by mouth or sublingually every 4 hours at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.

Review of Resident #3's PCP order dated 10/07/18 revealed:
-There was an order to discontinue Morphine.
-There was an order for Morphine Sulfate 100mg/5ml take 0.5ml (10mg) by mouth every 3 hours (may use 2 of the 0.25ml prefilled syringes).

Review of Resident #3's PCP order dated 10/09/18 at 5:00pm revealed:
-There was an order to discontinue all current medication orders.
-There was an order for Morphine Sulfate 100mg/5ml take 0.5ml (10mg) by mouth every 3.5 hours at 1:30am, 4:30am, 7:30am, 10:30am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm (may use current supply).

Review of Resident #3's PCP order dated 10/09/18 at 9:32pm revealed:
-This was a clarification order.
-There was an order for Morphine Sulfate 100mg/5ml take 0.5ml (10mg) by mouth every 3

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hours, continue same administration times at 1:30am, 4:30am, 7:30am, 10:30am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm .
-There was a handwritten note that the order sheet was faxed to the pharmacy on 10/09/18 (no time notes).

Review of Resident #3's PCP order dated 10/10/18 revealed there was an order for Morphine Sulfate 100mg/5ml take 0.25ml by mouth every 30 minutes as needed for pain or shortness of breath.

Review of Resident #3's pharmacy dispensing records for Morphine Sulfate for October 2018 revealed:
-There was 20ml (80 prefilled syringes) of Morphine Sulfate dispensed on 10/08/18.
-There was 5ml (20 prefilled syringes) of Morphine Sulfate dispensed on 10/10/18.

Review of Resident #3's October 2018 MAR revealed:
-There was an entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml (5mg) by mouth / sublingually every 4 hours with scheduled administration times of 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was a second entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take "2X" 0.25ml syringes (10mg) by mouth every 3 hours with scheduled administration times of 2:00am, 5:00am, 8:00am, 11:00am, 2:00pm, 5:00pm, 8:00pm, and 11:00pm.
-There was a third entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take "2X" 0.25ml syringes (10mg) by mouth every 3 hours with scheduled administration times of 1:30am, 4:30am, 7:30am, 10:30am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm.

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-Morphine was not documented as administered on the following 5 occasions with no reasons documented.
-On 10/01/18, the 12:00am dose of Morphine was not documented as administered.
-On 10/05/18, the 5:00pm dose of Morphine was not documented as administered.
-On 10/09/18, the 8:00pm dose of Morphine was not documented as administered.
-On 10/10/18, the 1:30am and 4:30am doses of Morphine were not documented as administered.
-Morphine was documented as withheld per doctor orders on 3 occasions: 10/05/18 at 4:00pm and 10/06/18 at 12:00am and 4:00am, but there was no order to withhold it.

Review of Resident #3's CS log for October 2018 revealed:
-There was a total of 71 doses of Morphine documented as administered on the CS log but 72 doses were documented as administered on the MAR from 10/01/18 - 10/10/18.
-There were 4 scheduled doses of Morphine not documented as administered.
-On 10/09/18, the 8:00pm and 10:30pm doses of Morphine were not documented as administered.
-On 10/10/18, the 1:30am and 4:30am doses of Morphine were not documented as administered.
-On 10/06/18, there was 1 dose of Morphine administered at 11:53am and again 31 minutes later at 12:24pm but it should have been every 4 hours.
-There were 3 doses of Morphine documented as administered late, more than 1 hour after the scheduled time.
-The late doses ranged from 1 hour 32 minutes after the scheduled time up to 2 hours 49 minutes after the scheduled time.
-For example, on 10/04/18, the 8:00am dose was documented as administered at 9:32am.

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-For example, on 10/08/18, the 12:00pm dose was documented as administered at 2:49pm.

Review of a hospice visit note report revealed Resident #3 passed away on 10/10/18.

Interview with a MA on 11/05/18 at 5:40pm revealed:
-Resident #3 would grimace in pain and she was restless.
-The Morphine seemed to help with those symptoms.
-She did not have any recollection of Resident #3 running out of Morphine.

Interview with a second MA on 11/05/18 at 4:58pm revealed:
-The MAs were supposed to order medications when there was a 6 or 7 day supply remaining.
-She thought there had been some miscommunication with getting some prescriptions for Resident #3.
-The resident's Morphine had run out but she could not recall the dates.
-If Resident #3's Morphine was documented as refused or withheld it was probably because the resident was sleeping.
-Near the end of Resident #3's life, the PCP had told the MAs not to hold the medication even if the resident was asleep because the resident needed it.
-She could not explain why they continued to hold the doses.
-Resident #3's face was always grimaced and she looked like she was in pain.

Interview with a third MA on 11/07/18 at 10:50am revealed:
-Resident #3 was on hospice and she was very restless.

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-The last 1 to 2 months of the resident's life, you could tell she was in a lot of pain by her facial grimacing.
-The resident was taking Morphine in prefilled syringes.
-She would call hospice to get a new order when there was about a 2 day supply of Morphine remaining.
-Hospice would notify the PCP and the PCP would write the order.
-The hospice nurse would always asked each visit about the resident's supply of medication.
-She could not recall if Resident #3 had run out of Morphine.

Interview with the SCC on 11/02/18 at 11:56am revealed:
-The SCM mostly handled the medications for Resident #3.
-She was aware the resident's Morphine ran out and was unavailable to be administered.
-She could not recall specific dates.
-She thought on one occasion the pharmacy sent a bottle instead of prefilled syringes of Morphine.
-The facility's policy was to use prefilled syringes for safety reasons so the MAs would not have to measure the dosage themselves from the bottle.
-The bottle of Morphine was sent back to the pharmacy.
-The MAs were supposed to order all medications 7 days prior to running out, including controlled substances.
-The MAs "just don't do it", some will order in time and some will not.
-The medication carts were supposed to be audited weekly to check supply on hand by the MAs and the MAs were supposed to notify the providers and remind them on Fridays if refills were needed.
-She started pulling the CS logs on Fridays about

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two weeks ago to check the inventory counts on hand.

Interview with the ED on 11/06/18 at 1:00pm revealed:
-She was not aware of anyone instructing the MAs to administer Resident #3's Morphine more frequently than it was ordered.
-On one occasion, a MA held Resident #3's Morphine so the resident could eat lunch and the MA forgot to go back and administer it.
-The resident's family notified the ED of the missed dose so she called the PCP and the PCP wrote an order to hold the Morphine until 5:00pm.
-She could not recall the date of this incident.
-She remembered Resident #3 ran out of Morphine but she could not recall the details.
-She thought the SCM had taken care of it.
-The MAs were responsible for ordering the medications prior to the meds running out.

Telephone interview with Resident #3's power of attorney (POA) on 11/01/18 at 3:05pm revealed:
-Near the end, Resident #3 was in a lot of pain.
-The facility ran out of the resident's medications a few times including her Morphine.
-The resident was in a lot of pain when they were out of her Morphine.
-He could tell by the look on the resident's face that she was in pain because she would grimace.
-He did not know why they ran out of her Morphine.

Telephone interview with Resident #3's family member on 11/09/18 at 10:15am revealed:
-There were repeated issues with the resident's medications at the facility.
-The medications were not being given as ordered and not being given in a timely manner.
-The resident was without her Morphine for

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"several days".
-She could not recall the specific dates.
-The resident was in a lot of pain; she was restless and she would grimace.
-When the order changed to 2 prefilled syringes, some of the MAs were not aware and would still give 1 syringe and she would have to tell the MAs that it was supposed to be 2 syringes.
-She made the ED and the SCM aware of the issues and they seemed to be concerned but did not always follow up.
-Sometimes the MAs would not administer Morphine if Resident #3 was resting but they were supposed to give it on a scheduled basis.

Interview with Resident #3's PCP on 11/05/18 at 11:32am revealed:
-There were many issues with the resident's Morphine including missed doses, late doses, and withheld doses.
-She got a call from the ED on 10/05/18 indicating the MA had given the scheduled Morphine 3 hours late.
-The resident was more agitated and in more pain when the medication was missed or administered late.
-The facility ran out of the resident's Morphine but would still document it was administered on the MARs when she reviewed the MARs.
-She worked out a system with hospice that only PCP would write the prescriptions for the controlled medications because the facility would request them from multiple sources.
-Staff would document the Morphine was withheld per doctor orders on the MARs but there was no current order to hold those medications.
-The resident would grimace and arch her back when she was in pain because she could not speak.

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b. Review of Resident #3's physician's order dated 07/03/18 revealed an order for Lorazepam 0.5mg take 1 tablet 3 times a day. (Lorazepam in a controlled substance used to treat anxiety and agitation.)

Review of Resident #3's pharmacy dispensing records for Lorazepam 0.5mg for August 2018 revealed:
-There were 45 tablets dispensed on 08/04/18.
-There were 45 tablets dispensed on 08/19/18.

Review of Resident #3's August 2018 medication administration record (MAR) revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet 3 times a day with scheduled administration times of 8:00am, 2:00pm, and 8:00pm.
-Lorazepam was documented as "withheld per doctor orders" on 08/02/18 at 8:00pm.
-Lorazepam was documented as refused on 7 occasions from 08/01/18 - 08/31/18.
-Refusals included: 2:00pm on 08/16/18. and 8:00pm on 08/08/18, 08/10/18, 08/11/18, 08/24/18, 08/30/18, and 08/31/18.
-If administered 3 times a day as ordered, 93 doses should be administered from 08/01/18 - 08/31/18.
-There were 85 Lorazepam 0.5mg tablets documented as administered in August 2018.

Review of Resident #3's controlled substance (CS) log for August 2018 revealed:
-There was a total of 85 doses of Lorazepam documented as administered on the CS log and the MAR.
-There were 3 doses of Lorazepam documented as administered late, more than 1 hour after the scheduled time.
-The late doses ranged from 1 hour 35 minutes after the scheduled time up to 2 hours 20 minutes

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after the scheduled time.
-For example, on 08/23/18, the 8:00am dose was documented as administered at 9:35am.
-For example, on 08/20/18, the 8:00am dose was documented as administered at 10:20am.

Review of Resident #3's charting note dated 09/19/18 at 11:48am revealed the refill for Lorazepam was not in yet.

Review of Resident #3's pharmacy dispensing records for Lorazepam 0.5mg for September 2018 revealed:
-There were 45 tablets dispensed on 09/03/18.
-There were 45 tablets dispensed on 09/20/18.

Review of Resident #3's September 2018 MAR revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet 3 times a day with scheduled administration times of 8:00am, 2:00pm, and 8:00pm..
-Lorazepam was documented as refused on 2 occasions at 8:00pm on 09/04/18 and 09/07/18.
-Lorazepam was not documented as administered on 5 occasions with no reasons documented.
-On 09/22/18, the 8:00am dose of Lorazepam was not documented as administered.
-On 09/27/18, the 8:00am dose of Lorazepam was not documented as administered.
-On 09/21/18, the 2:00pm and 8:00pm doses of Lorazepam were not documented as administered.
-On 09/22/18, the 2:00pm dose of Lorazepam was not documented as administered.
-If administered 3 times a day as ordered, 90 doses should be administered from 09/01/18 - 09/30/18.
-There was a total of 83 Lorazepam 0.5mg tablets documented as administered in

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September 2018.

Review of Resident #3's CS log for September 2018 revealed:
-There was a total of 81 doses of Lorazepam documented as administered on the CS log and 83 doses were documented as administered on the MAR from 09/01/18 - 09/30/18.
-There were 6 scheduled doses of Lorazepam not documented as administered.
-On 09/15/18, the 2:00pm dose of Lorazepam was not documented as administered.
-On 09/21/18, the 2:00pm and 8:00pm doses of Lorazepam were not documented as administered.
-On 09/22/18, the 8:00am and 2:00pm doses of Lorazepam were not documented as administered.
-On 09/27/18, the 8:00am dose of Lorazepam was not documented as administered.
-There were 5 doses of Lorazepam documented as administered late, more than 1 hour after the scheduled time.
-The late doses ranged from 1 hour 27 minutes after the scheduled time up to 2 hours 9 minutes after the scheduled time.
-For example, on 09/14/18, the 8:00am dose was documented as administered at 9:27am.
-For example, on 09/16/18, the 8:00am dose was documented as administered at 10:09am.

Review of Resident #3's primary care provider (PCP) visit note dated 10/01/18 revealed:
-The resident was being seen for follow up on pain management.
-Review of the MARs indicated that 9 scheduled doses of Lorazepam were not administered for reasons including "resident refused" and "withheld by doctor order", or no reason documented at all.

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-No orders had been written instructing the staff to withhold the resident's Lorazepam.
-The resident was non-verbal and cooperative with her medications.

Interview with Resident #3's PCP on 11/05/18 at 11:32am revealed:
-There were many issues with the resident's Lorazepam, including missed or late doses.
-The facility ran out of the resident's Lorazepam but would still document it was administered.
-Staff would document the Lorazepam was withheld per doctor orders but there was no order to hold it.
-The resident was more agitated when she missed doses of Lorazepam or when it was administered late.

Review of Resident #3's PCP orders dated 10/05/18 revealed:
-There was an order to discontinue current Lorazepam.
-There was an order for Lorazepam 0.5mg 1 tablet 3 times a day at 9:00am, 3:00pm, and 9:00pm.

Review of Resident #3's PCP orders dated 10/07/18 revealed:
-There was an order to discontinue current Lorazepam orders.
-There was an order for Lorazepam 0.5mg take 1 tablet every 4 hours.

Review of Resident #3's PCP order dated 10/08/18 revealed an order for Lorazepam 0.5mg take 1 tablet every 2 hours as needed for agitation or air hunger.

Review of Resident #3's PCP orders dated 10/09/18 at 5:00pm revealed:

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-There was an order to discontinue all current medication orders.
-There was an order for Lorazepam 0.5mg by mouth one dose at 7:00pm today (use current supply).
-There was an order for Lorazepam 0.5mg every 3.5 hours at 1:30am, 4:30am, 7:30am, 10:30am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm (may use current supply).
-There was an order for Lorazepam 0.5mg by mouth every 2 hours as needed for agitation or shortness of breath (use current supply).
-There was a handwritten note that the order sheet was faxed to the pharmacy on 10/09/18 at 7:15pm.

Review of Resident #3's PCP orders dated 10/09/18 at 9:32pm revealed:
-This was a clarification order.
-There was an order for Lorazepam 0.5mg every 3 hours, continue same administration times at 1:30am, 4:30am, 7:30am, 10:30am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm.
-There was a handwritten note that the order sheet was faxed to the pharmacy on 10/09/18 (no time noted).

Review of Resident #3's pharmacy dispensing records for Lorazepam 0.5mg for October 2018 revealed 45 tablets were dispensed on 10/05/18.

Review of Resident #3's October 2018 MAR revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet 3 times a day with scheduled administration times of 8:00am, 2:00pm, and 8:00pm.
-There was a second entry for Lorazepam 0.5mg take 1 tablet 3 times daily with scheduled administration times of 9:00am, 3:00pm, and 9:00pm, do not give at same time as Morphine.

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-There was a third entry for Lorazepam 0.5mg take 1 tablet every 4 hours with scheduled administration times of 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was a fourth entry for Lorazepam 0.5mg take 1 tablet every 3 hours (1:30am, 4:30am, 7:30am, 10:30am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm).
-There were 2 scheduled doses of Lorazepam not documented as administered with no reason.
-On 10/10/18, the 1:30am and 4:30am doses of Lorazepam were not documented as administered.

Review of Resident #3's CS log for October 2018 revealed:
-There were 2 doses of Lorazepam documented as administered late, more than 1 hour after the scheduled time.
-On 10/04/18, the 8:00am dose was documented as administered at 9:32am.
-On 10/06/18, the 9:00pm dose was documented as administered at 10:56pm.
-There was a dose documented on 10/06/18 at 11:53am but it was not scheduled to be administered until 3:00pm.

Review of a hospice visit note report revealed Resident #3 passed away on 10/10/18.

Interview with a medication aide (MA) on 11/05/18 at 5:40pm revealed:
-Resident #3 was restless and Lorazepam seemed to help with the restlessness.
-She did not recall Resident #3 running out of Lorazepam.

Interview with a second MA on 11/05/18 at 4:58pm revealed:
-She thought there had been some

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miscommunication with getting some prescriptions for Resident #3.
-If Resident #3's Lorazepam was documented as refused or withheld, it was probably because the resident was sleeping.
-Near the end of Resident #3's life, the PCP had told the MAs not to hold the Lorazepam even if the resident was asleep because the resident needed it.
-She could not explain why they held the Lorazepam without an order.

Interview with a third MA on 11/07/18 at 10:50am revealed:
-Resident #3 was on hospice and she was very restless.
-She could not recall if Resident #3 had run out of Lorazepam.

Interview with a fourth MA on 11/07/18 at 5:00pm revealed:
-Resident #3 was restless and did a lot of moving around in bed.
-She did not recall Resident #3 running out of Lorazepam.

Interview with the Executive Director (ED) on 11/06/18 at 1:00pm revealed:
-She remembered Resident #3 ran out of some medication but she could not recall the details.
-She thought the Special Care Manager (SCM) had taken care of the unavailable medications.
-The MAs were responsible for ordering the medications prior to the meds running out.

Interview with the SCM on 11/02/18 at 1:27pm revealed:
-Resident #3 was a hospice resident.
-She was aware Resident #3 ran out of Lorazepam but she could not recall the dates.

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-The MAs should have notified the PCP, pharmacy and hospice if the resident ran out of Lorazepam.
-The problem with Resident #3 running out of Lorazepam was caused by the MAs waiting too late to try to get a new prescription.
-Resident #3 was in pain and more restless towards the end of her life.
-Lorazepam should have been administered on time, within 1 hour of the scheduled time.
-If the MAs were late administering medications, they should contact the PCP about the late doses or any missed doses.

Interview with a hospice nurse on 11/09/18 at 2:40pm revealed:
-Resident #3 had missed doses of Lorazepam because the medication had ran out.
-The resident was grimacing in pain and had agonal shallow breathing when she missed the doses.
-The Lorazepam was used to help with her restlessness and shortness of breath.

6. Review of Resident #8's current FL-2 dated 04/10/18 revealed diagnoses included Alzheimer's disease, type 2 diabetes, chronic kidney disease, hyperlipidemia, and idiopathic gout.

Review of Resident #8's physician's order dated 08/09/18 revealed:
-There was an order for Morphine Sulfate 100mg/5ml take 0.25ml prefilled syringe) by mouth / sublingually every 2 hours as needed for pain / air hunger. (Morphine Sulfate is a controlled substance used to treat moderate to severe pain. It may also be used to treat difficulty in breathing at end of life with hospice patients.)

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Review of Resident #8's physician's order dated 08/27/18 revealed:
-There was an order to discontinue prn Morphine.
-There was an order for Morphine Sulfate 100mg/5ml take 0.25ml by mouth or sublingually every 4 hours (scheduled).

Review of Resident #8's charting note dated 08/29/18 at 11:00am revealed:
-The resident's Morphine did not come in prefilled syringes but came in a full bottle instead.
-The hospice nurse gave the resident his 12:00pm dosage.
-The resident's order was clarified.
-Prefilled syringes would be delivered tonight (08/29/18) from the primary pharmacy.

Review of Resident #8's physician's order dated 08/29/18 revealed there was an order for Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours scheduled, please prefill all syringes, "send STAT".

Review of Resident #8's pharmacy dispensing records for Morphine Sulfate for August 2018 revealed:
-There was 6.25ml (25 prefilled syringes) of Morphine Sulfate dispensed on 08/09/18.
-There was 30ml (one bottle) of Morphine Sulfate dispensed on 08/28/18.
-There was 22.5ml (90 prefilled syringes) of Morphine Sulfate dispensed on 08/30/18.

Review of pharmacy return records for Resident #8 revealed:
-The 30ml bottle of Morphine was returned to the pharmacy on 09/06/18.
-There were 29ml documented as returned.

Review of Resident #8's August 2018 medication

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administration record (MAR) revealed:
-There were entries for Morphine Sulfate 100mg/5ml, take 0.25ml (5mg) by mouth / sublingually every 4 hours scheduled for administration at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The administration of the scheduled Morphine ordered on 08/27/18 did not start until 08/28/18 at 4:00pm.
-On 08/27/18, there were no scheduled doses of Morphine documented as administered.
-On 08/28/18, 4 scheduled doses of Morphine were not documented as administered at 12:00am, 4:00am, 8:00am and 12:00pm.

Review of Resident #8's controlled substance (CS) log dated 08/10/18 - 08/31/18 revealed:
-On 08/27/18, there were no scheduled doses of Morphine documented as administered.
-On 08/28/18, 4 scheduled doses of Morphine were not documented as administered at 12:00am, 4:00am, 8:00am, and 12:00pm.
-On 08/30/18, 2 scheduled doses of Morphine were not documented as administered at 4:00am and 8:00am as there was no Morphine on hand with a balance of 0.
-There were 3 doses of Morphine documented as administered late, more than 1 hour after the scheduled time.
-The late doses ranged from 1 hour 25 minutes after the scheduled time up to 1 hours 48 minutes after the scheduled time.
-For example, on 08/30/18, the 12:00am dose was documented as administered at 1:48am.
-For example, on 08/30/18, the 4:00pm dose was documented as administered at 5:25pm

Review of Resident #8's primary care provider (PCP) visit note dated 09/03/18 revealed:
-The resident was being seen to evaluate his

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pain.
-On 08/30/18, Resident #8's power of attorney (POA) called the PCP's office to report the resident had not been receiving any Morphine for the past several days.
-A prescription for 90 doses of Morphine was provided to the facility on 08/27/18 and again on 08/29/18 after facility "claimed" they did not receive the first one.
-The facility staff "claimed" the resident was completely out of Morphine.
-The Morphine doses for 08/30/18 at 4:00am and 8:00am were blank so it was unknown if the doses were administered or not.
-The resident and his POA denied the resident received the Morphine for the past several days.
-The hospice nurse reported the resident had been exhibiting increased signs of pain and discomfort on the days that he allegedly did not receive the Morphine.
-During the PCP visit on 09/03/18, the resident was resting quietly in bed.
-A family member of the resident stated she thought the resident had been getting his pain medication every 4 hours today (09/03/18).

Interview with Resident #8's PCP on 11/05/18 at 11:32am revealed:
-She was concerned about Resident #8's Morphine running out and not being administered as ordered.
-She thought the resident's Morphine had been "disappearing" because she had written prescriptions and the facility had also requested prescriptions from the hospice provider and an on-call provider.
-On 08/25/18, she was notified by the hospice nurse that a prescription for 90 doses of Morphine had been written that morning.
-On 08/29/18, the facility requested another

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prescription for Morphine indicating it needed to say "prefilled syringes" on the prescription.
-On 08/29/18, the PCP instructed facility staff that only the PCP would write prescriptions for Resident #8's Morphine now.
-On 08/29/18, a MA called hospice and said they never received the Morphine prescription.
-The PCP had copies of confirmations that the Morphine prescription was sent to the facility.
-The facility MA indicated they did not receive the prescription.
-On 08/30/18, the PCP received a call from the resident's family member because facility staff told the family they could not get the resident's Morphine.
-Resident #8 had pancreatic cancer and he was in severe pain and miserable.
-The resident would grimace and yell out when he was in pain.

Review of Resident #8's physician's orders dated 09/10/18 and 09/21/18 revealed there were orders for Morphine Sulfate 100mg/5ml take 0.25ml by mouth / sublingually every 4 hours (scheduled).

Review of Resident #8's charting note dated 09/22/18 at 1:11pm revealed:
-The resident was currently out of Morphine.
-Staff attempted to contact hospice but the phone was out of order due to hurricane Florence.
-Staff would continue to try to contact.

Review of Resident #8's pharmacy dispensing records for Morphine Sulfate for September 2018 revealed:
-There was 10.5ml (42 prefilled syringes) of Morphine Sulfate dispensed on 09/10/18.
-There was 12ml (48 prefilled syringes) of Morphine Sulfate dispensed on 09/20/18.

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-There was 7.5ml (30 prefilled syringes) of Morphine Sulfate dispensed on 09/23/18.

Review of Resident #8's September 2018 MAR revealed:
-There was an entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml (5mg) by mouth or sublingually every 4 hours scheduled to be administered at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was a total of 178 doses (44.5ml) of scheduled Morphine documented as administered from 09/01/18 - 09/30/18.
-If administered every 4 hours as ordered, 180 dose of Morphine would have been administered.
-The Morphine was documented as refused on 09/08/18 at 4:00am.
-On 09/22/18, the 4:00am dose of Morphine was not documented as administered with no reason documented.

Review of Resident #8's CS log for September 2018 revealed:
-There were a total of 173 doses of Morphine documented as administered on the CS log
-If administered every 4 hours as ordered, 180 dose of Morphine would have been administered.
-There were 9 scheduled doses of Morphine not documented as administered.
-On 09/03/18, the 12:00am dose of Morphine was not documented as administered.
-On 09/11/18, the 12:00am and 4:00am doses of Morphine were not documented as administered.
-On 09/10/18, the 8:00pm dose of Morphine was not documented as administered.
-On 09/15/18, the 4:00pm dose of Morphine was not documented as administered.
-On 09/16/18, the 8:00am and 4:00pm doses of Morphine were not documented as administered.
-On 09/22/18, the 4:00am and 8:00am doses of

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Morphine were not documented as administered.
-On 09/13/18, a dose of Morphine was documented as administered at 4:51am and again 3 minutes later at 4:54am.
-On 09/22/18, a dose of Morphine was documented as administered at 11:46am and again 1 hour 10 minutes later at 12:56pm.
-There were at least 12 doses of Morphine administered late, more than 1 hour after the scheduled time.
-The late doses ranged from 1 hour 30 minutes up to 2 hours 36 minutes after the scheduled time.
-For example, the 12:00pm dose on 09/07/18 was administered late at 2:01pm.
-For example, the 8:00am dose on 09/14/18 was administered late at 10:36am.

Review of a hospice visit note revealed the resident passed away on 10/04/18.

Interview with a personal care aide (PCA) on 10/31/18 at 1:50pm revealed:
-She could tell Resident #8 was in pain because when staff tried to move him for incontinence care, he would scream out, "no baby, no baby".
-The PCAs would report the pain to the medication aides (MAs).

Interview with a MA on 11/05/18 at 4:58pm revealed:
-She did not recall Resident #8 running out of any medications.
-She was not sure why some of the Morphine doses were administered late.
-Resident #8 could not tell you if he was hurting.
-She was not sure if the resident was hurting because what he said made no sense.

Interview with a second MA on 11/07/18 at

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5:00pm revealed:
-Resident #8 never ran out of Morphine to her knowledge.
-If Morphine was administered it would have to be documented on the CS log in order to decline the count on the log.
-She was not sure why some of the Morphine doses were administered late.

Interview with a hospice nurse on 11/01/18 at 4:45pm revealed:
-There were many doses of Resident #8's Morphine that were not administered or "possibly missing".
-The resident had pain all over but he was unable to verbalize his pain.
-The resident would grimace and moan when he was in pain.

Telephone interview with Resident #8's POA on 11/08/18 at 10:49am revealed:
-Resident #8 did not like to be touched because he was in pain.
-The resident was receiving hospice services.
-She could not recall if the resident missed any doses of his medications.
-There was another family member who stayed with the resident day and night and would know more about his medications.

Telephone interview with Resident #8's family member on 11/8/18 at 11:50am revealed:
-The facility ran out of the resident's Morphine but she could not recall the date.
-The resident was supposed to get the Morphine every 2 or 4 hours.
-The resident missed about 2 or 3 doses of the Morphine.
-The resident was in a lot of pain.
-Every time the resident was touched, he would

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"holler out" and you could see the pain in his eyes.
-He would grimace when he was in pain too.

Interview with the Executive Director (ED) on 11/09/18 at 1:45pm revealed:
-The resident was receiving hospice services as he was actively dying.
-She did not recall any issues with the resident's Morphine.
-The MAs were responsible for ordering the medications prior to the meds running out.

7. Review of Resident #15's current FL-2 dated 06/04/18 revealed:
-Diagnoses included Alzheimer's dementia, hypertension, chronic kidney disease - stage 3, hypokalemia, hypothyroidism, schizophrenia, generalized muscle weakness, and depression.
-There was an order for Tramadol 50mg 1 tablet 3 times a day. (Tramadol is a controlled substance used for moderate to severe pain.)

Review of Resident #15's physician's order dated 07/19/18 revealed an order to increase Tramadol to 50mg 4 times per day.

Review of Resident #15's physician's orders dated 08/13/18 revealed there was an order for Tramadol 50mg 1 tablet daily at 8:00am, 12:00pm, 4:00pm, and 10:00pm.

Review of Resident #15's charting note dated 08/31/18 at 3:33pm revealed:
-A refill request for Tramadol was faxed to the primary care provider (PCP).
-The PCP faxed back and stated she needed the medication administration record (MAR).
-The MAR and the request for Tramadol was faxed back to the PCP.

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Review of Resident #15's prescription by the PCP dated 08/31/18 revealed:
-There was an order to discontinue all current Tramadol orders.
-There was an order for Tramadol 50mg 1 tablet 4 times a day at 8:00am, 12:00pm, 4:00pm, and 8:00pm.

Review of Resident #15's pharmacy dispensing records for Tramadol for August 2018 revealed 60 Tramadol 50mg tablets dispensed on 08/19/18.

Review of Resident #15's August 2018 MAR revealed:
-There was an entry for Tramadol 50mg take 1 tablet daily at 8:00am, 12:00pm, 4:00pm, and 10:00pm.
-There was a second entry for Tramadol 50mg 1 tablet every 6 hours (4 times a day) that started on 08/19/18 at 4:00pm.
-This Tramadol entry had 7 administration times listed on the MAR including 12:00am, 6:00am, 8:00am, 12:00pm, 4:00pm, 6:00pm and 10:00pm.
-Not all of the scheduled times were documented as administered by staff each day from 08/19/18 - 08/24/18.
-Tramadol was documented as administered more than every 6 hours (4 times a day) from 08/19/18 - 08/23/18.
-Tramadol was documented as administered 5 times on 08/19/18, 7 times on 08/20/18, 8 times on 08/21/18, 7 times on 08/22/18, and 6 times on 08/23/18.
-Tramadol was documented as withheld per doctor's orders on 4 occasions on 08/09/18, 08/20/18, 08/22/18, and 08/25/18 but there was no order to hold it.
-Starting on 08/25/18 through 08/31/18, Tramadol was documented as administered at 12:00am,

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6:00am, 12:00pm, and 6:00pm but the order specified times of 8:00am, 12:00pm, 4:00pm, and 8:00pm

Review of the electronic controlled substance (CS) log for August 2018 for Resident #15 revealed:
-There were a total of 119 Tramadol tablets documented as administered on the CS log from 08/01/18 - 08/31/18 but 134 tablets were initialed as administered on the MAR.
-If administered 4 times a day as ordered from 08/01/18 - 08/31/18, 124 tablets should have been documented as administered and declined from the CS count.
-Therefore, at least 5 doses of Tramadol were not administered as ordered in August 2018.

Review of Resident #15's PCP visit notes dated 09/03/18 revealed:
-The resident was being seen for evaluation of pain.
-Review of the resident's MAR indicated the resident was not receiving Tramadol as ordered.
-On 08/19/18, 08/20/18, 08/22/18, 08/25/18, and 08/27/18, facility staff documented that Tramadol was "withheld per doctor's orders" but no orders were given by the provider or the hospice provider to withhold Tramadol.
-During a PCP visit on 09/03/18, the resident complained of a pain level of "8 or 9 at least" with pain going from her breastbone to her ribs and all around her back.
-The resident also complained of pain in both hips and arms.
-The resident reported only receiving her pain medication once in the morning and once at night.
-The PCP noted concerns that the facility staff had been contacting both the PCP and the

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hospice nurse to obtain refills of Tramadol within 24 hours of receiving prescriptions from one provider.
-The PCP discussed issue with the hospice provider.
-The PCP noted going forward, she would be the only provider giving refills for controlled substances and the hospice provider was in agreement.

Review of a note to Resident #15's PCP dated 09/05/18 revealed:
-The resident needed a new prescription for Tramadol 1 tablet every 6 hours (4 times a day).
-There was a handwritten note bedside the date of 09/05/18 that read "med here".
-There was no initials to indicate who wrote the comment.
-The PCP signed the form on 09/10/18 and there was no comment by the PCP in the response section.

Review of Resident #15's verbal order dated 09/05/18 at 5:35pm revealed the pharmacy received a verbal order for Tramadol 50mg 1 tablet every 6 hours from the on-call provider.

Review of Resident #15's charting note dated 09/21/18 at 11:28pm revealed the resident did not have any Tramadol.

Review of Resident #15's charting note dated 09/22/18 at 11:46pm revealed:
-The PCP knew about Tramadol and the medication should be on its way.
-The pharmacy was notified, awaiting medication due to hurricane.

Review of Resident #15's prescription by the PCP dated 09/22/18 revealed:

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-There was an order for Tramadol 50mg 1 tablet 4 times a day at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Facility to request weekly refills, "only 7 days will be prescribed at a time, no early refills".

Review of Resident #15's pharmacy dispensing records for Tramadol for September 2018 revealed:
-There were 60 Tramadol 50mg tablets dispensed on 09/05/18.
-There were 60 Tramadol 50mg tablets dispensed on 09/22/18.
-There were 28 Tramadol 50mg tablets dispensed on 09/28/18.

Review of Resident #15's September 2018 MAR revealed:
-There was an entry for Tramadol 50mg take 1 tablet every 6 hours (4 times daily) scheduled to be administered at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-On 09/22/18 and 09/23/18, the 12:00am doses were not documented as administered because it was "withheld per doctor orders" but there was no order to hold it.
-On 09/24/18, the 12:00pm dose of Tramadol was not documented as administered with no reason noted.
-There were 111 Tramadol 50mg tablets documented as administered in September 2018.

Review of the electronic CS log for September 2018 for Resident #15 revealed:
-There were a total of 99 Tramadol tablets documented as administered on the CS log from 09/01/18 - 09/30/18 but 111 tablets were initialed as administered on the MAR.
-If administered 4 times a day (or every 6 hours) as ordered from 09/01/18 - 09/30/18, 120 tablets

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should have been documented as administered and declined from the CS count.
-There were 18 scheduled doses of Tramadol not decremented as administered.
-On 09/10/18, 3 doses of Tramadol were documented as administered that morning at 4:31am, 4:41am, and 5:47am.
-On 09/15/18, 2 doses of Tramadol were documented as administered that morning at 5:09am and 6:07am.
-There were 7 times Tramadol was documented as administered late, more than 1 hour after the scheduled time.
-These 7 doses were administered from 1 hour and 32 minutes up to 2 hours and 35 minutes after the scheduled time.
-For example, on 09/16/18, the 12:00pm dose was documented as administered at 2:35pm.
-For example, on 09/19/18, the 12:00am dose was documented as administered at 2:10am.

Review of Resident #15's PCP visit notes dated 09/10/18 revealed:
-The resident was being seen for evaluation of pain.
-The resident reported she continued to have severe pain of "at least and 8 or 9" originating from her right breast, encircling her rib cage to her right scapula and going down her back.
-The resident continued to report that she was not receiving her pain medication as ordered.
-The resident stated she received the Tramadol once in the morning and once at night.
-Review of the MAR indicated that 9 out of 16 doses were omitted for unknown reasons and one dose was refused.
-On 09/10/18, the PCP observed the resident was in "visible pain".
-The PCP noted the Tramadol was to be administered 4 times a day at 8:00am, 12:00pm,

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4:00pm, and 8:00pm.

Review of Resident #15's PCP orders dated 10/21/18 revealed:
-There was an order to discontinue Tramadol 4 times a day.
-There was an order to start Tramadol 50mg 3 times a day at 8:00am, 2:00pm, and 8:00pm (hard script provided).

Review of Resident #15's prescription by the PCP dated 10/29/18 revealed:
-There was an order to discontinue Tramadol 50mg 3 times a day.
-There was an order for Tramadol 50mg twice a day at 8:00am and 8:00pm for 7 days (10/30/18 - 11/05/18).
-Then, Tramadol 50mg daily at 8:00am for 7 days (11/06/18 - 11/12/18).

Review of Resident #15's pharmacy dispensing records for Tramadol for October 2018 revealed:
-There were 28 Tramadol 50mg tablets dispensed on 10/15/18.
-There were 21 Tramadol 50mg tablets dispensed on 10/22/18.
-There were 21 Tramadol 50mg tablets dispensed on 10/29/18.

Review of Resident #15's October 2018 MAR revealed:
-There was an entry for Tramadol 50mg take 1 tablet 4 times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was a second entry for Tramadol 50mg 1 tablet 4 times a day at 4:00am, 8:00am, 2:00pm, and 8:00pm.
-There was a third entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm.

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-There was a fourth entry for Tramadol 50mg 1 tablet twice daily at 8:00am and 8:00pm for 7 days.
-On 10/29/18, the 2:00pm dose of Tramadol was not documented as administered with no reason noted.

Review of the electronic CS log for October 2018 for Resident #15 revealed:
-There were 9 doses of Tramadol documented as administered late, more than 1 hour after the scheduled time.
-These 9 doses were administered from 1 hour and 26 minutes up to 2 hours and 51 minutes after the scheduled time.
-For example, on 10/16/18, the 8:00am dose was documented as administered at 10:10am.
-For example, on 10/16/18, the 12:00pm dose was documented as administered at 2:51pm.
-For example, on 10/16/18, the 4:00pm dose was documented as administered at 5:31pm.
-These two doses on 10/16/18 were administered only 2 hours and 40 minutes apart.

Review of the electronic CS log for November 2018 for Resident #15 revealed:
-There were a total of 12 Tramadol tablets documented as administered on the CS log and the MAR from 11/01/18 - 11/07/18.
-There were 3 doses of Tramadol documented as administered late, more than 1 hour after the scheduled time.
-On 11/03/18, the 8:00am dose was documented as administered at 9:40am.
-On 11/04/18, the 8:00am dose was documented as administered at 9:22am.
-On 11/04/18, the 8:00pm dose was documented as administered at 9:43pm.

Interview with Resident #15 on 11/09/18 at

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5:10pm revealed:
-She complained of lower left back pain.
-She got her pain medications when she asked for them.
-She could not say how often she received pain medication.

Interview with a medication aide (MA) on 11/07/18 at 4:53pm revealed she did not recall having any problems running out of Resident #15's Tramadol.

Interview with the Executive Director (ED) on 11/09/18 at 10:47am revealed:
-She was not aware of any errors with Resident #15's Tramadol.
-The Special Care Coordinator (SCC) was responsible for checking medications, including cart audits and controlled substance counts.
-The Special Care Manager (SCM) was responsible for overseeing the medication aide duties, cart audits, chart audits, and implementing new policies and procedures.
-She was responsible for making sure everything was completed at the facility, including making sure the SCC and SCM were completing tasks
-The MA on duty was responsible for faxing orders to the pharmacy.
-They were supposed to use a bucket system to track the orders.
-The bucket system included making sure orders were checked once they were entered into the e-MAR and again when the medication was received.
-Either the assistant SCM or the SCM were supposed to check the orders and initial once the orders were checked as part of the bucket system.
-The bucket system was implemented about a month ago in October 2018.

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-Medications were supposed to be ordered before they ran out.
-All ordered medications should be available in the facility.

8. The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the 8:00am and 11:30am/12:00pm medication passes on 10/24/18 and the 11:30am/12:00pm medication pass on 10/25/18.

a. Review of Resident #19's current FL-2 dated 10/19/18 revealed:
-Diagnoses included dementia with behavioral disturbances, traumatic hydrocephalus, nystagmus, seizure disorder, and anemia.
-There was an order for Lidocaine 5% patch, place 1 to 3 patches onto the skin daily, remove and discard patch within 12 hours or as directed by the physician. (Lidocaine patch is a topical anesthetic used to relieve pain.)

Review of Resident #19's hospital discharge summary dated 10/19/18 revealed:
-The resident was admitted to the hospital on 08/19/18 and discharged on 10/19/18.
-There was an order for Lidocaine 5% patch, place 1 to 3 patches onto the skin daily, remove and discard patch within 12 hours or as directed by the physician.

Review of Resident #19's Resident Register revealed the resident was admitted to the facility on 10/19/18.

Review of Resident #19's physician's order dated 10/19/18 revealed a verbal clarification order for Lidocaine 5% patch place 1 patch onto the skin daily, remove and discard patch within 12 hours.

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Observation of the 8:00am medication pass on 10/24/18 revealed:
-Resident #19's morning medications were prepared and administered to the resident at 9:37am.
-A Lidocaine 5% patch was not applied to Resident #19's skin.

Review of Resident #19's October 2018 medication administration record (MAR) revealed:
-There was no entry for Lidocaine 5% patch on the MAR.
-No Lidocaine patch was documented as administered.

Observation of Resident #19's medications on 10/24/18 at 1:07pm revealed there was no Lidocaine patches on hand for application.

Interview with the medication aide (MA) on 10/24/18 at 1:07pm revealed:
-She had received a clarification order from the primary care provider (PCP) after Resident #19 was admitted on 10/19/18 because the original order had 1 to 3 patches in the instructions.
-The order was clarified to apply 1 patch and remove it after 12 hours.
-Resident #19's family member told the MA that the resident usually wore the Lidocaine patch on her lower back.
-She had contacted the pharmacy on Saturday (10/20/18) about Resident #19's Lidocaine Patches and the pharmacy was supposed to send the patches.
-She thought the Lidocaine order had been coming up on the electronic MAR at 8:00am but she did not see it on the MAR that morning (10/24/18).
-There were no Lidocaine 5% patches in the cart

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for Resident #19 and she did not know why.

Interviews with the Special Care Coordinator (SCC) on 10/24/18 at 1:25pm and 10/25/18 at 10:25am revealed:
-The MAs were responsible for making sure all orders were faxed to the pharmacy.
-They just had training with the MAs last week about faxing and checking medication orders.
-She was not aware Resident #19 had an order for Lidocaine that was not implemented.
-The FL-2 form should have been faxed to the pharmacy when the resident was admitted on 10/19/18.
-She would contact Resident #19's PCP about the Lidocaine patches.

Interview with the Special Care Manager (SCM) on 10/25/18 at 9:25am revealed:
-The MAs were responsible for faxing orders, including FL-2 forms, to the pharmacy and getting clarification if needed.
-A supervisor was supposed to check behind the MAs to make sure orders were faxed.
-She was not aware Resident #19 had not received any Lidocaine patches.
-There was no system to check orders behind the MAs prior to last week to her knowledge.

Telephone interview with the Operations Manager at the primary pharmacy on 10/25/18 at 10:35am revealed:
-The pharmacy never received Resident #19's FL-2 dated 10/19/18.
-The facility faxed FL-2 notes but not the actual FL-2 form.
-The pharmacy needed the signed FL-2 form in order to dispense the Lidocaine patches.
-They pharmacy requested more information from the facility but they facility kept sending the FL-2

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notes instead of signed orders.
-They never received the clarification order for Lidocaine patches dated 10/19/18.
-There were no documented notes in their records of any calls from the facility regarding Lidocaine patches for Resident #19.
-They never dispensed any Lidocaine patches for Resident #19 because they did not receive an order.

Interview with Resident #19 on 10/25/18 at 11:10am revealed:
-She used the Lidocaine patches for pain in her back and arms.
-She was not sure if she had worn any patches since she was admitted to the facility (10/19/18).
-Her back usually hurt some every day.

Interview with Resident #19's family member on 10/25/18 at 11:15am revealed:
-Resident #19 had always used Lidocaine patches on her back and the back of her arms because of nerve pain and arthritis.
-She was not sure if the resident had used any Lidocaine patches since she was admitted to the facility (10/19/18).

b. Review of Resident #20's current FL-2 dated 10/17/18 revealed:
-Diagnoses included Alzheimer's dementia, diabetes mellitus type II, hypertension, hypothyroidism, chronic kidney disease stage III, gastroesophageal reflux disease, and hyperlipidemia.
-There was an order for Novolog Flexpen insulin to be administered before meals and at bedtime according to the following scale: 151 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units; 401 = 7 units, notify primary care provider (PCP) if blood sugar

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is less than (<) 60 or greater than (>) 401. (Novolog insulin is rapid-acting insulin used to lower blood sugar. The manufacturer recommends eating a meal within 5 to 10 minutes after the injection. The Novolog Flexpen should be primed with a 2 unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)

Review of Resident #20's October 2018 medication administration record (MAR) revealed:
-There was an entry for Novolog Flexpen sliding scale to be administered before meals and at bedtime and it was scheduled for 7:30am, 11:30am, 4:30pm, and 8:00pm.
-The resident's blood sugar ranged from 63 - 516 from 10/01/18 - 10/25/18.

Interview with the medication aide (MA) on 10/25/18 at 11:25am revealed the lunch meal was normally served at 12:00pm

Observation of the 11:30am medication pass on 10/25/18 revealed:
-The resident's blood sugar was 357 at 11:30am.
-The MA administered 6 units of Novolog insulin into Resident #20's left abdomen at 11:37am.
-The MA performed a 1 unit air shot instead of a 2 unit air shot prior to dialing up and administering the 6 units of insulin with the Novolog Flexpen.
-The MA dialed and pressed the 1 unit air shot very rapidly and did not hold the pen up to check for a drop of insulin at the tip of the pen to make sure the insulin was flowing.

Observation on 10/25/18 revealed Resident #20 was served lunch at 12:23pm, 46 minutes after being administered Novolog, a rapid-acting insulin.

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Interview with the MA on 10/25/18 at 12:37pm revealed:
-The lunch meal was usually served on time at 12:00pm.
-The facility's policy was the insulin should be administered within 30 minutes of the meal.
-Sometimes she waited for Resident #20 to come to the dining room and she would administer the insulin then so it would be closer to the meal being served.
-If she administered the insulin while the resident was in her room, it was usually a longer time period before the resident received her meal.
-She had training on diabetes but she did not recall that a 2 unit air shot needed to be done or why it needed to be done.
-She usually did a 1 unit air shot with the insulin pens.

Interviews with the Special Care Coordinator (SCC) on 10/24/18 at 1:27pm and 10/25/18 at 3:28pm revealed:
-The facility's policy was to administer any insulin within 30 minutes of the meal.
-The MAs needed to check with dietary staff to see when meals would be served or if they were running late.
-The MAs had been trained on the facility's insulin policy and how to use the insulin pens.
-The MAs were taught to do a 2 unit air shot when using insulin pens.
-She would contact Resident #20's PCP about the time of the insulin.

Review of Resident #20's telephone order dated 10/25/18 revealed an order for the Novolog Flexpen to be administered 30 minutes before meals.

Interview with Resident #20 on 10/24/18 at

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1:04pm revealed:
-She usually had her blood sugar checked and received insulin before meals.
-She was not sure how long she waited for her meals after she received insulin.
-She did not usually feel any symptoms of low blood sugar while waiting for her meals.

c. Review of Resident #4's current FL-2 dated 05/14/18 revealed:
-Diagnoses included unspecified dementia without behavioral disturbance, pneumonia, fever, major depressive disorder single episode, and insomnia.
-There was an order for Tylenol 500mg take 2 caplets (1,000mg) 3 times daily. (Tylenol is used to treat minor aches and pains.)

Review of Resident #4's physician's orders dated 05/14/18 revealed:
-There was an order to discontinue the current Tylenol order.
-There was an order to start Tylenol 650mg 3 times a day.
-There were no initials or any documentation on the form to indicate the order had been faxed to the pharmacy.

Observation of the 12:00pm medication pass on 10/24/18 revealed Resident #4 was administered 2 Tylenol 500mg caplets (1,000mg) at 11:55am instead of 650mg as ordered.

Review of Resident #4's October 2018 medication administration record (MAR) revealed:
-There was an entry for Tylenol 500mg take 2 caplets (1,000mg) 3 times daily.
-Tylenol 500mg 2 caplets 3 times daily was documented as administered at 6:00am, 12:00pm, and 6:00pm from 10/01/8 - 10/24/18.

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-There was no entry on the MAR for Tylenol 650mg 3 times daily.

Interview with the medication aide (MA) on 10/24/18 at 1:15pm revealed:
-She administered the Tylenol 500mg 2 caplets as indicated on the MAR.
-There was no Tylenol 650mg in the medication cart for Resident #4.
-She did not know the Tylenol order had changed in May 2018.
-The MAs were responsible for faxing new orders to the pharmacy and they should initial and date it once faxed.

Interview with the Special Care Coordinator (SCC) on 10/24/18 at 1:25pm revealed:
-The MAs were responsible for making sure all orders were faxed to the pharmacy.
-The MAs were supposed to initial and date the orders once faxed.
-She contacted the pharmacy today about Resident #4's Tylenol order change on 05/14/18 and the pharmacy never received the order.
-The Tylenol 650mg order was never entered on the MAR or dispensed.
-She also contacted the primary care provider (PCP) today and she confirmed the resident was supposed to be receiving Tylenol 650mg 3 times a day.

Review of a clarification order dated 10/24/18 revealed Resident #4 was supposed to take Tylenol 650mg 3 times a day.

Telephone interview with the Operations Manager at the primary pharmacy on 10/25/18 at 10:35am revealed:
-The pharmacy entered any orders received from the facility into the e-MAR system.

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-The pharmacy never received Resident #4's order dated 05/14/18 to change the Tylenol to 650mg 3 times a day.

Interview with Resident #4 on 11/02/18 at 4:15pm revealed:
-His legs hurt all the time.
-He did not know how much Tylenol he received.
-The Tylenol helped with his pain sometimes.

___

The facility failed to administer medications as ordered for 7 of 8 sampled residents resulting in 3 hospice residents (#3, #8, #15) missing doses of narcotic pain medications resulting in severe pain for the residents; a resident not receiving medications used to treat infection, inflammation in the airways, and to prevent wheezing, coughing, and chest tightness ordered after an acute hospital stay (#4); increased risk of vision loss due to eye drops for glaucoma not being administered for seven months (#2), increased risk of prolonged and resistant infection with clostridium difficile due to a two week delay in administration of an antibiotic (#13). The failure of the facility to administer medications as ordered resulted in serious neglect and serious physical harm and constitutes a Type A1 Violation.

___

The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/02/18 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 9, 2018.

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10A NCAC 13F .1004 (o) Medication Administration

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10A NCAC 13F .1004 Medication Administration

(o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure medications were borrowed only in an emergency and replaced promptly and documented for 2 of 2 residents sampled (#3, #5) related to a controlled substance for moderate to severe pain (#3) and a controlled substance for anxiety (#5).

The findings are:

Review of the facility's policy for borrowing medications revealed:
-Any medication ordered for a resident shall not be used by any other resident, staff or individual, with the exception of emergency borrowing as defined in 10A NCAC 13F .1004(o).
-Medication(s) shall never be borrowed as an expediency measure or for the convenience of staff.
-Any borrowed non-narcotic medication must be replaced promptly and documented on the medication administration record (MAR) to indicate from whom the medication was borrowed and to whom it was given.
-This documentation must be done at the time of borrowing.
-Borrowed narcotic documentation must be

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documented on the MAR and the narcotic record.
-If any ordered non-narcotic medication cannot be accounted for, staff shall immediately notify the Administrator/Executive Director (ED).
-The Administrator/ED will be responsible for investigating the matter.

1. Review of Resident #3's current FL-2 dated 01/26/18 revealed diagnoses included Alzheimer's disease, hypertension, chronic kidney disease, hyperlipidemia, and history of cerebrovascular accident.

Review of Resident #3's physician's orders revealed:
-There was an order dated 09/02/18 to discontinue all Morphine orders and start Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours (scheduled). (Morphine Sulfate is a controlled substance used to treat moderate to severe pain).
-There was an order dated 09/24/18 Morphine Sulfate 100mg/5ml take 0.25ml by mouth or sublingually every 4 hours.

Review of Resident #3's charting notes dated 09/28/18 at 2:34pm and 5:35pm revealed they were waiting for Morphine to come in from pharmacy.

Telephone interview with a manager at the facility's primary pharmacy on 11/09/18 at 4:15pm revealed:
-The pharmacy received a prescription dated 09/28/18 for Morphine on 09/28/18 from the PCP.
-The pharmacy dispensed the medication on 09/28/18 and it was delivered to the facility on 09/29/18.
-Facility staff signed for the Morphine on 09/29/18 at 3:55am.

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Review of Resident #3's September 2018 medication administration record (MAR) revealed:
-There were 4 entries for Morphine Sulfate 100mg/5ml (prefilled syringes), 0.25ml (5mg) to be administered every 4 hours at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There were 8 blanks with no reason for the omissions documented from 09/24/18 (8:00am) - 09/24/18 (8:00pm) and from 09/28/18 (4:00am) - 09/28/18 (4:00pm).
-The 8:00pm dose on 09/28/18 was documented as administered.

Review of Resident #3's controlled substance (CS) log for September 2018 revealed:
-There was a delivery of 1 dose on 09/12/18 at 3:09pm with no explanation for a delivery of 1 dose.
-There were 4 doses not administered from 4:00am on 09/28/18 through 4:00pm on 09/28/18 due to a balance of 0.
-There was a delivery of 1 dose on 09/28/18 at 10:50pm with no explanation for a delivery of 1 dose.
-This dose was documented as administered on 09/28/18 at 10:51pm (due at 8:00pm).
-There was a delivery of 2 doses on 09/29/18 at 6:42am with no explanation for a delivery of 2 doses.
-There were 2 doses documented as administered on 09/29/18 at 6:43am, leaving a balance of 0.

Interview with a medication aide (MA) on 11/05/18 at 4:58pm revealed:
-The MAs were supposed to order medications when there was a 6 or 7 day supply remaining.
-She thought there had been some miscommunication with getting some medication

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orders for Resident #3.
-The resident's Morphine had run out but she could not recall the dates.
-The MAs had to borrow Morphine for Resident #3 from another resident.
-The MAs probably borrowed Morphine for Resident #3 from a male resident who had an order for prn (as needed) Morphine but she could not recall which resident for sure.
-She could not recall how many times the MAs borrowed Morphine for Resident #3.
-The delivery of 1 or 2 doses documented on Resident #3's CS log should have been documented as borrowed doses.
-The pharmacy did not send just 1 or 2 doses at a time.

Review of Resident #3's charting note dated 09/28/18 at 10:20pm revealed:
-The Special Care Manager (SCM) spoke with the pharmacy to see why the Morphine had not been delivered.
-The SCM let the pharmacy know the PCP had called and faxed the order in.
-The pharmacy stated they never received the order or a phone call from the PCP.
-The SCM notified the PCP that the facility never received the medication from the pharmacy and the resident had been out of Morphine for several days.
-The PCP called the pharmacy and faxed the order several times to the pharmacy.
-The PCP faxed the order to the facility and the facility faxed it to the pharmacy.
-The SCM called the pharmacy and they had received the fax but the prefilled syringes could not be sent through the back up pharmacy.
-The pharmacy would deliver the Morphine to the facility the next morning.
-The SCM notified the PCP and the ED.

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-They "had to borrow a one-time dose" until the medication arrived due to the resident feeling restless and in pain.

Interview with the SCM on 11/02/18 at 1:27pm revealed:
-Resident #3 was a hospice resident and she was aware Resident #3 ran out of Morphine.
-The MAs should have notified the PCP, pharmacy and hospice if the resident ran out of medication.
-The prescriptions were being faxed to the pharmacy.
-The MAs were supposed to start getting a new prescription when there was about a 10 day supply remaining of any controlled substance.
-The problem with Resident #3 running out of Morphine was caused by the MAs waiting too late to try to get a new prescription.
-The MAs had to borrow Morphine for Resident #3 from another resident but she could not recall specific dates or times.
-She did not recall details when staff borrowed Morphine for Resident #3 but it should have been documented when the Morphine was borrowed, how much was borrowed, and which resident it was borrowed from.
-The MAs should also document replacing any borrowed medications.

Attempted interview on 11/09/18 at 3:20pm with the MA who documented administration of a borrowed dose on 09/28/18 at 10:51pm was unsuccessful.

Review of Resident #3's PCP visit note dated 10/01/18 revealed:
-On 09/28/18, the hospice nurse reported the resident was completely out of Morphine.
-A prescription was faxed directly to the facility's

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primary pharmacy with confirmed received at 2:53pm.
-Later that evening, the facility reported the pharmacy never received the prescription.
-They also reported the pharmacy never received a prescription for Morphine on 09/24/18.
-Upon further investigation, the resident had been out of Morphine for the past 4 days and staff did not notify the provider about this problem.
-Staff were either borrowing Morphine from another resident or not administering it at all.

Interview with Resident #3's PCP on 11/05/18 at 11:32am revealed:
-There were many issues with the resident's Morphine.
-The facility ran out of the resident's Morphine but would still document it was administered.
-The resident would grimace and arch her back when she was in pain because she could not speak.
-The resident was agitated and in pain.
-The SCM called the PCP on 09/29/18 and stated Resident #3 was completely out of Morphine.
-The SCM reported the facility did not receive prescriptions for Morphine on 09/24/18 or 09/28/18.
-The SCM told the PCP that they ended up borrowing some Morphine for Resident #3 from another resident.

Interviews with the ED on 11/06/18 at 1:00pm and 11/09/18 at 11:15am revealed:
-She remembered that Resident #3 ran out of Morphine but she could not recall the details.
-She thought the SCM had taken care of the problem with the Morphine running out so the SCM would know more about it.
-She could not recall if any medications were borrowed for Resident #3.

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-The MAs were responsible for ordering the medications prior to the meds running out.

Interviews with the Special Care Coordinator (SCC) on 11/02/18 at 11:56am and 11/05/18 revealed:
-The SCM mostly handled the medications for Resident #3.
-She was aware that the resident's Morphine ran out and was unavailable to be administered.
-The MAs were supposed to order all medications 7 days prior to running out, including controlled substances.
-The MAs "just don't do it", some will order in time and some will not.
-Morphine was a hospice end of life medication and the residents need it.
-The MAs borrowed Morphine for Resident #3 from another resident.
-She did not know who staff borrowed from or how much was borrowed because she could not find the book that the MAs used to document borrowing of medications.
-The MAs should have documented who they borrowed Morphine from to administer to Resident #3 and if the borrowed Morphine was replaced.

Refer to interview with a medication aide (MA) on 11/05/18 at 4:58pm.

Refer to interview with the Executive Director (ED) on 11/09/18 at 11:15am.

Refer to interview with the Special Care Coordinator (SCC) on 11/05/18 at 1:23pm.

2. Review of Resident #5's current FL-2 dated 06/18/18 revealed diagnoses included Alzheimer's dementia, coronary artery disease,

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hearing loss, hyperlipidemia, hypertension, muscular degenerative, and macular degeneration.

Review of Resident #5's physician orders dated 06/18/18 revealed there was a medication order for Lorazepam 0.5mg take one tablet by mouth at bedtime (Lorazepam is a medication used to treat anxiety which produces a calming effect).

Review of Resident #5's April 2018 electronic controlled substance (CS) log for Lorazepam 0.5mg revealed there were 3 separate dates where there was delivery of one tablet on each day.

Review of Resident #5's May 2018 electronic CS log for Lorazepam 0.5mg revealed on 05/15/18 at 2:15pm there was a disposal of one tablet with no reason for the disposal documented.

Review of Resident #5's charting notes for 05/15/18 at 3:31pm revealed:
-Lorazepam 0.5mg 1 tablet needed to be borrowed for another resident.
-There was no documentation that revealed who it was borrowed for or that it was replaced.

Interview with two medication aides (MAs) on 11/06/18 around 5:15pm revealed:
-On 05/15/18 Lorazepam 0.5mg 1 tablet was borrowed for another resident. They did not remember who the Lorazepam was borrowed for, or if it was replaced to Resident #5.
-When medications were borrowed from a resident it was documented on the borrowed medication sheets.
-The Special Care Coordinator (SCC) and Special Care Manager (SCM) were in charge of the borrowed medication sheets.

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-The borrowed medication sheets could not be located.

Attempted interview with a MA on 11/07/18 at 2:10pm and 11/09/18 who documented the disposal of Lorazepam on 05/15/18 were unsuccessful.

Interview with the SCC and SCM on 11/06/18 at around 5:40pm revealed they were uncertain of where the borrowed medication sheets for May 2018 were and would attempt to locate them.

The borrowed medication sheets for May 2018 were not provided after several requests throughout the survey.

Refer to interview with a medication aide (MA) on 11/05/18 at 4:58pm.

Refer to interview with the Executive Director (ED) on 11/09/18 at 11:15am.

Refer to interview with the Special Care Coordinator (SCC) on 11/05/18 at 1:23pm.

____

Interview with a MA on 11/05/18 at 4:58pm revealed:
-The MAs had a book they were supposed to document any borrowed medications and they were supposed to document when it was replaced to the other resident.
-She could not locate the book with documentation of borrowed medications.
-The pharmacy did not usually just send 1 or 2 doses of a medication.
-If there was a delivery of 1 or 2 doses of a medication on the CS log, those doses could have been borrowed from another resident.

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-The MAs should document the doses were borrowed on the CS log as well.

Interview with the ED on 11/09/18 at 11:15am revealed:
-The doses documented as delivered on the CS logs should match the amounts dispensed by the pharmacy.
-She did not know why the MAs were documenting the delivery of single doses of medications on the CS log.
-The MAs should not be borrowing medications because the medications should be available in the facility.
-If there was an emergency and the MAs had to borrow a medication, it should be documented and they would have to replace what was borrowed.

Interview with the SCC on 11/05/18 at 1:23pm revealed:
-The MAs were supposed to document the borrowing of medications on a log book.
-She could not find the log book for borrowing medications.

D 379 10a NCAC 13F .1006 (c) Medication Storage D 379

10a NCAC 13F .1006 Medication Storage

(c) The medication storage area shall be clean, well-lighted, well-ventilated, large enough to store medications in an orderly manner, and located in areas other than the bathroom, kitchen or utility room. Medication carts shall be clean and medications shall be stored in an orderly manner.

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to assure 2 of 2 medication carts were kept clean as related to soiled areas on top of the medication carts where medications were prepared and medication administration supplies were stored.

The findings are:

Observation of the 200 hall medication cart on 10/24/18 from 9:00am - 9:40am revealed:
-There was a blue mouse pad on top of the medication cart used for the electronic medication administration records (e-MARs).
-The surface of the mouse pad was covered with a build-up of brown and black colored stains.
-The medication aide (MA) would sit the plastic medication cups used to prepare medications for residents on top of the soiled mouse pad.
-There was a rectangular piece of taupe shelf grip liner on the back right corner of the medication cart.
-The shelf grip liner had brown and black colored stains scattered on the surface of the liner.
-There was a bottle of hand sanitizer on top of the soiled shelf liner.
-There were stacks of plastic medication cups turned upside down with the rim of the cups touching the soiled surface of the shelf liner.
-There was a stack of plastic drinking cups turned upside down with the rim of the cups touching the soiled surface of the shelf liner.
-The MA used the plastic medication cups and drinking cups on top of the soiled shelf liner to serve to residents during the morning medication pass on 10/24/18.

Observation of the 100 hall medication cart on 10/24/18 at 9:42am revealed:

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D 379	Continued From page 265 -The medication cart was parked in the hall near the nurses' station. -There was a blue mouse pad on top of the medication cart used for the e-MARs. -The surface of the mouse pad was covered with a build-up of brown and black colored stains. -There was a rectangular piece of taupe shelf grip liner on the back right corner of the medication cart. -The shelf grip liner had brown and black colored stains scattered on the surface of the liner. -The pill crusher was sitting on top of the soiled shelf liner. Interview with the MA on 10/24/18 at 9:40am revealed: -The mouse pads and the shelf grip liners had been soiled for "a while". -She could not say how often the medication carts were cleaned. -The mouse pads and the shelf grip liners needed to be changed because they had not been changed "in a while". Interview with the Special Care Coordinator (SCC) on 10/24/18 at 9:45am revealed: -The MAs were responsible for cleaning the medication carts between each shift. -She had not noticed the mouse pads and shelf grip liners on both medication carts were soiled. -It appeared the build-up stains had been that way "a while". -She would remove the soiled items from the medication carts and have them cleaned.	D 379		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily	D 392		

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retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.

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

Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 4 of 7 residents sampled (#2, #3, #8, #15) including three residents receiving pain medications (#3, #8, #15) and two residents receiving medications for anxiety and agitation (#2, #3).

The findings are:

1. Review of Resident #3's current FL-2 dated 01/26/18 revealed diagnoses included Alzheimer's disease, hypertension, chronic kidney disease, hyperlipidemia, and history of cerebrovascular accident.

a. Review of Resident #3's physician's order dated 07/05/18 revealed an order for Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours, hold if sleeping. (Morphine Sulfate is a controlled substance used to treat moderate to severe pain).

Review of Resident #3's physician's order dated 08/17/18 revealed an order for Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours (scheduled), hold for sedation.

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Review of Resident #3's physician's orders dated 08/29/18 revealed:
-There was an order for Morphine Sulfate 100mg/5ml take 0.25ml by mouth every 4 hours as needed for pain, hold for sedation.
-There was an order for Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours.

Review of Resident #3's August 2018 medication administration record (MAR) revealed:
-There was an entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml (5mg) by mouth every 4 hours scheduled to be administered at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was a total of 76 doses (19ml) of Morphine Sulfate documented as administered from 08/18/18 - 08/31/18.

Review of Resident #3's controlled substance (CS) log dated 08/18/18 - 08/31/18 revealed:
-The CS log did not accurately reconcile with the MAR.
-There was a total of 72 doses of Morphine documented as administered on the CS log but 76 doses were documented as administered on the MAR from 08/18/18 - 08/31/18.
-On 08/29/18, the 12:00pm, 4:00pm, and 8:00pm doses were not documented as administered on the CS log but were documented as administered on the MAR.

Review of Resident #3's pharmacy dispensing records for Morphine Sulfate for August 2018 revealed:
-There was 15ml (60 prefilled syringes) of Morphine Sulfate dispensed on 08/17/18.
-There was 11.25ml (45 prefilled syringes) of Morphine Sulfate dispensed on 08/29/18.

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Attempted interview on 11/08/18 at 7:56pm with a former medication aide (MA) who initialed Morphine doses as administered on the MAR on 08/29/18 but not administered on the CS log was unsuccessful.

Review of Resident #3's physician's order dated 09/02/18 revealed:
-There was an order to discontinue all current Morphine orders.
-There was an order for Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours (scheduled).

Review of Resident #3's physician's order dated 09/10/18 revealed there was an order for Morphine Sulfate 100mg/5ml take 0.25ml by mouth every 4 hours.

Review of Resident #3's physician's orders dated 09/24/18 and 09/28/18 revealed orders for Morphine Sulfate 100mg/5ml take 0.25ml by mouth or sublingually every 4 hours.

Review of Resident #3's September 2018 MAR revealed:
-There were 4 entries for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml (5mg) sublingually and/or by mouth every 4 hours scheduled to be administered at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was a total of 172 doses (43ml) of Morphine Sulfate documented as administered in September 2018.

Review of Resident #3's CS log for September 2018 revealed:
-The CS log did not accurately reconcile with the MAR.

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-There was a total of 161 doses of Morphine documented as administered on the CS log but 172 doses were documented as administered on the MAR from 09/01/18 - 09/30/18.
-There were 5 doses not documented as administered or declined from the balance on the CS log that were documented as administered on the MAR.
-There was a disposal of 2 doses on 09/12/18 at 7:15am with no reason documented.
-There was a disposal of 1 dose on 09/22/18 at 11:34am with no reason documented.
-There was a disposal of 1 dose on 09/22/18 at 6:39pm with no reason documented.
-There was a delivery of 1 dose on 09/28/18 at 10:50pm with no explanation.
-There was a delivery of 2 doses on 09/29/18 at 6:42am with no explanation.
-There was a delivery of 2 doses on 09/29/18 at 6:40am but these 2 doses were disposed on 09/29/18 at 6:56am with no reason for the disposal.

Review of Resident #3's pharmacy dispensing records for Morphine Sulfate for September 2018 revealed:
-There was 15ml (60 prefilled syringes) of Morphine Sulfate dispensed on 09/03/18.
-There was 10.5ml (42 prefilled syringes) of Morphine Sulfate dispensed on 09/10/18.
-There was 4.5ml (18 prefilled syringes) of Morphine Sulfate dispensed on 09/24/18.
-There was 15ml (60 prefilled syringes) of Morphine Sulfate dispensed on 09/28/18.
-There were no supplies of 1 or 2 individual doses of Morphine Sulfate dispensed.

Review of Resident #3's physician's order dated 10/05/18 revealed:
-There was an order to discontinue all Morphine

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orders.
-There was an order for Morphine Sulfate 100mg/5ml take 0.25ml by mouth or sublingually every 4 hours at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.

Review of Resident #3's physician's order dated 10/07/18 revealed:
-There was an order to discontinue Morphine.
-There was an order for Morphine Sulfate 100mg/5ml take 0.5ml (10mg) by mouth every 3 hours (may use 2 of the 0.25ml prefilled syringes).

Review of Resident #3's physician's order dated 10/09/18 at 5:00pm revealed:
-There was an order to discontinue all current medication orders.
-There was an order for Morphine Sulfate 100mg/5ml take 0.5ml (10mg) by mouth every 3.5 hours at 1:30am, 4:30am, 7:30am, 10:30am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm (may use current supply).

Review of Resident #3's physician's order dated 10/09/18 at 9:32pm revealed:
-This was a clarification order.
-There was an order for Morphine Sulfate 100mg/5ml take 0.5ml (10mg) by mouth every 3 hours, "continue same administration times as previously ordered".

Review of Resident #3's physician's order dated 10/10/18 revealed there was an order for Morphine Sulfate 100mg/5ml take 0.25ml by mouth every 30 minutes as needed for pain or shortness of breath.

Review of Resident #3's October 2018 MAR revealed:

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-There was an entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml (5mg) by mouth / sublingually every 4 hours scheduled to be administered at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was a second entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take "2X" 0.25ml syringes (10mg) by mouth every 3 hours scheduled to be administered at 2:00am, 5:00am, 8:00am, 11:00am, 2:00pm, 5:00pm, 8:00pm, and 11:00pm.
-There was a third entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take "2X" 0.25ml syringes (10mg) by mouth every 3 hours scheduled to be administered at 1:30am, 4:30am, 7:30am, 10:30am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm.
-There was a fourth entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml (5mg) by mouth every 30 minutes as needed for pain or shortness of breath but none was documented as administered.
-There was a total of 72 doses (18ml) of Morphine Sulfate documented as administered in October 2018.

Review of Resident #3's CS log for October 2018 revealed:
-The CS log did not accurately reconcile with the MAR.
-There was a total of 71 doses of Morphine documented as administered on the CS log but 72 doses were documented as administered on the MAR from 10/01/18 - 10/10/18.
-There was a disposal of 3 doses on 10/07/18 at 10:51pm with no reason documented.
-There was a disposal of 4 doses on 10/08/18 at 5:46pm with no reason documented.
-There was a delivery of 5 doses on 10/08/18 at 7:45pm.

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-On 10/09/18, the 10:30pm dose was not documented as administered on the CS log but was documented as administered on the MAR.
-There was a delivery of 70 doses on 10/09/18 at 11:04pm and a disposal of these 70 doses on 10/09/18 at 11:55pm with no reason documented.
-There was a disposal of 2 doses on 10/09/18 at 11:56pm with no reason documented, leaving a balance of 68.
-The next page of the CS log started with a "med pass edit" deducting 2 doses leaving a -2 balance, with no reference to the remaining 68 doses on the previous page.
-There was a delivery of 2 doses after the "med pass edit" dated 10/09/18 at 11:52pm, leaving a balance of 0.
-There were 2 doses administered on 10/10/18 at 7:57am, leaving a balance of -2.
-There were 2 doses administered on 10/10/18 at 10:34am, leaving a balance of -4.
-There was a delivery of 60 doses on 10/10/18 at 12:21pm, leaving a balance of 56 doses.
-There was a delivery of 4 doses on 10/10/18 at 12:56pm, leaving a balance of 60 doses.
-There was a disposal of 1 dose on 10/11/18 at 7:20am with no reason documented.
-The final balance on 10/11/18 at 10:42pm was 53 doses of Morphine.

Review of Resident #3's pharmacy dispensing records for Morphine Sulfate for October 2018 revealed:
-There was 20ml (80 prefilled syringes) of Morphine Sulfate dispensed on 10/08/18.
-There was 5ml (20 prefilled syringes) of Morphine Sulfate dispensed on 10/10/18.
-There was no supply of 2, 4, 5, 60, or 70 doses of Morphine Sulfate dispensed in October 2018.

Review of Resident #3's pharmacy return record

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dated 10/11/18 revealed 53 Morphine prefilled syringes were returned to the pharmacy.

Telephone interview with a manager at the facility's primary pharmacy on 11/09/18 at 4:15pm revealed the pharmacy had not dispensed a quantity of less than 18 doses of Morphine for Resident #3.

Review of a hospice visit note report revealed Resident #3 passed away on 10/10/18.

Review of Resident #3's August 2018 - October 2018 MARs, CS logs, and pharmacy dispensing/return records revealed:
-There were 385 doses (prefilled syringes) of Morphine Sulfate dispensed from 08/17/18 - 10/10/18.
-There were 53 doses returned to the pharmacy on 10/11/18, indicating 332 dose had been used.
-There were 304 doses documented as administered on the CS log from 08/18/18 - 10/10/18.
-There were 320 doses documented as administered on the MAR from 08/18/18 - 10/10/18.
-The CS log did not accurately reconcile with the MARs or the quantity dispensed.

Interview with a MA on 11/05/18 at 5:40pm revealed:
-She documented the disposal of 3 Morphine doses on 10/07/18 for Resident #3.
-She did not document the reason for disposal but should have documented it.
-She thought 3 doses were disposed at one time because the Morphine prefilled syringes were leaking.
-She would have disposed of the leaking syringes in the sharp's container with a witness.

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-She documented the delivery and disposal of 70 Morphine doses on 10/09/18.
-She did not know why 70 doses of Morphine were documented as delivered then disposed on the CS log on 10/09/18 for Resident #3.
-She could not recall why she documented it.
-The delivery may have been entered on the wrong CS log.

Interview with a second MA on 11/07/18 at 10:50am revealed:
-The resident's Morphine usually came in prefilled syringes.
-The Morphine prefilled syringes were usually sent in a bundle with a rubber band around them.
-Sometimes, when they pulled a syringe out of the rubber banded bundle, it would break and they would have to dispose of it.
-The MAs would have to waste the dose by squirting it in the sink with a care manager as a witness.

Interview with a third MA on 11/07/18 at 3:05pm revealed:
-She was unsure why she had documented some of the deliveries and disposals on the CS log.
-Sometimes, a disposal on the CS log may be documented because they moved a dose to a different prescription number.
-Therefore, a documented disposal on the CS log did not necessarily mean a dose was wasted or destroyed.

Interview with the Special Care Manager (SCM) on 11/02/18 at 1:27pm revealed:
-She could not explain why 70 doses of Resident #3's Morphine were delivered then disposed on 10/09/18.
-She was not aware of any leaking Morphine syringes.

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-Morphine syringes should be disposed in the sharp's container with a witness and it should be documented.

Interview with the Special Care Coordinator (SCC) on 11/06/18 at 12:05pm revealed:
-No MAs had reported Resident #3's Morphine syringes had leaked.
-The Morphine syringes had a sealed blue cap and were not loose.
-If there was an issue with Morphine syringes leaking, the MAs should report it to her or the SCM.
-Morphine syringes should be disposed in the sharp's container and it should have been documented on the CS log.
-She was not aware of the negative balances for Resident #3's Morphine.
-She did not know why there would have been negative balances.

Interview with the Executive Director (ED) on 11/06/18 at 12:24pm revealed:
-She was not aware of any leaking Morphine syringes.
-If a controlled substance was disposed, the reason should be documented in the comments of the CS log.

Refer to interview with a MA on 11/05/18 at 5:40pm.

Refer to interview with a second MA on 11/07/18 at 10:50am.

Refer to interviews with the SCC on 11/02/18 at 11:56am and 11/06/18 at 12:05pm.

Refer to interview with the SCM on 11/02/18 at 1:27pm.

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Refer to interviews with the ED on 11/06/18 at 12:24pm and 11/09/18 at 10:47am.

b. Review of Resident #3's physician's order dated 07/03/18 revealed an order for Lorazepam 0.5mg take 1 tablet 3 times a day. (Lorazepam in a controlled substance used to treat anxiety and agitation.)

Review of Resident #3's September 2018 medication administration record (MAR) revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet 3 times a day scheduled to be administered at 8:00am, 2:00pm, and 8:00pm.
-If administered 3 times a day as ordered, 90 doses should be administered from 09/01/18 - 09/30/18.
-There was a total of 83 Lorazepam 0.5mg tablets documented as administered in September 2018.

Review of Resident #3's controlled substance (CS) log for September 2018 revealed:
-The CS log did not accurately reconcile with the MAR.
-There was a total of 81 doses of Lorazepam documented as administered on the CS log and 83 doses were documented as administered on the MAR from 09/01/18 - 09/30/18.
-On 09/15/18, the 2:00pm dose was not documented as administered on the CS log but was documented as administered on the MAR.
-There was a dose administered on 09/21/18 at 9:18am, leaving a balance of -1.
-There was a delivery of 1 tablet on 09/21/18 at 6:47pm, leaving a balance of 0.

Review of Resident #3's pharmacy dispensing records for Lorazepam 0.5mg for September

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2018 revealed:
-There were 45 tablets dispensed on 09/03/18.
-There were 45 tablets dispensed on 09/20/18.
-There were no individual doses of 1 tablet dispensed.

Review of Resident #3's physician's order dated 10/05/18 revealed:
-There was an order to discontinue current Lorazepam.
-There was an order for Lorazepam 0.5mg 1 tablet 3 times a day at 9:00am, 3:00pm, and 9:00pm.

Review of Resident #3's physician's order dated 10/07/18 revealed:
-There was an order to discontinue current Lorazepam orders.
-There was an order for Lorazepam 0.5mg take 1 tablet every 4 hours.

Review of Resident #3's physician's order dated 10/08/18 revealed there was an order for Lorazepam 0.5mg take 1 tablet every 2 hours as needed for agitation or "air hunger".

Review of Resident #3's physician's order dated 10/09/18 at 5:00pm revealed:
-There was an order to discontinue all current medication orders.
-There was an order for Lorazepam 0.5mg by mouth one dose at 7:00pm today (use current supply.
-There was an order for Lorazepam 0.5mg every 3.5 hours at 1:30am, 4:30am, 7:30am, 10:30am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm (may use current supply).
-There was an order for Lorazepam 0.5mg by mouth every 2 hours as needed for agitation or shortness of breath (use current supply).

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Review of Resident #3's physician's order dated 10/09/18 at 9:32pm revealed:
-This was a clarification order.
-There was an order for Lorazepam 0.5mg every 3 hours, "continue same administration times a previously ordered".

Review of Resident #3's October 2018 MAR revealed:
-There was an entry for Lorazepam 0.5mg take 1 tablet 3 times a day scheduled to be administered at 8:00am, 2:00pm, and 8:00pm.
-There was a second entry for Lorazepam 0.5mg take 1 tablet 3 times daily at 9:00am, 3:00pm, and 9:00pm, do not give at same time as Morphine.
-There was a third entry for Lorazepam 0.5mg take 1 tablet every 4 hours scheduled to be administered at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was a fourth entry for Lorazepam 0.5mg take 1 tablet every 3 hours (1:30am, 4:30am, 7:30am, 10:30am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm).
-There was a fifth entry for Lorazepam 0.5mg take 1 tablet every 2 hours as needed for agitation or shortness of breath but none was documented as administered.
-There was a total of 37 Lorazepam 0.5mg tablets documented as administered in October 2018.

Review of Resident #3's CS log for October 2018 revealed:
-There was a total of 37 doses of Lorazepam documented as administered on the CS log and the MAR from 10/01/18 - 10/10/18.
-The CS log did not accurately reconcile with the MAR or pharmacy dispensing records.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-There were multiple deliveries and disposals of Morphine doses with no explanations documented.
-There was a delivery of 6 tablets on 10/06/18 at 7:09am.
-There was a disposal of 43 tablets on 10/08/18 at 8:32am, leaving a balance of 0.
-There was a delivery of 43 tablets on 10/08/18 at 1:03pm, leaving a balance of 43.
-There was a delivery of 34 tablets on 10/09/18 at 11:04pm, and a disposal of those 34 tablets on 10/09/18 at 11:29pm.
-There was a disposal of 1 tablet on 10/09/18 at 11:57pm, leaving a balance of 33 tablets.
-There was a disposal of 33 tablets on 10/10/18 at 12:31pm, leaving a balance of 0.
-The next page started with a "med pass edit" on 10/09/18 with a deduction of 1 tablet but no reason documented, leaving a balance of -2.
-There was a disposal of 1 tablet on 10/09/18 at 11:30pm, leaving a balance of -2.
-There was a delivery of 2 tablets on 10/09/18 at 11:52pm, leaving a balance of 0.
-There were 2 tablets administered on 10/10/18, leaving a balance of -2.
-There was a delivery of 2 tablets on 10/10/18 at 12:40pm, leaving a balance of 0.
-There was a disposal of 5 tablets on 10/10/18 at 12:33pm.
-There was a delivery of 29 tablets on 10/10/18 and a disposal of 29 on 10/10/18 at 12:32pm.
-There was a second delivery of 29 tablets on 10/10/18 at 12:56pm and another disposal of 29 tablets on 10/10/18 at 1:13pm.
-The last page had a third delivery of 29 tablets on 10/10/18 at 1:14pm.
-The ending balance on 10/10/18 at 7:26pm was 26 tablets.

Review of Resident #3's pharmacy return record

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dated 10/11/18 revealed 26 Lorazepam 0.5mg tablets were returned to the pharmacy.

Review of Resident #3's pharmacy dispensing records for Lorazepam 0.5mg for October 2018 revealed:
-There were 45 tablets dispensed on 10/05/18.
-There were no other quantities of Lorazepam 0.5mg tablets dispensed in October 2018.

Review of a hospice visit note report revealed Resident #3 passed away on 10/10/18.

Review of Resident #3's September 2018 - October 2018 MARs, CS logs, and pharmacy dispensing/return records revealed:
-The September 2018 CS log started with a balance of 11 Lorazepam 0.5mg tablets.
-There were 135 tablets dispensed from 09/01/18 - 10/10/18.
-There was a total of 146 tablets available for administration from 09/01/18/ - 10/10/18.
-There were 26 tablets returned to the pharmacy on 10/11/18, indicating 120 tablets had been used.
-There were 118 doses documented as administered on the CS log from 09/01/18 - 10/10/18.
-There were 120 doses documented as administered on the MAR from 9/01/18 - 10/10/18.
-Two Lorazepam tablets were not accounted for.
-The CS log did not accurately reconcile with the MARs or quantity dispensed.

Interview with a medication aide (MA) on 11/05/18 at 5:40pm revealed:
-She was not sure why the CS log for Resident #3's Lorazepam did not match the MAR.
-When a new prescription came in, a delivery

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may be documented twice because it may have been initially put in under the wrong prescription number.
-So the delivery may be added to a previous prescription number.
-She may have documented a disposal on the CS log to adjust an incorrect delivery entry.

Interview with a second MA on 11/07/18 at 3:05pm revealed:
-She was unsure why she had documented some of the deliveries and disposals on the CS log.
-Sometimes, a disposal on the CS log may be documented because they moved a dose to a different prescription number.
-Therefore, a documented disposal on the CS log did not necessarily mean a dose was wasted or destroyed.

Interview with the Special Care Coordinator (SCC) on 11/02/18 at 11:56am revealed:
-The CS logs were confusing.
-She did not know why there were so many deliveries and disposals for Resident #3's Lorazepam.
-Sometimes there were duplicate orders on the MARs so counts on the CS log would be deducted twice.
-Any disposals for Resident #3 should have a reason documented in the column on the right of the CS log.
-There should not be any negative balances on the CS logs.
-She was not aware of the negative balances for Resident #3's Lorazepam.
-She did not know why there would have been negative balances.

Interview with the Special Care Manager (SCM) on 11/02/18 at 1:27pm revealed:

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-She could not explain why she had documented duplicate deliveries and disposals for Resident #3's Lorazepam.
-Sometimes, they had to do med pass edits on the CS log when it did not match because the computer would "freeze up".

Refer to interview with a MA on 11/05/18 at 5:40pm.

Refer to interview with a second MA on 11/07/18 at 10:50am.

Refer to interviews with the SCC on 11/02/18 at 11:56am and 11/06/18 at 12:05pm.

Refer to interview with the SCM on 11/02/18 at 1:27pm.

Refer to interviews with the Executive Director (ED) on 11/06/18 at 12:24pm and 11/09/18 at 10:47am.

2. Review of Resident #8's current FL-2 dated 04/10/18 revealed diagnoses included Alzheimer's disease, type 2 diabetes, chronic kidney disease, hyperlipidemia, and idiopathic gout.

Review of Resident #8's physician's order dated 08/09/18 revealed an order for Morphine Sulfate 100mg/5ml take 0.25ml prefilled syringe) by mouth / sublingually every 2 hours as needed (prn) for pain / "air hunger". (Morphine Sulfate is a controlled substance used to treat moderate to severe pain. It may also be used to treat difficulty in breathing at end of life.)

Review of Resident #8's physician's order dated 08/27/18 revealed:

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-There was an order to discontinue prn Morphine.
-There was an order for Morphine Sulfate 100mg/5ml take 0.25ml by mouth or sublingually every 4 hours (scheduled).

Review of Resident #8's charting note dated 08/29/18 at 11:00am revealed:
-The resident's Morphine did not come in prefilled syringes but came in a full bottle instead.
-The hospice nurse gave the resident his 12:00pm dosage.
-The resident's order was clarified.
-Prefilled syringes would be delivered tonight from the primary pharmacy.

Review of Resident #8's physician's order dated 08/29/18 revealed there was an order for Morphine Sulfate 100mg/5ml take 0.25ml sublingually every 4 hours scheduled, please prefill all syringes, "send STAT".

Review of Resident #8's August 2018 medication administration record (MAR) revealed:
-There were entries for Morphine Sulfate 100mg/5ml, take 0.25ml (5mg) by mouth / sublingually every 4 hours scheduled for administration at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was an entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml by mouth/sublingually every 2 hours prn for pain / air hunger.
-There was a total of 38 doses (9.5ml) of Morphine documented as administered from 08/10/18 - 08/31/18.

Review of Resident #8's controlled substance (CS) log dated 08/10/18 - 08/31/18 revealed:
-The balance for the CS log starting on 08/10/18 was 25 prefilled syringes (25 doses).

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-The CS log did not accurately reconcile with the MAR.
-There were a total of 36 doses of Morphine documented as administered on the CS log but 38 doses were documented as administered on the MAR from 08/10/18 - 08/31/18.
-On 08/11/18 at 8:05pm, "0.25" was documented as the dose administered (instead of 1 prefilled syringe), leaving a balance of 19.75 prefilled syringes.
-On 08/11/18 at 11:10pm, there was a disposal of "0.75" with no explanation, leaving a balance of 19 prefilled syringes.
-There was a disposal of 1 dose on 08/12/18 at 11:02pm with no reason documented.
-There was a delivery of 2 doses on 08/29/18 at 2:58pm with no explanation.
-There was a delivery of 1 dose on 08/30/18 at 1:29am with no explanation.
-On 08/30/18, the 4:00am and 8:00am doses were not documented as administered or deducted from the CS log balance but they were documented as administered on the MAR.
-There was no documented delivery of the 30ml bottle dispensed on 08/28/18.

Review of Resident #8's pharmacy dispensing records for Morphine Sulfate for August 2018 revealed:
-There was 6.25ml (25 prefilled syringes) of Morphine Sulfate dispensed on 08/09/18.
-There was 30ml (one bottle) of Morphine Sulfate dispensed on 08/28/18.
-There was 22.5ml (90 prefilled syringes) of Morphine Sulfate dispensed on 08/30/18.
-There was no dispensing of 1 or 2 individual doses of Morphine Sulfate.

Review of pharmacy return records for Resident #8 revealed:

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-The 30ml bottle of Morphine was returned to the pharmacy on 09/06/18.
-There were 29ml documented as returned.

Review of Resident #8's physician's orders dated 09/10/18 and 09/21/18 revealed there were orders for Morphine Sulfate 100mg/5ml take 0.25ml by mouth / sublingually every 4 hours (scheduled).

Review of Resident #8's September 2018 MAR revealed:
-There was an entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml (5mg) by mouth or sublingually every 4 hours scheduled to be administered at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The Morphine was blank on 09/22/18 at 4:00am with no reason for the omission.
-If administered every 4 hours as ordered, 180 dose of Morphine would have been administered.
-There was a total of 178 doses (44.5ml) of scheduled Morphine documented as administered from 09/01/18 - 09/30/18.

Review of Resident #8's CS log for September 2018 revealed:
-The CS log did not accurately reconcile with the MAR.
-There were a total of 173 doses of Morphine documented as administered on the CS log but 178 doses were documented as administered on the MAR for September 2018.
-There were 9 scheduled doses of Morphine not documented as administered on the CS log that were documented as administered on the MAR.
-For example, the 12:00am and 4:00am doses on 09/11/18 were not documented as administered on the CS log but were documented as administered on the MAR.

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-There was a disposal of 1 dose on 09/10/18 at 10:59pm with no reason documented.
-There was a delivery of 3 doses on 09/22/18 at 11:45am with no explanation.
-There was a delivery of 1 dose on 09/22/18 at 6:53pm with no explanation.

Review of Resident #8's pharmacy dispensing records for Morphine Sulfate for September 2018 revealed:
-There was 10.5ml (42 prefilled syringes) of Morphine Sulfate dispensed on 09/10/18.
-There was 12ml (48 prefilled syringes) of Morphine Sulfate dispensed on 09/20/18.
-There was 7.5ml (30 prefilled syringes) of Morphine Sulfate dispensed on 09/23/18.
-There was no dispensing of 1 or 3 individual doses of Morphine Sulfate.

Review of Resident #8's October 2018 MAR revealed:
-There was an entry for Morphine Sulfate 100mg/5ml (prefilled syringes), take 0.25ml (5mg) by mouth or sublingually every 4 hours scheduled for at 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was a total of 21 doses (5.25ml) of scheduled Morphine documented as administered from 10/01/18 - 10/04/18 at 8:00am.

Review of Resident #8's CS log for October 2018 revealed:
-The CS log did not accurately reconcile with the MAR.
-There was 20 doses of Morphine documented as administered on the CS log and 21 doses documented as administered on the MAR.
-The last dose documented was on 10/04/18 at 8:46am, leaving an ending balance of 6.

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Review of Resident #8's pharmacy dispensing records for Morphine Sulfate for October 2018 revealed no Morphine was dispensed in October 2018.

Review of a hospice visit note revealed the resident expired on 10/04/18.

Review of Resident #3's August 2018 - October 2018 MARs, CS logs, and pharmacy dispensing/return records revealed:
-There were 235 doses (prefilled syringes) of Morphine Sulfate dispensed from 08/09/18 - 10/05/18.
-One 30ml bottle was dispensed on 08/28/18 and it was returned to the pharmacy (29ml) on 09/06/18.
-There were 229 doses documented as administered on the CS log from 08/10/18 - 10/05/18.
-There were 6 doses remaining on 10/05/18.
-There were 237 doses documented as administered on the MAR from 08/10/18 - 10/05/18.
-There were 2 doses unaccounted for.
-The CS log did not accurately reconcile with the MARs or the quantity dispensed.

Interview with a medication aide (MA) on 11/05/18 at 5:40pm revealed:
-She was unsure why some doses of Morphine had been disposed for Resident #8.
-She did not document the reason for disposal but should have documented it.
-Sometimes the Morphine syringes would leak and they would have to dispose of them.

Interview with a second MA on 11/07/18 at 10:50am revealed:
-The MAs did not administer Morphine from a

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bottle.
-The residents' Morphine usually came in prefilled oral syringes.
-The Morphine oral syringes were usually sent in a bundle with a rubber band around them.
-Sometimes, when they pulled a syringe out of the rubber banded bundle, it would break and they would have to dispose of it.
-The MAs would have to waste the dose by squirting it in the sink with a care manager as a witness.

Interview with the Executive Director (ED) on 11/06/18 at 12:24pm revealed:
-She was not aware of any leaking Morphine syringes.
-If a controlled substance was disposed, the reason should be documented in the comments of the CS log.

Interview with the Special Care Coordinator (SCC) on 11/06/18 at 12:05pm revealed:
-No MAs had reported any leaking Morphine syringes to her.
-The Morphine syringes had a sealed blue cap and were not loose.
-If there was an issue with Morphine syringes leaking, the MAs should report it to her or the SCM.
-Morphine syringes should be disposed in the sharp's container.
-There was a section for comments on the CS logs that should be used to document the reason for disposals.

Interview with the Special Care Manager (SCM) on 11/02/18 at 1:27pm revealed:
-She was not aware of any leaking Morphine syringes.
-Morphine syringes should be disposed in the

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sharp's container.

Refer to interview with a MA on 11/05/18 at 5:40pm.

Refer to interview with a second MA on 11/07/18 at 10:50am.

Refer to interviews with the SCC on 11/02/18 at 11:56am and 11/06/18 at 12:05pm.

Refer to interview with the SCM on 11/02/18 at 1:27pm.

Refer to interviews with the ED on 11/06/18 at 12:24pm and 11/09/18 at 10:47am.

3. Review of Resident #15's current FL-2 dated 06/04/18 revealed:
-Diagnoses included Alzheimer's dementia, hypertension, chronic kidney disease - stage 3, hypokalemia, hypothyroidism, schizophrenia, generalized muscle weakness, and depression.
-There was an order for Tramadol 50mg 1 tablet 3 times a day. (Tramadol is a controlled substance used for moderate to severe pain.)

Review of Resident #15's physician's order dated 07/19/18 revealed an order to increase Tramadol to 50mg 4 times per day.

Review of Resident #15's physician's orders dated 08/13/18 revealed there was an order for Tramadol 50mg 1 tablet at 8:00am, 12:00pm, 4:00pm, and 10:00pm.

Review of Resident #15's physician's orders dated 08/23/18 at 2:56pm revealed:
-The primary care provider (PCP) noted the resident had 2 orders for Tramadol prescribed by

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two different providers.
-Tramadol 50mg 1 tablet 4 times a day was prescribed by the PCP on 07/31/18.
-Tramadol 50mg 1 every 6 hours was prescribed by the hospice provider on 08/19/18.
-The PCP asked to be advised if the resident had received both orders (100mg 4 times a day) in error.
-There was a handwritten note beside the PCP's Tramadol order on 07/31/18 that read "DC'd" (discontinued).
-There was a handwritten note beside the hospice Tramadol order on 08/19/18 that read "new".
-There was no initials beside the handwritten notes to indicate who wrote the comments.

Review of Resident #15's prescription by the PCP dated 08/31/18 revealed:
-There was an order to discontinue all current Tramadol orders.
-There was an order for Tramadol 50mg 1 tablet 4 times a day at 8:00am, 12:00pm, 4:00pm, and 8:00pm.

Review of Resident #15's August 2018 medication administration record (MAR) revealed:
-There was an entry for Tramadol 50mg take 1 tablet daily at 8:00am, 12:00pm, 4:00pm, and 10:00pm.
-There was a second entry for Tramadol 50mg 1 tablet every 6 hours (4 times a day) that started on 08/19/18 at 4:00pm.
-This Tramadol entry had 7 administration times listed on the MAR including 12:00am, 6:00am, 8:00am, 12:00pm, 4:00pm, 6:00pm and 10:00pm.
-Not all of the scheduled times were documented as administered by staff each day from 08/19/18 - 08/24/18.
-Tramadol was documented as administered

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more than every 6 hours (4 times a day) from 08/19/18 - 08/23/18.
-Tramadol was documented as administered 5 times on 08/19/18, 7 times on 08/20/18, 8 times on 08/21/18, 7 times on 08/22/18, and 6 times on 08/23/18.
-Starting on 08/25/18 through 08/31/18, Tramadol was documented as administered at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There were 134 Tramadol 50mg tablets documented as administered in August 2018.

Review of the controlled substance (CS) log for August 2018 for Resident #15 revealed:
-The CS log did not accurately reconcile with the MAR.
-There were a total of 119 Tramadol tablets documented as administered on the CS log from 08/01/18 - 08/31/18 but 134 tablets were documented as administered on the MAR.
-If administered 4 times a day as ordered from 08/01/18 - 08/31/18, 124 tablets should have been documented as administered and declined from the CS log balance.
-On 08/06/18 at 1:37pm, there was a disposal of 1 tablet with no reason documented.
-On 08/11/18, the 12:00pm dose was not documented as administered on the CS log but was documented as administered on the MAR.
-On 08/19/18 at 9:53am, 12:26pm, and 4:29pm, there was a delivery of 1 tablet each time with no explanations.
-There was no documentation to indicate where the single doses of Tramadol were delivered from or why 1 dose was delivered at a time.
-On 08/20/18 at 7:21am, there was a disposal of 2 tablets with no reason documented.
-On 08/20/18 at 10:56pm there was a disposal of 1 tablet with no reason documented.
-On 08/21/18 at 11:27pm, there was a disposal of

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1 tablet with no reason documented.
-On 08/22/18 at 7:16am, there was a disposal of 2 tablets with no reason documented.
-On 08/22/18 at 9:40am, there was a disposal of 2 tablets with no reason documented.
-On 08/23/18 at 9:10am, there was a disposal of 1 tablet with no reason documented.
-Tramadol was documented as administered 4 times on 08/19/18 on the CS log but 5 times on the MAR.
-Tramadol was documented as administered 4 times on 08/20/18 on the CS log but 7 times on the MAR.
-Tramadol was documented as administered 4 times on 08/21/18 on the CS log but 8 times on the MAR.
-Tramadol was documented as administered 3 times on 08/22/18 on the CS log but 7 times on the MAR.

Review of Resident #15's pharmacy dispensing records for August 2018 revealed:
-There were 60 Tramadol 50mg tablets dispensed on 08/19/18.
-There were no supplies of 1 individual tablet dispensed.

Review of Resident #15's prescription by the PCP dated 09/22/18 revealed an order for Tramadol 50mg 1 tablet 4 times a day at 8:00am, 12:00pm, 4:00pm, and 8:00pm.

Review of Resident #15's September 2018 MAR revealed:
-There was an entry for Tramadol 50mg take 1 tablet every 6 hours (4 times daily) scheduled to be administered at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was a second entry for Tramadol 50mg 1 tablet 4 times a day scheduled to be administered

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at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There were 111 Tramadol 50mg tablets documented as administered in September 2018.

Review of the CS log for September 2018 for Resident #15 revealed:
-The CS log did not accurately reconcile with the MAR.
-There were a total of 99 Tramadol tablets documented as administered on the CS log from 09/01/18 - 09/30/18 but 111 tablets were initialed as administered on the MAR.
-If administered 4 times a day (or every 6 hours) as ordered from 09/01/18 - 09/30/18, 120 tablets should have been documented as administered and deducted from the CS log balance.
-There were 13 scheduled doses of Morphine not documented as administered on the CS log that were documented as administered on the MAR.
-For example, the 6:00am, 12:00pm, and 6:00pm doses on 09/02/18 were not documented as administered on the CS log but were documented as administered on the MAR.
-There was a delivery of 1 tablet each on 11 different occasions.
-For example, there was a delivery of 1 tablet on 09/02/18 at 12:41am
-There was no documentation to indicate where the single doses of Tramadol were delivered from or why 1 dose was delivered at a time.
-There was a disposal of 1 tablet on 09/07/18 at 7:09am with no reason documented.
-There was a disposal of 1 tablet on 09/25/18 at 12:37pm with no reason documented.

Review of Resident #15's pharmacy dispensing records from September 2018 revealed:
-There were 60 Tramadol 50mg tablets dispensed on 09/05/18.
-There were 60 Tramadol 50mg tablets

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dispensed on 09/22/18.
-There were 28 Tramadol 50mg tablets dispensed on 09/28/18.
-There was no dispensing of 1 tablet of Tramadol on any occasion.

Review of Resident #15's PCP's orders dated 10/21/18 revealed:
-There was an order to discontinue Tramadol 4 times a day.
-There was an order to start Tramadol 50mg 3 times a day at 8:00am, 2:00pm, and 8:00pm.

Review of Resident #15's prescription by the PCP dated 10/29/18 revealed:
-There was an order to discontinue Tramadol 50mg 3 times a day.
-There was an order for Tramadol 50mg twice a day at 8:00am and 8:00pm for 7 days (10/30/18 - 11/05/18).
-Then, Tramadol 50mg daily at 8:00am for 7 days (11/06/18 - 11/12/18).

Review of Resident #15's October 2018 MAR revealed:
-There was an entry for Tramadol 50mg take 1 tablet 4 times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was a second entry for Tramadol 50mg 1 tablet 4 times a day at 4:00am, 8:00am, 2:00pm, and 8:00pm.
-There was a third entry for Tramadol 50mg 1 tablet 3 times a day scheduled for 8:00am, 2:00pm, and 8:00pm.
-There was a fourth entry for Tramadol 50mg 1 tablet twice daily at 8:00am and 8:00pm for 7 days.
-There were 111 Tramadol 50mg tablets documented as administered in October 2018.

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D 392	Continued From page 295 Review of the CS log for October 2018 for Resident #15 revealed: -The CS log did not accurately reconcile with the MAR. -There were a total of 111 Tramadol tablets documented as administered on the CS log and the MAR from 10/01/18 - 10/31/18. -There was a delivery of 1 tablet on 10/07/18 at 7:03pm with no explanation. -There was a balance of 3 tablets on 10/29/18 at 10:37pm. -The next page of the CS log had only 1 entry and it was for the same date and time, 10/29/18 at 10:37pm but showed a balance of 0. -There was no documentation on the CS log to indicate why the balance changed from 3 to 0. -There was no documentation on the CS log to account for those 3 tablets. Review of Resident #15's pharmacy dispensing records from October 2018 revealed: -There were 28 Tramadol 50mg tablets dispensed on 10/15/18. -There were 21 Tramadol 50mg tablets dispensed on 10/22/18. -There were 21 Tramadol 50mg tablets dispensed on 10/29/18. -There was no dispensing of 1 tablet of Tramadol on any occasion. Review of Resident #15's November 2018 MAR revealed: -There was an entry for Tramadol 50mg 1 tablet twice daily at 8:00am and 8:00pm for 7 days. -There was an entry for Tramadol 50mg 1 tablet daily at 8:00am for 7 days. -There were 12 Tramadol 50mg tablets documented as administered from 11/01/18 - 11/07/18.	D 392		

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Review of the CS log for November 2018 for Resident #15 revealed:
-There were a total of 12 Tramadol tablets documented as administered on the CS log and the MAR from 11/01/18 - 11/07/18.
-The ending balance on 11/017/18 at 3:07pm was 5 tablets.

Observation of Resident #15's medications on hand on 11/07/18 at 4:53pm revealed a supply of 21 Tramadol 50mg tablets dispensed on 10/29/18 and 5 tablets remained.

Review of Resident #15's August 2018 - October 2018 MARs, CS logs, and pharmacy dispensing/return records revealed:
-The beginning balance of Tramadol on 08/01/18 was 72 tablets.
-There were 278 tablets dispensed from 08/01/18 - 11/07/18.
-There was a total of 350 tablets available to be administered from 08/01/18 - 11/07/18.
-There were 5 of the 350 tablets on hand on 11/07/18, indicating 345 tablets had been used.
-There were 341 tablets doses documented as administered on the CS log from 08/01/18 - 11/07/18.
-There were 368 doses documented as administered on the MAR from 08/01/18 - 11/07//18.
-There were 4 tablets unaccounted for.
-The CS log did not accurately reconcile with the MARs or the quantity dispensed.

Interview with a medication aide (MA) on 11/05/18 at 5:40pm revealed:
-She was not sure why the CS log for Resident #15's Tramadol did not match the MAR.
-When a new prescription came in, a delivery may be documented twice because it may have

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been initially put in under the wrong prescription number.
-So the delivery may be added to a previous prescription number.
-She may have documented a disposal on the CS log to adjust an incorrect delivery entry.

Interview with a second MA on 11/07/18 at 3:05pm revealed:
-She was unsure why she had documented some of the deliveries and disposals on the CS log.
-Sometimes, a disposal on the CS log may be documented because they moved a dose to a different prescription number.

Interview with the Special Care Coordinator (SCC) on 11/02/18 at 11:56am revealed:
-The CS logs were confusing.
-She did not know why there were deliveries of 1 tablet and disposals for Resident #15's Tramadol.
-Sometimes there were duplicate orders on the MARs so counts on the CS log would be deducted twice.
-Any disposals for Resident #15 should have a reason documented in the column on the right of the CS log.

Interview with the Special Care Manager (SCM) on 11/02/18 at 1:27pm revealed:
-She could not explain the deliveries and disposals for Resident #15's Tramadol.
-Sometimes, they had to do med pass edits on the CS log when it did not match because the computer would "freeze up".

Refer to interview with a MA on 11/05/18 at 5:40pm.

Refer to interview with a second MA on 11/07/18 at 10:50am.

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Refer to interviews with the SCC on 11/02/18 at 11:56am and 11/06/18 at 12:05pm.

Refer to interview with the SCM on 11/02/18 at 1:27pm.

Refer to interviews with the Executive Director (ED) on 11/06/18 at 12:24pm and 11/09/18 at 10:47am.

4. Review of Resident #2's current FL-2 dated 03/07/18 revealed:
-Diagnoses included Alzheimer's dementia with behaviors, hypertension, schizoaffective disorder, major neurocognitive disorder and seizure disorder.
-There was an order for clonazepam 1mg three times daily (TID) at 8:00am, 2:00pm and 8:00pm.
-There was an order for clonazepam 1mg every 24 hours as needed (PRN) for agitation.
(Clonazepam is used to treat anxiety.)

a. Review of a mental health provider (MHP) order for Resident #2 dated 03/20/18 revealed there was an order for clonazepam 1mg daily PRN for agitation.

Review of the contracted pharmacy's dispensing record for Resident #2 revealed:
-There were 30 clonazepam 1mg tablets dispensed on 07/13/18.
-There were 30 clonazepam 1mg tablets dispensed on 09/27/18.
-There were 90 clonazepam 1mg tablets dispensed on 10/24/18.

Review of Resident #2's August 2018 electronic medication administration record (eMAR) revealed:

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-There was an entry for clonazepam 1mg daily PRN for agitation (take with haloperidol). (Haloperidol is used to treat psychosis.)
-Staff documented administering 3 doses of clonazepam 1mg PRN.

Upon request on 10/31/18 and 11/07/18, the electronic Controlled Substance (CS) Log for Resident #2's clonazepam 1mg tablets dated 08/01/18 through 08/08/18 was not available for review.

Interview with the Executive Director (ED) on 11/07/18 at 4:42pm revealed she did not know why the CS Log did not print for 08/01/18 through 09/26/18; she would reprint Resident #2's CS log to include 08/01/18 through 09/26/18.

Review of a CS Log for Resident #2's clonazepam 1mg tablets dated 08/09/18 through 09/27/18 revealed:
-The starting balance for 08/09/18 at 7:05am was 52 tablets.
-There was a total of 3 tablets documented as administered on the CS Log between 08/09/18 and 08/31/18.
-There was documentation of a disposal of one tablet on 08/29/18 at 11:16pm.
-There was documentation of a delivery of one tablet on 08/30/18 at 7:14am.
-The ending balance on 08/31/18 at 11:10pm was 49 tablets.

Review of a MHP order for Resident #2 dated 09/27/18 revealed:
-There was an order to discontinue clonazepam 1mg daily PRN for agitation.
-There was an order for clonazepam 1mg TID PRN for anxiety.

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Review of Resident #2's September 2018 eMAR revealed:
-There was an entry for clonazepam 1mg daily PRN for agitation (take with haloperidol) that was discontinued on 09/27/18.
-Staff documented administering 1 dose of clonazepam 1mg daily PRN.
-There was an entry for clonazepam 1mg TID PRN for anxiety.
-Staff documented administering 4 doses of clonazepam 1mg TID PRN.

Review of a CS Log for Resident #2's clonazepam 1mg tablets dated 08/09/18 through 09/27/18 revealed:
-The starting balance for 09/01/18 at 7:10am was 49 tablets.
-There was a total of one tablet documented as administered between 09/01/18 and 09/27/18.
-The ending balance on 09/27/18 at 7:09pm was 48 tablets.

Review of a CS Log for Resident #2's clonazepam 1mg tablets dated 09/27/18 through 10/31/18 revealed:
-The starting balance on 09/27/18 at 7:09pm was zero tablets.
-There was a total of 4 tablets documented as administered between 09/27/18 and 09/30/18.
-There was documentation of a delivery of 30 tablets on 09/28/18 at 12:41am.
-The ending balance on 09/30/18 at 7:00pm was 26 tablets.

Attempted interview on 11/08/18 at 8:01pm, with one of the medication aides (MAs) that documented the 48 clonazepam 1mg tablets that were unaccounted for on 09/27/18, was unsuccessful.

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The second MA that documented the 48 clonazepam 1mg tablets that were unaccounted for on 09/27/18, was not available for interview on 11/09/18.

Interview with the ED on 11/09/18 at 10:48am revealed:
-She did not know there were 48 clonazepam 1mg tablets unaccounted for on 09/27/18.
-She was going to look at the electronic CS Log to see if she could determine what happened to the 48 clonazepam 1mg tablets.

Review of a Physician's Order Request form for Resident #2 dated 10/12/18 revealed:
-There was a notation of PRN haloperidol 1mg, PRN clonazepam 1mg and routine clonazepam was 0.5mg for Resident #2.
-There was an order to give PRN at 11:00am and 3:00pm.
-The order did not specify to give clonazepam, haloperidol or both.
-The order did not specify for 10/12/18 or daily at 11:00am and 3:00pm.

Review of a Physician's Order form for Resident #2 dated 10/14/18 revealed there was an order for clonazepam 1mg TID PRN for anxiety.

Review of a Physician's Order form for Resident #2 dated 10/24/18 revealed there was a telephone order for clonazepam 1mg TID at 8:00am, 2:00pm and 8:00pm (hold for sedation).

Review of Resident #2's October 2018 eMAR revealed:
-There was an entry for clonazepam 1mg TID PRN for anxiety.
-Staff documented administering 10 doses of clonazepam 1mg TID PRN between 10/01/18 and

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10/30/18.
-There was no entry for clonazepam 1mg at 11:00am and 3:00pm.
-There was an entry for clonazepam 1mg TID at 8:00am, 2:00pm and 8:00pm.
-Staff documented administering 16 doses between 10/25/18 at 8:00am and 10/30/18 at 8:00am.

Review of a CS Log for Resident #2's clonazepam 1mg tablets dated 09/27/18 through 10/31/18 revealed:
-The starting balance on 10/01/18 at 7:07am was 26 tablets.
-There was a disposal of 1 tablet by two staff on 10/20/18 at 6:53pm with no reason documented.
-There was a disposal of 1 tablet by two staff on 10/29/18 at 7:11pm with no reason documented.
-There was a total of 10 tablets documented as administered between 10/01/18 and 10/31/18.
-The ending balance on 10/25/18 at 7:00am was 15 tablets.
-The ending balance on 10/31/18 at 7:13am was 14 tablets.

Observation of medications on hand for Resident #2 on 10/25/18 at 4:05pm revealed there was a bubble pack with a dispense date of 09/27/18 for 30 tablets with 15 tablets remaining.

Review of a CS Log for Resident #2's clonazepam 1mg tablets dated 10/25/18 through 10/31/18 revealed:
-The starting balance on 10/25/18 at 7:00am was zero tablets.
-There was a delivery of 90 tablets on 10/25/18 at 10:19am.
-There was a total of 16 doses documented as administered between 10/25/18 at 10:19am and 10/30/18 at 8:45am.

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-The ending balance on 10/30/18 at 8:45am was 74 tablets.

The MA who documented the 14 clonazepam 1mg tablets on the 09/27/18 through 10/31/18 CS Log, but not on the 10/25/18 through 10/31/18 CS Log, declined interview on 11/09/18 at 3:00pm.

The Assistant Care Manager (ACM) in training who also documented the 15 clonazepam 1mg tablets on the 09/27/18 through 10/31/18 CS Log, but not on the 10/25/18 through 10/31/18 CS Log, was not available for interview on 11/09/18.

Interview with the Special Care Coordinator (SCC) on 11/05/18 at 5:45pm revealed:
-There had been changes to the clonazepam orders for Resident #2.
-Clonazepam tablets had been returned to the pharmacy.

Review of a controlled substance prescription returned to pharmacy form dated 10/26/18 revealed there were no clonazepam 1mg tablets returned to the pharmacy.

Review of Resident #2's August 2018 - October 2018 eMARs, CS Logs, pharmacy dispensing/return records and medications on hand revealed:
-There were 150 clonazepam 1mg tablets dispensed between 07/13/18 and 10/24/18.
-There were no documented returns to the pharmacy for clonazepam 1mg tablets.
-There were 34 tablets documented as administered on the CS Log from 08/01/18 through 10/30/18.
-There were 34 doses documented as administered on the eMAR from 08/01/18 through 10/30/18.

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-The CS Log, did not accurately reconcile with the eMAR, quantity dispensed and medications on hand.
-There was no accounting for 48 clonazepam 1mg tablets documented on the 08/09/18 through 09/27/18 CS Log, but not on the 09/27/18 through 10/31/18 CS Log.
-There was no accounting for 14 clonazepam 1mg tablets documented on the 09/27/18 through 10/31/18 CS Log, but not on the 10/25/18 through 10/31/18 CS Log.

Refer to interview with a MA on 11/05/18 at 5:40pm.

Refer to interview with a second MA on 11/07/18 at 10:50am.

Refer to interviews with the SCC on 11/02/18 at 11:56am and 11/06/18 at 12:05pm.

Refer to interview with the Special Care Manager (SCM) on 11/02/18 at 1:27pm.

Refer to interviews with the ED on 11/06/18 at 12:24pm and 11/09/18 at 10:47am.

b. Review of a MHP order for Resident #2 dated 08/17/18 and 09/29/18 revealed there was an order for clonazepam 0.5mg three times daily (TID) at 8:00am, 2:00pm and 8:00pm.

Review of a Physician's Order form for Resident #2 dated 10/14/18 revealed there was an order for clonazepam 0.5mg TID at 8:00am, 2:00pm and 8:00pm.

Review of the contracted pharmacy's dispensing record for Resident #2 revealed:
-There were 90 clonazepam 0.5mg tablets

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dispensed on 07/13/18.
-There were 15 clonazepam 0.5mg tablets dispensed on 08/17/18.
-There were 90 clonazepam 0.5mg tablets dispensed on 08/28/18.
-There were 90 clonazepam 0.5mg tablets dispensed on 10/22/18.

Review of Resident #2's August 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 0.5mg TID at 8:00am, 2:00pm and 8:00pm.
-There was documentation clonazepam 0.5mg was administered at 8:00pm on 08/16/18, 8:00am and 2:00pm on 08/17/18, 8:00pm on 08/27/18, and 8:00am and 2:00pm on 08/28/18; and the CS log documented a balance of zero tablets.
-Staff documented administering 93 doses of clonazepam 0.5mg (43 of the 93 were documented as administered between 08/17/18 at 8:00pm and 08/31/18 at 8:00pm).

Upon request on 11/07/18, the electronic Controlled Substance (CS) Log for Resident #2's clonazepam 0.5mg tablets dated 08/01/18 was not available for review.

Interview with the Executive Director (ED) on 11/07/18 at 4:42pm revealed she did not know why the CS Log did not print for 08/01/18; she would reprint Resident #2's CS log to include 08/01/18.

Review of the CS Log for Resident #2's clonazepam 0.5mg tablets dated 08/02/18 through 08/28/18 revealed:
-The starting balance on 08/02/18 at 7:39am was 42 tablets.
-There was a delivery of 1 tablet on 08/04/18 at

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10:57pm.
-The balance on 08/16/18 at 8:52am was zero tablets.
-There was a delivery of 1 tablet on 08/16/18 at 2:04pm.
-The balance on 08/16/18 at 2:05pm was zero tablets.
-There was a delivery of 15 tablets on 08/17/18 at 9:10pm.
-The balance on 08/27/18 at 1:26pm was zero tablets.
-There was a total of 74 tablets documented as administered between 08/02/18 and 08/28/18 (30 of the 74 tablets were documented as administered between 08/17/18 at 9:11pm and 08/28/18 at 10:59pm).
-The ending balance on 08/28/18 at 10:59pm was zero tablets.

Review of the CS Log for Resident #2's clonazepam 0.5mg tablets dated 08/28/18 through 09/05/18 revealed:
-The starting balance on 08/28/18 at 10:59pm was zero tablets.
-There was a delivery of 90 tablets on 08/28/18 at 11:01pm.
-There was a disposal of 2 tablets by two staff on 08/29/18 at 2:57pm with no reason documented.
-There was a total of 7 tablets documented as administered between 08/28/18 and 08/31/18.
-The ending balance on 08/31/18 at 11:10pm was 81 tablets.

Review of Resident #2's September 2018 eMAR revealed:
-There was an entry for clonazepam 0.5mg TID at 8:00am, 2:00pm and 8:00pm.
-There was documentation the clonazepam was administered at 8:00am, 2:00pm and 8:00pm from 8:00am on 09/28/18 through 8:00pm on

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09/29/18; and the CS log documented a balance of zero tablets.
-Staff documented administering 90 doses of clonazepam 0.5mg.

Review of the CS Log for Resident #2's clonazepam 0.5mg tablets dated 08/28/18 through 09/05/18 revealed:
-The starting balance on 09/01/18 at 7:10am was 81 tablets.
-There was a total of 13 tablets documented as administered between 09/01/18 and 09/05/18.
-The ending balance on 09/05/18 at 8:05am was 68 tablets.

Review of the CS Log for Resident #2's clonazepam 0.5mg tablets dated 09/04/18 through 10/24/18 revealed:
-The starting balance on 09/04/18 at 11:06pm was zero tablets.
-There was a delivery of 69 tablets on 09/05/18 at 7:02am.
-There was a disposal of 2 tablets by two staff on 09/05/18 at 3:32pm with no reason documented.
-There was a disposal of 1 tablet by two staff on 09/05/18 at 11:06pm with no reason documented.
-There was a disposal of 2 tablets by two staff on 09/06/18 at 2:52pm with no reason documented.
-There was a disposal of 1 tablet by two staff on 09/06/18 at 11:07pm with no reason documented.
-There was a disposal of 2 tablets by two staff on 09/07/18 at 3:07pm with no reason documented.
-There was a disposal of 1 tablet by two staff on 09/07/18 at 11:04pm with no reason documented.
-There was a disposal of 2 tablets by two staff on 09/08/18 at 3:00pm with no reason documented.
-There was a disposal of 1 tablet by two staff on 09/08/18 at 9:43pm with no reason documented.
-There was a disposal of 3 tablets by two staff on 09/09/18 at 10:55pm with no reason documented.

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-There was a disposal of 1 tablet by two staff on 09/10/18 at 11:49am with no reason documented.
-There was a disposal of 2 tablets by two staff on 09/10/18 at 11:00pm with no reason documented.
-There was a disposal of 2 tablets by two staff on 09/11/18 at 3:12pm with no reason documented.
-The balance was zero tablets on 09/27/18 at 7:24pm.
-There was a delivery of 90 tablets on 09/30/18 at 3:38am, but there was no pharmacy dispensing record of 90 tablets on 09/30/18.
-There was a total of 52 tablets documented as administered between 09/04/18 and 09/30/18.
-The ending balance on 09/30/18 at 7:30pm was 87 tablets.

The medication aide (MA) who documented the delivery of 90 clonazepam 0.5mg tablets on 09/30/18 was not available for interview on 11/09/18.

Telephone interview with a technician at the facility's contracted pharmacy on 11/09/18 at 4:29pm revealed there was no clonazepam 0.5mg dispensed on 09/30/18 for Resident #2.

Interview with the ED on 11/09/18 at 10:48am revealed she did not know where the 90 tablets came from on 09/30/18 for Resident #2.

Review of Resident #2's October 2018 eMAR revealed:
-There was an entry for clonazepam 0.5mg TID at 8:00am, 2:00pm and 8:00pm.
-Staff documented administering 69 doses of clonazepam 0.5mg between 10/01/18 at 8:00am and 10/24/18 at 8:00pm.

Review of the CS Log for Resident #2's clonazepam 0.5mg tablets dated 09/04/18

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through 10/24/18 revealed:
-The starting count on 10/01/18 at 7:07am was 87 tablets.
-There was a disposal of 1 tablet by two staff on 10/13/18 at 6:37pm with no reason documented.
-There was a disposal of 1 tablet by two staff on 10/17/18 at 6:37pm with no reason documented.
-There was a delivery of 90 tablets on 10/23/18 at 2:10am.
-There was a total of 69 tablets documented as administered between 09/04/18 and 09/30/18.
-The ending balance on 10/24/18 at 7:26pm was 106 tablets.

Observation of medications on hand for Resident #2 on 10/25/18 at 4:05pm revealed there were three bubble packs with with a dispense date of 10/24/18 for 90 tablets with 88 tablets remaining.

Review of a controlled substance prescription returned to pharmacy form dated 10/26/18 revealed Resident #2 had 105 clonazepam 0.5mg tablets were returned to the pharmacy.

Review of Resident #2's August 2018 - October 2018 eMARs, CS Logs, pharmacy dispensing/return records and medications on hand revealed:
-There were 195 clonazepam 0.5mg tablets dispensed between 08/17/18 and 10/22/18.
-There were 171 tablets documented as administered on the CS Log from 08/17/18 through 10/24/18.
-There were 202 doses documented as administered on the eMAR from 08/01/18 through 10/30/18.
-The CS Log, did not accurately reconcile with the eMAR, quantity dispensed and medications on hand.
-There was a return of 105 clonazepam 0.5mg

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tablets to the pharmacy on 10/26/18.
-There was a discrepancy of 18 tablets of clonazepam 0.5mg between what was on hand (88 tablets) on 10/25/18 and what was documented on the CS log dated 09/04/18 through 10/24/18 (106 tablets).

The MA who documented the ending balance on the CS Log dated 09/04/18 through 10/24/18 and assisted with medications on hand for Resident #2, declined further interview on 11/09/18 at 3:00pm.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Interview with a MA on 10/25/18 at 4:05pm revealed:
-A controlled drug count was done at the change of each shift.
-The MA coming on checked the actual medications and the MA leaving entered the count.
-There had not been any problems with the controlled drug counts.
-Sometimes the computer "knocked the count off," but staff were always able to reconcile the count.
-The controlled drug count was kept electronically, there were no paper controlled drug count sheets.

Interview with a second MA on 11/06/18 at 12:30pm revealed:
-She did not know why she had documented a delivery of one clonazepam 0.5mg tablet on 08/04/18 for Resident #2.
-There was documentation that the 8:00pm dose of clonazepam had been administered so she did

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not know why there would have been a delivery of one tablet after the dose had been administered.

Interview with a third MA on 11/05/18 at 5:30pm revealed:
-She could not say why the clonazepam 0.5mg controlled drug record for Resident #2 had disposals documented repeatedly from 09/05/18 through 09/11/18.
-The electronic medication system may not have been counting down when staff documented the medication was administered.
-When the electronic medication system did not subtract the dose, then staff entered a deduction under the "Med Dep" tab.

Interview with the first MA on 11/06/18 at 1:23pm revealed:
-The documentation of a disposal of two tablets of clonazepam 0.5mg on 09/05/18, 09/07/18 and 09/08/18 for Resident #2 was probably because the computer did not count down the medication after it was administered.
-If she pulled a medication to administer and noticed that the count was not right, she would click on the inventory tab and change the count.
-The electronic medication system required two MAs to witness a change made in the count.
-She knew when the count was not right from a medication not being deducted verses from an unknown discrepancy because she would have done the count at the change of shift and would have been able to see a medication she had administered had not been deducted.

Interview with a fourth MA on 11/07/18 at 5:35pm revealed:
-The disposal documentation came from the electronic medication system not counting down medications as they were administered.

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-The medication was administered to the resident, but the system did not subtract the medication properly.
-She did not know why the system documented disposal because she always typed in "not counted down on the MAR."

Interview with the Special Care Coordinator (SCC) on 11/05/18 at 5:45pm revealed:
-She had not been aware staff were documenting repeated disposals of clonazepam tablets for Resident #2.
-She had no idea why staff would be documenting a delivery of 1 clonazepam tablet for Resident #2, unless staff borrowed the medication from another resident.
-She was not aware of the multiple entries for disposals on Resident #2's clonazepam CS Log and had no idea why staff would document disposals repeatedly.
-The clonazepam 0.5mg was changed on 10/26/18 to 1mg so 106 tablets of 0.5mg clonazepam were returned to the pharmacy.

Refer to interview with a MA on 11/05/18 at 5:40pm.

Refer to interview with a second MA on 11/07/18 at 10:50am.

Refer to interviews with the SCC on 11/02/18 at 11:56am and 11/06/18 at 12:05pm.

Refer to interview with the Special Care Manager (SCM) on 11/02/18 at 1:27pm.

Refer to interviews with the ED on 11/06/18 at 12:24pm and 11/09/18 at 10:47am.

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Interview with a medication aide (MA) on 11/05/18

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at 5:40pm revealed:
-The MAs did shift counts of the controlled substances (CS) at each change of shift.
-The MAs would enter the quantities of controlled substances on hand into the electronic system.
-If the count entered did not match the current balance, the computer would flag it and the MAs could not move to the next entry.
-Two staff had to change the balance if the number was incorrect before they could enter the count for the next controlled substance.
-Sometimes the computer would not always deduct when they entered and administered a controlled substance so the count would not match the balance.
-If they had to correct the count, it was usually marked as an "adjustment" on the CS log.

Interview with a second MA on 11/07/18 at 10:50am revealed:
-The MAs did shift counts of controlled substances every shift.
-The MA coming on duty would physically count the doses on hand and the MA getting off duty would enter the count into the computer system.
-Once all of the numbers were entered for all of the controlled substances on hand, they would click on the reconcile button.
-If a number came up red, it was a miscount so they would count it again.
-If the count was still incorrect (red), they would have to make an adjustment on the electronic CS log to get the numbers to match.
-Sometimes they would document a disposal if the numbers did not match in order to get the numbers to match.
-They should document a comment on the CS log when an adjustment or change was made.
-The numbers did not always match because the computer did not always deduct a dosage when it

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was administered.
-This usually happened when the computer would go offline and it went offline "a lot".
-The ED was responsible for correcting the CS log when it did not count down correctly.
-The counts frequently did not match the balance on the CS logs.

Interviews with the Special Care Coordinator (SCC) on 11/02/18 at 11:56am and 11/06/18 at 12:05pm revealed:
-The CS logs were confusing.
-Sometimes there were duplicate orders on the MARs so counts on the CS log would be deducted twice.
-The MAs or a manager would transfer balances from previous supplies to the balance of a new prescription.
-If a new order had not been approved on the electronic MAR by a manager, the CS log would not show it was administered.
-If the count did not match the balance on the CS log, they adjusted the balance on the CS log.
-There was a section for comments on the CS logs that should be used to document the reason for disposals.
-Sometimes if the computer was offline, it would not deduct doses of controlled substances that were administered.
-The MAs did shift counts of controlled substance at the change of every shift.
-The MAs could not see the balance on the computer when they entered the amounts on hand.
-If the amount on hand did not match the balance on the CS log, it would flag the system.
-The count would have to be changed before they could move on.
-The MAs were supposed to go to the ED, SCC, or SCM to adjust any balances on the CS log.

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-She was not aware the MAs had access on the computer to adjust the balances.
-They would have the system changed so only the ED, SCC, or SCM could adjust balances on the CS log.

Interview with the Special Care Manager (SCM) on 11/02/18 at 1:27pm revealed:
-Sometimes, the managers had to do med pass edits on the CS log when it did not match because the computer would "freeze up".
-If the controlled substances on hand did not match the balance on the CS log during shift count, the managers could adjust the count.
-The ED, SCC, or SCM would correct the balance on the CS log so it would match the count on hand.

Interviews with the Executive Director (ED) on 11/06/18 at 12:24pm and 11/09/18 at 10:47am revealed:
-The facility contracted with one pharmacy, there was no other pharmacy used.
-The MAs did shift counts at the end of each shift or anytime a different MA took over a med cart.
-The oncoming MA would count the controlled substances on hand and the MA going off duty would enter the count into the electronic system.
-The balance on the CS log did not appear on the screen when the MAs were entering the information.
-After all the counts on hand were entered, the MA would click the reconcile button and any errors would show up in red.
-If the numbers did not reconcile, the MAs would have to recount and re-enter the numbers.
-If the counts were red again, they did a third count and re-entered the numbers.
-If the numbers still did not match after the third attempt, the MAs had to notify a manager (ED,

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D 392	Continued From page 316 SCC, or SCM). -The manager had to physically check the count at that time before the next MA took over the med cart. -The manager would have to change the balance on the CS log before the electronic system would move to the next screen. -The reconciliation could be canceled by a MA and that would allow the oncoming MA to log onto the system to administer medications without reconciling any discrepancies. -If the MAs had to dispose of a controlled substance, it had to be witnessed by a MA/Supervisor. -If a controlled substance was disposed, the reason for the disposal should be documented in the comments of the CS log. -The amounts documented as "delivery" on the CS log should match the amount dispensed and delivered to the facility by the pharmacy. -When the medication was given and the staff clicked off on the medication, the electronic medication system should automatically deduct the amount from the remaining count. -The most common problem occurred when a new supply came in from the pharmacy, the countdown dosage amount was not entered correctly such as one tablet per dose. -The countdown box would need to set for the correct dosage to be deducted so the electronic medication system how much to deduct from the balance each time a dose was given. -She was not aware the MAs had access to adjust the balances. -They would change the electronic system that no one could adjust the balances on the CS logs except 3 management staff, the ED, SCC, and SCM. -Usually the SCC and the SCM monitored the controlled substance counts.	D 392		

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D 392	Continued From page 317 ___________________________ The facility's failure to assure controlled substance (CS) logs for 4 residents (#2, #3, #8, #15) accurately reconciled the administration, receipt and disposal of controlled substances. The facility's failure to assure oversight of the administration and receipt of controlled substances resulted in missed doses of medications for moderate to severe pain for 3 hospice residents (#3, #8, #15). There were 2 residents (#2, #3) with CS logs for medications for anxiety and agitation that did not accurately reconcile with the MARs. The facility's failure 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 11/06/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 24, 2018.	D 392		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION	D 438		

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Based on observations, interviews, and record reviews, the facility failed to assure 4 of 4 sampled residents (#1, #3, #14, #15) with injuries of an unknown origin had an initial and 5 day report completed and sent to the Health Care Personnel Registry.

The findings are:

1. Review of Resident #1's current FL-2 dated 08/09/18 revealed diagnoses included Alzheimer's disease, frontal dementia, panic disorder, insomnia, psoriasis, hypertension, hyperlipidemia, lupus erythematosus and history of pituitary adenoma.

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

Review of Resident #1's electronic Charting Notes dated 03/28/18 at 12:06 p.m. by a medication aide (MA) revealed:
-There was documentation the resident had a bruise on the bottom of her right jaw that was a little swollen.
-Staff would continue to monitor the resident for the remainder of the shift.
-Staff would pass this (information) to the oncoming MA.

Review of Resident #1's electronic Charting Notes dated 03/28/18 at 6:55 p.m. by the Executive Director (ED) as a late entry revealed:
-The resident had a bruise on her lower right cheek.
-The resident was unaware of how it happened and even that there was a bruise.
-The ED called the family member and informed

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the family member of the bruise.

Review of Resident #1's Charting Notes revealed there was no further entries regarding the bruise on the resident's cheek.

Interview with the ED on 11/06/18 at 12:25 p.m. revealed:
-She was not sure how the bruise occurred on Resident #1's lower right cheek.
-She didn't have a Health Care Personnel Registry (HCPR) Initial Allegation report for the bruise on Resident #1's right cheek she had observed on 03/28/18.
-She would complete the HCPR report now.

Review of Resident #1's electronic "Charting Notes" dated 09/19/18 at 12:53 p.m. by a MA revealed the resident had bruises on both upper arms.

Review of Resident #1's electronic "Charting Notes" dated 09/20/18 at 11:11 a.m. by the special care manager (SCM) revealed:
-The resident's primary care provider (PCP) and family member were notified of the dark colored areas on both of her upper arms.
-The resident complained of no pain or discomfort in these areas.
-The PCP would do a follow-up visit to evaluate.

Review of Resident #1's PCP's "Patient Notes" dated 09/20/18 revealed:
-A text message received from the Special Care Manager (SCM) at 7:38 p.m. tonight (09/20/18) along with two photographs of Resident #1's upper arms.
-The PCP's notes included that the photographs showed multiple bruises in an obvious hand-shaped pattern on both upper extremities,

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appearing that the resident was forcefully grabbed or jerked by another person.
-The PCP collaborated with another provider, who agreed that the appearance of the bruises was consistent with this method of this injury.
-The PCP called the SCM to discuss this further and she was going to call in all staff members who had worked with this resident for the last 72 hours and have a meeting with the ED.
-The PCP reminded the SCM that adult care home regulations required a 24 hour report filed with the state while the investigation was underway.
-The SCM would call the PCP tomorrow (09/21/18) with a status update.

Review of Resident #1's PCP's visit note dated 09/26/18 revealed:
-The reason for the visit included new reports of bruises of unknown origin on the bilateral upper arms.
-On 09/20/18, facility staff had reported multiple bruises on the bilateral upper extremities that were first noted two days ago and staff reported that they "don't know how they happened". The bruises were reported blue-purple in color, indicating that the bruises were fairly recent. Staff were unable to provide any further details or information.

Review of an "Accident/Injury Report" for Resident #1 dated 09/20/18 revealed:
-The time of the incident was 7:00 p.m. and the location of the incident was unknown.
-In the description section, there was an entry the resident had dark discolored areas on her upper arms.

Interview with a personal care aide (PCA) on 10/30/18 at 4:05 p.m. revealed the PCAs were

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responsible for reporting injuries to the MA.

Interview with the Special Care Coordinator (SCC) on 10/25/18 at 5:00 p.m. revealed:
-She was aware of an incident where a MA had reported some bruising on Resident #1's upper arms and knew local DSS came to the facility.
-She was not directly involved in the incident concerning the bruises on Resident #1's upper arms but the SCM was.

Interview with the SCC on 11/09/18 at 5:15pm revealed the Executive Director (ED) would be responsible for reporting to the HCPR.

Interview with the SCM on 10/25/16 at 5:25 p.m. revealed:
-After the evacuation on 09/15/18 there were "marks" on Resident #1's arms but she could not say that they were bruises.
-The areas were purple and black in color.
-The areas on the resident's upper arms were reported to her by a MA on 09/19/18
-She contacted Resident #1's PCP when the MA reported it to her.
-The areas on the resident's upper arms and on her elbows were in the exact same spot on both sides and it appeared the areas could have come from someone trying to redirect her during the evacuation when there was a threat of flooding because of the hurricane.
-The resident was horrified that day, it flooded quickly.

Telephone interview with Resident #1's PCP on 10/25/18 at 3:58 p.m. revealed the resident has had bruises of unknown cause with one being extreme on the resident's bilateral upper arms on 09/20/18.

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Interview with the ED on 11/06/18 at 12:25 p.m. revealed:
-The bruises on Resident #1's upper arms occurred during the evacuation during the hurricane in September 2018.
-The evacuation was rushed due to flooding with the rain water backing up to the brick columns of the facility.
-Everyone (residents) was pushed up at the front door.
-The residents were brought to the front door of the facility and the residents started "freezing" meaning not wanting to move forward because the rain was coming down sideways,.
-"That was the only thing I can explain" about the bruises on Resident #1's upper arms.
-She noticed the bruises on Resident #1's arms a couple of days later.
-She did not complete a HCPR report regarding the bruising to Resident #1's upper arms.
-She would complete a late HCPR report.

Review of Resident #1's electronic "Charting Notes" dated 10/12/18 at 3:22 p.m., there was documentation by a MA upon arrival it was noticed that the resident had a long scratch on the right side of her face and check area.

Review of Resident #1's PCP's visit note dated 10/15/18 revealed the resident had a large superficial scratch along the jawline on the right side of her face and was unaware how the scratch occurred.

Interview with the SCM on 11/02/18 at 1:27 p.m. revealed she had not reported anything to the HCPR since she had worked at the facility.

Interview with the SCM on 11/09/18 at 5:17pm revealed the ED would be responsible for

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reporting to the HCPR.

Interview with the ED on 11/06/18 at 12:25 p.m. revealed:
-There had not been a HCPR report done for the scratch along Resident #1's jawline.
-She would complete a late HCPR report.

Interview with the ED on 11/06/18 at 12:25 p.m. revealed:
-If a PCA noticed a bruise or injury of a resident, the PCA should report it to the MA.
-The MA should report it to the SCM or the ED.
-Then the ED would complete and send a report to the HCPR.
-She was not sure who was supposed to report the bruising/injury to the PCP but she thought she was supposed to report it.

Review of a HCPR Initial Allegation report for Resident #1's dated 11/07/18 revealed:
-The type of allegation was for an injury of unknown source.
-The date of the incident and when the facility became aware of the incident was on 03/22/18
-In the allegation section there was an entry that the resident had a bruise on her right jaw.
-The ED prepared and signed the report on 11/07/18.
-There was an attached transaction report with a confirmation the fax was received and sent to HCPR on 11/07/18 at 11:21 a.m.

Review of a second HCPR Initial Allegation report for Resident #1 dated 11/07/18 revealed:
-The type of allegation was for an injury of unknown source.
-The date of the incident was on 09/15/18 and the facility became aware of the incident on 09/21/18.
-In the allegation section there was an entry that

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the resident had bruising on both forearms.
-The ED prepared and signed the report on 11/07/18.
-There was an attached transaction report with a confirmation the fax was received and sent to HCPR on 11/07/18 at 11:23 a.m.

Review of a third HCPR Initial Allegation report for Resident #1 dated 11/07/18 revealed:
-The type of allegation was for an injury of unknown source.
-The date of the incident and when the facility became aware of the incident was on 10/12/18.
-In the allegation section there was an entry that the resident had a scratch on her face.
-The ED prepared and signed the report on 11/07/18.
-There was an attached transaction report with a confirmation the fax was received and sent to HCPR on 11/07/18 at 11:24 a.m.

2. Review of Resident #15's current FL-2 dated 06/04/18 revealed diagnoses included Alzheimer's dementia, hypertension, chronic kidney disease - stage 3, hypokalemia, hypothyroidism, schizophrenia, generalized muscle weakness, and depression.

Review of Resident #15's current assessment and care plan dated 05/29/18 revealed:
-The resident used a rollator walker.
-The resident required extensive assistance with bathing, grooming, dressing, toileting, and eating.
-The resident required limited assistance with transferring and ambulation.
-The section regarding the residents' orientation was blank.

Review of Resident #15's licensed health professional support (LHPS) review dated

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06/25/18 revealed:
-The resident was recently admitted to hospice with a gradual decline in health and mobility.
-The resident had not been walking around as much the last few weeks and was requiring assistance with ambulation and transfers.

Review of Resident #15's hospice visit note dated 08/01/18 revealed the resident had bruising on her right shoulder.

Review of Resident #15's hospice visit note dated 08/02/18 revealed the resident had bruising on her left hand.

Review of Resident #15's hospice visit note dated 08/23/18 revealed the resident had scattered bruising on bilateral upper extremities.

Review of Resident #15's hospice visit notes dated 08/29/18 revealed:
-The resident had random scattered bruising to extremities.
-There was no documentation of what caused the bruising.

Interview with a hospice nurse on 11/09/18 at 2:35pm revealed:
-Resident #15 had small scattered bruising throughout her body in various stages of healing.
-Resident #15 had a bruise on her left hand.
-Facility staff did not know how the resident got the bruises.

Review of Resident #15's accident/incident reports, charting notes, and provider visit notes revealed no falls were documented prior to 09/13/18.

Review of a note from Resident #15's primary

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care provider (PCP) dated 09/13/18 revealed:
-The resident was being sent to the hospital for "apparent fall".
-The resident had a bruise and swelling on her left cheek and also complained of pain from her right hip to her ankle.
-There was no documentation of any injury to the resident's hands.
-The PCP signed the form on 09/26/18 and wrote "noted" in the response section.

Review of Resident #15's charting note dated 09/14/18 at 5:07pm revealed:
-The resident had a medium sized bruise, purple in color, on her left hand, soft when touched.
-The resident did not complain of any pain.
-The PCP was notified.
-There was no documentation to indicate what caused the bruise.

Attempted interviews on 11/07/18 at 2:10pm and 11/09/18 with the medication aide (MA) who wrote the charting note dated 09/14/18 were unsuccessful.

Review of Resident #15's PCP visit notes dated 09/26/18 revealed:
-The resident was being seen to follow-up on pain management and to evaluate several bruises of unknown origin.
-On 09/14/18, facility staff reported several bruises of unknown origin on the resident's bilateral hands and forearms.
-Photos were sent to the provider revealing recent purple-blue bruises on the dorsal aspects of both hands and red-purple bruises on the forearms.
-Staff did not know how the bruises happened.
-The resident did not remember having any falls or injuries.

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-The resident denied being hit, pushed, or otherwise injured by another person.
-On 09/26/18, the PCP observed the contusions on the bilateral hands and forearms were nearly resolved, with only some faint, yellow-green marks barely visible on the right upper extremity.

Review of Resident #15's PCP visit notes dated 10/01/18 revealed:
-The resident was being seen to follow-up on pain management and to evaluate a new bruise on her face.
-On 09/29/18, the hospice nurse reported that Resident #15 had fresh, purple-blue bruising on the left side of her face extending from the temple to below the cheekbone and encircling the eye.
-Facility staff reportedly could not explain what may have caused the bruising.
-The PCP observed purple-red contusions on the left side of the resident's face, from the temporal region to the maxillary region, and encircling the left orbit on 10/01/18.
-Contusions on the resident's bilateral hands and forearms were resolved.
-The PCP noted to continue to monitor for injuries of unknown origin.

Review of Resident #15's PCP visit notes dated 10/15/18 revealed:
-The contusions on the face and around the left eye were now yellow in color and nearly resolved.
-The PCP noted for the facility to monitor for injuries of unknown origin.

Observation of Resident #15 on 11/09/18 at 5:10pm revealed:
-The resident was sitting in a wheelchair in the dining room.
-The resident had a yellow bruise on the left side of her face from the temple area down to her

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cheek.

Interview with Resident #15 on 11/09/18 at 5:10pm revealed:
-She had fallen but she did not recall when or how many times.
-She complained of lower left back pain.
-She was not sure what caused the bruise on her face.

Interview with a personal care aide (PCA) on 11/09/18 at 1:20pm revealed:
-She had seen some bruising on Resident #15 but she did not know what caused the bruising.
-Resident #15 did not fall a lot so she did not know if the bruising was caused by falls.
-She could not recall when she saw unexplained bruising on the resident.
-The PCAs reported any bruising to the MAs.

Interview with the Special Care Coordinator (SCC) on 11/09/18 at 5:15pm revealed:
-She did not recall Resident #15's unexplained bruising on 08/29/18.
-She was working at a sister facility on 09/14/18 when more unexplained bruising was noted on Resident #15.
-She had not reported any unexplained bruising to the Health Care Personnel Registry (HCPR).
-The Executive Director (ED) would be responsible for reporting to the HCPR.

Interview with the Special Care Manager (SCM) on 11/09/18 at 5:17pm revealed:
-She could not recall if anyone reported unexplained bruising for Resident #15 to her.
-She had not reported any bruising or injuries of unknown origin to the HCPR.
-The ED would be responsible for reporting to the HCPR.

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Interview with the ED on 11/09/18 at 10:47am revealed:
-She was not aware of scattered bruising on Resident #15.
-She was aware of Resident #15 having bruising after a fall on 09/14/18 but not prior to the fall.
-Staff should report any bruising or other injuries "up the chain" of command.
-PCAs should report to the MAs and the MAs to the SCC or the SCM.
-The SCC and SCM should report to the ED.
-The ED was responsible for conducting investigations and reporting any injuries of unknown origin to the HCPR.
-She had not reported any of Resident #15's bruising of unknown origin to the HCPR because she was not aware of it.
-She would report Resident #15's injuries of unknown origin to the HCPR since she was aware of it now.

3. Review of Resident #3's current FL-2 dated 01/26/18 revealed diagnoses included Alzheimer's disease, hypertension, chronic kidney disease, hyperlipidemia, and history of cerebrovascular accident.

Review of Resident #3's assessment and care plan dated 01/12/18 revealed:
-The resident was non-ambulatory and had limited range of motion in her upper extremities.
-The resident had daily incontinence of bowel and bladder.
-The resident had significant memory loss and must be redirected.
-The resident's speech was weak.
-The resident had limited vision and could hear loud voices.
-The resident required extensive assistance with

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eating, ambulation, dressing, and transferring.
-The resident was totally dependent with toileting, bathing, and grooming.

Review of Resident #3's charting note dated 04/16/18 at 2:58pm revealed:
-The resident had a bruise over her right eye and a bruise on her upper left arm.
-There was no documentation to indicate what caused the bruises.

Interview on 11/07/18 at 10:50am with the medication aide (MA) who wrote the charting note on 04/16/18 revealed:
-She wrote the note about Resident #3's bruises on 04/16/18 but she did not know what caused the bruises.
-Resident #3 had some falls but she could not recall when she had the falls.
-Resident #3 would sometimes slide off of the bed.
-It took two staff to get the resident off the floor and back on the bed.
-The resident had a wheelchair, a fall mat, and a bed/chair alarm.
-The MAs were supposed to report bruises or injuries to the Special Care Manager (SCM) and notify the physician.
-She could not recall if she reported the bruises in April 2018 or who she reported it.
-It should have been documented in the charting note.
-She did not know why it was not documented.

Interview with Resident #3's primary care provider (PCP) on 11/05/18 at 11:32am revealed she was unaware of Resident #3's bruising on 04/16/18 because it was not reported.

Review of Resident #3's charting note dated

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09/20/18 at 11:06pm (late entry) written by the SCM revealed:
-Staff noticed a small size circular area on the resident's forehead.
-The resident was asleep in her bed with no signs that she had fallen.
-Her bed was next to the wall and she was turned next to the wall with her head close to the wall.
-She did not complain of pain or discomfort.
-The physician was notified.

Interview with the SCM on 11/02/18 at 1:27pm revealed:
-The SCM did not recall seeing any bruises on Resident #3 and no one had reported any to her.
-If a resident had bruises or injuries, the personal care aide (PCA) would tell the MA and the MA would tell the SCM.
-The MA, SCM or the Executive Director (ED) would contact the physician and the family and document an incident report to include the location of the bruises.
-The ED would do an investigation and report it to the Health Care Personnel Registry (HCPR).
-She had not reported anything to the HCPR since she had worked at the facility.
-After showing the SCM the charting note she wrote on 09/20/18, the SCM recalled writing the note.
-The residents were evacuated to a local school on 09/15/18 due to the hurricane and came back to the facility the next day.
-She was not sure if the resident had the bruise on her forehead prior to the evacuation.
-She reported the bruise to the ED but she could not recall when she reported it.
-She did not know what caused the resident's bruise but she thought it may have come from the resident hitting her head on a wall while lying on the mattresses.

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-She could not confirm that.
-She had not reported Resident #3's bruise to the HCPR and no one else had reported it to her knowledge.
-It should have been reported.

Review of Resident #3's hospice note dated 09/20/18 revealed:
-Hospice was notified by PCP and the facility that Resident #3 had a bruise on her forehead, etiology unknown.
-Hospice nurse was unable to assess due to the hurricane.

Review of Resident #3's charting note dated 09/24/18 at 7:00pm revealed the resident still had a bruise on her forehead.

Review of Resident #3's hospice visit note dated 09/26/18 revealed the resident had a bruise on her forehead in various stages of healing, etiology unknown.

Interview with a hospice nurse on 11/01/18 at 3:20pm revealed:
-Resident #3 had a very large bruise on her forehead in September 2018.
-Facility staff did not know how it happened.
-It was reported to the ED and the ED concluded that the resident had hit her head on the wall.

Review of Resident #3's a visit note written by the PCP on 09/26/18 revealed:
-The resident was being seen for follow-up on pain management and for new reports of a bruise.
-On 09/18/18, facility staff reported a bruise on the resident's forehead.
-A photograph was sent to the PCP showing a very large bruise, blue-purple in color, with a pale

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yellow-colored center.
-The bruise occupied almost all of the resident's forehead.
-Facility staff were unaware of the origin of the bruise but surmised that it may have resulted from the resident pressing her head up against the wall when in bed.
-The characteristics of the bruise, however, were inconsistent with this theory.
-This bruise was discussed with the ED today (09/26/18) and the ED stated the resident had been sleeping on a mat on the floor during the hurricane evacuation and that was likely the cause of the bruise.
-This theory did not seem consistent with the appearance of the bruise nor did it seem possible for the resident to be able to get onto and off the floor for purposes of sleeping without extensive assistance.
-Upon physical exam by the PCP on 09/26/18, the resident had a very large contusion, purple-red in color, occupying nearly the entire forehead.

Interview with Resident #3's PCP on 11/05/18 at 11:32am revealed:
-She was notified by facility staff on 09/18/18 that Resident #3 had a minor, small bruise on her forehead.
-After she saw a picture of Resident #3, the bruise actually covered almost the entire forehead.
-She did not physically see the resident in person to assess the bruise until 09/26/18 due to roads being flooded from the hurricane.
-She felt it was very unlikely that the resident hit her head on the wall because the resident was physically unable to turn herself as she was total care.

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D 438	Continued From page 334 Review of Resident #3's hospice visit note dated 10/01/18 revealed the resident had bruising on her left shoulder. Review of Resident #3's PCP visit note dated 10/01/18 revealed: -The resident was being seen for follow-up on pain management, reports of a recent fall, two hip lacerations, and a bruise on her shoulder. -The family expressed concern to the PCP about the number of and circumstances surrounding the bruises that have been appearing on the resident. -The family was especially concerned about the large bruise recently observed on her forehead. -Upon physical exam, the contusion present (on the forehead) at the previous visit had almost resolved. Review of Resident #3's hospice visit note dated 10/02/18 revealed the resident had a healing bruise on forehead and small scattered bruising throughout. Review of Resident #3's hospice visit note dated 10/03/18 revealed the resident had small scattered bruising throughout entire body in various stages of healing. Review of Resident #3's hospice visit note dated 10/08/18 revealed the resident had small scattered bruising throughout. Review of Resident #3's hospice visit note dated 10/09/18 revealed the resident had scattered bruising in various stages of healing all over. Interview with a hospice nurse on 11/09/18 at 2:40pm revealed: -Resident #3 had soft, small bruising in various stages of healing on her hands, trunk, and legs.	D 438		

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D 438	Continued From page 335 -Staff did not know what caused the bruising. Interview with a MA on 11/05/18 at 4:58pm revealed: -When they evacuated to the elementary school for the hurricane in September 2018, Resident #3 kept fidgeting while she was laying down. -She thought the resident may have rubbed her head on the plastic mat beside her. -She observed a red burn mark on the resident's forehead. -She did not recall seeing a bruise on the resident's forehead. -If MAs observed bruising or other injuries, they were supposed to report it to the ED and SCM. -The MAs would also contact the physician and document it. Interview with a PCA on 10/31/18 at 1:50pm revealed: -Resident #3 was total care and needed assistance with everything. -She did not notice any bruises on Resident #3. -If the PCAs observed bruising on residents, the PCAs were supposed to report it to the MAs and the MAs would document it. Interview with the Special Care Coordinator (SCC) on 11/02/18 at 11:56am revealed: -The PCAs were supposed to report any bruising or injuries to the MAs. -If unexplained bruising or injuries, the MAs should fill out an incident report and notify the physician and family. -The incident report should go to the SCM first and then to the ED. -The SCM or the ED would send the report to the Protocols Nurse. -The ED would be responsible for reporting to the HCPR.	D 438		

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-No one reported Resident #3's bruises to her in September 2018.
-She did not recall seeing bruises on Resident #3 because she worked at a sister facility during the hurricane in September 2018.
-She would check for any documentation about the resident's bruises.

Interview with the SCC on 11/05/18 at 1:23pm revealed she could not find any documentation of what caused the bruises on Resident #3 in April 2018 or September 2018.

Telephone interview with Resident #3's power of attorney (POA) on 11/01/18 at 3:05pm revealed:
-He remembered the resident having "a little" bruising on her arms.
-He thought the resident did not recognize staff and would sometimes "fight them off".

Telephone interview with Resident #3's family member on 11/09/18 at 10:15am revealed:
-The resident had bruises "quite a bit" from time to time.
-She had a bruise on her forehead on one occasion.
-She thought staff said the resident had rolled out of bed during the hurricane evacuation.

Interview with the ED on 11/06/18 at 1:00pm revealed:
-If a PCA noticed a bruise or injury of a resident, the PCA should report it to the MA.
-The MA should report it to the SCM or the ED.
-Then the ED would complete and send a report to the HCPR.
-She was not sure who was supposed to report the bruising/injury to the PCP but she thought she was supposed to report it.
-She did not recall being aware of the bruising on

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Resident #3 on 04/16/18.
-She would have reported Resident #3's bruising of unknown origin on 04/16/18 if she had been aware.
-Resident #3 also had a bruise on her forehead during the hurricane in September 2018.
-The resident's evacuated one night and stayed in a local school and slept on mattresses on the floor that were touching each other.
-She recalled that Resident #3 kept rolling in the cracks between the mattresses.
-The next morning she recalled seeing a red spot around the center of the resident's forehead.
-She thought the resident may have been on medication that could cause the bruising also.
-She did not investigate or report the injury to the HCPR because she assumed it came from the resident rolling off the mattress.
-She would do a late report to the HCPR for Resident #3's bruises of unknown origin now.

Review of an Initial Allegation Report for Resident #3's bruising revealed the ED faxed the report to the HCPR on 11/07/18 with fax confirmation.

4. Review of Resident #14's current FL-2 dated 04/20/18 revealed diagnoses included vascular dementia, abnormal posture, paroxysmal atrial fibrillation, essential hypertension, heart failure, major depressive disorder, cerebral vascular accident, dysphagia, hemiplegia and hemiparesis.

Review of a charting note for resident #14 dated 05/09/18 at 10:34am revealed:
-Resident #14 had a "big bruise on her right arm."
-Staff was going to monitor Resident #14 for the remainder of the shift.
-There was no documentation of notification to Resident #14's Responsible Person (RP) or

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primary care provider (PCP).

The medication aide (MA) that documented the charting note dated 05/09/18 at 10:34am was not available for interview on 11/09/18.

Attempted interview with Resident #14's Responsible Person on 11/06/18 at 12:17pm was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #14 was deceased.

Telephone interview with Resident #14's primary care provider (PCP) on 11/08/18 at 8:29pm revealed:
-She had not been notified of Resident #14 having a big bruise on her right arm on 05/09/18.
-She had seen Resident #14 on 05/14/18 for follow up after a fall on 05/13/18 which resulted in the resident being sent to the emergency room (ER).
-On 05/14/18, she noted that Resident #14 had bruises in various stages of healing on her face, arms and legs.

Interview with the Executive Director (ED) on 11/09/18 at 2:55pm revealed:
-She was not aware of the bruise on Resident #14's arm from 05/09/18 prior to 11/07/18.
-She did not know the cause of the bruise on Resident #14's arm, but Resident #14 bruised easily.
-She had completed several HCPR Initial Reports on Resident #14 on 11/07/18 because the resident's record had been requested for review.
-She reviewed Resident #14's record and knew the HCPR reports needed to be done so she did them on 11/07/18.

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-When a PCA observed a bruise on a resident, the PCA was expected to report the bruise to the MA.
-The MA was expected to follow the chain of command and report to the Special Care Manager (SCM).
-If there was no known cause for the bruise, the SCM or the ED completed a HCPR Initial Report and conducted an investigation.
-There was no investigation completed for Resident #14 and the resident was no longer in the facility.

____

The facility failed to report bruises of an unknown origin to the Health Care Personal Registry (HCPR) and conduct an investigation for 4 residents in the special care unit. The facility's failure to report bruising on the jaw, bilateral upper arm bruises resembling hand prints and a scratch on the face for Resident #1; bruising over the right eye, on the upper left arm, and on the forehead for Resident #3; bruising on left side of face, bilateral hands and forearms, and scattered bruising throughout the body for Resident #15; and a bruise on Resident #14's right arm resulted in neglect of ruling out potential abuse and placed residents at substantial risk of further serious injury from the unidentified cause. The facility's failure to report, investigate and protect residents from further harm 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 11/06/18 and 11/09/18 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 24, 2018.

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10A NCAC 13F .1211Written Policies And Procedures

(a) An adult care home shall develop written policies and procedures that comply with applicable rules of this Subchapter, on the following:
(1) ordering, receiving, storage, discontinuation, disposition, administration, including self-administration, and monitoring the resident's reaction to medications, as developed in consultation with a licensed health professional who is authorized to dispense or administer medications;
(2) use of alternatives to physical restraints and the care of residents who are physically restrained, as developed in consultation with a registered nurse;
(3) accident, fire safety and emergency procedures;
(4) infection control;
(5) refunds;
(6) missing resident;
(7) identification and supervision of wandering residents;
(8) management of physical aggression or assault by a resident;
(9) handling of resident grievances;
(10) visitation in the facility by guests; and
(11) smoking and alcohol use.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to develop a written policy and

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ASHE GARDENS	**300 WEST ASHE STREET** **BURGAW, NC 28425**

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procedure for infection prevention specific to the management of a resident (#13) diagnosed with clostridium difficile (C-Diff, which is a potentially fatal bacterial infection that can be transmitted from person to person through contact with the person and/or their environment).

The findings are:

Review of Resident #13's current FL-2 dated 10/25/17 revealed diagnoses included Alzheimer's dementia, type II diabetes mellitus, hypertension, stage III chronic kidney disease, and anemia.

Review of hospital records for Resident #13 dated 04/11/18 through 04/13/18 revealed:
-Resident #13 presented to the hospital on 04/11/18 after a fall with vomiting and diarrhea.
-Resident #13 was admitted to the hospital with acute gastroenteritis with dehydration and placed on isolation until a stool specimen was obtained.
-Resident #13 was discharged on 04/13/18 with no further episodes of vomiting and diarrhea.

Review of a Physician's Order Request for Resident #13 dated 04/13/18 (received from the pharmacy on 11/09/18) revealed:
-Staff documented an update that the hospital contacted the facility that Resident #13's stool specimen came back positive for norovirus and clostridium difficile (C-Diff).
-The hospital requested Resident #13's primary care provider (PCP) prescribe antibiotics.
-There was an order for metronidazole 500mg twice daily for seven days signed by the PCP and dated 04/20/18. (Metronidazole is an antibiotic used to treat infections.)

According to the Centers for Disease Control

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(CDC) website C-Diff infection prevention includes:
-Rapidly identify and isolate patients with C-Diff infection.
-Wear gowns and gloves when treating patients with C-Diff.
-Clean room surfaces with Environmental Protection Agency (EPA) approved spore killing disinfectant (such as bleach) where C-Diff patients are treated.

Interview with a personal care aide (PCA) on 10/30/18 at 11:45am revealed:
-She had worked at the facility since February 2018.
-She had not seen any residents on isolation precautions for any infectious disease since she had worked at the facility.

Interview with a medication aide (MA) on 10/31/18 at 4:03pm revealed:
-She was familiar with handling contagious outbreaks such as the flu.
-If a resident was sick with flu symptoms, the resident would not be brought to the dining room for meals.
-She knew what C-Diff was; there had not been any residents with C-diff at the facility.
-Staff had been trained on using protective equipment such as gowns, gloves, masks and foot covers.
-Protective equipment was kept in the medication room and a small supply on the medication carts.

Observation of the medication room on 10/31/18 at 4:50pm revealed there were 2 unopened boxes of face masks, 1 unopened package of disposable gowns and 1 opened package of disposable gowns.

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Interview with Resident #13's PCP on 11/06/18 at 12:40pm revealed Resident #13 did not have a history of C-Diff.

Telephone interview with Resident #11's PCP on 11/09/18 at 4:42pm revealed:
-Resident #13 was treated for C-Diff when he was in the hospital for gastritis (04/11/18).
-He was not on any isolation precautions while he was at the facility.
-She was not aware of the order written 04/20/18 for metronidazole in response to the notification of a C-Diff positive stool culture for Resident #13.
-She thought the staff was just notifying her of the culture result and that Resident #13 had been treated in the hospital.

Interview with the Executive Director (ED) on 11/09/18 at 5:37pm revealed:
-She did not recall Resident #13 having been on any isolation precautions in April/May 2018 for C-Diff.
-The facility's procedure for managing things like C-Diff was to contact the Health Department and get their protocol.
-She did not recall getting a protocol for Resident #13 testing positive for C-Diff.
-She was not aware of any problems with residents having C-Diff at the facility in April/May 2018 or since then.
-There were no residents with nausea, vomiting or diarrhea.

Attempted interview with Resident #13's Responsible Person on 11/06/18 at 12:15pm was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #13 was not interviewable.

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D 448	Continued From page 344 Attempted telephone interview with the medication aide (MA) who wrote the PCP notification on 11/08/18 at 8:01pm was unsuccessful. The former Director of Nursing (DON) was not available for interview on 11/09/18. Upon request, a policy and procedure for isolation precautions for infectious diseases such as C-Diff was not available for review.	D 448		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to immediately notify local law enforcement authorities as ordered for 1 of 1 resident sampled (#1) after staff reported an allegation of sexual assault. The findings are: Review of Resident #1's current FL-2 dated 08/09/18 revealed: -Diagnoses included Alzheimer's disease, frontal dementia, panic disorder, insomnia, hypertension,	D 453		

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hyperlipidemia, lupus erythematosus and history of pituitary adenoma.
-The resident was constantly disoriented and wandered.
-The resident was ambulatory.

Review of Resident #1's assessment and care plan dated 03/26/18 revealed the resident was ambulatory, wandered, was disoriented and had significant memory loss requiring direction.

Interview with Resident #1's primary care provider (PCP) on 10/25/18 at 3:58 p.m. revealed:
-On 10/03/18, at 10:58 a.m., Special Care Coordinator (SCC) called stating the facility Executive Director (ED) had instructed her to call to report the following: The resident was found in [a male resident's] bed with her incontinent brief down and bruising between her thighs. The ED wanted the PCP to come to the facility immediately and do a "rape kit".
-The SCC was advised that performing a rape kit was not in her scope of practice and gave an order to send Resident #1 to the Emergency Room (ER) and to notify local law enforcement.
-At 11:41 a.m., the PCP received another phone call from the facility's Regional Protocol Registered Nurse and informed the provider that the appropriate procedure for handling situations such as this one was to send the resident to the ER and to notify law enforcement. The facility's Regional Protocol Registered Nurse was told that this order had been given multiple times and to do just that.
-The PCP called the facility to get a status update on the resident from the ER visit on 10/03/18 at 3:03 p.m.
-The PCP was told by the Special Care Manager (SCM) that Regional Director of Operations (RDO) had instructed the facility staff not to send

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Resident #1 to the ER as ordered.

Interview with the Regional Protocol Registered Nurse on 11/01/18 at 3:15 p.m. revealed calling the police was never mentioned when he had spoken with Resident #1's PCP and to no one else in the building.

Interview with the ED on 10/31/18 3:38 p.m. revealed she did not know that an order was given by the PCP to send Resident #1 to the ER and call local law enforcement.

Interview with the Vice President of Quality Assurance and Regulatory Compliance on 11/09/18 at 5:20 p.m. revealed:
-Someone used the terminology of rape without seeing the facts.
-She was contacted by the Regional Protocol Registered Nurse when he was talking back and forth with the PCP on 10/03/18.
-Notifying law enforcement was never mentioned to her knowledge.

A second interview with Resident #1's PCP on 11/05/18 at 10:32 a.m. revealed:
-She was contacted by the ED on 11/01/18 at 12:15 p.m. and was placed on the speaker phone with the facility's corporate nurse and the SCM in the room.
-She was asked a series of questions regarding the alleged rape on 10/03/18.
-The Regional Protocol Registered Nurse asked her if at any time was it suggested that Resident #1 did not have to follow-up in the ER or call local law enforcement and she responded "absolutely not", the order given should have been followed.

Based on observations, interviews, and record reviews it was determined Resident # 1 was not

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interviewable.

Attempted telephone interview with Resident #1's family member was unsuccessful on 10/26/18 at 4:00 p.m. and 11/05/18 at 5:24 p.m.

D 465 10A NCAC 13F .1308(a) Special Care Unit Staff D 465

10A NCAC 13F .1308 Special Care Unit Staff
(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 4 of 48 shifts sampled for 16 days in September 2018 and October 2018.

The findings are:

Review of the facility's 2018 license from the Division of Health Service Regulation revealed the entire facility was licensed as a special care unit with a capacity of 60 beds.

Interview with a personal care aide (PCA) on 10/26/18 at 1:23pm revealed:
-There was not enough staff to care for other

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residents when [a named resident] needed one to one staff.
-There were two PCAs for the 100 hall, two PCAs for the 200 hall and sometimes a "floater" PCA to float between both halls.
-Since 10/23/18, there were two PCAs for the 100 hall, two PCAs for the 200 hall and two floater PCAs.
-The 7:00am until 7:00pm shift was responsible for all three meals and most of the showers.
-The residents were already sleeping when the 7:00pm until 7:00am shift came in.
-The night shift did not have as many showers and was responsible for getting all residents up and dressed before 7:00am.
-Staff [PCAs and medication aides (MAs)] had been working 12 hour shifts for about 1 ½ months because they were short staffed.

Telephone interview with a resident's family member on 11/06/18 at 9:14 a.m. revealed:
-The family member visited at all times during the day.
-During visits at the facility, the family member observed staff stayed busy taking care of the residents but at times observed residents wandering in the halls and there would be no staff on the floor monitoring the halls.

Confidential interview with a staff revealed there were some residents at the facility [named] that needed one on one attention but there was not enough staffing each shift to meet those residents' needs and care for the other residents.

Review of the "Punch Detail" timecard reports and census report dated 09/27/18 revealed:
-The census was 55 residents.
-44 hours of staff time were required for third shift.

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-There were 42.28 hours provided on third shift leaving the shift short 1.72 staff hours.

Review of the "Punch Detail" timecard reports and census report dated 10/18/18 revealed:
-The census was 57 residents.
-45.6 hours of staff time were required for third shift.
-There were 39.63 hours provided on third shift leaving the shift short 4.31 staff hours.

Review of the "Punch Detail" timecard reports and the census report dated 10/20/18 revealed:
-The census was 58 residents.
-58 hours of staff time were required for second shift.
-There were 55.75 hours provided on second shift leaving the shift short 2.25 staff hours.
-46.4 hours of staff time were required for third shift.
-There were 40.35 hours provided on third shift leaving the shift short 6.05 staff hours.

Interview with the Executive Director (ED) on 11/06/18 at 2:45 p.m. revealed there were no missed time recordings for staff on the "Punch Detail" timecards dated 09/27/18, 10/18/18, and 10/20/18.

Interview with the ED on 11/09/18 at 10:47 am revealed:
-The Special Care Coordinator (SCC) was responsible for doing the staffing schedule.
-There were "call outs" from time to time when staff did not come in for their assigned shift.
-Staff were supposed to find their own coverage if they could not work for their assigned shift.
-If a staff person could not find coverage, they were supposed to call the medication aide (MA) on duty prior to their assigned shift.

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-The MA was supposed to notify the SCC.
-Sometimes, they were not notified about a call out or an employee not showing up for their shift until after the shift had already started.
-They would get staff to come in and cover the shift but the fill-in staff may not get there at the beginning of the shift.
-They had some problems in the past with staffing so they had staff working 12 hour shifts instead of 8 hour shifts.
-She thought issues with the facility being short staffed had improved over last couple of months.
-They just changed back to three 8 hour shifts last week instead of the 12 hour shifts.

Interview with the SCC on 11/07/18 at 3:54pm revealed:
-She was responsible for making the monthly schedule for staff since 08/30/18.
-Anytime there were staffing needs, she placed a needs list of shifts at the bottom of the schedule for staff to pick up.
-Staff had been instructed to contact the SCC exclusively whenever they were going to call out for a shift.
-Staff called any other staff when they were calling out for a shift, but not the SCC.
-All staff were given a copy of the new policy and procedure for calling out (effective 08/30/18).

D911 G.S. 131D-21(1) Declaration of Residents' Rights D911

G.S. 131D-21 Declaration of Resident's Rights
Every resident shall have the following rights:
1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.

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

Based on observations, record reviews, and interviews, the facility failed to assure residents were treated with respect, dignity, consideration, and right to privacy as related to staff failing to knock on a resident's door before entering (#22); failing to close the bathroom door while toileting a resident (#21); obtaining a urine sample without explanation to the resident (#22); and failed to maintain privacy for residents as related to uninvited residents (#1, #6) entering other residents' rooms.

The findings are:

1. Review of Resident #22's current FL-2 dated 02/21/18 revealed diagnoses included Alzheimer's dementia, schizoaffective disorder - bipolar type, and anxiety.

Observation on 10/26/18 at 11:20am revealed:
-One medication aide (MA) and one supervisor went into Resident #22 room with gloves and a urinal hat.
-Neither staff knocked upon entering Resident #22's room, did not greet her, introduce themselves, explain to Resident #22 why they came into her room, or what they wanted with her.
-The MA asked Resident #22 if she had to urinate. The supervisor just stood there.
-The resident appeared to look puzzled and confused.
-The supervisor left the resident room.
-The resident angrily responded yes, got up from her chair walked to her bathroom, and the MA followed Resident #22 into the bathroom and closed the bathroom door.

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-The supervisor reenters the resident room, did not knock on the door, explain why she returned, or what she wanted.
-The supervisor goes into the resident bathroom with the resident and MA to assist the MA.
-The resident came out of the bathroom fussing and walked backed to her chair and sat down.
-The MA walked out the bathroom with a clear container with liquid inside the container wrapping it up in brown paper towel.
-The resident raised her voice, shouted angrily and questioned the MA, "why are you collecting my urine?"
-The MA responded back, "to check you for a UTI." (Urinary Tract Infection)
-The medication aide and supervisor left the resident room with no other explanation.

Interview with MA on 10/26/18 at 11:23am revealed:
-The resident was not acting like herself.
-The MA was getting a UA (Urinalysis) on Resident #22 for a UTI.
-The MA gave no other comment, or explanation.

Interview with Resident #22 on 10/26/18 at 11:28am revealed:
-She was angered with the staff, "the girls have to shape up."
-Staff come into our....my room, don't knock, barge right in, this happens a lot.
-She began to cry, she felt dehumanized and worthless.
-She felt awful and violated by the staff, how they came in, took her urine and left.

Interview with the Executive Director (ED) on 10/26/18 at 4:45pm revealed:
-She had been the Administrator in Charge from November 2017 until June 2018 when she started

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as the Administrator at the facility.
-She could not think of ever having had any complaints about how staff treated residents.
-She had not observed anything of concern with how staff interacted with residents.
-She had not received any complaints from family members or residents.
-Even if a resident was not cognitively able to understand, staff were expected to explain what they were doing.
-She did randomly observe staff interactions with residents.
-Her office door was always open so she could hear a lot of what was happening out in the facility.
-There were managers on duty over the weekend, but they were off this weekend (10/27/18 and 10/28/18).
-She also would randomly pop up through the back door of the facility to check on things.

2. Review of Resident #21's current FL-2 dated 10/11/18 revealed:
-Diagnoses included dementia without behavioral disturbance, muscle weakness, lack of coordination, cognitive communication deficit, and obsessive compulsive disorder.
-The resident was constantly disoriented.
-The resident was semi-ambulatory with wheelchair.
-The resident was incontinent of bowel and bladder.
-The resident required assistance with bathing, feeding, and dressing.

Observation on 10/26/18 at 11:04am revealed:
-Resident #21 was brought into her room by two personal care aides (PCAs) for toileting.
-Resident #21 was pushed into the bathroom in her wheelchair by one PCA.

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-The first PCA called for help from the second PCA to toilet Resident #21.
-The second PCA entered the bathroom to assist the first PCA with toileting Resident #21.
-The two PCAs gave prompts to Resident #21 to move with them from the wheelchair to the commode.
-Resident #21 was being toileted with the bathroom door opened, while her roommate was in the room.
-The roommate listened, looked and watched the two PCAs toilet Resident #21.
-The two PCAs completed toileting Resident #21, transferred her back into her wheelchair and pushed her out the bathroom into her room and wheeled her out of the room into the hallway.

Interview with the PCA on 10/26/18 at 1:14pm revealed:
-She had been at the facility since March 2018.
-She was familiar with Resident #21 and her care needs.
-Resident #21 required two staff's assistance, She can't self-transfer.
-She had inservice training on Dementia a few months ago, how staff are to treat residents, participated in scenario skits and role playing on resident rights.

Interview with the second PCA on 10/26/18 at 2:44pm revealed:
-She had been at the facility for some time, she shared excitement with it being her birthday.
-She was familiar with the care needs of Resident #21.
-She required two staff's assistance, she can't self-transfer.
-She participated in staff training, how to care for residents.

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Interview attempted with Resident #22, resident non interviewable on 10/26/18 at 11:12am.

Interview with Resident #21's roommate on 10/26/18 at 11:32am revealed:
-She really cares for and looks out for her roommate.
-She had a lot of needs, especially toileting needs.
-She always need help from "the girls."
-The staff upset her a lot, the girls come in, change her diaper right in front of her on the bed, or they leave the bathroom door open and she sees and smells everything.
-She had diarrhea a few times, it was everywhere, the girls stripped her down cleaned her up right in front of me. She felt awful for the roommate.
-She really needs the help in the bathroom, but she don't want too see her stripped down naked and cleaned up, it happens a lot.

Interview with the Executive Director (ED) on 10/26/18 at 4:46pm revealed staff had been trained to close doors for privacy when toileting a resident.

Interview with the Executive Director (ED) on 10/26/18 at 4:45pm revealed:
-She had been the Administrator in Charge from November 2017 until June 2018 when she started as the Administrator at the facility.
-She could not think of ever having had any complaints about how staff treated residents.
-She had not observed anything of concern with how staff interacted with residents.
-She had not received any complaints from family members or residents.
-Even if a resident was not cognitively able to understand, staff were expected to explain what

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they were doing.
-She did randomly observe staff interactions with residents.
-Her office door was always open so she could hear a lot of what was happening out in the facility.
-There were managers on duty over the weekend, but they were off this weekend (10/27/18 and 10/28/18).
-She also would randomly pop up through the back door of the facility to check on things.

3. Observation of Resident #1 on 10/25/18 from 10:02 a.m. to 10:07 a.m.
-The resident was walking down the 100 hallway.
-The resident entered resident room 103 (assigned to two female residents) while there was a personal care aide (PCA) assisting another resident at the medication cart stored on the right side of the 100 hallway located close to the nurse's station.
-The female residents assigned to the room were not in the room.
-Resident #1 walked to the opposite side of the room and picked up personal items belonging to the residents assigned to resident room 103.
-At 10:07 a.m., Resident #1 walked out of resident room 103 toward the nurse's station where staff were located.
-A MA asked Resident #1 what she had in her hand and then walked away from the resident and a second MA took a picture from Resident #1.

Interview with a resident on 10/23/18 at 11:35 a.m. revealed:
-Resident #1 came into his room a lot and sometimes tried to get in bed with him.
-Resident #1 would come into the room, walk around or lay down on the bed.

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-The resident had to go down the hall and get staff to come get Resident #1 out of his room.
-It was a daily occurrence that Resident #1 would come in and out of other residents' rooms and staff had to go and get her out.

Interview with another resident on 10/23/18 at 11:54 a.m. revealed:
-There was a female resident with blonde hair that lived at the facility and staff "better keep her out of my room" because that was their (staff) jobs and not her job.
-If the resident came into her room anymore "she was going to kill her"; "she was a pain in the [expletive]".
-Resident #1 went into everybody's space.
-The resident was not sure why Resident #1 bothered her so much.
-Staff would come to her room to get Resident #1 out of the room, but by then Resident #1 had done what she wanted to.
-The resident usually had to get out of bed and go down the hallway to get staff to come to her room and have Resident #1 removed.
-She was not sure if Resident #1 had been back in her room "lately."

Interview with a PCA on 10/23/18 at 4:44 p.m. revealed:
-Resident #1 needed someone with her "step by step" because she was into everything.
-Most staff did every 30 minute checks on Resident #1 but she tried to keep an extra watch on the resident because of her going everywhere including going in and out of other residents' rooms.
Interview with a second PCA on 10/26/18 at 1:23pm revealed Resident #1 would get into everything; went into other residents' rooms and took things.

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Interview with a medication aide (MA) on 11/07/18 at 10:49 a.m. revealed:
-Resident #1 was in and out of other residents' rooms which caused other residents to fuss and want staff to come and get Resident #1 out of the room.
-Resident #1 could go anywhere when staff were busy assisting other residents.
Interview with a housekeeper on 10/25/18 at 11:19 a.m. revealed:
-Resident #1 went into other resident rooms.
-Some of the residents did not like for Resident #1 to come into their room but some "don't mind" when Resident #1 went into their rooms.
-She had never been told by management what was expected when Resident #1 was seen in someone else's room; she just knew to redirect Resident #1 out of the room.
-Resident #1 went into other residents' rooms daily and would pick up baby dolls or pillows and "tote" the item around with her.
-Some residents became upset with Resident #1 when she was seen in the hallways with their personal items.

Interview with the laundry staff on 10/24/18 at 9:10 a.m. revealed:
-Resident #1 wandered and went in and out of other resident rooms by walking in and then walking back out.
-She had seen Resident #1 in other rooms when she delivered the residents' laundry.
-She had not been told of any specific interventions for Resident #1 if she saw her in another residents' room but just knew to redirect the resident.

Confidential interview with a staff revealed:
-Resident #1 would get into an empty resident's

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bed but staff had never seen her get in another resident's bed while another resident was in the bed.
-Resident #1 did not take residents' clothes but would take other items such as stuffed animals which was no big deal to some residents. However, some residents would try to get back the item that belonged to them from Resident #1 which caused Resident #1 and the other resident to sometime start "swatting and fighting".

Confidential interview with a concerned citizen revealed:
-The concerned citizen visited the facility often.
-It had been observed that staff "ignored" Resident #1 which left the resident free to wander in and out of resident rooms and up and down the hallways of the facility.

Interview with the Executive Director (ED) on 10/25/18 at 12:53pm revealed staff were expected to redirect Resident #1 when the resident went into other residents' rooms.

4. Interview with a male resident on 10/23/18 at 11:35 a.m. revealed:
-A resident (Resident #6's name) who was a "tall, bald-headed guy" had been getting into his bed for about a week now.
-He had told a medication aide (MA) and they would come and get the male resident out of his bed but could not remember which MA he had told.

Interview with a female resident on 10/23/18 at 12:20 p.m. revealed:
-She had lived at the facility for about two months.
-The female resident had a recent concern of a male resident who was an "old man, white hair who wears Bermuda shorts" coming into her

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room. They (staff) had to keep the male resident out of rooms.
-When this male resident came into her room, he mostly just stood in the room.
-She would use her call bell to alert staff that "he" was in her room.

Observation of Resident #6 on 10/23/18 at 11:56 a.m. revealed:
-Resident #6 was walking down the 100 hallway.
-Resident #6 was a tall male with white colored hair and was wearing khaki colored Bermuda type shorts.

Telephone interview with a resident's family member on 11/06/18 at 9:14 a.m. revealed:
-The family member had visited the Friday (10/26/18); during the family member's visit a white, tall "burly" male resident came into the resident's room.
-The family member told the male resident to "go on back out" and the male resident left the room.
-The family member reported to staff that a male resident had entered the resident's room when she visited on 10/26/18 but she was unable to remember the staff's name or title.
-The staff member told the family member "oh they all do that, they have dementia" and just "brushed it off".

Interview with a MA on 11/09/18 at 10:20 a.m. revealed
-Resident #6 wandered in other residents' room.
-She was not given any specific instructions or aware of a concern that Resident #6 was entering a named female resident's room.
-She knew from past experience to redirect residents as an intervention when they were confused and wandered.
Interview with a housekeeper on 11/07/18 at 4:45

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p.m. revealed Resident #6 wandered and it was common for him to get into other residents' beds. Interview with the Special Care Manager (SCM) on 11/09/18 at 4:52 p.m. revealed she had never been told there was a concern about Resident #6 going into a named female resident's room; "he wandered" but this was the first she had heard of this.

Interview with the ED on 11/09/18 at 10:48 a.m. revealed:
-Staff had not made her aware of Resident #6 going into a named female resident's room.
-If this was reported, she would have documented it.
-She would have thought about moving Resident #6 to the 100 hall where three male rooms were side by side.
-Resident #6's mental health provider had been contacted previously concerning the resident going from room to room following staff and residents.
-She had instructed staff to always redirect Resident #6 and engage him in conversation of his interest to help divert behaviors.

Telephone interview with Resident #6's PCP on 11/09/18 at 4:36 p.m. revealed:
-She had only seen the resident twice.
-There was a misunderstanding and she was not aware of the resident going into other resident rooms.
-The resident had to be discharged out of the facility and into a mental health inpatient unit because of his behaviors at the facility.

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The facility failed to assure each resident was treated with dignity, respect, consideration, and a right to privacy while staff failed to knock on a resident's door before entering and obtained a

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D911	Continued From page 362 urine sample without explanation which resulted in the resident becoming angry and crying with feelings that included worthlessness (Resident #22); and failed to close the bathroom door while toileting (Resident #21); and failed to maintain privacy for residents as related to uninvited residents (#1, #6) entering other residents' rooms. The facility's noncompliance was detrimental to the welfare of the residents and constitutes a Type B Violation. _______________________ The facility provided a plan of protection in accordance with G.S. 131D-21 on 10/26/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 24, 2018.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision, health care, medication administration, controlled	D912		

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substances, health care personnel registry, and implementation.

The findings are:

1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 11 of 16 residents sampled (#1, #2, #6, #8, #9, #13, #14, #17, #18, #25, #26) including 5 residents (#1, #2, #6, #25, #26) with assaultive, aggressive, sexually expressive and wandering behaviors leading to numerous resident to resident altercations; 5 residents (#8, #9, #13, #14, #18) with multiple falls resulting in serious physical injuries to include head laceration requiring staples (#8, #14), traumatic head injury (#13), closed head injury, facial contusion and multiple skin tears (#9), and left wrist sprain (#8, #18); and a resident, who had an order for nectar thick liquids but was allowed to drink another resident's thin liquids resulting in the resident coughing (#17). [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).]

2. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for acute and routine health care needs were met for 4 of 8 sampled residents (#1, #2, #4, #13) related to failing to send Resident #1 to the emergency room after being found in a male resident's room and failing to notify the primary care provider (PCP) that a urinalysis and culture had not been sent for testing; failing to notify the PCP of a productive cough and cold symptoms and failed to send an x-ray result that was positive for a fracture for Resident #4; failing to notify Resident #13's PCP of the resident drinking liquid body wash; and failing to report Resident #2's rectal bleeding to the PCP. [Refer to Tag

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D912	Continued From page 364 D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 3. Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 3 of 7 sampled residents (#2, #11, #14), which included orders to discontinue and remove a fall mat from the resident's room (Resident #14), orders for a chair alarm and compression stockings (Resident #2), and an order for a thyroid stimulating hormone (TSH) level (Resident #11). [Refer to Tag D276 10A NCAC 13F .0902(c)(3)(4) Health Care (Type B Violation)] 4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 6 residents (#4, #19, #20) observed during the medication passes including errors with insulin (#20), a topical pain relief patch (#19), and a medication for mild to moderate pain (#4); and for 7 of 8 residents sampled (#1, #2, #3, #4, #8, #13, #15) for record review including errors with narcotic pain relievers (#3, #8, #15), antibiotics for infection (#4, #13), medications for breathing problems (#4), narcotics used to treat anxiety and agitation (#1, #2, #3), an antipsychotic (#2), a steroid to treat inflammation (#4) and an eye drop for glaucoma (#2). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)] 5. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 4 of 7 residents sampled (#2, #3, #8, #15) including three	D912		

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D912	Continued From page 365 residents receiving pain medications (#3, #8, #15) and two residents receiving medications for anxiety and agitation (#2, #3). [Refer to Tag D392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)] 6. Based on observations, interviews, and record reviews, the facility failed to assure 4 of 4 sampled residents (#1, #3, #14, #15) with injuries of an unknown origin had an initial and 5 day report completed and sent to the Health Care Personnel Registry. [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)] 7. Based on observations, interviews, and record reviews, the Executive Director failed to assure the total operation of the facility to meet and maintain rules related to personal care and supervision, health care, residents' rights, medication administration, controlled substances, and health care personnel registry. [Refer to Tag D980 G.S. 131D-25 Implementation (Type A1 Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure residents	D914		

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were protected from harm and injury from residents with known aggressive behaviors resulting in Resident #7 sustaining a subdural hematoma following an assault by another resident and a hip fracture after being pushed out of the bed by a second resident; failed to protect one resident diagnosed with dementia (#16) from sexual exploitation by a resident with known sexually aggressive behaviors; and mistreatment by staff (#2); and neglected the safety needs of Resident #10 who had a history of violent behavior associated with falls and injuries, was found by a family member on the floor in the hallway during the lunch meal sustaining a pelvic fracture and died one week later.

The findings are:

1. Review of Resident #7's current FL-2 dated 10/13/18 revealed:
-Diagnoses included vascular dementia, cardiomyopathy, Type II diabetes and spinal stenosis.
-The resident was intermittently disoriented and wandered.
-The resident was semi-ambulatory.

Review of Resident #7's Resident Register revealed an admission date of 06/21/18.

a. Review of Resident #7's primary care provider's (PCP's) "Patient Notes" dated 10/16/18 revealed:
-The PCP received a call from an outside provider that a male resident had been coming into Resident #7's room at night and staring at her.
-This had happened multiple times.
-Resident #7 denied the male resident had touched her inappropriately; "he just stares and I

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wish he wouldn't do that".
-The outside provider stated that this situation was reported to the special care manager (SCM) whose response was "We know about it and we're keeping a watch on it"
-According to Resident #7, this problem had not improved at all since the SCM had been notified, which was why she sought assistance from the outside provider.

Review of Resident #7's electronic "Charting Notes" dated 10/27/18 at 5:08 p.m. revealed:
-There was documentation by a medication aide (MA) the resident was found on the floor yelling in pain and complained about her hip and knee.
-The resident was sent out to the Emergency Room (ER) and admitted with a fractured femur.

Review of Resident #7's PCP'S "Patient Notes" dated 10/28/18 revealed:
-A MA reported yesterday (10/27/18) the resident was "found on the floor" in her room, complaining of knee and hip pain.
-The on call provider was notified Resident #7 was taken to a local ER, diagnosed with a fractured femur and admitted to the hospital.

Review of Resident #7's Orthopaedic Surgery History/Physical and Discharge Summary dated 10/27/18 revealed:
-The resident presented to the ER following a fall on her right side on 10/27/18 and was admitted.
-Trauma was documented as the chief complaint.
-The resident reported that sometime after breakfast she was pushed and fell to the floor.
-The resident denied loss of consciousness.
-The resident was admitted with a diagnoses of a closed fracture of the right femur.
-Orthopaedic services were consulted to assume the care of the resident.

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-The resident had surgery on 10/28/18 for a Titanium Trochanteric Fixation Nail (a surgical procedure implanting a hardware device to treat fractures).
-The resident developed post-operative acute blood loss and required a blood transfusion.
-The resident was discharged on 10/31/18 to a skilled nursing facility for rehabilitation.

Review of PCP's "Patient Notes" dated 10/31/18 for Resident #7 revealed:
-In a phone call with the special care manager (SCM) on 10/31/18 at 7:21 p.m., she was informed when Resident #7 fell a named male resident was present in the room.
-Resident #7 had previously voiced her concern to both the PCP and another outside provider about the named male resident coming into her room uninvited multiple times throughout the night and standing by her bed "staring" at her and this behavior reportedly made the resident feel uncomfortable.
-This had been reported verbally to the SCM (most recent report 10/24/18).
-The SCM's response was "we are aware and keeping an eye on the situation".
-The named male resident's behavior, however, continued and staff reportedly provided no increased supervision to ensure the protection for Resident #7.
-When the facility reported the incident in which Resident #7 sustained the fracture on 10/28/18 to the PCP, they stated that it was "unwitnessed", indicating the male resident, who was in Resident #7's room was under no supervision by staff.
-Resident #7 was not accustomed to having falls. She walked without assistance and was independent with mobility.
-Further investigation was needed to determine if this incident was indeed a "fall" as reported, or if

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some kind of altercation occurred between Resident #7 and the named male resident which resulted in an injury.

Interview with Resident #7's PCP on 11/05/18 at 10:32 a.m. revealed:
-She was not sure what the SCM meant when she stated they were keeping "a watch" on the situation involving Resident #7 and the male resident, however, they (staff) "let it keep happening".
-She would have expected staff to have implemented interventions immediately such as one on one supervision or relocating the resident's room closer to the nurse's station.
-There had not been any interventions implemented to improve the situation which resulted in Resident #7's fracture.

Telephone interview with Resident #7's family member on 11/06/18 at 9:14 a.m. revealed:
-The resident was currently in rehabilitation for a fracture of her right leg.
-The resident told the family member on 10/27/18 she went into her room to sit on her bed and there was a male resident in her bed.
-The resident did not see the male resident because he was covered up.
-As the resident sat down on the side of the bed the male resident attempted to get up and knocked her down on the floor.
-The family member was contacted by facility staff about the incident around 9:00 a.m. to 9:30 a.m.
-The family member had visited the Friday (10/26/18) before the incident occurred on 10/27/18 and during the family member's visit a tall "burly" male resident came into the resident's room.
-The family member told the male resident to "go

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on back out" and the male resident left the room.
-The family member reported to staff that a male resident had entered the resident's room when she visited on 10/26/18 but she was unable to remember the staff's name or title.
-The staff told the family member "oh they all do that, they have dementia" and just "brushed it off".
-The resident would not be returning to the facility because the family member thought the resident would be hurt again.

Interview with Resident #7's roommate on 10/30/18 at 1:25 p.m. revealed:
-Resident #7 was in the hospital because "he" pushed her when "he" was in her (Resident #7's) bed.
-She was in the room when Resident #7 was pushed but she did not know the male resident's name.
-"It scared her (Resident #7) so bad".
-Resident #7 had broken her leg when she fell.

Interview with the Special Care Coordinator (SCC) on 10/30/18 at 12:10 p.m. revealed:
-The SCC received a call from a MA that Resident #7 had a fall on 10/27/18.
-The MA reported that Resident #7 was pushed out of her bed by the male resident.
-The Executive Director (ED) knew about the incident because the same MA who called her called the ED after the incident occurred on 10/27/18.

Interview with a male resident on 10/23/18 at 11:37 a.m. revealed a named male resident had been getting in his bed for about a week.

Interview with a personal care aide (PCA) on 10/30/18 at 4:44 p.m. revealed:

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-The PCA did not know what happened but heard yelling from Resident #7's room.
-Resident #7 was laying on the floor on her right side beside the bed and a named male resident was in Resident #7's bed.

Interview with a MA on 11/09/18 at 10:20 a.m. revealed:
-The male resident was confused and combative to staff and residents.
-She was not given any specific instructions or aware of a concern that the male resident was entering Resident #7's room.

Confidential staff interview revealed the ED kept certain residents here and waited until something happened; the male resident should have been moved that day (10/27/18). It was the same situation (waited for something to happen) when Resident #7 was hit by another male resident.

Observation on the 200 hall of the facility on 11/02/18 at 9:51 a.m. revealed Resident #7's room and the named male resident's room were both located on the same side of the hall with four resident rooms between them.

Interview with the ED on 10/30/18 at 1:43 p.m. revealed:
-It was "alleged' that Resident #7 was pushed by a male resident (named).
-The MA called the ED immediately on 10/27/18 when the incident occurred.
-The MA had reported when she entered Resident #7's room, Resident #7 was on the floor and the male resident was in the Resident #7's bed.
-The ED had not done an investigation of the incident because none of the staff had witnessed the incident.

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-She had not interviewed Resident #7's roommate because she was "not coherent".
-Resident #7 told local hospital staff that a resident had pushed her out of bed.

Interview with the SCM on 11/09/18 at 4:52 p.m. revealed:
-She had never been told there was a concern about the named male resident (named) going into Resident 7's room.
-The male resident "wandered" but this was the first she had heard of this.
-If she had known there was a concern about a male resident going into Resident #7's room then she would have notified the ED, contacted the named male resident's PCP and family and would have "jumped right on it" by implementing interventions to prevent the male resident from entering Resident #7's room uninvited.
-She thought it was possible it could have been a day it was chaotic in the facility and she may not have remembered being told about Resident #7's concerns of a named male resident going into her room, particularly if she didn't document the concern at that time.

A second interview with the ED on 11/09/18 at 10:48 a.m. revealed:
-Resident #7, nor her family, nor staff had made her aware of any male residents going into her room
-If this was reported to her, she would have documented it.
-She would have thought about moving the male resident to the 100 hall where three male rooms were side by side.
-She would have expected staff to immediately report this to her so that interventions could have been implemented.

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b. Review of Resident #7's electronic "Charting Notes" revealed:
-On 07/25/18 at 8:01 a.m., there was documentation by a medication aide (MA) the resident was sent to a hospital due to a resident to resident altercation.
-The resident was transferred to another hospital and admitted.

Review of an Accident/Injury Report for Resident #7 dated 07/25/18 at 7:00 a.m. revealed:
-The incident was documented as a resident to resident altercation.
-The incident was witnessed and occurred in the hall of the facility.
-The type of injury was documented as a laceration, bruising and abrasion with the location documented as the back of the head.

Attempted interview with one of the personal care aides (PCAs) who witnessed the assault on 07/25/18 of Resident #7 on 11/06/18 at 5:30 a.m. was unsuccessful.

Review of an Incident/Investigation Report from the local Police Department dated 07/25/18 at 6:54 a.m. revealed:
-On 07/25/18 at 6:54 a.m. the Officer was dispatched to the facility in reference to a resident that had been assaulted by another resident who was actively fighting with a staff.
-Resident #7 was listed as the victim and the type of injury was documented as severe lacerations.
-A female resident was lying straight down the hallway and a male resident fighting a male staff.
-The Officer proceeded to check on the victim (Resident #7) and noticed that the she was bleeding heavily from her head.
-The assaulted victim (Resident #7) was loaded for transport to the hospital by emergency

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medical services (EMS).

Review of Resident #7's hospital records dated 07/25/18 - 07/26/18 revealed:
-The resident arrived at the Emergency Room (ER) at 7:49 a.m. on 07/25/18.
-The chief complaint was documented as an assault, assaulted by another resident, found on the floor in a prone position, a laceration to the forehead, pain to the left hip and back and was vomiting on arrival.
-EMS reported the resident was knocked to the ground and her "forehead was smashed into the ground" by another resident at the facility.
-EMS was initially not able to stop the bleeding with direct pressure, however, the bleeding was controlled in the ER.
-The resident was taking Aspirin (used to thin the blood and could cause increased risk for bleeding).
-In the Trauma History and Physical Information section there was documentation that the resident had a head injury.
-The impression from a computerized tomography (CT) (an image that shows bones, organs, blood vessels and soft tissue) showed a left frontal scalp hematoma, small right parafalcine subdural hematoma (a collection of blood outside of the brain), small focus of extra-axial clot (likely subarachnoid) at the left lateral frontal convexity and a tiny hemorrhagic contusion (bleeding within the brain tissue) in the anteromedial left frontal lobe .
-The resident had a laceration repair to the resident's left forehead.
-The resident was transferred from the local hospital to another hospital in another county and was seen by the trauma team and neurosurgery was consulted.
-The discharge diagnoses included a subdural

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hematoma and laceration to the forehead.
-A repeat CT was done and found to be stable and the resident was cleared for discharge back to the facility.

Review of primary care provider's (PCP'S) "Patient Notes" dated 07/31/18 for Resident #7 revealed:
-On 07/25/18 the resident was sent to the hospital because she was "attacked" by another resident.
-The resident was seen on 07/30/18 regarding this incident.

Review of a PCP's visit note dated 07/30/18 for Resident #7 revealed:
-The resident was being seen to follow-up on a recent ER visit.
-On 07/24/18, it was reported that the resident was assaulted by another resident.
-Resident #7 was sitting in her wheelchair near the nursing station when another resident, behaving aggressively, approached her and pushed her out of her chair, causing her to hit her head on the floor.
-According to staff, the other resident then proceeded to "smash her head into the ground", resulting in extensive bleeding that would not resolve with pressure.
-The resident was sent to the ER for evaluation and treatment and diagnosed with a subdural hematoma and laceration to the forehead, in addition to extensive contusions to the face.

Confidential telephone interview with staff revealed:
-The staff remembered the male resident "went off".
-Resident #7 was" punched and thrown to the floor" and hit her head on the handrail.
-The male resident that punched Resident #7 was

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attacking people on a regular basis.
-The ED "constantly"' told staff to just send the male resident out and not contact the PCP.
-The male resident did not return to the facility after the incident and was sent to an inpatient behavioral health unit.

Telephone interview with the former Director of Nursing (DON) on 11/01/18 at 1:25pm revealed:
-She remembered when a named male resident knocked Resident #7 to the floor and she got a head injury.
-The male resident that knocked Resident #7 to the floor would get in a rage every time the grass was cut and would say someone stole his lawnmower and slam the door to his room so hard the frame was messed up.

Confidential interview with a former staff on 11/08/18 at 7:35 p.m. revealed:
-The former staff saw staff trying to calm the named male resident down at the dining room door and Resident #7 "got in his way" and the male resident just started hitting her.
-The male resident that hit Resident #7 had a dangerous mood and was dangerous to have been around other residents.
-The ED was aware of the named male resident's mood, his behavior was known to everyone.
-The former staff thought Resident #7 was hit by the male resident 2 to 3 times before she fell to the floor.
-The former staff did not see Resident #7's head being smashed into the floor by the male resident.
-The first blow, Resident #7 was pushed against the wall and the second blow Resident #7 was knocked to the floor by the male resident.
-Resident #7 was hit in the chest by the male resident with a closed fist.

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-The ED knew the male resident was having behaviors and no interventions were put into place to protect the other residents.
-The male resident that hit Resident #7 was "violent".

Interview with the ED on 10/30/18 at 1:43 p.m. revealed:
-She thought the incident on 07/25/18 between Resident #7 and the male resident was a "space thing".
-The ED was not at the facility when Resident #7 was pushed by the male resident but watched the video footage of the incident.
-The male resident that pushed Resident #7 was no longer at the facility and was sent out to a behavioral health unit after the incident on 07/25/18.
-"He did push her" (Resident #7).
-The incident occurred in the hallway.
-Resident #7 was walking behind the male resident in the hall.
-The male resident initially pushed Resident #7, but Resident #7 did not fall.
-Resident #7 was pushed a second time by the male resident but she did not fall. The second push was a hit in the chest, then the male resident walked and turned around and hit Resident #7 with his fist but she did not remember where.
-Resident #7 fell into the handrails in the hallway with her head hitting the rail and the male resident walked off.
-Staff got the male resident back to front area of the facility.
-She was not sure if Resident #7 hit her head on the floor.

Interview with the ED on 11/07/18 at 5:30 pm revealed:

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-The named male resident involved in the incident on 07/25/18 with Resident #7 would have outbursts every now and then.
-If something triggered the named male resident he would start slamming doors, kicking trash cans and might would go in the dining room and flip over a table, which happened once per week.
-She was aware of past aggressive behaviors the named male resident had toward other residents and encouraged staff to redirect the named male resident; if that didn't work, staff should have sent him out to the hospital.
2. Review of Resident #16's FL-2 dated 10/05/18 revealed:
- A diagnosis of dementia.
-The resident was constantly disoriented and wandered.

Review of Resident #16's Resident Register revealed:
- She was admitted to the facility on 10/08/18.
-The resident had a significant memory loss and must be redirected.
-The resident required assistance with personal care tasks which included bathing, dressing, toileting, skin care and grooming.

Interview with a medication aide (MA) on 10/31/18 at 4:03pm revealed:
-She could not remember the date but about 2-3 weeks ago, another MA had walked down to a male resident's room and Resident #16 was sitting on the bed naked from the waist down.
-The male resident was down in front of Resident #16 looking between her legs, in the perineal area.
-Resident #16 told the other MA to get out.
-The other MA called personal care aides (PCAs) to come and help her.

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Interview with Resident #16's primary care provider (PCP) on 11/01/18 at 12:40pm revealed:
-On 10/23/18, the facility reported staff found Resident #16 sitting on a male resident's bed and the male resident was kneeling in front of her on the floor.
-The male resident told the staff to leave the room because he was going to have sex with her.
-Resident #16 did not have her bottoms on.
-The PCP talked to both residents separately and neither had any memory of the incident.
-Resident #16 had dementia and was not able to give consent to have sex.

Interview with a medication aide (MA) on 11/01/08 at 3:30pm revealed:
- She received a shift report about 2 weeks ago in October 2018 that Resident #16 was found in a male resident's room on his bed with her pants down. He was looking at Resident #16's vagina.
-She did not document anything about the incident since she did not witness the incident.

Interview with another MA on 11/06/18 at 1:40pm revealed:
-About 2-3 weeks ago between 8:30pm - 9:00pm, the MA was administering medications on the 200 hall.
-When she entered a male resident's room to administer his medications, she observed Resident # 16 sitting on the side of his bed with her pants partially down at mid-thigh. The male resident was on his knees, on the floor in front of her.
-The MA asked the residents "What is going on here" and Resident #16 answered "you can write this down in your books and you can get the [explicative] out of here".
-The MA walked to the door (partially out of the room) and called for help. One of the PCAs came

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to the room and informed the MA that by law, she was not supposed to stop them.
-The MA left the door opened and both walked away. In a few minutes, Resident #16 walked out of the room with her pants pulled up.
-The incident was reported to the oncoming 3rd shift MA and to the Executive Director (ED) the next morning. An incident report was not completed.
-Resident #16 was placed on 30 minute supervisory checks after the incident and staff encouraged her to stay off 200 hall.

Review of a physician's order for Resident #16 dated 10/24/18 revealed orders for Prozac 20mg, one time a day for decreased libido (desire for sexual activity) and Ativan 0.5mg, by mouth, at bedtime for anxiety.

Interview with the ED on 11/07/28 at 3:18pm revealed:
-She was informed by a MA that Resident #16 was found in a male resident's bed and both residents were fully dressed about 2-3 weeks ago in October, 2018.
-The MA reported she found them when she walked into the male resident's room to administer his medications. When the MA asked them what they were doing, Resident #16 informed her they were going to have sex.
-The MA reported the residents told her to leave; the MA left the room and did not go back into the room.
-Resident #16 came out of the male resident's room fully dressed but the MA did not report how long the residents were alone in the room.
-She interviewed both residents about the incident and both residents denied the incident.
-The MA should have redirected Resident #16 out of the male resident's room or stayed in the room

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with them.

3. Review of Resident #10's current FL-2 dated 07/13/18 revealed diagnoses included major neurocognitive disorder and dementia.

Upon request on 11/05/18, there was no care plan for Resident #10 available for review.

Review of a Resident Assessment Pre-Screening form for Resident #10 dated 06/18/18 revealed:
-Resident #10 required extensive assistance with bathing, dressing, toileting, eating, transfers and ambulating.
-Resident #10 had cognitive impairment and an abnormal gait.

Review of hospital records for Resident #10 dated 07/29/18 through 08/01/18 revealed:
-Resident #10 presented to the ER after an unwitnessed fall.
-Resident #10 was found down on the floor, complaining of pain.
-Resident #10's injuries included a pelvic fracture and possible fracture of his 4-5 cervical spine.

Review of a charting note for Resident #10 dated 07/29/18 at 1:41pm revealed:
-Resident #10 was observed laying on his right side on the floor and had a skin tear on his right elbow.
-Resident #10's Responsible Person (RP) was in the building at the time of the incident.
-Resident #10 was sent to the ER.

Review of an Accident/Injury Report form for Resident #10 dated 07/29/18 at 12:40pm revealed:
-Resident #10 was observed laying on his right side on the floor.

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-There was documentation of a skin tear on Resident #10's right elbow.
-There was a note Resident #10 was admitted to the hospital.

Attempted interview on 11/09/18 at 3:00pm, with the MA who documented the charting note dated 07/29/18 at 1:41pm, was unsuccessful.

Telephone interview with Resident #10's RP on 11/04/18 at 6:50pm revealed:
-Resident #10 was only at the facility for a few weeks, fell three times in five days and then died.
-The first incident was about 1:00am on a Monday night going into Tuesday (07/24/18), when staff at the facility called and said Resident #10 had an altercation with another resident.
-Staff reported as a result of the altercation Resident #10 fell, was injured and was being sent to the emergency room (ER).
-Then staff called again at 1:00am on Wednesday night going into Thursday (07/26/18) and said Resident #10 fell again and was sent to the ER again.
-He went to visit Resident #10 on Sunday (07/29/18).
-He entered the front door of the facility and noticed everyone was in the dining room and there was a man lying on the floor in the hallway to the left just past the fire doors.
-Before he could say anything, the staff came around from behind the front desk and asked who the RP was there to see.
-The staff then walked straight to the dining room past where the man was lying on the floor.
-The staff went in the dining room and asked the other staff where Resident #10 was.
-Staff came out of the dining room to look for Resident #10 and saw the man lying on the floor.
-That was when the RP realized the man lying on

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the floor was Resident #10.
-Resident #10 must have been lying on the floor for a while because the blood on his elbow was already dried up.
-The doctor at the hospital said Resident #10 fractured his pelvis and his spine.
-The doctor did not think Resident #10 would make it through a surgical repair.
-Resident #10 was discharged from the hospital to rehabilitation center, returned to the hospital and died on 08/05/18.

Interview with Resident #10's primary care provider (PCP) on 11/06/18 at 12:40pm revealed she "did not precisely remember (Resident #10) having fractured his pelvis, just that he fell" on 07/29/18.

Interview with the ED on 11/09/18 at 10:48am revealed:
-She was not aware Resident #10 was found by his RP on the floor in the hallway with dried blood on his elbow.
-She was told by staff Resident #10 had fallen just before the resident's RP came through the door.
-She was aware of the prior incidents and injuries for Resident #10 on 07/24/18 and 07/26/18.
-She was not aware if any safety measures were implemented after the incidents on 07/24/18 and 07/26/18 to protect Resident #10 from harm.

4. Review of Resident #2's current FL-2 dated 03/07/18 revealed diagnoses included Alzheimer's dementia with behaviors, schizoaffective disorder, major neurocognitive disorder and seizure disorder.

Confidential interview with a concerned citizen revealed:

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-The citizen was visiting a resident early in the afternoon on 09/25/18 or 09/26/18.
-Resident #2 was in the hallway with a purple Bible that belonged to another resident.
-Resident #2 was wheeling himself down the hall towards the Executive Director's (ED's) office.
-Resident #2 and the other resident were yelling at each other.
-The ED came running towards Resident #2 like she was going to hit Resident #2.
-The ED put her hands on Resident #2's shoulders and yelled into the resident's ear, "I'm going to call the law on you."
-Resident #2 slapped his hands down on his wheelchair like he was trying to defend himself.
-The ED called for staff to help hold Resident #2 down.
-The citizen had seen the ED and staff holding Resident #2 down in his wheelchair.
-Resident #2 had not hit anyone prior to the ED going to the resident.
-Resident #2 was wiggling around trying to get loose but could not because he was being restrained.
-Resident #2 could not hit or kick anyone because he was being restrained.

Confidential interview with a staff revealed there was an incident when Resident #2 hit the Activity Director (AD) because the AD was trying to get a Bible that belonged to another resident from Resident #2.

Review of a Mental Health Attendance Record for Resident #2 dated 09/26/18 revealed:
-Resident #2 was confused and difficult to understand.
-Staff reported Resident #2 took a watch off of a female resident's wrist and stole her Bible.
-Resident #2 appeared confused paranoid and

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said the watch was his "old lady's."

Interview with a personal care aide (PCA) on 10/31/18 at 3:30pm revealed:
-She remembered 09/26/18, Resident #2 was "on a rampage that day."
-Resident #2 had taken a watch off of a resident's arm and was trying to fight everybody.
-The ED, the Assistant Care Manager (ACM) in training, the Activity Director (AD) and a medication aide (MA) were all present on 09/26/18.
-There were no other residents in the hall, just Resident #2 and the resident that Resident #2 took the watch from.
-She could not remember all the details of what happened; she she could not remember if any staff grabbed or held down Resident #2.
-The local police department was called because of Resident #2's behaviors.

Interview with the AD on 11/01/18 at 11:59am revealed:
-Resident #2 had grabbed a watch off of a resident's arm on 09/26/18.
-She, the ED, a PCA and other staff she could not remember, went down to Resident #2, who was about half way down the 200 hall near the other resident's room, to get the watch from him.
-Resident #2 got hostile and started swinging at staff when staff tried to get the resident's watch from the resident.
-The ED was talking to Resident #2 trying to get the watch from him.
-The watch had a stretch band which Resident #2 had wrapped around his four fingers so staff were attempting to pull the from Resident #2's hand by pulling on the band of the watch on the outside of Resident #2's hand.
-She was standing to the left side rear of

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Resident #2's wheelchair, Resident #2 was seated in his wheelchair and the ED was standing in front of Resident #2 during the incident.
-She did not have a specific response as to why it was necessary to get the other resident's watch back at that moment by trying to physically take the watch from Resident #2's hand.
-She, the ED and other staff were in the hallway for only a few minutes with Resident #2 trying to get the watch and then they just backed off and let Resident #2 go to his room to calm down.
-Resident #2 was not held down because he was in his wheelchair.

Interview on 11/06/18 at 12:38pm with a MA who was present on 09/26/18 revealed:
-She was working on 09/26/18 and witnessed the incident involving Resident #2.
-Resident #2 had taken another resident's watch and the ED and the AD went to get the watch from Resident #2.
-Resident #2 became agitated, swinging at the ED and the AD and trying to use his wheelchair to run staff over.

Observation on 11/06/18 at 12:39pm revealed the interview with the MA was interupted for resident care.

The same MA was not available for a follow up interview on 11/07/18 and 11/09/18.

Interview on 11/06/18 at 1:23pm with a second MA who was present on 09/26/18 revealed:
-Resident #2 took a watch from another resident's wrist on 09/26/18.
-"Basically all of us (staff)" were trying to get the watch back.
-Resident #2 became combative when staff asked for the watch.

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-She could not remember the staff involved in the incident.
-She could not remember what happened after Resident #2 became combative because she walked away.

Second interview with the ED on 11/07/18 at 4:42pm revealed:
-She did not have a specific response as to why it was necessary to get the other resident's watch back at that moment by trying to physically take the watch from Resident #2's hand.
-At no point on 09/26/18 did any staff hold Resident #2 down or try to restrain him.

____

The facility failed to protect residents from abuse and neglect. The facility's failure resulted in Resident #7 sustaining a subdural hematoma following an assault by another resident and a hip fracture after being pushed out of the bed by a second resident; a resident diagnosed with dementia (#16) being sexual exploited by a resident with known sexually aggressive behaviors; residents hit by other residents (#1) and mistreated by staff (#2) and Resident #10 being left on the floor with a fractured pelvis. The facility's failure resulted in serious injury and neglect of residents and constitutes a Type A1 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/18 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 9, 2018.

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D980 G.S. § 131D-25 Implementation D980

G.S. 131D-25 Implementation

Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the Executive Director failed to assure the total operation of the facility to meet and maintain rules related to personal care and supervision, health care, residents' rights, medication administration, controlled substances, and health care personnel registry.

The findings are:

Confidential interview with a family member revealed:
-The family member had some concerns in the past about repeated issues with a resident's medications.
-The concerns were shared with the Executive Director (ED) and the Special Care Manager (SCM).
-The SCM called a meeting with staff on duty but only on a particular shift so it was not addressed with all staff.
-The ED always seemed very concerned but she did not always follow up on the concerns.

Confidential interview with a second family member revealed:

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-He visited a resident on the weekends and it seemed like there was no one in charge at the facility.
-The staff stayed around the front desk area while the residents did their own thing.

Confidential interview with a concerned citizen revealed:
-There was absolute concern that residents were in danger at the facility.
-The staff and the ED did not care about the residents.
-The ED covered up any incidents that happened involving residents being injured.
-The ED would make up stories about how the residents had been injured that just did not make sense.
-Residents had injuries of an unknown origin that had not been reported.
-Residents were not supervised; there were residents that were fondling other residents.
-The ED had been told about injuries of unknown origin and sexual abuse toward residents and nothing was done.
-Residents were not getting their medications as ordered by their provider.
-There were no systems being followed because the staff just did not care.

Confidential interview with a staff revealed:
-Residents were not being taken care of; there were so many residents that had frequent falls.
-The care would be different if there weren't so many residents who were inappropriate for a special care unit (SCU).
-There were two residents that were kept at the facility until something bad happened.
-Another resident should have been discharged long before he was because he was hitting residents and throwing things since he got to the

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facility.
-Staff had told the ED many times those residents were not right for the SCU and the ED did not say much about it.
-The ED was rude to family members and staff.

Confidential interview with a second staff revealed:
-The ED worked Monday through Friday but "not really on the weekends".
-The ED's normal working hours were from 8:00 a.m. until 5:00 p.m. or 6:00 p.m.
-The ED did not interact with the residents or monitor the hallways of the facility unless someone such as corporate or someone other than regular staff were at the facility,
-The staff thought there was a "disconnect" between staff and the ED.
-Staff did not know who to report to. Staff were told one thing from the ED and something different from the care managers.

Interview with the Special Care Coordinator (SCC) on 11/07/18 at 3:30pm and 3:54pm revealed:
-The medication aides (MAs) were responsible for making sure personal care aides (PCAs) provided personal care and supervision for residents.
-The MA was expected to report any concerns to the Special Care Manager (SCM) and if the concern was not addressed, then report to the ED.
-The SCM was responsible for supervising the MAs, assuring medications were administered timely and that medication cart audits were completed.
-The SCM supervised MAs by reviewing reports from the electronic medication administrations system which allowed a real time online review of

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a medication pass in progress.
-The SCM and SCC were responsible for monitoring primary care provider (PCP) orders, follow up with PCPs and documentation of contact with PCPs.
-She was the SCC and reported to the Regional Protocol Registered Nurse and the Regional Director of Operations.
-She had been sent to help out at the facility in August 2018.
-The ED had instructed staff not to listen to the SCC and the SCM because they were only temporary.
-Communication between staff, the SCC, SCM and ED was a problem and staff did not know who to listen to.
-There was friction between the ED, the SCC and SCM which "hurt us a lot" as far as seeing improvements in systems implemented to improve care and services.
-There had been recent improvements since the arrival of the Regional Clinical Director on 11/05/18.
-The corporate offices had been made aware of concerns with the ED prior to 10/23/18.

Interview with the ED on 10/30/18 at 1:44pm revealed:
-The MAs were responsible for monitoring the PCAs each shift.
-The Assistant Care Manager (ACM) in training, the SCC and the SCM were responsible for supervising the MAs.
-There was a manager on duty for 4 hours per day on Saturdays and Sundays.
-The MAs supervised staff in the building on 2nd and 3rd shifts.

A second interview with the ED on 11/09/18 at 10:48am revealed:

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-PCAs were responsible for the direct care and supervision of residents and reported to the MAs.
-The MAs were responsible for administering medications, contacting the PCPs and family members, completing incident reports and making sure PCAs completed their daily tasks.
-The SCC was responsible for scheduling, monitoring medication cart audits and controlled substances and reported to the Regional Protocol Registered Nurse and Regional Director of Operations.
-The SCM was responsible for overseeing the MAs, chart audits and implementing new policies and procedures and reported to the Regional Protocol Registered Nurse and Regional Director of Operations.
-She did not have a verbal response on which staff reported to the ED.
-She was responsible for making sure the residents were taken care of.
-The SCC and SCM were overseeing the MAs and the MAs were following the PCAs.
-She, the SCC and SCM were frequently out on the floor interacting with staff and residents and monitoring what was going on.

Noncompliance identified at violation levels included:

1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 11 of 16 residents sampled (#1, #2, #6, #8, #9, #13, #14, #17, #18, #25, #26) including 5 residents (#1, #2, #6, #25, #26) with assaultive, aggressive, sexually expressive and wandering behaviors leading to numerous resident to resident altercations; 5 residents (#8, #9, #13, #14, #18) with multiple falls resulting in serious physical injuries to include head laceration requiring staples (#8, #14), traumatic head injury

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(#13), closed head injury, facial contusion and multiple skin tears (#9), and left wrist sprain (#8, #18); and a resident, who had an order for nectar thick liquids but was allowed to drink another resident's thin liquids resulting in the resident coughing (#17). [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).]

2. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for acute and routine health care needs were met for 4 of 8 sampled residents (#1, #2, #4, #13) related to failing to send Resident #1 to the emergency room after being found in a male resident's room and failing to notify the primary care provider (PCP) that a urinalysis and culture had not been sent for testing; failing to notify the PCP of a productive cough and cold symptoms and failed to send an x-ray result that was positive for a fracture for Resident #4; failing to notify Resident #13's PCP of the resident drinking liquid body wash; and failing to report Resident #2's rectal bleeding to the PCP. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]

3. Based on observations, interviews and record reviews, the facility failed to assure primary care provider orders were implemented for 3 of 7 sampled residents (#2, #11, #14), which included orders to discontinue and remove a fall mat from the resident's room (Resident #14), orders for a chair alarm and compression stockings (Resident #2), and an order for a thyroid stimulating hormone (TSH) level (Resident #11). [Refer to Tag D276 10A NCAC 13F .0902(c)(3)(4) Health Care (Type B Violation)]

4. Based on observations, interviews, and record

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reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 6 residents (#4, #19, #20) observed during the medication passes including errors with insulin (#20), a topical pain relief patch (#19), and a medication for mild to moderate pain (#4); and for 7 of 8 residents sampled (#1, #2, #3, #4, #8, #13, #15) for record review including errors with narcotic pain relievers (#3, #8, #15), antibiotics for infection (#4, #13), medications for breathing problems (#4), narcotics used to treat anxiety and agitation (#1, #2, #3), an antipsychotic (#2), a steroid to treat inflammation (#4) and an eye drop for glaucoma (#2). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)]

5. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 4 of 7 residents sampled (#2, #3, #8, #15) including three residents receiving pain medications (#3, #8, #15) and two residents receiving medications for anxiety and agitation (#2, #3). [Refer to Tag D392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)]

6. Based on observations, interviews, and record reviews, the facility failed to assure 4 of 4 sampled residents (#1, #3, #14, #15) with injuries of an unknown origin had an initial and 5 day report completed and sent to the Health Care Personnel Registry. [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]

7. Based on observations, record reviews, and

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interviews, the facility failed to assure residents were treated with respect, dignity, consideration, and right to privacy as related to staff failing to knock on a resident's door before entering (#22); failing to close the bathroom door while toileting a resident (#21); obtaining a urine sample without explanation to the resident (#22); and failed to maintain privacy for residents as related to uninvited residents (#1, #6) entering other residents' rooms. [Refer to Tag D911 G.S. 131D-21(1) Declaration of Resident Rights (Type B Violation)]

8. Based on observations, interviews and record reviews, the facility failed to assure residents were protected from harm and injury from residents with known aggressive behaviors resulting in Resident #7 sustaining a subdural hematoma following an assault by another resident and a hip fracture after being pushed out of the bed by a second resident; failed to protect one resident diagnosed with dementia (#16) from sexual exploitation by a resident with known sexually aggressive behaviors; and mistreatment by staff (#2); and neglected the safety needs of Resident #10 who had a history of violent behavior associated with falls and injuries, was found by a family member on the floor in the hallway during the lunch meal sustaining a pelvic fracture and died one week later. [Refer to Tag D914 G.S. 131D-21(4) Declaration of Resident Rights (Type A1 Violation)]

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The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing supervision, health care, medication administration, residents' rights, controlled substances and health care personnel registry. The Administrator's failure to assure

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responsibility resulted in serious physical injuries including a subdural hematoma and hip fracture for Resident #7, head laceration requiring staples/sutures for Resident #8 and Resident #14, traumatic head injury for Resident #13, closed head injury with a facial contusion for Resident #9, wrist sprains for Resident #8 and Resident #18, and four residents having unreported facial, arm and body bruising of an unknown origin (#1, #3, #14, #15); absent and delayed health care referrals including not being sent for emergency room (ER) evaluation and treatment as ordered by the primary care provider (PCP) and a 17 delay in treatment for a urinary tract infection for Resident #1, a five day delay in treatment for a shoulder fracture and ER evaluation and treatment for cold symptoms not reported to the PCP for Resident #4; three hospice residents experiencing severe pain as a result of not receiving narcotic pain relievers (#3, #8, #15); an inaccurate accounting of controlled substance logs for 4 residents (#2, #3, #8, #15); and feelings of anger and worthlessness for Resident #22 who was toileted without regard to privacy. The Administrator's failure to assure responsibility for implementation of rules and regulations governing assisted living facilities resulted in serious physical harm, abuse and neglect which constitutes a Type A1 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/09/18 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 9, 2018.

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Telephone interview with the HN on 11/09/18 at 8:51am revealed:
-Falls should not have been an issue for Resident #14 because the resident was non-ambulatory and required two staff to assist with transfers.
-He had a concern with facial injuries of residents at the facility.
-It was odd that Resident #14 had a fall mat and ended up with a laceration on her forehead.

Based on observations, interviews and record reviews, it was determined Resident #14 was not available for interview.

Telephone interview with Resident #14's PCP on 11/09/18 at 10:24am revealed:
-She was confused as to how Resident #14 fell onto a floor mat and sustained such horrible head injuries.
-It was the HN that had informed the PCP that Resident #14 got up and tripped over the fall mat.
-She had spoken with several PCAs, the Assistant Care Manager (ACM) in training and the Special Care Manager (SCM) about removing the fall mat on 08/16/18, 08/20/18, 08/27/18 and 09/03/18.
-She heard one PCA say she was not removing the mat following the 08/20/18 visit with with Resident #14.
-The PCP did not remember the name of the PCA.

Interview with the Executive Director (ED) on 11/09/18 at 10:48am revealed:

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-Safety interventions to reduce the frequency and severity of Resident #14's injuries included hospice services, a low bed, and a bed and chair alarm.
-Because Resident #14 had a low bed, the resident would roll onto the floor mat.
-Resident #14 would try to get up from her wheelchair unassisted.
-She could not recall Resident #14 sustaining a forehead laceration requiring sutures from a fall onto a floor mat on 08/16/18.
-She was not aware the fall mat had been discontinued.
-She was not aware of an order for a concave mattress.

b. Review of Resident #13's current FL-2 dated 10/25/17 revealed diagnoses included Alzheimer's dementia, type II diabetes mellitus, anemia and stage III chronic kidney disease.

Review of Resident #13's current care plan dated 02/21/18 revealed:
-Resident #13 was ambulatory without assistance or device.
-Resident #13 was incontinent of bladder and had occasional bowel incontinence.
-Resident #13 required limited assistance with bathing, dressing and toileting.
-Resident #13 was independent with ambulation.

Review of a charting note for Resident #13 dated 04/04/18 at 8:16pm revealed the resident had complained of knee and leg pain for two days and an x-ray was ordered by the primary care provider (PCP).

Review of a charting note for Resident #13 dated 04/11/18 at 7:40am revealed Resident #13 was sent to the emergency room (ER) for an apparent

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fall and vomiting.

Attempted interview on 11/08/18 at 8:01pm, with the medication aide (MA) who documented the charting note dated 04/11/18 at 7:40am, was unsuccessful.

Review of an Accident /Incident Report for Resident #13 dated 04/11/18 at 6:02am revealed:
-Resident #13 was observed on the floor of his room.
-Resident #13 was aggressive and complained of back pain.

Review of a charting note for Resident #13 dated 06/16/18 at 12:18pm revealed Resident #13 was not feeling good and had a knot on the center of his head due to a fall on 06/15/18.

The MA who documented the charting note dated 06/16/18 at 12:18pm declined interview on 11/09/18 at 3:00pm.

Review of a charting note for Resident #13 dated 06/18/18 at 12:45pm revealed:
-The Executive Director (ED) documented a late entry that Resident #13 went to the ER after a fall due to a head injury and was picked up from the ER on 06/15/18 at 7:24pm.
-There were no safety interventions documented for Resident #13.

Review of an Accident /Incident Report for Resident #13 dated 06/15/18 at 5:25pm revealed:
-Resident #13 fell in his room and hit his forehead.
-Resident #13 was alone at the time of the fall.

The MA who completed the Accident/Incident Report for Resident #13 dated 06/15/18 at

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5:25pm was not available for interview on 11/09/18.

Review of an ER Encounter form for Resident #13 dated 06/15/18 revealed:
-Resident #13 presented to the ER after a fall.
-Facility staff reported Resident #13 was walking, stumbled and fell into a wall.
-Resident #13 complained of left shoulder pain.
-Resident #13 did not remember the fall.
-Resident #13 sustained a 1.5 centimeter (cm) laceration to his left forehead and a 1cm laceration to his left eyebrow.
-Both lacerations were repaired with medical glue.

Review of an Accident /Incident Report for Resident #13 dated 07/17/18 at 12:20am revealed:
-Resident #13 was observed on the floor.
-Resident #13 complained of pain around his stomach and had bleeding around his right arm.

The MA who completed the Accident/Incident Report for Resident #13 dated 07/17/18 at 12:20am was not available for interview on 11/09/18.

Review of an ER Encounter form for Resident #13 dated 07/17/18 revealed Resident #13 was seen in the ER for an unwitnessed fall and had a right elbow skin tear.

Review of a charting note for Resident #13 dated 08/01/18 at 1:00pm revealed staff had received orders from the PCP for physical and occupational therapy and a raised toilet seat for safe toileting.

Review of an Accident /Incident Report for

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Resident #13 dated 08/24/18 at 10:00pm revealed:
-Resident #13 was observed on the floor of his room on his right side.
-Resident #13 did not have an injury documented.

Review of a charting note for Resident #13 dated 08/24/18 at 10:31pm revealed Resident #13 was sent to the ER following a fall for altered mental status.

Attempted interview on 10/30/18 at 3:50pm, with the MA who documented the charting note dated 08/24/18 at 10:31pm, was unsuccessful.

Review of an ER Encounter form for Resident #13 dated 08/24/18 revealed Resident #13 was seen in the ER for increased confusion and a swollen lower left lip.

Review of an Accident /Incident Report for Resident #13 dated 09/01/18 at 10:30pm revealed:
-Resident #13 was found lying on the floor.
-Resident #13 reported hitting his head and there was a knot.

Review of a charting note for Resident #13 dated 09/01/18 at 10:58pm revealed Resident #13 was sent to the ER for a fall from a standing position and having a knot on the back of his head.

The MA who documented the charting note dated 09/01/18 at 10:58pm was not available for interview on 11/09/18.

Review of an ER Encounter form for Resident #13 dated 09/01/18 revealed Resident #13 was seen in the ER for a fall from a standing position and a raised area to the posterior head.

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Review of a 72 Hour Follow Up on Resident Fall forms for Resident #13 dated 09/01/18 through 09/04/18 revealed there was no post fall monitoring documentation for 9 of 15 shifts.

Review of a charting note for Resident #13 dated 09/14/18 at 10:42pm revealed:
-Resident #13 was found on the floor.
-Resident #13 did not have any bruises or skin tears.
-Resident #13 got back in the bed.
-There were no safety interventions documented for Resident #13.

The MA who documented the charting note dated 09/14/18 at 10:42pm, was not available for interview on 11/09/18.

Review of a charting note for Resident #13 dated 09/15/18 at 3:57am revealed:
-Resident #13 slid onto the floor from his wheelchair.
-Resident #13 did not have any visible injuries or complaints of pain.
-There were no safety interventions documented for Resident #13.

Attempted interview on 11/08/18 at 8:01pm, with the MA who documented the charting dated 09/15/18 at 3:57am, was unsuccessful.

Review of a charting note for Resident #13 dated 09/22/18 at 2:27pm revealed:
-Resident #13 was found lying on the floor between the bathroom and the (resident's) room.
-Staff assisted Resident #13 with getting up and noted bleeding from the residents left elbow.
-There were no safety interventions documented for Resident #13.

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The MA who documented the charting note dated 09/22/18 at 2:27pm, was not available for interview on 11/09/18.

Review of a 72 Hour Follow Up on Resident Fall forms for Resident #13 dated 09/22/18 through 09/24/18 revealed there was no post fall monitoring documentation for 4 of 9 shifts.

Review of an Accident /Incident Report for Resident #13 dated 09/24/18 at 10:55pm revealed:
-Resident #13 fell in his room.
-Resident #13 had skin tears and swelling to his left elbow and right knee.

The MA who completed the accident/incident report dated 09/24/18 at 10:55pm, was not available for interview on 11/09/18.

Review of a charting note for Resident #13 dated 09/25/18 at 3:07am revealed Resident #13 fell and was sent to the ER.

The MA who documented the charting note dated 09/25/18 at 3:07am, was not available for interview on 11/09/18.

Upon request on 11/07/18, the ER discharge information for Resident #13 dated 09/25/18 was not available for review.

Review of a 72 Hour Follow Up on Resident Fall forms for Resident #13 dated 09/27/18 through 09/30/18 revealed:
-There was no post fall monitoring documentation for 5 of 9 shifts.
-There was partial documentation for an additional 3 of 9 shifts.

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Review of a charting note for Resident #13 dated 10/14/18 at 6:53pm revealed:
-Resident #13 was observed lying on the floor on his left side.
-Resident #13 did not have any bruises or abrasions.
-Resident #13 had a skin tear on his right elbow.
-There were no safety interventions documented for Resident #13.

The MA who documented the charting note dated 10/14/18 at 6:53pm, was not available for interview 11/07/18 and 11/09/18.

Review of a 72 Hour Follow Up on Resident Fall forms for Resident #13 dated 10/14/18 through 10/17/18 revealed there was no post fall monitoring documentation for 5 of 9 shifts.

Interview with Resident #13's primary care provider (PCP) on 11/06/18 at 12:40pm revealed:
-Resident #13 was noncompliant with allowing staff to assist him.
-"The main thing with (Resident #13) was ...falls."
-Resident #13 repeatedly refused physical and occupational therapy for fall prevention.

Based on observations, interviews and record reviews, it was determined Resident #13 was not interviewable.

Interview with the ED on 11/09/18 at 10:48am revealed:
-She was aware Resident #13 had 10 falls between April and October 2018.
-Prior to Resident #13 being discharged on 11/02/18, fall prevention interventions for Resident #13 included a night light in the bathroom, the resident's room was rearranged for

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a clear path to the door and bathroom and clutter was removed from the resident's room.
-She had not considered moving Resident #13's room from the end of the 200 hall closer to the front desk.
-Resident #13 was ambulatory most of the time and used a wheelchair once in a while.
-Resident #13 did not have a fall mat or a chair alarm.
-Resident #13 was not on increased supervision.

c. Review of Resident #9's FL-2 dated 08/16/18 revealed:
- Diagnoses included dementia, Parkinson disease, altered mental status, and anxiety.
-The resident was constantly disoriented, non-ambulatory and required the use of a wheelchair to ambulate.

Review of Resident #9's care plan dated 02/23/18 revealed:
-The resident was fully dependent upon staff for transfers to/from bed and to/from chair.
-The resident required extensive assistance with ambulation.

Review of staff notes revealed Resident #9 was discharged to an inpatient psychiatric facility on 08/30/18.

Review of an Accident/Injury report for Resident #9 dated 06/21/18 at 6:57pm revealed:
-Staff reported Resident #9 had a skin tear on her left leg which was "bleeding really bad".
-The resident was transported to the local emergency room (ER) for evaluation by emergency medical service (EMS).

Review of an emergency room (ER) report for Resident #9, dated 06/21/18 revealed:

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-Resident #9 presented status post accidental fall with skin injury.
-The resident hit her left leg against her wheelchair, sustained a skin tear to the left anterior shin region. X-rays of the left tibia and fibula revealed no acute abnormality.

Review of an Accident/Injury report for Resident #9 dated 07/12/18 at 1:45pm revealed:
-Staff observed Resident #9 lying on the floor on her right side.
-The resident sustained skin tears on both arms and was transported to the local ER by EMS.

Review of an ER report for Resident #9 dated 07/12/18 revealed:
- Resident #9 was transported to the ER via EMS after falling forward out of her wheelchair.
-There was no report of loss of consciousness.
-The resident had a hematoma and abrasion just above the right ear.
- Computed Tomography (CT) scans of the resident's head and spine revealed no acute abnormalities and the resident was discharged back to the facility.

Review of an Accident/Injury report for Resident #9 dated 07/25/18 at 7:00am revealed:
-Resident #9 fell out of her wheelchair and hit her head on the floor.
-The resident was transported to the local ER and was diagnosed with a closed head injury and contusion on her face.

Review of an ER report for Resident #9 dated 07/25/18 revealed:
-Resident #9 was transported to the ER after falling out of her wheelchair. The resident hit her head.
-The resident complained of pain to the left lower

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leg and had a large superficial skin tear to the lateral portion of the lower leg. The resident had right frontal scalp swelling.
-The CT scan of head revealed acute intracranial abnormality. The CT scan of spine revealed no fracture or acute abnormality.
-The resident was diagnosed with a closed head injury and facial contusions and discharged back to the facility.

Review of an Accident/Injury report for Resident #9 dated 08/02/18 at 6:25pm revealed:
-Staff was taking Resident #9 to her room and the resident put her foot down and fell out of the wheelchair.
-The resident sustained a skin tear on her left lower leg and was transported to the ER by EMS.

Review of an ER report for Resident #9 dated 08/02/18 revealed:
-Resident #9 fell out of a wheelchair which was being pushed by a staff.
-The resident injured her left lower leg. X-rays of the left tibia and fibula were negative for fracture.
-Wound care was provided for the skin tears and the resident was discharged back to the facility.

Interview with Resident #9's family member on 11/05/18 at 1:15pm revealed:
-The resident was admitted to the facility last November 2017 and was transferred to an inpatient psychiatric hospital around the end of August 2018. The resident developed a urinary tract infection and expired on 09/23/18.
-Resident #9 was confused, non-ambulatory and required assistance with transfers and personal care.
-The resident sustained multiple falls and the facility staff called the family regarding the resident's falls/incidents.

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-The resident sustained a fall from a wheelchair on 06/21/18 and was transported to the ER.
-On 07/12/18, the family member came to the facility and found the resident on the floor, in her room. The resident sustained a hematoma on her scalp.
-On 07/25/18, the resident fell out of the wheelchair and hit her head again. The facility staff never explained what happened.
-On 08/02/18, the resident fell out of the wheelchair again while the staff was pushing the chair.
-The family member was concerned about the resident's care and supervision. The staff were not watching the resident close enough and she was falling too much. Another family member was afraid if the resident was not moved from the facility, she was going to die from the multiple falls.
-The facility did not have enough staff and every time the family member visited the facility, she was told by staff they were "short-staffed".
-There were many times when the family member was visiting the resident, she could not find a PCA. On a Sunday, about 2-3 months ago, the supervisor was looking for the PCA and she was in another resident's room asleep.
-The family member talked to the Executive Director (ED) about the falls but nothing ever changed.
-It was difficult looking at her injuries from the falls and the family member could only pray for the resident.

Interview with Resident #9's primary care provider (PCP) on 11/06/18 at 12:40pm revealed:
-Resident #9 had multiple fall and always had skin tears and bruises. The staff called "all the time" to report incidents which included falls and injuries.

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-The resident attempted to get out of her wheelchair without assistance and sustained falls.
-The staff should have kept her up front (near the living room) to keep a constant eye on her.
-She did not know how often the staff checked on the resident.

Interview with the Special Care Manager (SCM) on 11/07/18 at 2:30pm revealed:
-She was aware of Resident #9's multiple falls.
-Residents who sustained falls were placed on 15 - 30 minutes supervision checks for 72 hours after the first fall which would have been on 06/21/18.
-A fall risk assessment should have been completed after the first fall on 6/21/18, but was not in the the Resident #9's records.
-She did not know if Resident #9 was placed on 15 - 30 minutes checks or if any change in supervision was put in place after each fall since there was no documentation of interventions and the resident was discharged.

Interview with the ED on 11/07/18 at 3:18pm revealed:
-She was aware Resident #9 sustained multiple falls with injuries.
-The staff increased monitoring/supervision of the resident after the first fall in June 2018, but there was no documentation of efforts to decrease falls.
-The resident was placed in the commons area, and went to activities and a chair alarm was placed on her wheelchair.

Review of Resident #9's PCP orders revealed there was no order for use of chair alarm for Resident #9.

d. Review of Resident #18's current FL-2 dated 06/04/18 revealed:

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-Diagnoses included vascular dementia, anemia, spinal stenosis, hypertension, osteoarthritis, hypothyroidism, and left rotator cuff syndrome.
-The resident was intermittently disoriented and wandered.
-The resident was incontinent of bowel and bladder.
-The resident required assistance with bathing and dressing.

Review of Resident #18's most current assessment and care plan dated 02/14/17 revealed:
-The resident wandered and resisted care at times.
-It sometimes took multiple attempts by staff to get the resident to let the staff help her with activities of daily living.
-The resident was ambulatory with a rollator walker.
-The resident had limited range of motion in her upper extremities.
-The resident had occasional incontinence of bowel and daily incontinence of bladder.
-The resident was sometimes disoriented, had significant memory loss, and must be redirected.
-The resident's assistive device requirements included shower chair, hand held shower, and rollator walker.
-The resident required extensive assistance with bathing, grooming, dressing, and toileting.
-The resident required limited assistance with transferring and supervision with ambulation.

Review of Resident #18's accident/injury reports, charting notes, and hospital records revealed:
-The resident had 8 falls from 02/28/18 - 10/27/18.
-The resident went to the emergency room (ER) for evaluation of injuries for 7 of the 8 falls.

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-The resident's injuries included sprain of left wrist; lower back pain; right elbow pain with skin tear; mouth and right shoulder pain; small hematoma to left face; left knee and leg pain, swelling, and discoloration; pain in head, neck, and left shoulder; and right shoulder and leg pain.

Review of Resident #18's accident/injury report dated 02/28/18 at 6:20am revealed:
-The resident was observed sitting on the floor of the bedroom.
-The resident had a skin tear and swelling to the left hand.
-The resident had some pain in the left shoulder, forearm, and hand.
-The resident was taken to the ER.
-The resident had a sprained left wrist.

Review of Resident #18's hospital ER notes dated 02/28/18 revealed:
-The chief complaint was a fall.
-The resident reported she had gotten up to use the bathroom and slipped and fell.
-The resident complained of pain in her left shoulder and forearm.
-The resident had mild swelling over the left forearm.
-The resident was diagnosed with a sprain of the left wrist.

Review of Resident #18's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 02/28/18.

Review of Resident #18's accident/injury report dated 04/13/18 at 4:45pm revealed:
-The resident was walking down the hall and fell.
-The resident was "complaining with her left knee and lower back".
-The resident was sent to the ER and an x-ray of

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her pelvis was normal.

Review of Resident #18's hospital ER notes dated 04/13/18 revealed:
-The chief complaint was a mechanical fall with lower back pain.
-A pelvic x-ray was negative.

Review of Resident #18's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 04/13/18.

Interview with the medication aide (MA) who signed the 04/13/18 accident/injury report on 11/05/18 at 4:58pm revealed:
-Resident #18 had falls but the MA could not recall specific details of all of the resident's falls.
-Resident #18 had a fall "the other week".
-The resident claimed she got dizzy.
-The resident also fell one night (could not recall date) and hit her face on her walker and had a laceration and was sent to the ER.
-She thought the resident had a new order for physical therapy/occupation therapy (PT/OT) recently but she could not recall the date or if it had been started yet.
-She did not know why the 72 hour forms were not done or incomplete for some of Resident #18's falls.
-Resident #18 was on routine 30 minute checks, the same as all residents.
-She was not aware of any increased supervision for Resident #18 after any falls.

Review of Resident #18's accident/injury report dated 05/02/18 at 1:15pm revealed:
-The resident was walking and tripped over her feet.
-The resident had a skin tear on her right elbow.
-The resident was taken to the ER and an x-ray of

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her right humerus was done.

Attempted interviews with the MA who wrote and signed the 05/02/18 accident/injury report on 11/07/18 at 2:10pm and 11/09/18 at 3:00pm were unsuccessful.

Review of Resident #18's hospital ER notes dated 05/02/18 revealed:
-The chief complaint was a fall.
-The resident presented with right elbow pain with laceration.
-The resident was diagnosed with a skin tear of the right elbow.

Review of Resident #18's 72 hour fall follow-up report dated 05/02/18 revealed:
-The resident fell on first shift on 05/02/18 but the location of the fall was blank.
-Section B for assessing the resident was blank including questions related to the resident's vital signs, if the resident was wearing proper shoes or using an assistive device.
-The section for vital signs each shift, bruising, increased difficulty in walking, soreness around injured area, behavior change, or needed pain medication was blank for third shift on 05/02/18, 05/03/18 and 05/04/18.

Review of Resident #18's charting note dated 05/12/18 at 10:27am revealed:
-The Assistant Care Manager (ACM) in training noted the resident was walking and stumbled and fell on her right side.
-The resident had a skin tear on her right elbow and ointment and a bandage was put on the skin tear.
-The primary care provider (PCP) and family were notified.

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Review of Resident #18's accident/injury reports revealed there was no report completed for the resident's fall on 05/12/18.

The ACM in training was unavailable for interview from 11/07/18 - 11/09/18.

Review of a physician notification form for Resident #18 dated 05/12/18 revealed:
-The resident was walking and stumbled and fell on her right side.
-The resident did not hit her head but had a skin tear on the right elbow.
-The resident was not sent to the hospital.
-The PCP signed the note on 05/14/18 with no orders or comments.

Review of Resident #18's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 05/12/18.

Review of Resident #18's accident/injury report dated 07/04/18 at 6:30pm revealed:
-The ACM in training noted the resident tripped and fell.
-The resident had a laceration to her face and was sent to the ER.

The ACM in training was unavailable for interview from 11/07/18 - 11/09/18.

Review of Resident #18's hospital ER notes dated 07/04/18 revealed:
-The chief complaint was a fall.
-The resident fell from a standing position into her walker.
-The resident complained of mouth and right shoulder pain.
-The resident said she felt she was unable to get up.

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D9999	Continued From page 415 -The resident's "downtime was unknown". -The resident complained of bilateral shoulder pain and had a small hematoma (collection of blood outside of the blood vessel) to her left face. -The resident was diagnosed with acute cystitis (inflammation of the bladder usually caused by infection) with hematuria (blood in the urine). Review of Resident #18's 72 hour fall follow-up report dated 07/04/18 revealed: -The resident fell on second shift on 07/04/18 but the location of the fall was blank. -Section B for assessing the resident after the fall was blank. -On first shift on 07/05/18 and 07/06/18 and third shift on 07/06/18, staff documented "yes" to bruising and soreness around the injured area and to the resident receiving pain medication (Tylenol). -The physician was to be notified if "yes" was answered to any of the questions but there was no documentation the physician was notified. Review of Resident #18's accident/injury report dated 07/08/18 at 4:00pm revealed: -The resident had bruising and swelling to left lower extremity. -Per physician's orders, the resident was sent to the ER. Review of Resident #18's hospital ER notes dated 07/08/18 revealed: -The chief complaint was leg injury. -The resident complained of left knee and leg pain with swelling and discoloration. -The resident had traumatic bruising of multiple sites of the left lower extremity. -The resident reportedly had a mechanical fall a couple of days ago. -The resident also had left hand ring finger	D9999		

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swelling and bruising.
-Over the last 2 days, the resident had developed swelling and bruising to her left knee with several blisters overlaying the bruising.

Review of Resident #18's PCP visit notes dated 07/11/18 revealed:
-The resident was seen for a follow up to a recent ER visit.
-The resident fell on 07/04/18 and was sent to the ER and returned to the facility the same day.
-On 07/08/18, a staff sent a picture of Resident #18's left knee with a very large contusion, purple in color.
-An order was faxed to the facility on 07/08/18 to send the resident back to the ER for evaluation and treatment.

Review of Resident #18's PCP visit notes dated 07/23/18 revealed:
-The resident was being seen at the request of facility staff who report the resident may benefit from PT/OT services.
-The resident reportedly had several falls over the past few weeks.
-The resident had generalized weakness which was progressively worsening and contributing to the falls.
-The resident was able to follow basic instructions and was willing to participate in therapy services if determined to be a candidate.
-The PCP ordered PT/OT to evaluate and treat.

Review of Resident #18's interdisciplinary notes revealed the resident received PT from 07/23/18 - 08/24/18 and OT from 07/30/18 - 08/23/18.

Review of Resident #18's quarterly profile and care plan update form dated 08/27/18 revealed:
-The resident was independent with transferring

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and ambulation.
-The resident was dependent with toileting.
-The resident required supervision with bathing and dressing.
-There was no documentation related to a plan of care for the resident's falls.
-There was no documentation of any interventions, including any additional supervision needed, related to the resident's falls.

Review of Resident #18's charting note dated 10/25/18 revealed the resident had 2 falls today and was sent to the ER both times.

Review of Resident #18's accident/injury report dated 10/25/18 at 5:30am revealed:
-The resident complained of severe head pain.
-The resident was sent to the ER and head and spine scans were negative.

Attempted interview with a personal care aide (PCA) listed on the 10/25/18 accident/injury report on 11/06/18 at 5:30am was unsuccessful.

Attempted interview with a MA who signed the 10/25/18 accident/injury report on 11/09/18 at 3:20pm was unsuccessful.

Review of Resident #18's hospital ER notes dated 10/25/18 at 6:30am revealed:
-The chief complaint was a fall.
-The resident complained of pain in the back of the head, neck pain on palpation, and left shoulder pain.

Observation on 10/25/18 from 1:00pm to 1:23pm revealed:
-A loud noise was heard on the 100 hall at approximately 1:00pm.
-Resident #18 was observed lying on her back in

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the hallway with her rolling walker beside her.
-Facility staff went to the resident to check on her.
-The MA checked the resident's vital signs.
-The resident told staff that she got dizzy, turned her ankle and lost her balance.
-The resident complained of her head hurting and said she felt a knot on the back of her head.
-The resident complained her left elbow hurt and she could not move it.
-Staff said 911 had been called and the resident was going to be sent to the ER.
-Emergency Medical Services (EMS) arrived at 1:16pm and the resident told them her head hit the wall.
-EMS left with the resident to go to the local ER at 1:23pm.

Interview with a second MA on 10/25/18 at 1:30pm revealed:
-When the MA arrived to work that morning around 6:15am, EMS was at the facility picking up Resident #18 because she fell in her room.
-The resident complained of head pain.
-Scans of Resident #18's neck and shoulder were negative.
-The resident returned to the facility about 8:30am that morning on 10/25/18.
-The fall at 1:00pm was Resident #18's second fall that day.
-She took the resident's vital signs after the second fall and EMS took the resident to the ER for the second time today.
-The resident used a rolling walker and had falls before but not two falls in one day.

Interview with a PCA on 10/25/18 at 4:10pm revealed:
-She was in a resident's room on 100 hall earlier that afternoon and heard a noise in the hallway.
-When she came out of the room into the hallway,

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D9999	Continued From page 419 she saw Resident #18 lying on the floor. -She did not see the resident fall. -The resident said she lost her balance. Review of Resident #18's accident/injury report dated 10/25/18 at 1:00pm revealed: -The resident fell from a standing position. -Staff documented no injury was present but the resident was sent to the ER. Review of Resident #18's hospital ER notes dated 10/25/18 at 1:43pm revealed: -The chief complaint was a fall with chronic right shoulder pain and right leg pain. -The resident was seen in the ER for another fall this morning. -The resident had dementia and sometimes tried to ambulate without her walker. -The resident should ambulate with assistance or a wheelchair. -The resident was a very high risk for fall. Review of Resident #18's 72 hour falls follow-up report dated 10/25/18 revealed: -The resident fell in hallway on first shift on 10/25/18. -The section for vital signs each shift, bruising, increased difficulty in walking, soreness around injured area, behavior change, or needed pain medication was blank for second shift on 10/25/18. -It was incomplete for third shift on 10/25/18, second and third shift on 10/26/18, and second shift on 10/27/18. -Staff noted on third shift on 10/27/18, the resident had increased difficulty in walking and had another fall in bedroom and went to the ER. Review of Resident #18's accident/injury reports revealed there was no report completed for the	D9999		

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resident's fall on 10/27/18.

Review of Resident #18's hospital ER notes dated 10/27/18 revealed:
-The chief complaint was a fall.
-The resident was using a walker and fell to her knees.
-The resident was complaining of low back pain.

Review of Resident #18's 72 hour falls follow-up report dated 10/27/18 revealed:
-The resident fell on second shift on 10/27/18 but location of fall was blank.
-Section B for assessing the resident after the fall was blank.
-The section for vital signs each shift, bruising, increased difficulty in walking, soreness around injured area, behavior change, or needed pain medication was blank for second shift on 10/28/18 and third shift on 10/29/18.-It was incomplete for second and third shift on 10/27/18, third shift on 10/28/18, and first shift on 10/29/18.

Review of Resident #18's PCP visit notes dated 10/29/18 revealed:
-The resident was seen for follow-up on three falls and three ER visits.
-The resident fell twice on 10/25/18 and again on 10/27/18.
-The resident was observed ambulating the hallways with her rolling walker today and her gait was steady.
-The resident was unable to explain what led up to the three recent falls.
-The PCP ordered PT/OT to evaluate and treat.

Interview with the Special Care Coordinator (SCC) on 11/09/18 at 5:15pm revealed:
-Resident #18 had an order (dated 10/29/18) for PT/OT evaluation.

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-PT/OT was scheduled to come to the facility next week to evaluate the resident.

Review of an updated assessment and care plan for Resident #18 dated 10/25/18 and signed by the PCP on 11/07/18 revealed:
-The resident wandered.
-The resident had no problems with ambulation and used a rollator walker.
-The resident had no problems with her upper extremities.
-The resident had occasional incontinence of bowel and daily incontinence of bladder.
-The resident was sometimes disoriented, forgetful, and needed reminders.
-The resident' risk management provisions included "falls precautions".
-Listed under falls precautions was assistive device requirements which included "transfers with a rollator walker".
-The resident required extensive assistance with bathing, grooming, dressing, and toileting.
-The resident required limited assistance with transferring and supervision with ambulation.

Interview with a third MA on 11/07/18 at 5:00pm revealed:
-Resident #18 would lose her balance and drag her feet.
-She thought the resident had PT in the past.
-She was not aware of any interventions other than PT for Resident #18's falls.
-The resident was on routine 30 minute checks.
-Resident #18's supervision had not been increased after any falls.

Interview with a second PCA on 11/09/18 at 5:12pm revealed:
-Resident #18 fell frequently.
-The resident's legs would get "wobbly" and she

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would lose her balance.
-All residents, including Resident #18 were on routine 30 minute checks.
-There was no increased supervision related to Resident #18's falls to her knowledge.

Based on observations, interviews, and record reviews, it was determined Resident #18 was not interviewable.

Telephone interview with Resident #18's family member on 11/09/18 at 4:50pm revealed:
-The resident had bilateral knee replacements in the past and was at high risk for falls.
-Resident #18 had some falls and facility staff made her aware of the falls.
-The facility staff usually sent Resident #18 to the hospital each time she fell because the resident usually complained that she was hurt.
-The facility staff had mentioned getting the resident a wheelchair but she did not know if they had gotten one yet.
-She thought the resident had PT/OT in the past.
-She thought it would help decrease Resident #18's falls if facility staff would increase supervision of the resident.

Interview with Resident #18's PCP on 11/05/18 at 11:32am revealed:
-She was aware Resident #18 had falls but she was not sure if she was aware of all of the falls.
-Resident #18 had bruising from her falls.
-She ordered a PT/OT evaluation in July 2018 that was completed.
-She was not aware of any interventions the facility had put in place for the resident's falls.
-The facility should provide interventions such as making sure the resident was wearing appropriate shoes, using the rollator walker appropriately, and increasing supervision of the

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resident.

Interviews with the SCC on 11/06/18 at 9:27am and 9:42am revealed:
-They had provided all of the 72 hour fall reports for Resident #18 that could be located.
-There were some 'holes and gaps" in the documentation on the 72 hour fall reports for Resident #18 but they should be complete.
-She did not know why staff was not completing the reports.

Interview with the Executive Director (ED) on 11/09/18 at 1:45pm revealed:
-She was not aware of any interventions for Resident #18's falls except for PT/OT that was done a few months ago.
-Resident #18 was on the same routine 30 minute checks as the other residents.
-Resident #18's supervision had not been increased after any of her falls.
-She could not say how many falls or what would trigger increased supervision for a resident with falls but it was "based on the individual".
-Resident #18 was very independent and strong-minded.
-Resident #18 was in the activity room or sitting near the nurses' station frequently.
-Staff would supervise the resident while she was in these common areas but it was not documented.

Interview with the SCC on 11/09/18 at 5:15pm revealed:
-Resident #18 had several falls.
-They started 15 minutes checks on Resident #18 today (11/09/18) because of her falls.
-Prior to today, Resident #18 was on routine monitoring every 30 minutes.
-She did not know why supervision of the resident

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was not increased until 11/09/18.

e. Review of Resident #8's current FL-2 dated 04/10/18 revealed:
-Diagnoses included Alzheimer's disease, type 2 diabetes, chronic kidney disease, hyperlipidemia, and idiopathic gout.
-The resident was constantly disoriented.
-The resident was ambulatory and required assistance with bathing.
-The resident was incontinent of bowel and bladder.

Review of Resident #8's Resident Register revealed:
-The resident was admitted to the facility on 04/18/18.
-The resident required assistance for bathing, dressing, nail care, shaving, toileting, mouth care, scheduling appointments, and orientation to time and place.
-The resident was forgetful and needed reminders.

Review of a hospice visit note revealed Resident #8 expired on 10/04/18.

Review of Resident #8's most current assessment and care plan dated 05/11/18 revealed:
-The resident required extensive assistance with bathing, grooming, and dressing.
-The resident required limited assistance with toileting and eating.
-The resident was independent with transferring and ambulation.

Review of Resident #8's accident/injury reports, charting notes, and hospital records revealed:
-The resident had 9 falls from 07/10/18 -

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08/22/18.
-The resident went to the emergency room (ER) for evaluation of injuries for 2 of the 9 falls.
-The resident's injuries included right upper extremity pain, skin tear to right elbow, pink spots on right cheek, left wrist sprain, and staples to laceration on the top of his head.

Review of Resident #8's charting note dated 07/10/18 at 9:59pm revealed:
-The resident fell in the hallway hitting his head on the wall on the way down.
-The hospice nurse was called and came to the facility to check on the resident.
-The hospice nurse said she was going to order the resident a wheelchair and a mattress.

Review of Resident #8's hospice physician order dated 07/10/18 revealed orders for an eggcrate foam mattress pad and wheelchair/wheelchair cushion due to increased immobility.

Review of Resident #8's accident/injury reports revealed there was no report for the fall on 07/10/18.

Review of Resident #8's 72 hour falls follow-up report dated 07/10/18 revealed:
-The resident fell on 07/10/18 but the shift and the location of the fall was blank.
-The section for vital signs each shift, bruising, increased difficulty in walking, soreness around injured area, behavior change, or needed pain medication was blank for third shift on 07/11/18 and 07/12/18.

Review of Resident #8's charting notes dated 07/11/18 at 11:01pm and 07/12/18 at 10:30pm revealed the resident was still unsteady on his feet.

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Review of Resident #8's charting note dated 07/29/18 at 6:40am revealed:
-The resident had a fall in front of the nurses' station.
-The resident was asleep in a chair and got up and lost his balance.
-The resident hit his head on the wall and landed on the floor.
-Hospice was called and they said not to send the resident to the ER and a hospice nurse would be out today to assess him.

Review of Resident #8's accident/injury report dated 07/29/18 at 3:30am revealed:
-The resident lost his balance, hit the wall, and landed on the floor.
-No injuries were present.
-Hospice was called and a hospice nurse was coming today to assess the resident.
-The resident was not sent to the ER.

Attempted interview with the former medication aide (MA) who wrote the charting note and signed the 07/29/18 (3:30am) accident/injury report on 11/08/18 at 7:56pm was unsuccessful.

Review of Resident #8's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 07/29/18 at 3:30am.

Review of Resident #8's second accident/injury report dated 07/29/18 at 3:50pm revealed:
-The resident was observed on the floor on his right side.
-No injuries were present.
-The resident was taken to the ER.

Review of Resident #8's hospital ER notes dated

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07/29/18 revealed:
-The resident was ambulating at the facility when he tripped over his own feet and fell onto his right side.
-It was not known if the resident hit his head.
-The resident did not follow commands and was not speaking at the ER.
-The resident was holding his right upper extremity as though he was in pain at the ER.
-The final diagnosis was fall with right upper extremity pain.

Review of Resident #8's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 07/29/18 at 3:50pm.

Review of Resident #8's primary care provider (PCP) visit notes dated 07/30/18 revealed:
-The resident was seen to follow up on a recent fall and ER visit.
-The resident fell on 07/29/18 while attempting to get out of bed without assistance.
-The resident returned to the facility later that night and hospice nurse also came out to evaluate the resident.

Review of a facility communication note to Resident #8's PCP dated 08/03/18 revealed:
-Facility staff noted the licensed health professional support (LHPS) nurse recommended a falls mat, bed/chair alarm, and low bed for the resident.
-The PCP signed and dated the note on 08/06/18.
-The PCP responded a fall mat was not appropriate as the resident was ambulatory.

Review of Resident #8's charting note dated 08/04/18 at 3:05pm revealed:
-The resident was observed sitting on his

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buttocks on the floor.
-Hospice was contacted and would have a nurse come to the facility to assess the resident.

Review of Resident #8's accident/injury reports revealed there was no report for the fall on 08/04/18.

Review of Resident #8's 72 hour falls follow-up report dated 08/04/18 revealed:
-The resident fell on first shift on 08/04/18 but the location of the fall was blank.
-The section for vital signs each shift, bruising, increased difficulty in walking, soreness around injured area, behavior change, or needed pain medication was blank for first and third shift on 08/04/18, third shift on 08/05/18, and first shift on 08/06/18.

Review of Resident #8's charting note dated 08/08/18 at 10:06am revealed:
-The resident was observed sitting on the floor in his room and there were no apparent injuries.
-The hospice nurse, who was in the facility, was notified.

Review of Resident #8's accident/injury reports revealed there was no report for the fall on 08/08/18.

Review of Resident #8's charting note dated 08/08/18 at 10:25am revealed a bed alarm had been ordered by the hospice nurse for the resident.

Review of Resident #8's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 08/08/18.

Review of Resident #8's charting note dated

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08/14/18 at 3:23pm revealed:
-The resident stood up out of his wheelchair and fell down on his right side.
-The resident had a skin tear on his right elbow.
-The hospice nurse was notified.

Review of Resident #8's accident/injury reports revealed there was no report for the fall on 08/14/18.

Review of Resident #8's 72 hour falls follow-up report dated 08/14/18 revealed:
-The resident fell on first shift on 08/14/18 but the location was blank.
-The section for vital signs each shift, bruising, increased difficulty in walking, soreness around injured area, behavior change, or needed pain medication was blank for third shift on 08/15/18 and second shift on 08/16/18.

Review of Resident #8's charting note dated 08/19/18 at 10:45pm revealed:
-The resident was seen coming out of a room stumbling and fell on his right side.
-The resident had a laceration on his right cheek and some small lacerations on his right arm.
-The hospice nurse was notified.

Interview with the MA who wrote the 08/19/18 charting note on 11/07/18 at 5:00pm revealed:
-Resident #8's condition was "back and forth", sometimes he was up walking around and sometimes he was bedbound.
-Resident #8 would fall because he would try to get up and walk by himself.
-She remembered calling hospice one time when the resident fell and had to get staples in his head (could not recall specific date).
-Resident #8 was on routine 30 minute checks, the same for all residents.

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D9999	Continued From page 430 -Supervision of Resident #8 was not increased after his falls; he remained on routine 30 minute checks. Review of Resident #8's accident/injury reports revealed there was no report for the fall on 08/19/18. Review of a hospice visit note dated 08/19/18 revealed: -The nurse made a visit due to a fall. -Initially staff thought the resident had lacerations to right cheek and right arm. -The resident had pink spots to his right cheek but no skin tears. -The resident's right arm had old scabbed over sites but no new skin tears to right arm. Review of Resident #8's 72 hour falls follow-up report dated 08/19/18 revealed: -The resident fell on second shift on 08/19/18. -Section B for assessing the resident was blank other than the initial vital signs. -The section for vital signs each shift, bruising, increased difficulty in walking, soreness around injured area, behavior change, or needed pain medication was blank for all shifts from 08/19/18 - 08/21/18. Review of Resident #8's charting note dated 08/20/18 at 1:28pm revealed the resident's left arm was swollen and the hospice nurse ordered a mobile x-ray. Review of Resident #8's charting note dated 08/21/18 at 1:23am revealed: -The resident "fell on room door in another resident's room". -The resident was observed on the floor with a laceration on top of his head.	D9999		

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-The resident was sent to the ER.
-The PCP, hospice provider, and family were notified.

Attempted interview with the former MA who wrote the charting note dated 08/21/18 on 11/08/18 at 7:56pm was unsuccessful.

Review of Resident #8's accident/injury report dated 08/21/18 at 1:02am revealed:
-The resident was observed by the door on the floor.
-The resident had a laceration on top of his head.
-The resident's head scan and wrist x-ray were negative.
-The resident had 3 staples due to the laceration on his head.
-The resident was to follow-up with the PCP in 7 days.

Attempted interview with a personal care aide (PCA) listed on the accident/injury report dated 08/21/18 on 11/06/18 at 5:30am was unsuccessful.

Attempted interview with the former MA who signed the accident/injury report dated 08/21/18 on 11/08/18 at 7:56pm was unsuccessful.

Review of Resident #8's hospital ER note dated 08/21/18 revealed:
-The chief complaint was a fall.
-The resident fell out of bed and had laceration with minimal bleeding to the back of his head.
-The fall was unwitnessed and it was unknown if there was a loss of consciousness.
-The resident currently reported pain to his left hand and wrist.
-The resident reported left arm pain from a previous fall earlier today.

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-EMS reported the resident had a fall earlier in the day and landed on his left arm.
-The facility reported x-rays were done to the left arm but the results were pending.
-The wound on the back of the head was repaired with staples.
-The final diagnoses were fall with scalp laceration and left wrist sprain.

Review of Resident #8's charting note dated 08/21/18 at 4:39am revealed:
-The resident came back to the facility from the hospital.
-The resident had 3 staples where the laceration was on the back of his head.
-A head scan and an x-ray of his wrist were negative.

Attempted interview with the former MA who wrote the charting note dated 08/21/18 on 11/08/18 at 7:56pm was unsuccessful.

Review of Resident #8's 72 hour fall follow-up report dated 08/21/18 revealed:
-The resident fell on third shift on 08/21/18 but the location was blank.
-The section for vital signs each shift, bruising, increased difficulty in walking, soreness around injured area, behavior change, or needed pain medication was blank for all shifts on 08/22/18 and 08/23/18.

Review of Resident #8's charting note dated 08/22/18 at 4:09pm revealed the resident was observed on the floor in front of the business office and the hospice nurse was notified.

Review of Resident #8's 72 hour falls follow-up reports revealed there was no form documented for monitoring or follow-up for the fall on 08/22/18.

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Review of Resident #8's PCP visit notes dated 08/27/18 revealed:
-The resident was seen to follow up on a recent fall and ER visit.
-The resident fell on 08/21/18 sustaining a laceration to his head which was bleeding heavily.
-The facility staff sent the resident to the ER for evaluation and he returned to the facility with no new orders.
-The hospice nurse visited the resident later that same day and reported the resident complained of severe pain in the left arm.
-An order for an x-ray was given.
-X-rays were done and no fractures were noted.

Review of Resident #8's verbal order from the hospice physician dated 08/28/18 revealed:
-There was an order to discontinue bed alarm and chair alarm.
-There was an order to keep floor mat, keep bed in lowest position, and keep head of bed up at 30 degree angle.

Interviews with the Special Care Coordinator (SCC) on 11/06/18 at 9:27am and 9:42am revealed:
-They had provided all of the 72 hour fall reports for Resident #8 that could be located.
-There were some 'holes and gaps" in the documentation on the 72 hour fall reports for Resident #8 but they should be complete.

Interview with a PCA on 10/31/18 at 1:50pm revealed:
-When Resident #8 first came to the facility, he was mostly independent but required some supervision and limited assistance with activities of daily living (ADLs).
-The resident was receiving hospice services and

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he required total assistance with ADLs and was more confused during the last 3 months of his life.
-The resident had a wheelchair and his feet and legs were swollen.
-The resident had a bed/chair alarm and a fall mat.
-The resident had falls because he would try to get up and walk by himself.
-The resident was on routine 30 minute checks, the same as all residents.
-She was not aware of any increased supervision for Resident #8.

Interview with a MA on 11/05/18 at 4:58pm revealed:
-Resident #8 had some falls and staff would find him on the floor.
-She did not recall the resident having injuries from his falls.
-The resident started using a wheelchair about a month before he passed away.
-The resident had a fall mat and a chair alarm.
-The resident was on routine 30 minute checks.
-She did not recall the resident's supervision being increased after any falls.

Telephone interview with Resident #8's power of attorney (POA) on 11/08/18 at 10:49am revealed:
-Resident #8 was having a lot of falls because he would try to get up on his own.
-She was not sure what interventions were put in place for his falls.

Telephone interview with Resident #8's family member on 11/8/18 at 11:50am revealed:
-She was at the facility with Resident #8 "a lot".
-The resident had a fall mat.
-The family member was aware of the resident having at least two falls.

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-The resident had a sprained wrist and staples in his head because of falls.

Interview with a hospice nurse on 11/01/18 at 4:45pm revealed:
-Resident #8 had history of falls at the facility.
-The resident was "all over the place" in his physical ability.
-One day he would be up walking around and the next day, he would be bedbound.
-She had gotten an order for a fall mat and for the bed to be in the lowest position.

Interview with Resident #8's PCP on 11/05/18 at 11:32am revealed:
-She received a report on 08/20/18 that Resident #8 fell and had severe arm pain.
-She ordered a portable x-ray of the resident's arm and shoulder and there was no fracture.
-The call center was notified the resident was sent to the ER for bleeding on top of his head.
-The facility should have provided interventions such as increased supervision of the resident.

Interview with the Executive Director (ED) on 11/09/18 at 1:45pm revealed:
-Resident #8 had falls when trying to get up or he would roll out of bed.
-The resident was receiving hospice services as he was actively dying.
-The resident used a wheelchair, had an air mattress, and a bed alarm.
-She could not think of any other interventions put in place for the resident's falls.
-The resident was on routine 30 minutes checks (the same for all residents).
-There was no additional supervision put in place for the resident's falls.
-The 72 hour falls sheets were not being completed as required when Resident #8 was

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having falls.
-She did not know why staff was not completing the 72 hour falls monitoring sheets as required.
-She addressed the problem of the 72 hour monitoring sheets not being done or being incomplete with the former SCC and other staff at that time.
-About 3 weeks ago, the new Special Care Manager (SCM) set up a system to make sure the 72 hour falls sheets were being done.

3. Observation of the dining room on 10/24/18 from 12:28pm to 1:05pm revealed:
-Resident #17 was one of four residents sitting at the table awaiting his lunch meal.
-A personal care aide (PCA) was sitting beside Resident #17 and another resident at the same table.
-Resident #17 had two cups filled with nectar thickened sweetened tea and nectar thickened water sitting before him.
-Resident #17 reached over the left side of the table and picked up another resident's cup that was not thickened and drank the water from the cup.
-Resident #17 began to cough loudly and repeatedly.
-The PCA who was seated right beside Resident #17 looked at Resident #17 coughing repeatedly, looked away from Resident #17, and continued to assist feeding another resident at the dining room table. No assistance was provided to Resident #17.
-Another PCA who was passing out lunch meals, assisted Resident #17 after prompting.
-The PCA made several attempts to redirect and remove the cup of water from Resident #17.
-Resident #17 grunted and verbally expressed he wasn't giving it back. After several more prompts from the PCA, Resident #17 released the cup of

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water and gave it back to the PCA.

Interview with the dietary manager (DM) on 10/24/18 at 8:50am revealed Resident #17 was on a special diet list and was ordered a regular diet with mechanical soft textures and nectar thickened liquids.

Observation to kitchen on 10/24/18 at 9:09am revealed the dietary manager provided prethickened cranberry cocktail, prethickened sweetened tea, prethickened milk, and prethickened water to give to Resident #17.

Review of the diet list on 10/24/18 revealed Resident #17 was listed for mechanical soft, with nectar thickened liquids.

Review of a physician order for Resident #17 dated 10/19/18 revealed an order for regular diet with mechanical soft textures (entire meal), and nectar thick liquids with no straws.

Review of Resident #17's current assessment and care plan dated 07/18/18 revealed:
-The resident required limited assistance with cutting food.
-The feeding, utensil usage, equipment setup, open packages, chop, grind, puree, and thicken assistance task were blank.

Interview with the PCA on 10/25/18 at 9:15am revealed:
-All the residents at the table required assistance with eating or required feeding assistance.
-She was there just for that day, helping out with another resident. Resident #17 could feed himself.
-Resident #17 was on thickened liquids diet; he was the only one at the table with that diet.

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-Normally, the PCA passed all the plates to the residents, then sat down to assist residents with eating or to provide feeding assistance.
-Three PCAs stayed in the dining room, and three PCAs would go down the halls to double check residents' rooms to see if there were any residents left.
-All of the PCAs were responsible for supervising the residents, including making sure no one fell, or any assistance was needed with their drinks.
-She did not intervene because she did not have any extra gloves to put on. She did see him drink the regular water. -It did bother her to see him cough.

Interview with the Executive Director (ED) on 10/25/18 at 12:53pm revealed:
-Staff were expected to intervene in situations like Resident #17 drinking thin liquids from another resident on 10/24/18.
-Resident #17 should have been seated at the thickened liquids table.

Interview with the Regional Director of Operations (RDO) on 10/25/18 at 12:53pm revealed the PCA had been working with another resident including touching the other resident and did not want to touch Resident #17 without changing her gloves.

____

The facility failed to provide supervision of 5 residents (#1, #2, #6, #25, #26) with assaultive, aggressive, sexually expressive and wandering behaviors leading to numerous resident to resident altercations resulting in serious physical injuries to resident. The facility's failure to supervise 5 sampled residents (#8, #9, #13, #14, #18) who had multiple falls resulted in serious neglect and serious physical injuries including head lacerations requiring staples for Residents #8 and #14; a traumatic head injury for Resident

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#13, a closed head injury and facial contusion for Resident #9; and sprained left wrists for Residents #8 and #18. The facility's failure to supervise residents with behaviors and residents with multiple falls resulted in serious neglect and serious physical harm to the residents which constitutes a Type A1 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/25/18, 10/30/18, and 11/09/18 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 9, 2018.