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D 000	Initial Comments The Adult Care Licensure Section and the Cleveland County Department of Social Services conducted a follow-up survey and a complaint investigation on 01/28/20 to 01/31/20. The complaint investigations were initiated by the Cleveland County Department of Social Services on 12/11/19, 12/30/19 and on 01/17/20.	D 000		
D 106	10A NCAC 13F .0311(b) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. This rule apply to new & existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the temperature in the dining room and in two of the resident's rooms (#12 and #13) were maintained at 75 degrees Fahrenheit under winter design conditions. The findings are: Observation on 01/28/20 between 6:30am and 8:00am of resident rooms #12 and #13 on the back hallway near the nurse's station revealed: -Upon entering two resident's rooms they were cold. -The doors were closed, and the thermostats could not be controlled in either room. -The resident in one room was laying wrapped under the covers on his bed. Interview on 01/28/20 between 6:30am and	D 106		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DeLetha C Brooks, RN TITLE: Divisional Director of Clinical Services (X6) DATE: 3-13-2020

Acknowledged and reviewed 03/17/20 Jeanna S Robinson RN

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8:00am the resident in room #12 revealed:
-His room was cold all the time.
-His hands were extremely cold.

Observation on 01/28/20 between 6:30am and 8:00am of the nurse's station on the back hallway revealed the thermostat was set to 72.

Interview with the Maintenance Director on 01/28/20 at 9:15am revealed some rooms were cooler than others, due to the constant flow of residents going in and out to smoke and visitors coming into the facility using the door near those rooms.

Telephone interview with previous Administrator on 01/17/20 at 3:11pm revealed:
-The facility's dining room heat was not working.
-The heating unit had not worked in two months.

Observation during initial tour on 01/17/20 at 4:48pm revealed the dining room thermostat read 67 degrees Fahrenheit.

Interview with the current Administrator on 01/29/20 at 8:53am revealed:
-The heating unit had been replaced.
-The work was completed by a contracted heating and air company on 01/23/20.

Telephone interview with contracted heating and air company on 01/29/20 at 10:25am revealed:
-The heating unit for the dining room area had been replaced on 01/20/20.
-They had not serviced any other areas in the facility only the dining room heating system.

Interview with a resident on 01/30/20 at 3:19pm revealed:
-The heat was out in the dining room a few weeks

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D 106	Continued From page 2 ago. -The air was cold, residents were shivering. -"I had to wear a jacket or sweater and sit with arms crossed." -The resident advised staff that the dining room was too cold to eat in. Interview with a second resident on 01/30/20 at 3:30pm revealed: -The dining room was cold a few weeks ago. -"I had to wear extra clothing while in dining room." -The heat was now fixed. Interview with a third resident on 01/30/20 at 3:34pm revealed: -While the heat was out, the dining room was "unbearably cold". -I had to wear extra clothes or a jacket to keep warm. Observation of the dining room on 01/30/20 at 4:10pm revealed the thermostat was registering 73 degrees.	D 106		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by:	D 137		

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D 137	Continued From page 3 TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 10/10/19 as a medication aide (MA). -A HCPR check was completed on 10/15/19. -Staff A had two substantiated findings of neglect of a resident documented findings on 04/28/99. Review of a December 2019 electronic Medication Administration Record (eMAR) revealed Staff A worked as a MA and administered medications on 12/04/19, 12/08/19 and 12/22/19. Interview with previous Administrator on 01/08/20 at 5:15pm revealed: -The Administrator was unaware of substantiated findings pertaining to Staff A's HCPR check. -The HCPR check was completed by a former staff member who was no longer with the company. Interview with current Administrator on 01/29/20 at 8:53am revealed: -Her hire date was 01/28/20 as the current Administrator. -If an applicant was eligible for hire, a HCPR check would be completed. -If the HCPR revealed substantiated finding, the applicant would no longer be considered for hire. -All employees (cooks, floor, office staff) had	D 137		

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D 137	Continued From page 4 HCPR checks completed upon hire. -The current Administrator was unaware of the terminated employee with substantiated findings. Interview with Business Office Manager (BOM) on 01/31/20 at 11:32am revealed: -The BOM completed HCPR checks upon receiving applications for employment. -She was not employed as the BOM when Staff A was hired. -Current employees had HCPR checks completed annually to ensure no findings have occurred since date of hire. The facility failed to assure a medication aide who worked in the facility had no substantiated findings listed on the North Carolina Health Care Personnel Registry upon hire, resulting in a HCPR check completed on 10/15/19 with two substantiated findings of neglect of a resident. This failure was detrimental to the health, safety and welfare of all the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/30/20 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 15, 2020.	D 137		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care	D 269		

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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:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to ensure personal care was provided to 2 of 5 sampled residents (#1 and #18) related to a genital/buttock rash (#1) and a dried, soiled incontinent brief which had adhered to the resident's skin (#18).

The findings are:

1. Review of Resident #1's current FL2 12/09/19 revealed:
-Diagnoses included dementia, hyperthyroidism, hypertension, and intermediate vertigo.
-Resident #1 was intermittently disoriented.
-Resident #1 was continent with bladder and bowel.

Review of Resident #1's Care Plan dated 09/23/19 revealed she required limited assistance with bathing and dressing.

Review of a hospital history and physical report for Resident #1 (undated) revealed:
-The resident was admitted to the hospital on 12/28/19.
-The resident was discharged from the hospital

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on 01/04/20.
-The resident had vesicular lesions (small blisters on the skin) noted over the vaginal area and scattered along the right buttock with scab formation with redness and swelling.
-There was a diagnosis of cellulitis in the perianal (around the anus) and perineum (diamond shaped area that includes the anus and vagina) area.
-The resident expired during her stay in the hospital.

Review of a picture of Resident #1 dated 12/18/19 revealed:
-There were multiple lesions on the genitals that were pus-filled.
-There were a cluster of red and purple sores and lesions along the buttocks.
-The lesions on the buttocks were scabbed over and there were open sores present.

Interview with the Responsible Party (RP) for Resident #1 on 01/28/20 at 6:18pm revealed:
-Resident #1 had dementia and could not provide much information about the care she received.
-He went to visit Resident #1 on 12/26/19 in the evening and she did not want to get up.
-Resident #1 was complaining of "hurting so bad" she could not go to the bathroom.
-He observed red sores on her hip and went to get a home health nurse who informed him that it appeared to be shingles.
-The residents' vagina was red and swollen.
-He visited the resident at the facility regularly and no staff informed him that Resident #1 was experiencing lesions, sores and pain prior to the resident informing him on 12/26/19.
-Resident #1 was continent and he thought staff assisted with showers and dressing.
-When he would visit her at the facility she

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appeared to have showered and was dressed properly and did not have an odor.

Review of Resident #1's progress notes revealed:
-On 12/26/19 at 7:41pm, there was documentation "resident observed with redness and blisters on right hip and right buttock region.
-There was a new order for acyclovir 800mg (used to treat herpes virus infections) every four hours while awake for 7days".
-On 12/27/19 at 7:05pm there was documentation "resident noted to have blister like sores on right buttock, redness in the vaginal/rectal area, resident stated sores had been there 3 days but she had not told anyone about them until 12/26/19, no bruising at the time." [Recorded as late entry on 12/28/19 at 7:09pm]
-On 12/27/19 at 7:30pm there was documentation "resident declined to come to dinner ... there was blood on her sheets. When turned over to change, the med tech notified the people on shift of the residents' status, noted to have increased agitation, confusion, and abnormal gait, med tech contacted on call physician and it was requested she be sent out for further evaluation." [Recorded as late entry on 12/28/19 at 12:35am]
-There was no other documentation regarding Resident #1 complaining of a skin rash prior to 12/26/19.

Review of Resident #1's progress notes revealed there was no documentation she refused showers or personal care.

Review of Resident #1's "Point of Care History" revealed:
-There was documentation every Tuesday, Thursday and Saturday in December 2019, that Resident #1 received bathing to the upper and lower body.

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-There was documentation on 12/26/19 Resident #1's tub or shower transfer was "not done-deferred due to condition" [amended on 12/31/19, reason; incorrect data].
-There was documentation at each shift, daily for December 2019, that Resident #1 received assistance with dressing.

Telephone interview with a previous medication aide (MA)/personal care aide (PCA) on 01/28/20 at 2:45pm revealed:
-She worked in the facility at the end of December 2019 as a MA/PCA.
-Resident #1 would refuse showers, during the 8-9 months she worked she was only able to bathe her once.
-Showers scheduled during 2nd shift were completed between 3pm-9pm and after 3 attempts the resident would refuse.
-She was not able to observe Resident #1's skin as she refused showers and did not assist her with dressing.
-She told the previous Resident Care Director (RCD) about resident #1 refusing showers.
-She attempted to talk to the primary care provider (PCP) a few times and he instructed not to force the resident and he would adjust medications.

Interview with a MA on 01/30/20 at 12:25pm revealed:
-She was working the day Resident #1 was sent to the hospital.
-She did not observe Resident #1's buttock or genital area.
-Resident #1 informed that she her genital area was "itchy and painful".
-She documented on 12/16/19 that she provided bathing assistance for Resident #1, however she had not completed bathing tasks.

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-She documented that she provided personal care because the PCAs informed her that it was completed, however sometimes they got behind, and she documented on their behalf.
-She documented showers to "help them out".
-She did not know if showers were completed for residents, she just documented after the PCAs told her it was complete.
-She did not know how the PCAs could have missed Resident #1's skin.

Telephone interview with the previous Resident Care Coordinator (RCC) on 01/28/20 at 6:02pm revealed:
-She worked at the facility from February 2016-January 2020.
-She remembered working with Resident #1, she was pleasant and never refused care.
-She remembered Resident #1 had dementia but was "well with it".
-No staff ever complained about Resident #1 refusing care.
-She never assessed Resident #1's skin, the resident did not want to be touched.
-Skin assessments were to be completed during showers and documented on the "Body Evaluation and Observation" form.
-There were issues in the past with staff not providing showers to the residents, therefore skin assessments were not completed.

Upon request from the facility it was determined there were no "Body Evaluation and Observation" forms completed for Resident #1.

Interview with the previous Resident Care Director (RCD) on 01/30/20 at 8:31am revealed:
-She worked as the previous RCD in December 2019 when Resident #1 was a resident.
-The PCAs/MAs did not notify her of any issues

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or complications with Resident #1's skin before the family member alerted her 12/26/19.
-PCAs were responsible for completing showers and should have let her know if there were any changes in the skin.
-PCAs could have noticed the condition of her skin during showers and dressing, but no one said anything.

Interview with an emergency department (ED) physician on 01/28/20 at 10:23am revealed:
-She assessed Resident #1 when she was admitted to the hospital on 12/28/19.
-She observed a vesicular rash on Resident #1's genitals and buttocks, she could not determine if it was shingles or another type of lesion.
-The resident had multiple lesions in various stages that occurred greater than 24 hours prior to her admission.
-The lesions were vesicular, and she had a bacterial cellulitis infection that was probably caused by scratching.
-The lesions appeared to have been present from at least 3-5 days and the resident should have been sent to the hospital immediately due to pain and irritation.
-She had concern for neglect in care due to the appearance of the skin, "someone should have noticed sooner and had her seen".
-The lesions would have been observed during bathing and dressing and staff should have had the resident seen by a physician sooner.

Interview with the previous Administrator on 01/29/20 at 5:12pm revealed:
-The previous RCD was made aware of Resident #1's skin condition on her buttocks.
-Resident #1's condition had been reported to the physician once noticed and the resident was prescribed cream.

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-Staff should have been completing skin assessment during showers.
-Staff were to complete skin assessments and document any issues on the observation form.
-PCAs were to notify the MAs, and then the RCD was to be notified of any changes in skin.
-The physician was also to be notified and she thought the staff reached out to the physician timely.

Interview with the Interim Executive Director (ED) on 01/31/20 at 12:45pm revealed:
-She became the Interim ED on 01/28/20.
-She was not working in the facility while Resident #1 was a resident.
-She expected each resident to receive care according to their care plan.
-She expected PCAs and MAs to provide personal care according to the care plan.
-Staff were to complete the "Body Evaluation and Observation" form after each shower.

2. Review of Resident #18's current FL2 dated 07/19/19 revealed:
-Diagnoses included dementia and hypertension.
-Personal care assistance was needed for dressing.
-She was continent of bladder but incontinent of bowel on occasions.

Review of Resident #18's current care plan dated 09/23/19 revealed:
-Resident #18 required limited assistance with toileting, ambulation, bathing and grooming.
-Resident #18 required supervision with transfers.
-Resident #18 used a walker.
-Resident #18 was incontinent of bowel and bladder daily.
-Resident #18 was sometimes disoriented, and

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D 269	Continued From page 12 memory was forgetful, need reminders. Observation of Resident #18 on 01/30/20 at 11:49am revealed Resident #18 was being transferred to the dining room via wheelchair by staff. Confidential interview with a staff revealed: -Resident #18 had diarrhea for 4 days. -Resident #18 could not go to the bathroom by herself. -Resident #18 was confused and could not use the call bell for assistance. -Staff walked into Resident #18's room on 01/29/20 and smelled a strong odor of bowel movement. -Resident #18 wore an adult brief due to her incontinence. -When staff tried to remove the soiled dried brief from Resident #18, the brief was stuck to Resident #18's skin. -"It was like it was glued on." -The staff had to use a soaked warm wash cloth and leave it on Resident #18's brief before the brief would come off. -"I did not want to rip the brief off because I thought her [Resident #18] skin might come off." -Resident #18's bottom was "bright red with blisters on both sides of the butt cheeks." -The staff reported the incident to her supervisor and was told, " I ain't got time for that, just kidding. I will check her in a little while." -Resident #18 was never checked by the supervisor on that shift. Interview with the medication aide (MA) on 01/30/20 at 10:42am revealed; -Resident #18 had diarrhea for several days. -Resident #18 had an order for nystatin powder to the affected areas two times daily.	D 269		

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-She had applied the nystatin powder to Resident #18's bottom on 01/29/20 at 9:00am.
-She knew Resident #18's bottom was red from all the diarrhea but had not noticed any blisters.
- [Resident #18's] "bottom was red and in between her legs too, like she was galled from all the diarrhea".
-She did not know Resident #18's incontinent brief was stuck to her skin on 01/29/20 and had to be soaked off to prevent tearing and damaging the skin tissue to her bottom area.

Observation of Resident #18's on 01/30/20 at 11:30am revealed:
-Resident #18 was being assisted with incontinent care by 2 staff who were in Resident #18's bathroom.
-There was watery brownish diarrhea on the toilet seat and on the floor near the toilet.
-The 2 staff were assisting Resident #18 to stand while they cleaned Resident #18 bottom and provided personal care.
-Resident #18 was confused.
-Resident #18 had aggravated red and raw areas to her bottom in the fold of her buttocks.
-Resident #18 had bright redness and irritated areas to her inner thighs near her vaginal area.
-Resident #18 appeared to be in discomfort as the staff cleaned her bottom and her vaginal area.

Interview with Resident #18 on 01/30/20 at 11:30am revealed:
-She had diarrhea but could not remember for how long.
-She was sore on her bottom and "in my crack".
-She was weak and did not feel well.
-She could not clean herself up and relied on the staff to attended to her personal care.

Interview with the Resident Care Director (RCD)

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D 269	Continued From page 14 on 01/31/20 at 11:15am revealed: -She was in the facility daily Monday through Friday and available for staff to call 24/7. -She had administered medications to the residents on 01/31/20. -Staff had not made her aware of any diarrhea for Resident #18. -She was not aware Resident #18 had diarrhea for several days or what she had ordered for diarrhea. -She was not aware staff had found Resident #18 in a brief that was stuck to her skin and had to be soaked off to prevent skin tears. Interview with the Interim Executive Director (ED) on 01/31/20 at 12:10pm revealed: -Her first day in the facility as Administrator was on 01/28/20. -She was not aware staff had found a soiled dried brief that was stuck to Resident #18's skin and had to be soaked off using warm washcloth soaks. -She relied on the staff to provide personal care to all the residents in the facility. REFER TO TAG 914 The facility failed to provide bathing and dressing assistance for Resident #1 in accordance with her care plan, which resulted in staff not identifying a severe rash and bacterial infection which led to a hypostatization in which the physician had concerns for neglect in care and Resident #18 who had diarrhea for 4 days and was found by staff wearing a dried feces soiled brief which was stuck to her skin requiring staff to use warm wet washcloth soaks to prevent tearing the skin to her buttocks area. The facility's failure to provide personal care resulted serious physical harm and neglect which constitutes a Type A1 Violation.	D 269		

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D 269	Continued From page 15 The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/30/20 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 29, 2020.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews the facility failed to ensure the health care needs were met for 2 of 7 sampled residents related to timely primary care provider (PCP) notification of a painful itchy genital/buttock rash (Resident #1) and not notifying the psychiatric physician a resident's psychotropic medication was not available for administration for up to 28 days (Resident #16). The findings are:	D 273		

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1. Review of Resident #1's FL2 dated 12/09/19 revealed:
-Diagnoses included dementia, hyperthyroidism, hypertension, and intermediate vertigo.
-Resident #1 was intermittently disoriented.
-Resident #1 was continent with bladder and bowel.

Review of Resident #1's Care Plan dated 09/23/19 revealed she required limited assistance with bathing and dressing.

Interview with Resident #1's family member on 01/28/20 at 8:54am revealed:
-Resident #1 was admitted to the hospital on 12/28/19 as she was sent out by the facility staff.
-When Resident #1 was treated in the hospital, the family was told by the emergency room nurse that the resident had "broken out really bad in her vaginal area".
-No one could provide information about what actually happened to Resident #1's vaginal and buttock area.
-Resident #1 had "some type" of infection in her vaginal and buttock area.
-The emergency room nurse informed the family Resident #1 had not been taken care of and the infection had not happened over a day or two.
-When Resident #1 received antibiotics, she began to have seizures which led the physician to believe the infection spread to the brain.
-After receiving antibiotics, Resident #1 had seizures for about an one hour and she expired at the hospital days later.

Review of a picture of Resident #1 dated 12/18/19 revealed:
-There were multiple lesions on the vaginal area that were small blisters.
-There were a cluster of red and purple sores and

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lesions along the buttocks.
-The lesions on the buttocks were scabbed over and there were open sores present.

Interview with the Responsible Party (RP) for Resident #1 on 01/28/20 at 6:18pm revealed:
-He went to visit Resident #1 on 12/26/19 in the evening and she did not want to get up.
-Resident #1 was complaining of "hurting so bad" she could not go to the bathroom.
-He observed red sores on her hip and went to get a home health nurse who informed that it appeared to be shingles.
-He had not observed Resident #1's vaginal area, however she informed him that she was in pain.
-The home health nurse told the Resident Care Director (RCD) who contacted the physician who prescribed a medication.
-When Resident #1 got to the hospital, the resident's "front side appeared to be ate up, the hospital said it was the worse they ever seen".
-The resident's vagina was red and swollen.
-The resident received medication and suffered a traumatic seizure.
-He thought staff assisted with showers and dressing.
-When he visited Resident #1 at the facility she appeared to have showered and was dressed properly.
-No one from the facility notified him prior to his visit on 12/26/19, that Resident #1 had a vaginal/buttock skin rash.

Review of Resident #1's progress notes revealed:
-On 12/26/19 at 7:41pm, there was documentation "resident observed with redness and blisters on right hip and right buttock region."
-There was a new order for acyclovir 800mg (used to treat certain viral infections) every four hours while awake for 7 days".

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D 273	Continued From page 18 -On 12/27/19 at 11:45am, there was documentation "resident observed laying in bed, resident sat up and talked with staff; staff encouraged resident to eat lunch, but she insisted lunch in her room; no complaints of pain voiced". -On 12/27/19 at 2:06pm, there was documentation "resident had been resting all day, will continue to monitor resident for any changes". -On 12/27/19 at 7:04pm, there was documentation "med tech spoke with [family member] regarding resident status and being sent to the emergency room". [Recorded as late entry on 12/28/19 at 7:05pm] -On 12/27/19 at 7:05pm, there was documentation "resident noted to have blister like sores on right buttock, redness in the vaginal/rectal area, resident stated sores had been there 3 days but she had not told anyone about them until 12/26/19, no bruising at the time." [Recorded as late entry on 12/28/19 at 7:09pm] -On 12/27/19 at 7:30pm, there was documentation "resident declined to come to dinner, when this med tech confirmed that this was her choice and found resident with blood on her sheets. When turned over to change, the med tech notified the people on shift of the residents' status, noted to have increased agitation, confusion, and abnormal gait, med tech contacted on call physician and it was requested she be sent out for further evaluation." [Recorded as late entry on 12/28/19 at 12:35am] -There was no documentation staff observed a skin rash on Resident #1 prior to 12/26/19. Review of a hospital history and physical report for Resident #1 revealed: -The resident was admitted to the hospital on 12/28/19 at 12:07am. -There was a discharge date of 01/04/20, the	D 273		

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resident expired during her stay in the hospital.
-Resident #1 was admitted with a temperature of 102 degrees Fahrenheit (F).
-The resident's blood pressure was 185/111, and the heart rate was "tachycardic (a high resting heart rate above 100 beats per minute b/m) at 120 b/m."
-The resident had vesicular lesions (small blisters on the skin) noted over the vaginal area and scattered along the right buttock with scab formation with redness and swelling.
-There was a diagnosis of cellulitis in the perianal (around the anus) and perineum (diamond shaped area that includes the anus and vagina) area.
-There was conversation between three physicians that "there was concern about geriatric neglect and abuse and discussion was made with the family along with [named the two physicians] in room."

Interview with a emergency department (ED) physician on 01/28/20 at 10:23am revealed:
-She assessed Resident #1 when she was admitted to the hospital on 12/28/19.
-She observed a vesicular rash on Resident #1's genitals and buttocks, she could not determine if it was shingles or another type of lesion.
-The resident had multiple lesions in various stages that occurred greater than 24 hours prior to her admission.
-The lesions were vesicular, and she had a bacterial cellulitis infection that was probably caused by scratching.
-During her stay at the hospital, testing was completed for genital herpes and it was negative.
-The resident had multiple seizures which could have been a result of an infection that traveled to the brain causing meningitis (an inflammation of the membrane around the brain).

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-The lesions appeared to have been present from at least 3-5 days and the resident should have been sent to the hospital immediately due to pain and irritation.
-She had concern for neglect in care due to the appearance of the skin, "someone should have noticed sooner and had her seen".
-The lesions would have been observed during bathing and dressing and staff should have had the resident seen by a physician sooner.

Review of Resident #1's "Point of Care History" revealed:
-There was documentation every Tuesday, Thursday and Saturday in December 2019, that Resident #1 received bathing to the upper and lower body.
-There was documentation on 12/26/19 Resident #1's tub or shower transfer was "not done-deferred due to condition" [amended on 12/31/19, reason; incorrect data].
-There was documentation at each shift, daily for December 2019, that Resident #1 received assistance with dressing.

Telephone interview with a previous medication aide (MA)/personal care aide (PCA) on 01/28/20 at 2:45pm revealed:
-She worked in the facility at the end of December 2019 as a MA/PCA.
-She was not able to observe Resident #1's skin as she refused showers and therefore did not assist her with dressing.
-She told the previous Resident Care Director (RCD) about resident #1 refusing showers.
-She attempted to talk to the primary care provider (PCP) a few times and he instructed not to force the resident and he would adjust medications.
-Resident #1 complained about burning with her

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urination in December 2019 when she worked.
-She told the previous RCD about the resident complaining of burning with urination.

Review of Resident #1's progress notes from 03/22/19-12/27/19 revealed there was no documentation she refused showers or personal care.

Interview with a MA on 01/30/20 at 12:25pm revealed:
-She was working the day Resident #1 was sent to the hospital.
-She did not observe Resident #1's buttock or genital area.
-Resident #1 informed her that her genital area was "itchy and painful".
-She could not remember when the resident told her.
-She did not notify the physician, she thought the previous RCD had notified the physician.
-She documented on 12/16/19 that she provided bathing assistance for Resident #1, however she had not completed bathing tasks.
-She documented that she provided personal care because the PCAs informed that it was completed, however sometimes they got behind, and she documented on their behalf.
-She documented showers to "help them out".
-She did not know if showers were completed for residents, she just documented after the PCAs told her it was complete.
-She did not know how the PCAs could have missed Resident #1's skin.

Telephone interview with the previous Resident Care Coordinator (RCC) on 01/28/20 at 6:02pm revealed:
-She worked at the facility from February 2016-January 2020.

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-She was informed by the previous RCD that she thought the resident had shingles on her hips and buttocks and the physician had been notified around the end of December 2019.
-She never assessed Resident #1's skin, because the resident did not want to be touched.
-She had not contacted Resident #1's physician, because she thought the previous RCD had contacted him.
-Skin assessments were to be completed during showers and documented on the "Body Evaluation and Observation" form.
-No resident was to be left alone during showers and if the resident refused, it was to be documented in the progress notes and the RCD was to be notified.
-No staff had notified her about any issues with Resident #1 prior to the RCD informing that the physician was contacted about shingles.

Interview with the previous RCD on 01/30/20 at 8:31am revealed:
-She observed Resident #1's vaginal and buttock area at the end of December 2019.
-She was alerted of the rash by the home health nurse and family member that was in the building on 12/26/19.
-She appeared to have "a nasty rash, it was really bad, she had been clawing and scratching, it looked red and blistered".
-She called the physician to inform him that it appeared the resident had shingles and she received a telephone order for "antibiotic".
-If someone would have alerted her prior to the nurse and family member, she could have brought it to the attention of the physician sooner.
-The PCAs/MAs did not notify her of any issues or complications with Resident #1's skin before the family member alerted her 12/26/19.
-PCAs were responsible for completing showers

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and should have let her know.
-PCAs could have noticed the condition of her skin during showers and dressing, but no one said anything.

Interview with the Adult Protective Services (APS) Investigator on 01/01/29/20 at 8:45am revealed:
-An APS report was made regarding Resident #1 related to geriatric neglect.
-She observed Resident #1 in the hospital on 12/28/19.
-Resident #1 was unable to be interviewed.

Interview with a second ED physician on 01/28/19 at 9:25am revealed:
-He was one of the physicians who admitted Resident #1 at the hospital on 12/28/19.
-There was concern as to whether Resident #1 had genital herpes.
-After completing an examination, the resident was administered antibiotics for cellulitis and she then began to have seizures.
-After the seizures, the family decided to keep Resident #1 comfortable, therefore further testing could not be completed.
-During his assessment he observed multiple rashes in the vaginal and buttocks area that were red and painful.
-He also observed cellulitis and a bacterial infection on her genital area.
-The resident's condition did not occur overnight, it could have been 3-4 days that she had the rash.

Interview with the previous Administrator on 01/29/20 at 5:12pm revealed:
-The previous RCD was made aware of Resident #1's skin condition on her buttocks.
-Resident #1's condition had been reported to the physician once noticed and the resident was

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prescribed cream.
-On 12/27/19, the resident began to decline cognitively, and she was sent to the hospital.
-She did not know the resident had been experiencing symptoms prior to the physician being notified.
-Staff should have been completing skin assessment during showers.
-Staff were to complete skin assessments and document any issues on the observation form.
-PCAs were to notify the MAs, and then the RCD was to be notified of any changes in skin.
-The physician was also to be notified and she thought the staff reached out to the physician.

Interview with the Interim Executive Director (ED) on 01/31/20 at 12:45pm revealed:
-She became the Interim ED on 01/28/20.
-She was not working in the facility while Resident #1 was a resident.
-She expected each resident to receive care according to their care plan.
-She expected PCAs and MAs to provide personal care and notify the RCD of any changes promptly.
-The MAs and the RCD were responsible for contacting the PCP immediately if there were any changes in a resident's condition.

2. Review of Resident #16's current FL2 dated 12/17/19 revealed:
-Diagnoses included physical deconditioning, Parkinson disease and diabetes mellitus.
-The medications prescribed included Clozapine 25mg, 6 tablets (150mg) every evening. (Clozapine was used to treat schizophrenia).

The Pharmacy Review dated 01/02/20 revealed:
-The recommendation for Resident #16 was to

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have a Complete Blood Count (CBC) every 7 days for 6 months due to the current Clozapine order.
-If the absolute neutrophil count (the absolute neutrophil count -ANC- was used to identify the number of white blood cells that are neutrophils), remained at goal, the ANC should be repeated every 14 days for the next 6 months.
-The primary care physician (PCP) signed the pharmacy recommendation on 01/13/20 as an approved order.

Telephone interview with a representative from the facility's contracted pharmacy on 01/29/20 at 10:00am revealed:
-Resident #16's FL2 was sent from the facility on 12/20/19.
-Clozapine 25mg, administer 6 tablets to equal 150mg at bedtime was listed on the FL2.
-The physician who signed the FL2 was not licensed as a REMS provider so the prescription could not be filled.
-No laboratory results were provided to the pharmacy as a prerequisite for filling the Clozapine per the REMS program.
-The pharmacy attempted to contact the facility on three separate occasions.
-The pharmacy did not document who they spoke to in regards to Resident #16's Clozapine.

Interview with Resident #16's previous PCP on 01/29/20 at 12:15pm revealed:
-She managed Resident #16's medical concerns as his family care physician until 12/20/19, prior to admission at his current facility.
-She signed Resident #16's FL2 dated 12/17/19 upon discharge from the previous facility.
-She was not the prescribing physician for Clozapine 25mg, six tablets every evening.
-She was not certified as a Risk Evaluation and

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Mitigation Strategy program (REMS) physician.
-The Food and Drug Administration (FDA) worked in conjunction with the REMS program to ensure clients relying on Clozapine medication have appropriate management of associated risks.
-Physicians must be certified in the program to prescribe Clozapine.
-Pharmacists must be certified in the program to dispense Clozapine.
-She referred Resident #16 to a Mental Health provider on 11/08/19 to prescribe and follow his psychotropic medications.

Observation of Resident #16's medications on hand on 01/29/20 at 11:35am revealed there was no Clozapine on the medication cart or in the medication room.

Interview with Resident #16's current PCP on 01/29/19 at 4:40pm revealed:
-He had been the PCP for Resident #16 since he was admitted to the facility on 12/20/19.
-He was not licensed in the REMS program to prescribe Clozapine for Resident #16.
-The PCP referred Resident #16 to a mental health provider on 12/24/19.
-He ordered a CBC and ANC laboratory test to be taken on 01/02/20, and ordered for a second time for the facility to refer Resident #16 to a REMS certified mental health provider.
-The pharmacy required current laboratory results before filling a prescription for Clozapine. (One of the side effects of taking Clozapine was decreased white blood cells).
-His records showed on 01/03/20 the laboratory test results were within normal limits.
-He was concerned it took 30 days after the referral for Resident #16 to be seen by the Mental Health provider.
-The Clozapine was documented as administered

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on the electronic medication administration record (eMAR) so he thought Resident #16 was receiving the Clozapine.
-He was very concerned Resident #16 was not receiving the Clozapine.
-He did not feel qualified to state the possible effects to Resident #16 in not receiving his Clozapine as prescribed.
-He gave his orders to the Resident Care Director (RCD) when he made his rounds at the facility.
-He faxed his orders to the facility if he was off site.
-He relied on the previous Resident Care Coordinator (RCC) and the current RCD to inform him if his residents needed medications or laboratory tests to be ordered.
-He was not informed Resident #16 was not receiving Clozapine every evening.

Telephone interview with the previous Administrator on 01/29/20 at 5:05pm revealed:
-She was the Administrator at the facility until 01/16/20.
-She was not aware of any time resident's medications were unavailable for administration.
-She would have notified the Mental Health provider and the PCP if Resident #16 did not have Clozapine to administer nightly.

Interview with Resident #16 on 01/30/20 at 9:30am revealed:
-Resident #16 was in his bedroom in a wheelchair.
-He said he felt a "bit more shaky lately".
-He had the sensation his head " felt full."
-He was experiencing a "sucking sensation around his mouth", which was also new.
-He thought he had mentioned these sensations to the mental health provider.
-He would rather stay in his room than be in the

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D 273	Continued From page 28 common areas of the community. Interview with Resident #16's previous Mental Health physician on 1/30/20 at 9:38am revealed: -He was a Mental Health physician who was REMS certified and had prescribed Clozapine to Resident #16. -Resident #16 had been taking Clozapine since 1992. -Clozapine was the preferred drug for schizophrenic patients. -Resident #16's symptoms were well controlled at the time he was discharged. -He ordered laboratory tests once a month to check the CBC and ANC levels of patients taking Clozapine. -The pharmacy he used would contact him if a client had not received their laboratory tests for CBC and ANC in 4-6 weeks. The pharmacy would not fill the prescription without the results. -Clozapine was only filled on a monthly basis-31 doses. -The last fill date for Resident #16's Clozapine was 12/08/19. -The next refill should have been 01/08/20. -The adverse effects of stopping Clozapine would be an increase in the resident's psychosis, auditory hallucinations, agitation and insomnia. -If he was the prescribing physician at this time, he would order laboratory tests for CBC and ANC, restart Clozapine and prescribe Ativan until the Clozapine was effective. Observation at Resident #16's bedroom door on 01/30/20 at 11:28am revealed: -Resident #16 was having a conversation. -There was no one else in his room. Interview with Resident #16 on 01/30/20 at 11:28am revealed:	D 273		

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-When asked who he was speaking to in his room he stated "he was talking out loud".
-Resident #16 said he had not been getting his Clozapine.
-When he was experiencing behaviors, they were mostly auditory hallucinations.

Observation outside Resident #16's bedroom door on 01/30/20 at 11:33am revealed Resident #16 continued his conversation stating "I hope they don't roast us."

Interview with the Interim Executive Director (ED) and the Regional Vice President of Operations on 01/30/20 at 3:50pm revealed:
-The Resident Care Director (RCD) should follow up with the pharmacy and the physician when orders have not been completed within 2 or 3 days.
-They were not aware Resident #16's PCP and mental health provider were not notified Clozapine was unavailable for administration to the resident since 12/31/19.

Review of the current Mental Health providers Visit Summary notes revealed:
-On 01/17/20, a representative from the mental health provider agency conducted an assessment for admission for Resident #16.
-The Nurse Practitioner (NP) made the initial visit to Resident #16 on 01/23/20.
-At that visit, Resident #16 stated the facility was not administering Clozapine to him, so "someone from the outside" brought him Clozapine and he was taking those pills.
-The NP brought this information to the attention of the RCD, and gave the medication to the RCD.
-The NP noted the Clozapine medication bottle was currently locked in the RCD's office.
-During the 01/23/20 visit, Resident #16 had

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some "thought blocking and minimal paranoia and hallucinations".
-The NP ordered an immediate CBC laboratory test and monthly CBC tests moving forward.
-The NP also ordered a Clozapine level to be tested, and Clozapine 150mg to be restarted.
-The staff were made aware to contact the NP with any abnormalities with these orders.

Telephone interview with the Mental Health NP on 01/30/20 at 5:30pm revealed:
-He was currently the mental health provider for Resident #16.
-He had been informed by the resident he was not receiving Clozapine in the evening.
-Resident #16 stated someone from the outside brought him a bottle of Clozapine.
-Resident #16 produced a medicine bottle with a handwritten note wrapped around the bottle stating "psychotropics, not narcotics".
-There was no pharmacy generated label on the medicine bottle indicating the medication name or dosage.
-The NP brought the bottle of medication to the RCD.
-He did not know if Resident #16 had taken any of the unidentified pills in the bottle, or when they were prescribed.
-He did not know the prescription for Clozapine he had left on 01/23/20 had not been filled.
-The staff should have informed him the pharmacy refused to fill the prescription, per his visit summary notes.
-He spoke with the RCD last week and he did not know Resident #16 was still not getting his Clozapine.
-The Clozapine laboratory results showed Resident #16 had not been receiving his medication-the level was 0.

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Review of Resident #16's eMAR Progress Notes revealed:
-On 01/02/20 at 5:58pm there was an entry: Resident #16 complained of being paranoid and feeling agitated due to not receiving his Clozapine.
-The supervisor notified the PCP and reported Resident #16 needed blood work to have the Clozapine prescription filled by the pharmacy.
-The PCP instructed staff to "hold Clozapine until the medication arrived".

Review of Resident #16's record revealed:
-There was no verbal order written by the staff or signed by the physician to "hold Clozapine until the medication arrived".
-There was a physician's order dated 01/02/20, for a second time, for the facility to refer Resident #16 to a REMS certified mental health provider.

Interview with the RCD on 01/30/20 at 2:25pm revealed:
-She did not know Resident #1's Clozapine was not on the cart.
-She had not been notified by the medication aides (MAs) the Clozapine was not available for administration.
-She had sent the Clozapine prescription to the pharmacy on 01/23/20.
-She relied on the MAs to inform her when a medication was not available to administer.
-She did not know why the pharmacy had not filled the prescription to date.
-She had not contacted the pharmacy regarding the Clozapine.
-She did not have the mental health providers notes from the visit on 01/23/20.
-She was not sure if that was the first visit the mental health provider had with Resident #16.
-She did not know why it took a month for the

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mental health provider to visit with the resident.
-She was not aware of a bottle of unidentified medication brought in by another person to Resident #16.
-She was informed a staff person found the medicine bottle in the record room on 01/30/20.
-She had not observed a change in behavior in Resident #16 nor was it reported to her.

Interview with a MA on 01/31/20 at 11:29am revealed:
-Resident #16's Clozapine has not been available to administer "for awhile".
-The previous RCC and Administrator knew the medication was not available.
-The RCC was the liaison with the resident's physicians.
-The MA had not notified the physician the medication was not available.

Telephone interview with a second MA on 01/31/20 at 12:00pm revealed:
-Resident #16 had not been administered Clozapine for awhile.
-When he first arrived at the facility (12/20/20) he had his medication, but Clozapine had not been available for administration for a few weeks.
-She sent the prescription to the pharmacy, but the medication was never filled.
-The MA informed the previous RCC Resident #16 had no Clozapine to administer.
-The RCC said Resident #16 had to see the physician and "Lets see how he does off the medication."
-The RCC scheduled visits with the resident's physicians and took their orders.
-After she spoke with the previous RCC and Administrator, she understood she should "just keep signing Clozapine was administered until it came in".

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-Resident #16's behavior had changed over the past few weeks. He would sit in his room in the dark and talk to himself. "He was not doing that when he first arrived."

Telephone interview with a representative from the facility's contracted pharmacy on 01/31/20 at 12:00pm revealed:
-They had not filled Resident #16's Clozapine prescription.
-They had been waiting for laboratory results and a REMS provider to prescribe.
-On 01/23/20 the facility faxed a new prescription for Resident #16's Clozapine.
-The pharmacy staff faxed the facility to inform them the prescription could not be filled as written.
-There was no further communication from the facility and no new prescriptions as of 01/31/20.

Interview with the power of attorney (POA) on 01/31/20 at 10:15am revealed:
-Resident #16 was living in a supervised apartment for mental health residents until a fall in November 2019.
-He was sent to a rehabilitation facility from the hospital for deconditioning, and was discharged to the current facility on 12/20/19.
-Resident #16 had complained to his family member that he was not receiving his evening dose of Clozapine at the facility.
-A few weeks ago, he took Resident #16 to clean out his apartment and he brought back a bottle of pills Resident #16 thought were Clozapine.
-He did not know if Resident #16 had taken any of the pills or how many were in the bottle.
-He knew Resident #16 had given the bottle to the staff a few weeks ago, and did not have any additional medication in his room.
-He stated the resident was hearing voices again

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and was agitated at dinner this week when they went out.
-Resident #16 also stated he was not sleeping well.

Observation of the count of the pills in the medication bottle in the Administrator's office on 01/30/20 at 4:12pm revealed:
-There was a medication bottle with a handwritten label "psychotropics, not narcotics" was found in the facility's record room.
-There was no pharmacy label on the medication bottle.
-196 pills were counted in the medication bottle.

Review of Resident #16's laboratory results on 01/31/20 at 8:30am revealed:
-On 01/03/20 CBC laboratory results were within normal limits.
-On 01/23/20 CBC laboratory results were within normal limits.
-On 01/23/20 laboratory results for Clozapine were "0"- no Clozapine was detected in the blood work.

The facility failed to assure the acute health care needs were met for Residents (#1) who sustained pain and itching from a genital and buttock rash due to a delay in medical care; the ER noted the lesions appeared to have been present at least 3-5 days, the ER physician had concern for neglect in care due to the appearance of the skin, the lesions would have been observed during bathing and dressing and staff should have had the resident seen by a physician sooner, Resident #1 had multiple seizures during the hospital admission which could have been a result of an infection, Resident #1 had expired while in the hospital. Resident (#16) whose mental health

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D 273	Continued From page 35 provider and primary care physician were not notified his psychotropic prescription was not filled for 6 weeks resulting in an increase in hallucinations, agitation and insomnia. This failure resulted in serious risk for physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/30/20 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 29, 2020.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Follow-up to a Type B violation. The previous Type B violation was not abated. Non-compliance continues. Based on observations, record reviews and interviews, the facility failed to ensure residents were treated with respect and dignity related to residents denied showers due to the norovirus outbreak in the facility. The findings are: Review of the facility "Ethical Standards of Conduct-code of Ethics" in the employee's	D 338		

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handbook revealed employees will treat residents with dignity and respect and in the manner that is in the best interest of the resident.

Review of the control measures for suspected Norovirus outbreaks N.C. Public Health Recommendations for Long Term Care Facilities revealed:
-Noroviruses were highly contagious.
-Symptoms included acute onset of vomiting, watery, non-bloody diarrhea with abdominal cramps, and nausea.
- Body weakness and headaches were also common as well as a low-grade temperature.
-Symptoms usually last for 1 to 3 days.

Interview with a resident in the facility on 01/30/20 at 11:27am revealed:
-Residents had to change their own brief and take sponge baths by themselves.
-The previous Administrator told residents they could not take showers.
-Staff did not care about residents and how they felt about being nasty and dirty.
-We had to put our trash outside the door to our room in the hallway for staff to pick up.

Interview with a second resident in the facility on 01/30/20 at 11:38am revealed:
-"I am blind and could not take a sponge baths at the sink, I needed help but could not get it."
-The previous Administrator told residents they could not take showers because the facility was out of towels and the washer was broke, later residents found out it was because of the norovirus.
-"I like to be clean, I take 3 showers a week and I could not get one for 10 days."
-"They have not changed my bed in three weeks now."

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D 338	Continued From page 37 -The previous Administrator told me "I could not take a shower." -"Nobody gives a S--T." -"I feel gross sleeping on the dirty sheets." -"I felt nasty, germs were floating around in here." -"I tried to sponge bathe myself, but I still felt nasty." Interview with third resident in the facility on 01/30/20 at 3:19pm revealed: -"My roommate and I were sick for 6 days". -"She cannot stand and needed help with her personal care when she had the norovirus." -She tried to use the sink to wash up, but she was weak and could not do for herself. -"I felt terrible without taking a shower." Interview with a fourth resident in the facility on 01/30/20 at 3:34pm revealed: -"We did not get showers or baths for a week." -"Staff told us to stay in our rooms". Interview with a fifth resident in the facility on 01/30/20 at 3:45pm revealed: -"One night I sat on the toilet with diarrhea and was holding a trash can in my lap throwing up." -All the residents ate in their rooms. -"I drove my car one day, but I wore a mask." Interview with a sixth resident in the facility on 01/30/20 at 3:39pm revealed: -The staff told the residents to stay in their rooms, but she would go out and smoke a cigarette when she wanted to. -"I did not get a shower for 10 days". -The staff would not let her use the spa shower, so she had no place to sit down when she showered. -"This pissed me off." -She told the staff she was pissed.	D 338		

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-They did not have a lot of staff working.
-"I felt disgusting, nasty and just gross."
-"I had to do my own sponge bath and change my own soiled underwear."
-"My hair was dirty and greasy for 10 days".
-"We were lucky to get our clothes back if they washed them."
-The facility staff had not washed her bedcovers in over a month.

Telephone interview with the local Health Department Infectious Disease nurse revealed:
-She knew the facility had an outbreak of Norovirus in January 2020.
-She emailed the facility previous Administrator the proper guidelines for control measures and education to prevent the contamination of the norovirus.
-She never told the previous Administrator not provide showers to the residents in the facility.
-The residents needed a shower or bath daily in regard to staying clean.
-The common shower area and the shower seats must be cleaned with the bleach mixture.

Interview with the Resident Care Director (RCD) on 01/28/20 at 3:20am revealed:
-The previous Administrator told residents they could not use the common spa bathrooms for about 2 weeks during the norovirus.
-During the norovirus the previous Administrator told staff not provide showers to the residents due to "cross contamination."
-The residents shared a common bathroom in their rooms, but staff were told not to provide shower even in the resident's personal bathrooms.
-The facility had an awful smell of diarrhea and vomit.
-The previous Administrator provided no

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education during the norovirus to staff or to residents.

Telephone interview with the previous Administrator on 01/29/20 at 5:00pm revealed:
-She contacted the local health department in January 2020 via telephone when she suspected the norovirus.
-She told staff not to allow the residents to leave their rooms and to not provide showers to the residents due to the cross contamination possible by sharing showers.
-The local health department never told her to not to give residents showers during the norovirus outbreak.
-She could not rely on housekeeping or the facility staff to assure the showers were completely clean using bleach to prevent the spread of norovirus.

Interview with the two local county Department of Social Services (DSS) Adult Home Specialist (AHS) on 01/29/20 at 1:00pm revealed:
-The county AHS visited the facility on 01/19/20.
-Residents were walking around inside the facility and some residents were sitting in the common area.
-The whole facility had a strong awful smell of feces and urine.
-As soon as they entered the facility a strong smell of cigarettes hit them.
-The county had a resident (Ward of the State) in the facility who was blind and had a dementia diagnosis.
-Upon entering his room, the hallway smelled of feces and urine.
-They found the resident sitting in a wheelchair wearing pants that were dirty and saturated with urine.
-There were diarrhea stains on his bed linens.

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D 338	Continued From page 40 -They identified several resident's rooms with diarrhea stained sheets. Interview with the Resident Care Director on 01/30/20 at 3:30pm revealed: -Every resident was quarantined to their room. -She did not see showers given during the quarantine. Observation during the survey conducted on 01/28/20 thought 01/31/20 revealed several residents in the facility had loose watery diarrhea. Interview with the Administrator on 01/29/20 at 3:30pm revealed: -She was not aware the previous Administrator was not allowing residents to shower during the norovirus outbreak. -"I would think you would need to keep the resident's cleaner when they were sick." -She was unsure where the previous Administrator got the information, but all residents should be attended to for personal care daily. -"I cannot believe residents in the facility went 10 days to 2 weeks without a shower." -I really don't understand why residents could not take a shower." -Housekeeping could clean the showers and the shower seat after each resident used the shower. -"I cannot believe staff were not providing residents with personal care and assisting with sponge baths during the norovirus outbreak." -The facility had standards of operations and they were not being followed by the previous Administrator. Interview with the Interim Executive Director (ED) on 01/30/20 at 11:45am revealed: -She was not aware resident in the facility were not given showers for 10 days during the	D 338		

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D 338	Continued From page 41 norovirus outbreak. -She did not understand why the previous Administrator would tell staff not to provide showers to the residents. _____ Based on record reviews and interviews the facility failed to assure residents were treated with dignity and respect regarding neglecting to provided personal care and denying residents showers for 10 days to 2 weeks while the residents were quarantine to their rooms during the norovirus outbreak. This failure resulted in residents feeling dirty, sheets in multiple rooms had soiled diarrhea stains, residents required assistance with bathing were not provided care and could not provide care for themselves. These failures of the facility to assure residents rights was detrimental to the health and welfare of the residents and constitutes a Type Unabated B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/30/20 for this violation.	D 338		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be	D 352		

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indicated if a brand other than the brand prescribed is dispensed;
(7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date;
(8) auxiliary statements as required of the medication;
(9) the name, address, telephone number of the dispensing pharmacy; and
(10) the name or initials of the dispensing pharmacist.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure medications were properly labeled for 2 of 5 sampled residents (Resident #10 and #13), as related to multi-dose packaging of medications with no identification of the name of the medication, dosage or frequency of administration.

The findings are:

1. Review of Resident #10's current FL2 dated 12/09/19 revealed:
-Diagnoses included Diabetes Mellitus Type 2, diverticulitis, morbid obesity, anxiety and depression.
-Physician orders included: acetaminophen 650mg, divalproex 250mg, sertraline 100mg, Clonazepam 1mg, guanfacine 2mg, Vitamin D3 2000 units, cetirizine 10 mg, hydrochlorothiazide 25mg, montelukast 10mg, pramipexole 0.25mg, levothyroxine 50mcg, atorvastatin 40mg, tizanidine 2mg, metformin 500mg and docusate sodium 100mg.

Observation of Resident #10's medications on hand on 01/28/20 at 9:15am revealed:

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D 352	Continued From page 43 -There was a multi-dose package of medications with Resident #10's name handwritten on the outside of the package. -The multi-dose packaging was dated 01/26/20 through 02/01/20 and was divided into morning and evening doses. -There were also 7 medication tablets in the bubble packet labeled "1/28 AM" handwritten on the top and side. -There were no labels identifying the names of the medications or the dosages in each of the packets. -The 01/26/20 morning and evening dose medications had not been administered and were still in the multi-dose package. -The medication aide (MA) could not identify the medications in the multi-dose packet when questioned. Telephone interview with a pharmacist at the local pharmacy on 01/31/20 at 9:48 revealed: -Resident #10 had her prescription medications filled from the local pharmacy. -The facility requested the medications be sent in multi-dose packaging in October of 2019. -This was not a long-term care pharmacy and they had not filled medications in multi-dose packaging. -They were not able to generate labels for the medications that fit the packaging. -Not all the medications were in the multidose package, some were still filled in bottles. -The medications in the multi-dose package were last filled on 01/13/20 for 3 weeks. -Each cardboard sleeve had 7 days of morning and evening medications. -He was not familiar with who administered medications and how they were identified once they were delivered to the facility. -The facility staff could have contacted the	D 352		

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pharmacist and he would have identified the medications in the multi-dose packaging for them.
-The facility had returned to filling Resident #10's medications in bottles as of 01/29/20.
-The pharmacist felt more comfortable returning to medication bottles with computer generated labels on the bottles.

Interview with a first shift medication aide (MA) on 01/28/20 at 9:20am revealed:
-She did not usually work on this medication cart.
-She did not know what medications were bubble packed in the multi-dose package.
-The multi-dose packet had a handwritten label with the date and "AM" on the top and side of the card.

Interview with Resident #10 on 01/28/20 at 9:44am revealed she received a lot of medications in the morning and did not know if she received everything her physician prescribed every day.

Refer to interview with the Resident Care Director (RCD) on 01/30/20 at 12:00pm.

Refer to interview with interim Executive Director (ED) on 01/30/20 at 4:00pm revealed:

2. Review of Resident #13's current FL2 dated 12/09/19 revealed:
-Diagnoses included dementia, diabetes mellitus Type 2, chronic obstructive pulmonary disease (COPD) and hypertension.
-Physician orders included ibandronate 150mg, oyster shell calcium with vitamin D3, metformin 1000mg, glimepride 2 mg, quetiapine 25mg and metoprolol succinate 25mg.

Observation of Resident #13's medications on

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hand available for administration on 01/28/20 at 9:35am revealed:
-The multi-dose packaging was dated 01/26/20 through 02/01/20 and divided into morning and evening doses.
-There were 5 medication tablets in a multi-dose package with Resident 13's name handwritten on the cover of the package.
-There were no labels identifying the names of the medications or the dosages in each of the packets.

Interview with the medication aide (MA) on 01/28/20 at 9:40am revealed she could not identify the medications in the multi-dose packet when questioned.

Interview with the pharmacist at the local pharmacy on 01/31/20 at 9:48 revealed:
-Resident #13 had their prescription medications filled at the local pharmacy.
-In October of 2019, the facility requested the medications be sent in multi-dose packaging.
-They were not able to generate labels for the medications that fit the packaging.
-The medications in the multi-dose package were last filled on 01/13/20 for 3 weeks.
-Each cardboard sleeve had 7 days of morning and evening medications.
-The facility had returned to filling Resident #13's medications in bottles as of 01/29/20.

Refer to interview with the Resident Care Director (RCD) on 01/30/20 at 12:00pm.

Refer to interview with interim Executive Director (ED) on 01/30/20 at 4:00pm revealed:

_____

Interview with the Resident Care Director (RCD)

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D 352	Continued From page 46 on 01/30/20 at 12:00pm revealed: -The medication aides (MAs) were responsible for administering the medications as ordered. -Prior to her hire date 30 days ago the MAs were responsible for all medication cart audits on night shift. -Now she was responsible for medication cart audits weekly including checking medication on the medication cart with the orders, missing medications and supplies. -Most of the residents received their medications from the facility's contracted pharmacy. -The medications were packaged in multi-dosed packets with the medication label on the reverse side of the pills. -Residents whose medications were filled at smaller pharmacies were not able to label per regulation. -She had printed the medication list for those multi-dosed packages and attached the list to the cover of the package. -She thought this would fulfill the labeling regulation for medications. Interview with the interim Executive Director on 01/30/20 at 4:00pm revealed: -The MAs should be checking the labels of the medications to verify it matched the order. -If there was a discrepancy, the MAs should not administer the medication. -When the MAs were doing cart audits, they should also be comparing the label to the physician order summary and the eMARs. -They should notify the DRC or the Resident Care Coordinator (RCC) if the label was incorrect or missing information from the medication. -The RCD should follow up behind the MAs to assure medications were labeled properly. -It was the MAs responsibility to verify the accuracy of the labels with the order entries as	D 352		

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D 352	Continued From page 47 part of their check system when administering medications.	D 352		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 4 residents (Residents #10 and #19) observed during the medication pass related to diuretics not available for administration (Residents #10 and #19), an antihistamine and a vitamin D3 not available for administration (Resident #10), and 2 of 5 sampled residents (Residents #3 and #16) related to a psychotropic medication not available for administration (Resident #16), and 18 missed doses of magnesium chloride (Resident #3). The findings are: The medication error rate was 9.5 % as evidenced by the observation of 4 errors out of 42 opportunities during the 8:00am and 9:00am medication passes on 01/28/20.	D 358		

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D 358	Continued From page 48 1. Review of Resident #10's current FL2 dated 12/09/19 revealed diagnoses included diabetes mellitus Type 2, diverticulitis, morbid obesity, anxiety and depression. a. Review of Resident #10's FL2 dated 12/09/19 revealed a medication order for hydrochlorothiazide 25mg daily, hold for systolic blood pressure less than 100 and call the physician for blood pressure less than 100 or greater than 160. (Hydrochlorothiazide is used to treat high blood pressure and fluid retention). Observation of the morning medication pass on 01/28/20 at 8:00am revealed: -Resident #10 was sitting next to the medication cart waiting for the medication aide (MA) to administer her medications. -The MA could not find some of Resident 10's medications. -She made several trips to the medication room. -There were 4 medication bottles with pharmacy generated labels; acetaminophen, divalproex, sertraline and clonazepam. -There were also 7 medication tablets in a multi-dose package with Resident 10's name handwritten on the cover. -The medications in the multi-dose package were not labeled with the name of the medication or the dosage. -The MA removed 6 tablets from the medication bottles. -She attempted to pop the tablets in the multi-dose package. When questioned, she could not identify the medications. -She decided not to administer the medication until it was clarified. -Resident #10 was not administered her hydrochlorothiazide tablet.	D 358		

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D 358	Continued From page 49 Review of Resident #10's January 2020 electronic Medication Administration Records (eMARs) revealed: -There was an entry for hydrochlorothiazide 25mg daily, hold for systolic blood pressure less than 100 and call the physician for systolic blood pressure less than 100 or greater than 160. -There was documentation Resident #10's blood pressure was within normal limits from 01/01/20 through 01/28/20. -There was documentation hydrochlorothiazide was administered from 01/01/20 through 01/28/20. Observation of Resident #10's medications on hand on 01/28/20 at 9:15am revealed: -The multi-dose packaging was dated 01/26/20-02/01/20 and divided into morning and evening doses. -There were no labels identifying the names of the medications or the dosages in each of the packets. -There was no pharmacy generated label for hydrochlorothiazide on a medication bottle or the multi-dose package. -The 01/26/20 morning and evening dose medications had not been administered and were still in the multi-dose package. Telephone interview with the pharmacist at the local pharmacy on 01/31/20 at 9:48 revealed: -Resident #10 had her prescription medications filled from the local pharmacy. -The medications had been sent in medication bottles with pharmacy generated labels. -The facility requested the medications be sent in multi-dose packaging in October of 2019. -This was not a long-term care pharmacy and they had not filled medications in multi-dose	D 358		

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packaging.
-They were not able to generate labels for the medications that fit the packaging.
-The facility printed a list of Resident #10's medications and attached it to the inside of the cardboard cover. Not all the medications were in the multi-dose package.
-The morning medications in the multi-dose package were as follows:
-Cetirizine 10mg, hydrochlorothiazide 25mg, metformin 500mg and levothyroxine 50mcg.
-Cetirizine, hydrochlorothiazide and metformin were scheduled to be administered at 9:00am
-Levothyroxine was scheduled to be administered at 6:00am.
-The medications in the multi-dose package were last filled on 01/13/20 for 3 weeks.
-Each cardboard sleeve had 7 days of morning and evening medications.
-The facility staff could have contacted the pharmacist and he would have identified the medications in the multi-dose packaging for them, but they did not.

b. Review of Resident #10's FL2 dated 12/09/19 revealed a medication order for cetrizine 10mg daily. (Cetrizine was an antihistamine used for allergic reactions).

Review of Resident #10's January 2020 eMARs revealed:
-There was an entry for cetirizine 10mg to be administered daily at 8:00am.
-Cetrizine 10mg was documented as administered on 01/01/20 through 01/22/20 and 01/24/20 through 01/27/20.
-Cetrizine was documented as not administered on 01/23/20.
-The comments listed on the eMAR, initialed by the MA, documented "Not administered-drug

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D 358	Continued From page 51 unavailable". Observation of Resident #10's available medications on hand on 01/28/20 at 9:20am revealed there was no pharmacy generated label for cetrizine on a medication bottle or multi-dose package. Telephone interview with the pharmacist at the local pharmacy on 01/31/20 at 9:48am revealed: -Cetrizine was bubble packed in a multi-dose package. -The pharmacy did not get a request to send out any cetrizine or question why it was not in the bubble packet on 01/23/20. c. Review of Resident #10's FL2 dated 12/09/19 revealed a medication order for Vitamin D3 2000 units daily. (Vitamin D assists the absorption of calcium for bone development.) Review of Resident #10's January 2020 eMARs revealed: -There was an entry for Vitamin D3 2000 units to be administered daily at 9:00am. -There was documentation Vitamin D3 was documented daily from 01/01/20 through 01/27/20. Observation of Resident #10's available medications on hand on 01/28/20 at 9:25am revealed there was there was no pharmacy generated label for Vitamin D3 on a medication bottle or multi dose package. Interview with a first shift medication aide (MA) on 01/28/20 at 9:20am revealed: -She did not usually work on this medication cart. -She did not know what medications were bubble packed in the multidose package.	D 358		

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-The multi-dose packet had a handwritten label with the date and "AM" on the top and side of the card.
-She assumed the medications that were not in the labeled medication bottles were in the multi dose packet.

Interview with Resident #10 on 01/28/20 at 9:44am revealed:
-Her medications were frequently administered late.
-This made her very anxious.
-She received a lot of medications in the morning and did not know if she received everything her physician prescribed every day.

2. Review of Resident #19's current FL2 dated 12/09/19 revealed:
-Diagnoses included dementia, hypertension, bilateral leg edema and atrial fibrillation.
-Medications included triamterine-hydrochlorothiazide 37.5-25 daily. (Triamterine-hydrochlorothiazide was used to treat high blood pressure and edema).

Review of Resident #19's January 2020 electronic medication administration records (eMARs) revealed:
-There was an entry for triamterine-hydrochlorothiazide 37.5-25 daily to be administered at 9:00am.
-There was documentation triamterine-hydrochlorothiazide 37.5-25 was administered daily at 9:00am.

Observation of Resident #19's medications on hand on 01/28/20 at 2:25pm revealed there was no pharmacy generated label for triamterine-hydrochlorothiazide 37.5-25 on a medication bottle or multi-dose package.

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D 358	Continued From page 53 Interview with Resident #19 on 01/28/20 at 10:35am revealed: -The medication aides (MAs) administered her medications. -She was taking a diuretic for swelling in her legs. -She thought she received all her medications but relied on the MAs to keep up with that. 3. Review of Resident #16's current FL2 dated 12/17/19 revealed: -Diagnoses included physical deconditioning, Parkinson's disease and diabetes mellitus. -Medications included Clozapine 25mg, 6 tablets (150mg) every evening. (Clozapine was used to treat schizophrenia). Review of Resident #16's December 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Clozapine 25mg, 6 tablets (150mg) every evening, to be administered daily at 8:00pm. -There was documentation Clozapine was not administered on 12/31/20. -The comments listed on the eMAR, initialed by the medication aide (MA), documented "Drug unavailable". Observation of Resident #16's medications on hand on 01/29/20 at 11:35am revealed there was no Clozapine available for administration. Review of Resident #16's January 2020 eMAR revealed: -There was an entry for Clozapine 25mg, 6 tablets (150mg) every evening, to be administered daily at 8:00pm. -There was documentation Clozapine was not administered on 01/01/20 and 01/02/20.	D 358		

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D 358	Continued From page 54 -The comments listed on the eMAR documented "Not administered-drug on hold". -There was documentation Clozapine was not administered on 01/12/20, 01/18/20, 01/19/20, 01/22/20, 01/23/20 and 01/28/20. -The comments listed on the eMAR, initialed by the MA, documented "Not administered-drug unavailable". Interview with the Resident Care Director (RCD) on 01/28/20 at 3:20am revealed: -She was not aware Resident #16 was not administered Clozapine as ordered by the physician in January 2020. -She worked as a medication aide (MA) on the medication cart 2 days a week. -Medication cart audits were performed weekly by the RCD, MAs, and the Director of Sales. -The medication carts audits were not documented when they were completed. -She had not performed a medication cart audit in January 2020 due to "working the floor and I did not have enough time to complete the audits". -She was responsible for reviewing the eMAR for completion and holes. -She thought she had reviewed December 2019 but could not say for sure. -There was no one who checked behind her for completion of the RCD assignment or task. Interview with the interim Executive Director (ED) on 01/28/20 at 3:15pm revealed: -Her first day as ED was 01/28/20. -The policy was after a medication was missed three consecutive times the physician was to be notified. -She did not know why a resident would not be administered medications as ordered by their physician during the month of January 2020.	D 358		

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D 358	Continued From page 55 Telephone interview with a representative from the facility's contracted pharmacy on 01/29/20 at 10:00am revealed: -Resident #16's FL2 was sent from the facility on 12/20/19. -Clozapine 25mg, administer 6 tablets to equal 150mg at bedtime, was listed on the FL2. -The physician who signed the FL2 was not licensed as a Risk Evaluation and Mitigation Strategy program (REMS) provider so the prescription could not be filled. -The pharmacy attempted to contact the facility on three separate occasions. -The pharmacy did not document who they spoke to in regard to Resident #16's Clozapine prescription. Interview with the previous primary care provider (PCP) on 01/29/20 at 12:15pm revealed: -She managed Resident #16's medical concerns as his family care physician until 12/20/19. -She signed Resident #16's FL2 dated 12/17/19 upon discharge from the previous facility. -She was not the prescribing physician for Clozapine 25mg, six tablets every evening. -She referred Resident #16 to a mental health provider on 11/08/19 to prescribe and follow his psychotropic medications. Interview with the current PCP on 01/29/19 at 4:40pm revealed: -He had been the PCP for Resident #16 since he was admitted to the facility on 12/20/19. -He was not licensed in the REMS program to prescribe Clozapine for Resident #16. -The PCP referred Resident #16 to a mental health provider on 12/24/19. -The Clozapine was documented as administered on the electronic medication administration record (eMAR), so he thought Resident #16 was	D 358		

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receiving the Clozapine.
-He was very concerned Resident #16 was not receiving the Clozapine.
-He did not feel qualified to state the possible effects to Resident #16 in not receiving his Clozapine as prescribed.
-The PCP gave his orders to the Resident Care Director (RCD) when he made his rounds at the facility.
-He faxed his orders to the facility if he was off site.
-He relied on the previous Resident Care Coordinator (RCC) and the current RCD to inform him if his residents needed medications or laboratory tests to be ordered.
-He was not informed Resident #16 was not receiving Clozapine every evening.

Interview with Resident #16 on 01/30/20 at 9:30am revealed:
-Resident #16 was in his bedroom in a wheelchair.
-He reported he had felt a "bit more shaky lately".
-He had the sensation his head "felt full."
-He was experiencing a "sucking sensation around his mouth", which was also new.
-He would rather stay in his room than be in the common areas of the community.

Interview with the previous mental health physician on 01/30/20 at 9:38am revealed:
-He was a mental health physician who was REMS certified and had prescribed Clozapine to Resident #16.
-Resident #16 had been taking Clozapine since 1992.
-Clozapine was the preferred drug for schizophrenic patients.
-Resident #16's symptoms were well controlled at the time he was discharged.

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-Clozapine was only filled on a monthly basis-31 doses, 186 pills.
-The last fill date for Resident #16's Clozapine was 12/08/20.
-The next refill should have been 01/08/20.
-He did not know if Resident #16's medications were sent with him when he was discharged.
-The adverse effects of stopping Clozapine would be an increase in the resident's psychosis, auditory hallucinations, agitation and insomnia.
-If he was the prescribing physician at this time, he would restart Clozapine and prescribe Ativan until the Clozapine was effective.

Observation at Resident #16's bedroom door on 01/30/20 at 11:28am revealed:
-Resident #16 was having a conversation.
-There was no one else in his room.

Interview with Resident #16 on 01/30/20 at 11:28am revealed:
-When asked who he was speaking to in his room he stated "he was talking out loud".
-Resident #16 said he had not been getting his Clozapine, but did not think he was experiencing any behaviors at this time.
-When he was experiencing behaviors they were mostly auditory hallucinations.

Observation outside Resident #16's bedroom door on 01/30/20 at 11:33am revealed Resident #16 continued his conversation stating "I hope they don't roast us."

Interview with the RCD on 01/30/20 at 2:25pm revealed:
-She did not know Resident #1's Clozapine was not on the cart.
-She had not been notified by the MAs the Clozapine was not on the medication cart.

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-She had sent the Clozapine prescription to the pharmacy on 01/23/20.
-She relied on the MAs to inform her when a medication was not available to administer.
-She did not know why the pharmacy had not filled the prescription to date.
-She had not contacted the pharmacy regarding the Clozapine.
-She did not have the mental health providers notes from the visit on 01/23/20.
-She had not observed a change in behavior in Resident #16 nor was it reported to her.

Interview with the interim Executive Director (ED) and the Regional Vice President of Operations on 01/30/20 at 3:50pm revealed:
-When an order was received at the facility, it was immediately faxed to the pharmacy.
-The MAs as well as the RCD were responsible for faxing orders as they were received.
-If the MAs received a new order, it should be documented on the Shift Report and brought to the RCD.
-If a medication was not in the building the MAs should contact the pharmacy.
-If the medication continued to be unavailable after faxing the order to the pharmacy, the RCD should be notified.
-The RCD should follow up with the pharmacy and the physician when orders have not been completed in a timely manner-within 2 or 3 days.
-They were not aware Resident #16's Clozapine was unavailable for administration to the resident since 12/31/19.

Review of the Mental Health provider's Visit Summary notes revealed:
-The Nurse Practitioner (NP) made the initial visit to Resident #16 on 01/23/20.
-At that visit, Resident #16 stated the facility was

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not administering Clozapine to him.
-The NP brought this information to the attention of the RCD.
-Resident #16 did have some "thought blocking and minimal paranoia and hallucinations" at that time.
-The NP ordered a Clozapine level to be tested and wrote a prescription for Clozapine 150mg to be restarted.
-The staff were made aware to contact the NP with any "abnormalities" concerning these orders.

Telephone interview with the Mental Health NP on 01/30/20 at 5:30pm revealed:
-He was currently the Mental Health provider for Resident #16.
-He had been informed by the resident he was not receiving Clozapine in the evening.
-He did not know the prescription for Clozapine he had left on 01/23/20 had not been filled.
-The staff should have informed him the pharmacy refused to fill the prescription, per his visit summary notes.
-He spoke with the RCD last week and he did not know Resident #16 was still not getting his Clozapine. "No one reached out to me."
-The Clozapine laboratory results showed Resident #16 had not been receiving his medication-the level was 0.
-Resident #16 may experience an increase of hallucinations without the Clozapine.
-He had not had any reports of Resident #16 exhibiting aggressive behavior.

Interview with a MA on 01/31/20 at 11:29am revealed:
-Resident #16's Clozapine has not been available on the medication cart to administer for a while.
-The previous RCC and Administrator knew the medication was not available.

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D 358	Continued From page 60 -The RCC was the liaison with the resident's physicians. -The MA had not notified the physician the medication was not available. -She was informed, by the staff at the facility, they were waiting for the pharmacy to fill the Clozapine. -She did not know why it had not arrived yet. Telephone interview with another MA on 01/31/20 at 12:00pm revealed: -Resident #16 had not been on Clozapine for a while. -When he first arrived at the facility (12/20/19) he had his medication, but it had not been available for administration for several weeks. -She sent the prescription to the pharmacy, but the medication was never filled. -The MA informed the previous RCC Resident #16 had no Clozapine to administer. -The RCC said Resident #16 had to see the physician. "Let's see how he does off the medication." -The RCC scheduled visits with the residents' physicians and took the physician's orders. -After she spoke with the previous RCC and Administrator, she thought they stated, "just keep signing Clozapine was administered until it came in". -Resident #16's behavior had changed over the past few weeks. He sits in his room in the dark and talks to himself. -He was not doing that when he first arrived. Telephone interview with facility contracted pharmacy staff on 01/31/20 at 12:00pm revealed: -Resident #16's Clozapine prescription had not been filled on 12/20/19. -They had been waiting for laboratory results and a REMS provider to prescribe the Clozapine.	D 358		

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D 358	Continued From page 61 -On 01/23/20 the facility faxed a new prescription for Resident #16's Clozapine. -The pharmacy staff faxed the facility to inform them the prescription could not be filled as written. -There was no further communication from the facility and no new prescriptions as of 01/31/20. Interview with the power of attorney (POA) on 01/31/20 at 10:15am revealed: -Resident #16 has always been very accurate and attentive to his medications, especially Clozapine. -He was transported to this facility by the staff at the rehabilitation facility and the POA did not know if his medications followed him. -Resident #16 had complained to the POA that he was not receiving his evening dose of Clozapine at the facility. -This week the resident reported hearing voices again and was agitated at dinner when they went out. -Resident #16 also stated he wasn't sleeping well. Interview with a medication aide (MA) on 01/28/20 at 2:20pm revealed: -If a Resident missed three consecutive doses of a medication the policy was to contact the physician. -If you cannot find a medication on the medication cart you were to contact the pharmacy and find out why the medication was not in the facility. -You were to contact the physician to obtain a "Hold Order" until a medication was available for administration. -MAs and the RCD could obtain a verbal hold order on a medication from a physician. -The verbal hold order was to be transcribed on a physician communication form and sent to the physician for their signature.	D 358		

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D 358	Continued From page 62 -Once the hold order was signed, it was placed in the Resident's record. Review of Resident #16's record revealed there was not a verbal order to hold Clozapine signed by his primary care physician. Interview with the RCD on 01/31/20 at 11:00am revealed: -The MAs were responsible for administering the medications according to the physician's order. -The MAs were responsible for checking the order with the medications on hand and administering the medications to the correct resident. -The MAs were to verify the medications with the order and place the medications in the medication cup, click prepared on the eMAR, administer the medication to the resident and then click complete. -If the medications were not on the medication cart at the time of the medication pass, then the MA was to look for the medication in the medication cart. -If the medication was not found on the medication cart then the MA was to check the medication room. -If the MA could not find the medication in the facility then the pharmacy was called and the physician if necessary. -She was to be notified if there were any issues with missing medications. -She trained and counseled the MAs about week 2-3 weeks ago about medication administration and documentation of medications administered, refusals and medications not in the facility. -When a new resident arrived with medications from outside the facility, the staff was to write down every medication with the instructions and the amount of that medication on the medication	D 358		

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D 358	Continued From page 63 list and place a copy in the resident's chart. -The MAs were to document a medication as it was given. If the medication was not given, then it was to be documented as such-not as administered. -The MAs were to inform her of any issues during the medication pass if they arose. -She could not produce a list of medications Resident #16 arrived with, if any, upon admission. -She had been waiting for the mental health provider to write a prescription for Clozapine for Resident #16. -The Mental Health provider's first visit to Resident #16 was 01/23/20. -She did not know the pharmacy could not fill the prescription for Clozapine the mental health provider sent on 01/23/20. 3. Review of Resident #3's current FL2 dated 12/09/19 revealed: -Diagnoses included cardiomyopathy, diabetes, hypertension and cerebral vascular accident. -Medication orders included magnesium chloride (supplement to prevent low magnesium) 64mg take one tablet three times daily. Review of Resident #3's electronic Medication Administration Record (eMAR) for January 2020 revealed: -There was an entry for magnesium chloride 64mg three times daily scheduled at 9:00am, 3:00pm, and at 9:00pm. -There was documentation on 01/01/20 through 01/05/20 magnesium chloride 64mg was not administered, reason documented, "On Hold" not available. -There was documentation on 01/07/20 magnesium chloride 64mg was not administered reason documented, "On Hold".	D 358		

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D 358	Continued From page 64 -There was documentation on 01/10/20 through 01/16/20 magnesium chloride 64mg was not administered reason documented, "On hold". -There was documentation on 01/18/20 through 01/20/20 magnesium chloride was not administered reason documented, "On Hold". -There was not communication in reference to the physician notified Resident #3's magnesium chloride was not administered as order in January. Review of Resident #3's record revealed there was no communication note with the physician the magnesium chloride was not administered in January 2020. Telephone interview with the facility pharmacy on 01/28/20 at 10:40am revealed: -Resident #3's current order was magnesium chloride 64mg take one tablet three times daily. -The pharmacy dispensed Resident #3's magnesium chloride 64mg on 11/27/19 with a total of 84 tables a 28-day supply. -The pharmacy did not dispense any magnesium chloride for Resident #3 in December 2019. -The 84 tablets dispensed in November 2019 magnesium would had covered most of December 2019 administration of the magnesium chloride. -The facility had not requested magnesium chloride 64mg in December 2019 or January 2020 until 01/06/20. -The pharmacy dispensed Resident #3's magnesium chloride 64mg on 01/06/20 with a total of 60 tablets a 20-day supply. -The pharmacy dispensed Resident #3's magnesium chloride 64mg on 01/19/20 with a total of 60 tablets for a 20-day supply. -The facility was responsible for send or faxing over new orders or renewal of medications for the	D 358		

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residents.
-Magnesium chloride was a supplement for improving magnesium levels in the body.
-If a resident had a low magnesium, they could feel weakness and fatigue.
-Resident #3 was also on a diuretic which pulled electrolytes and could deplete the magnesium in her body.

Observation of medication on hand for Resident #3 on 01/28/20 revealed there were two punch cards with pharmacy generated labels for magnesium chloride 64mg dispensed 01/19/20 with a total amount of 46 tablets available for administering.

Interview on 01/28/20 at 2:20pm with a medication aide (MA) revealed:
-The policy was to contact the physician if a resident missed three consecutive doses of a medication.
-If you could not find a medication on the medication cart you were to contact the pharmacy and find out why the medication is not in the facility.
-They were to contact the physician to obtain a "Hold Order" until the medication comes in or is located.
-She could not recall Resident #3 magnesium chloride not being available to administer to Resident #3 in January 2020.

Telephone interview with a night shift MA on 01/29/20 at 5:30am revealed:
-She knew Resident #3's magnesium chloride was not available to administer in January 2020.
-The policy was to contact the physician if you could not find the medication on the medication cart and get a hold order until the medication was found or arrived from the pharmacy.

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-She could not find a pharmacy generated "sticker" for the magnesium chloride to place on the pharmacy re-order form to reorder the magnesium chloride for Resident #3 in January 2020.
-She had not thought to hand-write the magnesium chloride on the re-order form and fax to the pharmacy.
-She was not sure if another MA on first shift had ordered the magnesium chloride for Resident #3.
-She had told the Resident Care Director (RCD) and the former Administrator Resident #3 was out of the magnesium chloride around 01/03/20.
-She documented on Resident #3's eMAR the medication magnesium chloride was on hold and was not available to be administered during the month of January on multiple occasions.
-She had not contacted Resident #3's physician because she was worked night shift, and day shift should contact the physician.

Interview with the Resident Care Director (RCD) on 01/28/20 at 3:20am revealed:
-She was not aware Resident #3 magnesium chloride was not administered as ordered by the physician in January 2020.
-She worked as a MA on the medication cart 2 days a week.
-Medication cart audits were performed weekly by the RCD, MAs, and the Director of Sales.
-The medication carts audits were not documented when they were completed.
-She had not performed a medication cart audit in January 2020 due to "working the floor and I did not have enough time to complete the audits".
-She was responsible for reviewing the eMAR for completion and holes.
-She thought she had reviewed December 2019 but could not say for sure.
-There was no one who checked behind her for

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D 358	Continued From page 67 completion of the RCD assignment or task. Interview with the Interim Executive Director (ED) on 01/28/20 at 3:15pm revealed: -Her first day as the ED was today 01/28/20. -The policy of the company was after a medication was missed three consecutive times the physician was to be notified. -She did not know why Resident #3's magnesium chloride 64mg was not administered as ordered by the physician during the month of January 2020. Telephone interview with Resident #3's physician on 01/29/20 at 4:15pm revealed: -He was not aware the facility staff had not administered Resident #3's magnesium chloride as ordered three times daily during January 2020. -He did not know from 01/01/20 to 01/06/20 there were 18 missed doses of the magnesium chloride scheduled for three times daily. -If Resident #3 missed a few doses of the magnesium he would not be concerned but if Resident #3 was not administered the magnesium chloride for several days "this could be a big deal." -Magnesium chloride is a supplement used to prevent low magnesium levels in Resident #3 body, if the magnesium is low it could cause muscle weakness, fatigue, and lead to rhythm disturbances. -The facility was responsible for contacting the pharmacy for re-ordering medications for the residents. -"When there was an order to administer medications, I expect my orders to implemented and followed." _____ The facility failed to administer medications as	D 358		

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D 358	Continued From page 68 ordered by a physician for Resident # 16 who had an order for Clozapine to be administered as ordered but was not administered resulting in Resident #16 observed having conversations with himself, hearing voices again, was agitated at dinner and wasn't sleeping well. Resident # 10 was not administered hydrochlorothiazide daily with perimeters to hold for systolic blood pressure less than 100 and call the physician for blood pressure less than 100 or greater than 160 or cetirizine 10mg, Resident #19 triameterine-hydrochlorothiazide not on the eMAR or administered as ordered daily, and Resident #3's missed 18 doses of magnesium chloride due the medication was not in the facility to administer. This failure to administer medications as ordered was detrimental to the health, safety and welfare of the residents and constitutes a Type B violation. _____ A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 01/30/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 15, 2020	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered;	D 367		

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D 367	Continued From page 69 (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of the Medication Administration Records (MARs) for 2 of 5 sampled residents (Resident #16 and #12) related to documenting the administration of a psychotropic medication for a resident with schizophrenia that was not available for administration (Resident #16) and not documenting the fingerstick blood sugar readings(FSBS) on a diabetic resident as ordered by the physician (Resident #12). The findings are: Review of Resident #16's current FL2 dated 12/09/19 revealed:	D 367		

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D 367	Continued From page 70 -Diagnoses included schizophrenia. -Medications included Clozapine 25mg, administer 6 tablets to equal 150mg every evening. Review of Resident #16's January 2020 electronic Medication Administration Records (eMARs) revealed: -There was a computer-generated entry for Clozapine 25mg, administer 6 tablets to equal 150mg every evening at 8:00pm. -Clozapine 25mg was documented as administered on 01/03/20 through 01/11/20, 01/13/20 through 01/17/20, 01/20/20 and 01/21/20, and 01/24/20 through 01/26/20. -Clozapine was documented as unavailable for administration on 01/01/20 and 01/02/20, 01/12/20, 01/18/20 and 01/19/20, 01/22/20 and 01/23/20. Observation of Resident #16's medications on hand on 01/29/20 at 11:35am revealed there was no Clozapine available for administration. Interview with a MA on 01/31/20 at 11:29am revealed: -Resident #16's Clozapine has not been available on the medication cart to administer for a while. -The previous RCC and former Administrator knew the medication was not available. -She did not know why she had signed for the Clozapine on the January 2020 eMAR. -"Sometimes it gets very busy and mistakes can happen." Telephone interview with another MA on 01/31/20 at 12:00pm revealed: -Resident #16 had not been on Clozapine for a while. -When Resident #16 arrived at the facility	D 367		

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(12/20/20) he had some medication, but Clozapine had not been available for administration for several weeks.
-She did not remember documenting as administered Resident #16's Clozapine, "I guess it was a mistake."

Interview with the Resident Care Director (RCD) on 01/28/20 at 3:20pm revealed:
-She was not aware Resident #16 was not administered Clozapine as ordered by the physician in January 2020.
-She worked as a medication aide (MA) on the medication cart 2 days a week.
-Medication cart audits were performed weekly by the RCD, medication aides (MAs) and the Director of Sales.
-The medication carts audits were not documented when they were completed.
-She had not performed a medication cart audit in January 2020 due to "working the floor and I did not have enough time to complete the audits".
-She was responsible for reviewing the eMAR for completion and holes.
-She thought she had reviewed December 2019 but could not say for sure.
-There was no one who checked behind her for completion of the RCD assignment or task.

Interview with the interim Executive Director (ED) on 01/28/20 at 3:15pm revealed:
-She did not know why Resident #16's Clozapine would have been documented as administered if the medication was not available for administration.
-Her expectation was the MAs would document the administration of medications accurately.

Interview with the primary care physician (PCP) on 01/29/19 at 4:40pm revealed the Clozapine

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was documented as administered on the eMAR so he thought Resident #16 was receiving the Clozapine.

Interview with the power of attorney (POA) on 01/31/20 at 10:15am revealed Resident #16 had complained to the POA that he was not receiving his evening dose of Clozapine at the facility.

Telephone interview with facility contracted pharmacy staff on 01/31/20 at 12:15pm revealed:
-Resident #16's Clozapine prescription had not been filled on 12/20/19.
-They had been waiting for laboratory results and a REMS provider to prescribe the Clozapine.

2. Review of Resident #12"s FL2 dated 07/26/19 revealed diagnoses included hypertension, anxiety and hypothyroidism.

Review of a signed physician's order dated 01/17/20 revealed an order to check a FSBS every morning before breakfast for 14 days at 8:00am.

Review of Resident #12's January 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for finger stick blood sugar (FSBS) every morning before breakfast scheduled for 8:00am.
-The FSBS entries were blank 01/20/20 to 01/28/20 at 8:00am.
-A FSBS was documented as 152 on the eMAR on 01/29/20 at 8:00am.

Interview with a medication aide (MA) on 01/29/20 at 8:00am revealed:
-Resident #12's blood sugar was running low, so the physician ordered the FSBS to be checked

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D 367	Continued From page 73 every morning and documented. -She checked Resident #12's FSBS 4 out of 10 times on the eMAR. -She did not record a FSBS on 3 out of the 4 times on the eMAR. -Resident #12 did not have a place on the eMAR to put the FSBS. -On 01/22/20, she informed the RCD about the eMAR not having a place to document the FSBS. -She recorded the FSBS on 01/29/20 when the space became available. Interview with the Resident Care Director (RCD) on 01/28/20 at 3:20pm and on 01/30/20 at 12:00pm revealed: -The MAs were responsible for documenting the FSBS on the eMAR right after obtaining the results. -If there was a problem with where to document the FSBS then she was to be notified. -She had not performed medication cart audits in January 2020 due to "working the floor and I did not have enough time to complete the audits". -She was responsible for reviewing the eMAR for completion and holes. -There was no one who checked behind her for completion of the medication cart audits.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment	D 451		

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D 451	Continued From page 74 other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure notification to the County Department of Social Services (DSS) of any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization or medical treatment other than first aid for 6 of 26 sampled residents related to falls. The findings are: Review of the facility's "New Incident Reporting Procedure" dated August 2017 revealed: -Submit reportable incidents to your Divisional Director of Clinical Services for review and approval (this includes elopements). -Complete any necessary revisions. -Submit approved reportable incident reports to DSS / Licensing within the allotted time frame to include a confirmation of submission. Interview with previous Administrator on 01/09/2020 at 2:30 pm revealed: -The former Resident Care Director was responsible for submitting accident and incident reports. -The Administrator did not know how to complete accident and incident reports for DSS. -The Administrator had a stack of incident and accident reports on her desk that she and the Resident Care Coordinator were having to learn how to submit.	D 451		

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D 451	Continued From page 75 Interview with a medication aide (MA) on 01/09/2020 at 3:00pm revealed if an incident or accident occurred, staff were to contact 911, the Administrator and the Primary Care Provider. Review of the 911 call log for the facility on 01/10/2020 revealed: -From 10/01/2019 to 01/10/2020, EMS responded to the facility on 28 occasions related to falls. -Six of the falls required residents to be sent out to the local emergency department. Interview with the AHS for the DSS on 01/28-20 at 10:00am revealed of the six falls between 10/01/19 and 01/10/20, DSS had not received any incident and accident report from facility. Review of EMS reports on 01/24/2020 revealed EMS was dispatched to the facility on 12/27/2019, 12/28/2019, 12/31/2019, 01/05/2020 and 01/06/2020 (2 times) reference falls. Review of EMS report dated 12/27/2019 revealed: -EMS was dispatched to the facility at 4:55pm reference a fall. -Resident was a 75-year-old. -Resident had fallen while attempting to stand from a seated position on the bed. -The fall was not witnessed. -The fall was reported to staff by the resident several hours after occurring. -The resident was more confused than normal. -The resident presented with fever and dizziness upon standing and attempting to walk. -The resident was transported to the local emergency department for treatment. Review of EMS report dated 12/28/2019	D 451		

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revealed:
-EMS was dispatched to the facility at 2:41pm reference a fall.
-Resident was a 74-year-old.
-Resident was lying on the bathroom floor behind the door.
-The resident had pain to the left side of his head and was experiencing stomach pains.
-The resident was transported to the local emergency department for treatment.

Review of EMS report dated 12/31/2019 revealed:
-EMS was dispatched to the facility at 11:58pm reference a fall.
-Resident was a 78-year-old found lying on her right lateral side.
-Resident reported she rolled out of her bed hitting the corner of the nightstand.
-Resident complained of pain to her right eye and had bleeding from a laceration.
-The resident had a laceration approximately 1 inch and located over resident's right eye.
-The resident was transported to the local emergency department for treatment.

Review of EMS report dated 01/05/2020 revealed:
-EMS was dispatched to the facility at 1:22am reference a fall.
-Resident was a 86-year-old found on the floor of her room in a prone position.
-Resident had left hip pain and a deformity to her right shoulder.
-Resident was transported to the local emergency department for treatment.

Review of EMS report dated 01/06/2020 revealed:
-EMS was dispatched to the facility at 9:27am

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reference a fall.
-Resident was a 67-year-old dizzy and weak.
-The resident lost his balance and fell.
-The resident had a low blood pressure.
-Resident was transported to the local emergency department for treatment.

Review of EMS report dated 01/06/2020 revealed:
-EMS was dispatched to the facility at 4:12pm reference a fall.
-Resident was a 84-year-old.
-The resident was sitting in the dining room floor.
-He had been dizzy and had a low pressure after having medications changed.
-Resident was transported to the local emergency department for treatment.

Interview with current Administrator on 01/29/2020 at 8:53am revealed:
-She was unaware incident and accident reports were not being sent to DSS by previous Administrator.
-She knew reports needed to be submitted within 48 hours, but she liked the reports sent within 24 hours.

Interview with a second MA on 01/29/2020 at 1:05pm revealed:
-If an incident or accident occurred, a report was completed electronically and submitted.
-Submitted incident and accident reports were forwarded to management.
-If resident had an accident, facility staff were to contact 911 if needed and notify resident's primary care taker and power of attorney.

Interview with a personal care aide (PCA) on 01/30/2020 at 4:12pm revealed:
-If an incident or accident occurs, staff were to

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D 451	Continued From page 78 notify the on-duty MA so a report could be made. -She did not know where the reports went once, they were submitted. -The PCA kept a notebook on her person and wrote down accidents to have her own record. Interview with Resident Care Coordinator on 01/31/2020 at 10:15am revealed: -Staff who witness an incident or accident should also complete the incident and accident report. -Once reports were completed, they were submitted to management. -Management within the facility were responsible for sending/faxing incident and accident reports to the DSS.	D 451		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48	D 454		

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D 454	Continued From page 79 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to contact the responsible party within 24 hours for 1 of 5 sampled residents after an incident in which a resident required a hospital evaluation (Resident #1). The findings are: Review of Resident #1's FL2 dated 12/09/19 revealed diagnoses included dementia, hyperthyroidism, hypertension, and intermediate vertigo. Review of Resident #1's hospital history and physical report revealed: -The resident was admitted to the hospital on 12/28/19. -The resident was sent to the emergency department with complaints of fever and genital rash of unknown duration. -The resident was unable to provide any information regarding medical history. -Upon evaluation, the resident's family was present at bedside. -The family explained that they were not contacted that the resident was being transferred to the emergency department and was unsure why she was in the emergency room (ER). -The resident expired during her stay in the hospital.	D 454		

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Review of Resident #1's progress notes revealed on 12/27/19 at 7:04pm, there was documentation "med tech spoke with [family member] regarding resident status and being sent to the emergency room". [Recorded as late entry on 12/28/19 at 7:05pm]

Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 01/31/20 at 11:17am revealed:
-A previous MA who no longer worked at the facility, called Resident #1's family when she was sent out on 12/27/19.
-She thought another MA who worked third shift witnessed the telephone call to Resident #1's Responsible Party (RP).
-The MA, RCC, and Resident Care Director (RCD) would all be responsible for making sure the RP was contacted.
-She thought the family was notified of Resident #1 being sent out.

Interview with the Responsible Party (RP) for Resident #1 on 01/28/20 at 6:18pm revealed:
-Resident #1 was sent to the hospital on 12/27/19.
-No one at the facility contacted him to inform that his family member had been admitted to the hospital.
-He found out his family was admitted to the ER after a friend texted him on 12/27/19 in the evening to ask about the status of his mother after she was admitted.
-His friend informed him that she heard Resident #1 was sent out to the hospital.
-The residents' vagina was red and swollen.
-The resident had been at the hospital almost 3 hours before he knew she was admitted.
-Resident #1 was not a good historian of her medical history and required family to be present

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D 454	Continued From page 81	D 454		

with her.

Interview with a family member on 01/28/19 at 8:54am revealed:
-Resident #1 was admitted to the hospital on 12/28/19, she was sent out by the facility staff.
-The Responsible Party (RP)/family had not been notified that the resident was sent out to the hospital.

Interview with the previous Resident Care Director (RCD) on 01/30/20 at 8:31am revealed:
-Resident #1 was sent out to the hospital due to a change in her condition.
-The MAs were responsible to notifying the RP if their family was sent out to the emergency room once the resident has been sent out.
-She did not know Resident #1's RP had not been contacted regarding the ER admission on 12/27/19.

Interview with the previous Administrator on 01/29/20 at 5:12pm revealed:
-On 12/27/19, the resident began to decline cognitively, and she was sent to the hospital.
-The MAs were responsible for notifying the family member after the resident was sent to the emergency room.

Interview with the Regional Vice Present of Operations on 01/31/20 at 12:45pm revealed:
-Residents were to be sent to the hospital when there was a significant change in health.
-She expected the RP to be notified within 2 hours of hospitalization/emergency room visit.

Interview with the Interim Executive Director (ED) on 01/31/20 at 12:45pm revealed:
-She became the Interim ED on 01/28/20.
-She expected each resident RP to be notified the

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D 454	Continued From page 82 same day that the resident is sent out to the hospital and document the conversation in the progress notes once completed.	D 454		
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 ensure every resident had the right to receive care and services which are adequate, appropriate and in compliance with relevant state laws and rules related to Medication Administration, ACH Infection Prevention Requirements, Other Staff Requirements, Resident Rights' and Implementation. The findings are: 1. Based on observations, interviews, and record reviews, the previous Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care, referral and follow-up, medication administration, ACH infection prevention requirements, other staff requirements, and resident rights. [Refer to Tag D980 G.S. 131D-25 Implementation (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to implement a written	D912		

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D912	Continued From page 83	D912		

infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 9 of 9 diabetic residents sampled (Residents #3, #5, #9, #10, #12, #13, #14, #15, and #17) with orders for blood sugar monitoring resulting in sharing of glucometers between residents and facility staff not properly trained or provided the supplies to complete their tasks and provide personal care to the residents during the norovirus outbreak. [Refer to Tag D932 GS 131D4.4A ACH Infection Preventions Requirements (Type A2 Violation)].

3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 4 residents (Residents #10 and #19) observed during the medication pass related to diuretics not available for administration (Residents #10 and #19), an antihistamine and a vitamin D3 not available for administration (Resident #10), and 2 of 5 sampled residents (Residents #3 and #16) related to a psychotropic medication not available for administration (Resident #16), and 18 missed doses of magnesium chloride (Resident #3). [Refer to Tag D338 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

4. Based on interviews and record reviews, the facility failed to assure 1 of 5 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to Tag D137 10A NCAC 13F .0407(a)(5) Other Staff Requirements (Type B Violation)].

5. Based on observations, record reviews and

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D912	Continued From page 84 interviews, the facility failed to assure residents were treated with respect and dignity related to residents denied showers due to the norovirus outbreak in the facility. [Refer to Tag D338 10A NCAC 13F .0909 Residents' Rights (Unabated Type B 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: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect related personal care and referral and follow-up. The findings are: 1. Based on observations, interviews and record reviews the facility failed to assure the health care needs were met for 3 of 7 sampled residents related to timely primary care provider (PCP) notification of a painful itchy genital/buttock rash (Resident #1) and not notifying the psychiatric physician a resident's psychotropic medication was not available for administration for up to 28 days (Resident #16). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure personal care was provided to 2 of 5 sampled residents (#1 and	D914		

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D914	Continued From page 85 #18) related to a genital/buttock rash (#1) and a dried, soiled incontinent brief which had adhered to the resident's skin (#18). [Refer to Tag D269 10A NCAC 13F .0901(a) Personal Care (Type A1 Violation)].	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident,	D932		

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D932	Continued From page 86 equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 9 of 9 diabetic residents sampled (Residents #3, #5, #9, #10, #12, #13, #14, #15, and #17) with orders for blood sugar monitoring resulting in sharing of glucometers between residents and facility staff not properly trained or provided the supplies to complete their tasks and provide personal care to the residents during the norovirus outbreak.	D932		

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D932	Continued From page 87 The findings are: The local county Department of Social Services (DSS), Adult Home Specialist (AHS) arrived in the facility on 01/17/20. The AHS reviewed the electronic Medication Administration Record (eMAR) for a resident with ordered Finger Stick Blood Sugar (FSBS). The AHS could not locate the resident's glucometer in the facility. Interviews with staff at the facility acknowledge the resident's glucometer was missing, and they were using another residents' glucometer to obtain daily FSBS for the resident whose glucometer was missing. The AHS obtained a Plan Of Protection signed by the previous Administrator on 01/17/20 in the rule area GS 131D-4.4A ACH Infection Prevention Requirements. Interview with the MA on 01/28/20 at 8:05am revealed: -She did not know whose glucometer it belonged to because there was no name on it. -The glucometers were for single resident use only and every resident had their own glucometer. -The glucometers were to have the resident's name on the meter, the plastic bag, and the black bag each monitor was in as well. -She was trained to check for the name to be on all three things about 2 weeks ago by a Regional Physician Consultant and the nurse at the facility, the Resident Care Director (RCD). -All the glucometers in the facility were replaced around 01/21/20. Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be	D932		

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D932	Continued From page 88 cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the cleaning and disinfection instructions for the Brand A glucometer revealed the glucometer was intended to be used by a single person and should not be shared. Review of the facility's Infection Control Policy revealed the staff shall follow guidelines for diabetic testing/care to assure infection control was maintained. 1. Review of Resident #14's current FL2 dated 12/09/19 revealed: -Diagnoses included diabetes mellitus type 2. -There was an order to check FSBS three times a day before Novolog administration scheduled at 7:30am, 11:30am, 4:30pm. -There was an order to check FSBS, administer Levemir Flex Touch 25 units at bedtime, hold for FSBS less than 70. Observation of the medication pass on 01/28/20 at 9:00am revealed: -The MA pulled a clear plastic bag out of the glucometer drawer with Resident #14's name printed on the clear plastic bag. -The clear plastic bag with Resident #14's name on in contained, a round container of glucometer strips, disposable single use lancets and a black bag with resident #14's name on it but the glucometer did not have a name on it. -The MA pulled the glucometer without a name on it to use to obtain a FSBS from Resident #14 but stopped and retrieved a new glucometer from the RCD and Resident #14's name was written on the glucometer and a FSBS was obtained.	D932		

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D932	Continued From page 89 -Of the 12 glucometers in the drawer of the medication cart, there were 2 without names on the glucometers. Review of Resident #14's January 2020 eMAR revealed: -There was an entry to check FSBS three times a day before Novolog administration scheduled at 7:30am, 11:30am, 4:30pm. -There was an entry to check FSBS, administer Levemir Flex Touch 25 units at bedtime, hold for FSBS less than 70. Observation of the glucometer (Brand A) identified for Resident #14 revealed: -The plastic bag was labeled with Resident #14's name. -The black bag the glucometer was in had Resident #14's name on it. -The Brand A glucometer was not labeled with Resident #14's name on the back of the glucometer. -The date and time were set correctly for the actual date and time. Review of Resident #14's Brand A glucometer's history on 01/28/20 at 9:00am revealed: -FSBS values were inconsistent compared to values documented on Resident #14's January 2020 eMAR. -FSBS values documented on Resident #14's January 2020 eMAR were not recorded in Resident #14's glucometer history with examples of inconsistencies as follows: -On 01/24/20, FSBS value of 156 at 4:30pm, was documented on the eMAR, but not in Resident #14's glucometer history. -On 01/25/20, FSBS value of 120 at 7:30am, and 95 at 11:30am were documented on the eMAR, but was not recorded in Resident #14's	D932		

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D932	Continued From page 90	D932		

glucometer history.
-On 01/26/20, FSBS value of 114 at 11:30am, and 203 at 8:00pm were documented on the eMAR, but was not recorded in Resident #14's glucometer history.
-On 01/27/20, FSBS value of 90 at 7:30am, 129 at 8:00pm, were documented on the eMAR, but was not recorded in Resident #14's glucometer history.
-On 01/27/20, FSBS value of 153 at 12:44am and 82 at 7:29am, were documented in Resident #14's glucometer history but was not recorded on Resident #14's eMAR.

Interview with Resident #14 on 01/28/20 at 11:10am revealed she did not know staff had ever checked her blood sugar with another resident's glucometer.

Interview with the Resident Care Director (RCD) on 01/28/19 at 9:00am revealed:
-She did not know Resident #14's name was not on the glucometer.
-The glucometers were to have the resident's name on the plastic bag, the black bag and the glucometer, or it was not to be used.

Refer to interview with a MA on 01/29/20 at 8:00am.

Refer to interview with the RCD on 01/29/20 at 11:00am.

Refer to telephone interview with the previous Administrator on 01/29/20 at 5:05pm.

Refer to interview with the Divisional Director of Clinical Services on 01/31/20 at 12:50pm.

2. Review of Resident #12's current FL2 dated

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D932	Continued From page 91 07/26/19 revealed diagnoses included hypertension, anxiety and hypothyroidism. Review of a signed physician's order dated 01/17/20 revealed an order to check a FSBS every morning before breakfast for 14 days at 8:00am. Observation during the medication pass on 01/28/20 from 8:00am to 8:05am revealed: -There were 12 glucometers stored in a drawer in the locked medication cart. -The medication aide (MA) wore gloves to obtain the FSBS. -The medication aide (MA) pulled a clear plastic bag out of the glucometer drawer with Resident #12's name printed on the clear plastic bag. -The clear plastic bag with Resident #12's name on it contained a round container of glucometer strips, disposable single use lancets and a glucometer without a name on it. -The MA pulled the glucometer without a name on it to use to obtain a finger stick blood sugar (FSBS) from Resident #12. -The medication pass was stopped at this point and a new glucometer was obtained from the Resident Care Director (RCD) and Resident #12's name was written on the back of the glucometer. -The MA then obtained a FSBS from Resident #12 using a brand-new glucometer. Review of Resident #12's January 2020 electronic medication administration record (eMAR) revealed there was an entry to check FSBS before breakfast scheduled at 8:00am. Observation of the glucometer (Brand A) identified for Resident #12 revealed: -The plastic bag was labeled with Resident #12's	D932		

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D932	Continued From page 92	D932		

name.
-The Brand A glucometer was not labeled with Resident #12's name on the back of the glucometer.
-The date and time were not set correctly for the actual date and time.

Review of Resident #12's Brand A glucometer's history on 01/28/20 at 8:56am revealed:
-FSBS values were inconsistent compared to values documented on Resident #12's January 2020 eMAR.
-FSBS values documented on Resident #12's January 2020 eMAR were not recorded in Resident #12's glucometer history with an example of inconsistency as follows:
-On 01/26/20, FSBS value of 152 at 9:09am, was documented on the eMAR, but was not recorded in Resident #12's glucometer history.

Interview with Resident #12 on 01/28/20 at 11:00am revealed:
-She had her blood sugar checked usually after breakfast.
-The MA used a black glucometer to check her FSBS, but she did not see her name on it.
-She did not see if the glucometer was used on someone else.

Interview with the RCD on 01/28/19 at 8:05am revealed;
-She did not know Resident #12's name was not on the glucometer.
-The glucometers were to have the resident's name on the plastic bag, the black and on the glucometer, or it was not to be used.

Refer to interview with a MA on 01/29/20 at 8:00am.

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D932	Continued From page 93 Refer to interview with the RCD on 01/29/20 at 11:00am. Refer to telephone interview with the previous Administrator on 01/29/20 at 5:05pm. Refer to interview with the Divisional Director of Clinical Services on 01/31/20 at 12:50pm. 3. Review of Resident #5's current FL2 dated 12/09/19 revealed: -Diagnoses included diabetes mellitus type 2. -There was an order to check FSBS four times a day before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. Review of Resident #5's January 2020 eMAR revealed there was an entry to check FSBS four times a day before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. Observation of the glucometer (Brand A) identified for Resident #5 revealed: -The plastic bag was labeled with Resident #5's name. -The black bag the glucometer had Resident #5's name on it. -The Brand A glucometer was labeled with Resident #5's name on the back of the glucometer. -The date and time were set correctly for the actual date and time. Review of Resident #5's Brand A glucometer's history on 01/28/20 at 9:00am revealed: -FSBS values were inconsistent compared to values documented on Resident #5's January 2020 eMAR. -FSBS values recorded in Resident #5's	D932		

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D932	Continued From page 94 glucometer history was not documented on Resident #5's January 2020 eMAR with examples of inconsistencies as follows: -On 01/24/20, FSBS value of 179 at 9:15am, was recorded in Resident #5's glucometer history, but not documented on the eMAR. -On 01/25/20, FSBS value of 134 at 5:05pm, was recorded in Resident #5's glucometer history, but not documented on the eMAR. -On 01/26/20, FSBS value of 98 at 1:57pm, was recorded in Resident #5's glucometer history, but not documented on the eMAR. -On 01/27/20, FSBS value of 105 at 11:23am, 226 at 5:44pm and 246 at 8:12pm, were recorded in Resident #5's glucometer history but not documented on the eMAR. Interview with Resident #5 on 01/28/20 at 11:10am revealed: -She got her blood sugar checked before meals and at night. -She could not recall seeing her name on the monitor. -They check the FSBS "fast". -She did not notice if staff had ever checked her blood sugar with another resident's glucometer. Interview with a MA on 01/29/20 at 8:00am revealed: -She would check the name on the plastic bag, the black bag with the glucometer in it and the glucometer for the resident's name. -If the resident's name was not on all three of the items then she would not use the glucometer. -All of the residents glucometers were replaced on 01/19/20. -She did not check Resident #14's monitor and documented 5 times since 01/19/20. -She did not realize Resident #14's glucometer did not have a name on it.	D932		

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D932	Continued From page 95 Refer to interview with a MA on 01/29/20 at 8:00am. Refer to interview with the RCD on 01/29/20 at 11:00am. Refer to telephone interview with the previous Administrator on 01/29/20 at 5:05pm. Refer to interview with the Divisional Director of Clinical Services on 01/31/20 at 12:50pm. 4. Review of Resident #3's current FL2 dated 12/09/19 revealed: -Diagnoses included insulin dependent diabetes. -There was an order to check FSBS two times a day. Review of Resident #3's January 2020 eMAR revealed: -There was an entry to check FSBS every morning scheduled at 7:30am. -There was an entry to check FSBS at bedtime scheduled at 8:00pm. Observation of the glucometer (Brand A) identified for Resident #3 revealed: -The plastic bag was labeled with Resident #3's name. -The black bag the glucometer had Resident #3's name on it. -The Brand A glucometer was labeled with Resident #3's name on the back of the glucometer. -The date and time were set correctly for the actual date and time. Review of Resident #3's Brand A glucometer's history on 01/28/20 at 9:00am revealed:	D932		

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D932	Continued From page 96 -FSBS values were inconsistent compared to values documented on Resident #3's January 2020 eMAR. -FSBS values recorded in Resident #3's glucometer history was not documented on Resident #3's January 2020 eMAR with examples of inconsistencies as follows: -On 01/25/20, FSBS value of 90 at 9:36am, was recorded in Resident #3's glucometer history, but not documented on the eMAR. -On 01/26/20, FSBS value of 113 at 8:20am, was recorded in Resident #3's glucometer history, but not documented on the eMAR. -On 01/27/20, FSBS value of 95 at 8:17am, was recorded in Resident #3's glucometer history but not documented on the eMAR. Refer to interview with a MA on 01/29/20 at 8:00am. Refer to interview with the RCD on 01/29/20 at 11:00am. Refer to telephone interview with the previous Administrator on 01/29/20 at 5:05pm. Refer to interview with the Divisional Director of Clinical Services on 01/31/20 at 12:50pm. 5. Review of Resident #15's current FL2 dated 12/09/19 revealed: -Diagnoses included diabetes. -There was an order to check FSBS four times a day before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and 9:00pm. Review of Resident #15's January 2020 eMAR revealed there was an entry to check FSBS four times a day before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm and	D932		

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D932	Continued From page 97 9:00pm. Observation of the glucometer (Brand A) identified for Resident #15 revealed: -The plastic bag was labeled with Resident #15's name. -The black bag the glucometer had Resident #15's name on it. -The Brand A glucometer was labeled with Resident #15's name on the back of the glucometer. -The date and time were set correctly for the actual date and time. Review of Resident #15's Brand A glucometer's history on 01/28/20 at 9:00am revealed: -FSBS values were inconsistent compared to values documented on Resident #15's January 2020 eMAR. -FSBS values documented on Resident #15's January 2020 eMAR were not recorded in Resident #15's glucometer history with examples of inconsistencies as follows: -On 01/25/20, FSBS value of 139 at 7:30am, 90 at 11:30am and 134 at 4:30pm were documented on the eMAR, but not recorded in Resident #15's glucometer history. -On 01/26/20, FSBS value of 129 at 7:30am was documented on the eMAR, but not recorded in Resident #15's glucometer history. -On 01/27/20, FSBS value of 149 at 9:00pm was documented on the eMAR, but not recorded in Resident #15's glucometer history. Refer to interview with a MA on 01/29/20 at 8:00am. Refer to interview with the RCD on 01/29/20 at 11:00am.	D932		

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D932	Continued From page 98 Refer to telephone interview with the previous Administrator on 01/29/20 at 5:05pm. Refer to interview with the Divisional Director of Clinical Services on 01/31/20 at 12:50pm. 6. Review of Resident #9's current FL2 dated 12/09/19 revealed: -Diagnoses included diabetes, dementia and depression. -There was an order for fingerstick blood sugars (FSBS) three times daily before meals. Review of Resident #9's January 2020 electronic Medication Administration Record (eMAR) revealed there was an entry to check FSBS three times daily, at 7:30am, 11:30am and 4:30pm. Observation of the glucometer (Brand A) identified for Resident #9 revealed: -The glucometer was in the top locked compartment of the medication cart. -The glucometer was in a black zippered case inside a plastic zip lock bag labeled with Resident #9's name on both the bag and the case. -The Brand A glucometer was labeled with Resident #9's name on the back of the glucometer. -The date and time were not set correctly for the actual date and time. Review of Resident #9's Brand A glucometer's history on 01/28/20 at 10:55am revealed: -FSBS values were inconsistent compared to values documented on Resident #9's January 2020 eMAR. -FSBS values documented on Resident #9's January 2020 eMAR were not recorded in Resident #9's glucometer history with examples	D932		

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D932	Continued From page 99	D932		

of inconsistencies as follows:
-There were 5 FSBS readings documented on the eMAR that were not in Resident #9's glucometer history.
-On 01/23/20, the FSBS value of 93 was documented on the eMAR but not in Resident #9's glucometer history on 01/23/20 at 7:25pm.
-On 01/26/20, the FSBS values of 70 at 7:30am, 104 at 11:30pm and 70 at 4:30pm were documented on the eMAR, but not in Resident #9's glucometer history on 01/26/20 at 7:30am, 11:30am and 4:30pm.
-On 01/27/20, the FSBS value of 123 at 11:30am was documented on the eMAR, but not in Resident #9's glucometer history on 01/27/20 at 11:30am.

The last documented calibration for Resident #9's glucometer was 01/09/20.

Refer to interview with a MA on 01/29/20 at 8:00am.

Refer to interview with the RCD on 01/29/20 at 11:00am.

Refer to telephone interview with the previous Administrator on 01/29/20 at 5:05pm.

Refer to interview with the Divisional Director of Clinical Services on 01/31/20 at 12:50pm.

7. Review of Resident #10's current FL2 dated 12/09/19 revealed:
-Diagnoses included diabetes, dementia and depression.
-There was an order for fingerstick blood sugars (FSBS) four times daily before meals.

Review of Resident #10's January 2020

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D932	Continued From page 100	D932		

electronic Medication Administration Record (eMAR) revealed there was an entry to check FSBS four times daily, at 7:30am, 11:30am, 4:30pm and 8:00pm.

Observation of the glucometer (Brand A) identified for Resident #10 revealed:
-The glucometer was in the top locked compartment of the medication cart.
-The glucometer was in a black zippered case, inside a plastic zip lock bag, labeled with Resident #10's name on both the bag and the case.
-The Brand A glucometer was labeled with Resident #10's name on the back of the glucometer.
-The date and time were set correctly for the actual date and time.

Review of Resident #10's Brand A glucometer's history on 01/28/20 at 11:05am revealed:
-FSBS values were inconsistent compared to values documented on Resident #10's January 2020 eMAR.
-FSBS values documented on Resident #10's January 2020 eMAR were not recorded in Resident #10's glucometer history with examples of inconsistencies as follows:
-There were 7 FSBS readings documented on the eMAR that were not recorded in Resident #10's glucometer history.
-On 01/25/20, FSBS values of 142 at 7:30am, 88 at 11:30am, 178 at 4:30pm and 145 at 8:00pm were documented on the eMAR but not recorded in Resident #10's glucometer history.
-On 01/26/20, FSBS values of 121 at 4:30pm and 128 at 8:00pm were documented on the eMAR, but not recorded in Resident #10's glucometer history.
-On 01/27/20, FSBS value of 168 at 4:30pm were

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D932	Continued From page 101 documented on the eMAR, but not recorded in Resident #10's glucometer history. The last documented calibration for Resident #10's glucometer was 01/09/20. Refer to interview with a MA on 01/29/20 at 8:00am. Refer to interview with the RCD on 01/29/20 at 11:00am. Refer to telephone interview with the previous Administrator on 01/29/20 at 5:05pm. Refer to interview with the Divisional Director of Clinical Services on 01/31/20 at 12:50pm. 8. Review of Resident #13's current FL2 dated 12/09/19 revealed: -Diagnoses included diabetes mellitus Type 2, chronic obstructive pulmonary disease (COPD) and dementia. -There was an order to check finger stick blood sugars (FSBS) twice daily, at 6:00am and 4:00pm. Review of Resident #13's January 2020 eMAR revealed there was an entry to check FSBS 4 times daily at 7:30am, 11:30am, 4:30pm and 8:00pm. Observation of the glucometer (Brand A) identified for Resident #13 revealed: -The glucometer was in the top locked compartment of the medication cart. -The glucometer was in a black zippered case, inside a plastic zip lock bag, labeled with Resident #10's name on both the bag and the case.	D932		

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D932	Continued From page 102 -The Brand A glucometer was labeled with Resident #13's name on the back of the glucometer. -The date and time were set correctly for the actual date and time. Review of Resident #13's Brand A glucometer's history on 01/28/20 at 11:20am revealed: -FSBS values were inconsistent compared to values documented on Resident #13's January 2020 eMAR. -FSBS values documented on Resident #13's January 2020 eMAR were not recorded in Resident #13's glucometer history with examples of inconsistencies as follows: -There were 4 FSBS readings documented on the eMAR that were not recorded in Resident #13's glucometer history. -On 01/25/20, FSBS value of 135 at 4:00pm was documented on the MAR, but not recorded in Resident #13's glucometer history. -On 01/26/20, FSBS values of 139 at 4:00pm and 123 at 8:00pm were documented on the MAR, but not recorded in Resident #13's glucometer history. -On 01/27/20, FSBS values of 134 at 6:00am and 139 at 4:00pm were documented on the MAR, but not recorded in Resident #13's glucometer history. The last documented calibration for Resident #13's glucometer was 01/09/20. Refer to interview with a MA on 01/29/20 at 8:00am. Refer to interview with the RCD on 01/29/20 at 11:00am. Refer to telephone interview with the previous	D932		

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D932	Continued From page 103 Administrator on 01/29/20 at 5:05pm. Refer to interview with the Divisional Director of Clinical Services on 01/31/20 at 12:50pm. 9. Review of Resident #17's current FL2 dated 12/09/19 revealed: -Diagnoses included diabetes, schizoaffective disorder and hypertension. -There was an order to check finger stick blood sugars (FSBS) daily at 6:00am. Review of Resident #17's January 2020 eMAR revealed there was an entry to check FSBS daily at 6:00am. Observation of the glucometer (Brand A) identified for Resident #17 revealed: -The glucometer was in the top locked compartment of the medication cart. -The glucometer was in a black zippered case, inside a plastic zip lock bag, labeled with Resident #10's name on both the bag and the case. -The Brand A glucometer was labeled with Resident #13's name on the back of the glucometer. -The date and time were set correctly for the actual date and time. Review of Resident #17's Brand A glucometer's history on 01/28/20 at 11:20am revealed: -FSBS values were inconsistent compared to values documented on Resident #17's January 2020 eMAR. -FSBS values documented on Resident #17's January 2020 eMAR were not recorded in Resident #17's glucometer history with examples of inconsistencies as follows: -There was 1 FSBS reading documented on the	D932		

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D932	Continued From page 104 eMAR that were not recorded in Resident #17's glucometer history. -On 01/24/20, FSBS value of 129 at 6:00am was documented on the MAR, but not recorded in Resident #17's glucometer history. The last documented calibration for Resident #17's glucometer was 01/09/20. Refer to interview with a MA on 01/29/20 at 8:00am. Refer to interview with the RCD on 01/29/20 at 11:00am. Refer to telephone interview with the previous Administrator on 01/29/20 at 5:05pm. Refer to interview with the Divisional Director of Clinical Services on 01/31/20 at 12:50pm. _____ Interview with a MA on 01/29/20 at 8:00am revealed: -She would check the name on the plastic bag, the black bag with the glucometer in it and the glucometer for the resident's name. -If the resident's name was not on all three of the items then she would not use the glucometer. -All of the resident's glucometers were replaced with new ones on 01/19/20 because the old ones did not have names on them and were being shared. -She checked a residents FSBS and the name was not on the glucometer. Interview with the RCD on 01/29/20 at 11:00am revealed: -She was hired and started working at the facility 30 days ago. -She was trained by the facility's Regional	D932		

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D932	Continued From page 105 Physician Consultant during her 2nd week on the job. -The glucometers were single resident use only and to be cleaned with alcohol in between each use. -The MA's were responsible for checking the FSBS. -The MA's were responsible for making sure the names were on the plastic bag, black bag and the monitor. -If the name was not on the glucometer at the time the FSBS was to be taken then it was not to be used and replaced with a new one. -She replaced all of the glucometers around 01/23/20 and put the name on each black bag and monitor. Telephone interview with the previous Administrator on 01/29/20 at 5:05pm revealed: -The policy was to not share glucometers. They were to be used for only the resident whose name was on it. -The MAs were responsible for acquiring the FSBS and to document it in the eMAR immediately. -The MAs were not to use a glucometer that did not have a name on it. -If the glucometer did not have a name on it, it was to be reported to the RCD and replaced. -The Department of Social Services (DSS) notified her 2 week ago about the glucometers in her facility were being shared. -She replaced all of the glucometers in the facility with new ones and the staff were retrained on glucometer usage and infection control. -The training was done by the Divisional Director of Clinical Services the day after the plan of protection was obtained by the DSS. -The RCD was responsible for making sure all of the glucometers had the resident's name on them	D932		

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D932	Continued From page 106 and ordering new ones. -It was her expectation the staff did not share the glucometers. Interview with the Divisional Director of Clinical Services on 01/31/20 at 12:50pm revealed: -The glucometers were for single resident use only and were not to be shared. -The resident's name was to be placed on the black bag and the glucometer at all times. -If the glucometer did not have a name on it then it was not to be used and a new one was to be obtained. -The RCD had new glucometers if the need arose. 10. Control measures for suspected Norovirus outbreaks N.C. Public Health Recommendations for Long Term Care Facilities. -Noroviruses are highly contagious that cause gastroenteritis. -Symptoms include acute onset of vomiting, watery, non-bloody diarrhea with abdominal cramps, and nausea. - Body weakness and headaches are also common as well as a low-grade temperature. -Norovirus can lead to dehydration and may require intravenous replacement of fluids. -Symptom usually last for 1 to 3 days. -Norovirus can spread by fecal-oral route, or by direct contact with fecal or by droplet from vomitus. -Contamination can spread by contact with material, fomites, and environmental surfaces that have been contaminated with feces or vomitus. -Specific control measures: -Strict handwashing, wash hands with soap and warm water for at least 15 seconds. Discontinue use of alcohol-based sanitizer because they are	D932		

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not effective against the norovirus.
-Exclude staff that are sick from working until 48 hours after last symptoms.
-Disinfect: recommends a bleach-based disinfectant. The minimum concentration effective for norovirus is 1/3 cups per gallon of water.
-For best efficacy, the bleach solution should be made daily.
-Facilities should ensure information is readily available explaining the illness impacting the facility.
-Maintain a list of all residents and staff affected by the norovirus and report to the Department of Health. This should continue for one week after the last case onset.
-These control measures should be implemented until the outbreak is over.
-An outbreak is over once two incubation periods have passed without illness which is 96 hours for the norovirus.

Confidential interview with multiple facility staff revealed:
-There were 50 or more residents who had the norovirus.
-They did not have training, in-service, or education on the norovirus.
-Management walked by and snicker at us for wearing face masks.
-"We were only told to wash our hands often."
-"We ran out of paper towels for about a week."
-"We had no fitted sheets in the facility to change soiled linens."
-Staff could not keep up with washing linens because, "all the residents had diarrhea."
-Residents' beds did not get changed when soiled.
-There was a staff person who did her personal laundry in the facility at the time of the norovirus, the previous Administrator was aware of this and

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D932	Continued From page 108 allowed it. -The facility ran out of bleach for a week and the previous Administrator was aware. -The facility used a disinfectant to clean with when they were out of bleach. -"I took bleach from the kitchen to use in the facility once." -Staff brought in their own cleaning supplies to use when cleaning the rooms and cleaning the door knobs. -There were still residents in the facility with watery diarrhea and probable norovirus. -"We ran out of rags to clean with and management tore up bedsheets for us to clean the facility with." -"I felt like the previous Administrator did not supply the staff with what we needed to keep ourselves safe from contacting the norovirus." -"I was out sick for 2 days with the norovirus." -All residents stayed in their rooms even if they were not affected by the norovirus. -No residents came out of the rooms, not even to eat. -Staff were told if a resident's call bell went off to go into the room and get out as fast as we could. -The residents put their trash and their soiled briefs outside the rooms in the hallway so staff would not enter the rooms. -Trash containers were piled full of dirty soiled briefs and trash from the resident's rooms. -Staff would throw away linens that were soiled with diarrhea because "they were so nasty and smelly." -No residents were allowed to shower in the facility common spa area or even in the adjoining bathrooms. -Some personal care aides (PCA) would go in and change a resident's brief and not provide personal care to the perineal area or the bottom. -Residents went without baths or showers for 2	D932		

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D932	Continued From page 109	D932		

weeks.
-We were told if we did not come to work, we would be terminated.
-Staff was seen in the emergency room for an upper respiratory infection and management made her come into work that day and provide care for the residents.

Interview with a resident on 01/30/20 at 3:30pm revealed:
-"The staff never asked us if we needed anything during the norovirus."
-Residents were told to stay in our rooms, but some residents went outside to smoke throughout the day.
-Residents changed their own soiled brief and some took sponge baths by themselves.
-Residents cleaned their own rooms and placed the trash and soiled briefs in the hallway because staff did not want to come into the resident's rooms.
-"We were lucky to get our clothes back, if they were washed at all."
-"They did not wash my bedcovers for a month, staff told me they did not have time."
-"I felt nasty, germs were floating around in here."

Interview with a second resident on 01/30/20 at 11:38am revealed:
-Residents were quarantined in their rooms and even ate all our meals in the room.
-"My bed was not changed for 3 weeks."
-Staff told residents they did not have time to change the sheets.
-"I feel gross sleeping on dirty sheets."

Interview with a third resident on 01/30/20 at 3:19pm revealed:
-"My roommate and I were sick for 6 days with diarrhea."

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D932	Continued From page 110 -"We had diarrhea day and night." -The resident's bed linens and bathrooms were messy with diarrhea. -Staff changed our beds one time during those 6 days. -"I tried to bath myself using the sink but could not stand, I was so weak." -"I felt terrible." Interview with a fourth resident on 01/30/20 at 3:34pm revealed: -Residents were told they could not shower for about a week or two. -Staff did not offer a sponge bath. Interview with a fifth resident on 01/30/20 at 3:45pm revealed: -Staff had an attitude when providing personal care. -"I stayed in the bathroom one night sitting on the toilet with a trash can in my lap, staff did not help me." Telephone interview with the local Health Department Infectious Disease nurse on 01/29/20 at 4:30pm revealed: -She knew the facility had an outbreak of Norovirus in January 2020. -The previous Administrator contacted her regarding the outbreak. -She emailed the previous Administrator the proper guidelines for control measures and education to prevent the contamination of the norovirus. -The email included recommendations and guidelines for cleaning the facility. -Her expectation was for the former Administrator place flyers in the facility for education and informing the staff and visitors the facility had an outbreak of norovirus.	D932		

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D932	Continued From page 111 -She did not know the staff were not trained or provided an in-service on preventing the spread of norovirus. -She never told the previous Administrator to not provide showers to the residents in the facility. -"Resident needed showers and baths even more if they were sick." Telephone interview with the previous Administrator on 01/29/20 at 5:00pm revealed: -Her last day of employment at the facility was 01/27/20. -She had contacted the local Health Department in January 2020 when she suspected the norovirus. -The Health Department had sent over instructions via email for cleaning the facility and what precautions to use when caring for the residents with the norovirus. -She had placed flyers in the facility for staff to refer to when cleaning the facility and caring for the residents affected by the norovirus. -She had told the staff to wash their hands often with soap and warm water. -The facility had gloves for the staff to use while providing personal care and while cleaning the facility. -Some staff wore masks, but it was not necessary because the norovirus was not airborne. -She knew the facility staff were out of paper towels and were out of toilet paper for a while during the norovirus, but she did not think it was for a week. -She was not aware the facility was out of bleach. -She was responsible for ordering the supplies in the facility. -The kitchen supplies were ordered by the kitchen staff. -She contacted the corporate office and got funds approved to purchase paper towels and toilet	D932		

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D932	Continued From page 112	D932		

paper for the facility.
-Three staff were affected by the norovirus and she was unsure how many residents were affected by the norovirus.
-She told the staff not to allow the residents to leave their rooms and to not provide showers to the residents due to the "cross contamination" possible by sharing showers.
-She could not rely on housekeeping or the facility staff to assure the showers were completely clean to prevent the spread of norovirus.
-She had not completed the spread sheet for the Health Department on the total amount of residents and staff that were affected with the norovirus.

A second telephone interview with the Infectious Disease nurse from the local Health Department on 01/31/20 at 10:33am revealed:
-She had contacted the previous Administrator on 01/17/20 and the facility still had active cases of the norovirus.
-She had received the spread sheet identifying the residents and the staff that were affected with the norovirus on 01/29/20.
-The Administrator had emailed her the information identifying 15 residents and 5 staff were affected by the norovirus.

Interview with the two local county Department of Social Services (DSS) Adult Home Specialist (AHS) on 01/29/20 at 1:00pm revealed:
-The county AHS visited the facility on 01/17/20 and on 01/19/20.
-There were no signs posted inside the facility or outside the facility identifying the norovirus outbreak and what precautions you needed to prevent contamination or contacting the norovirus on 01/17/20 or on 01/19/20.
-Residents were walking around inside the facility

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D932	Continued From page 113	D932		

and some residents were sitting in the common area.
-Resident were going outside to smoke using in the common smoking area located off the back of the facility.
-There was limited staff present in the facility on 01/17/20 and on 01/19/20.
-The whole facility had a of strong awful smell of feces and urine.
-They identified several resident's rooms with diarrhea stained sheets.

Interview with the Resident Care Director (RCD) on 01/30/20 at 3:30pm revealed:
-Every resident was quarantined to their room.
-The meals were served in each resident's room.
-She did not see showers given during the quarantine.
-On day 5 or 6 she helped clean the rooms with bleach and water solution.
-She did not know if there were any instructions from the Health Department or if the facility should post signs due to the norovirus.
-Only one resident was sent out during the quarantine, but it was not related to the Norovirus.
-She and the staff were to wear gloves and gowns when doing resident care while the Norovirus was in the facility.
-She did not wear a gown just gloves.
-She was not sure if the personal protective equipment (PPE) gowns were in the facility.
-She did not see other staff wearing PPE gowns with the resident but did see the staff wearing gloves during resident care.

Interview with the Dietary Manager on 01/30/20 at 4:22pm revealed:
-She had worked when the norovirus was in the facility.
-All the residents ate in their rooms.

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D932	Continued From page 114 -The kitchen prepared the meals and used plastic disposable place settings which include dishes and silverware. -The personal care aides served the meals to the residents in their rooms. -She ordered the supplies such as bleach for the kitchen but did not order the supplies for the facility. -The previous Administrator was responsible for ordering supplies which included bleach, paper towels, and toilet paper for the facility. Observation during the survey conducted on 01/28/20 through 01/31/20 revealed several residents in the facility had loose watery diarrhea. Review of the facility's Infection Control Policy revealed: -A designated staff shall assure the local county health department was notified upon occurrence of any outbreak, illness or disease of two or more or as otherwise directed by the Infection Control Disease Manual or Health Department. -The staff would also notify the local county Department of Social Services Adult Care representative, Community Management, Regional Directors of Operations and Care Services. -The designated staff and Community shall assure all staff received training in all the Community policies and guidelines related to infection control, all infection control practices, including Occupational Health and Safety Agency (OSHA) and the Department of Health and Human Services (DHHS) Department of Health Service Regulation Infection Control Course. -Standard precautions would be used by all staff at all times when necessary. -Hand hygiene (hand-washing/alcohol-based hand rubs) shall be used by the staff upon arrival	D932		

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D932	Continued From page 115 to work, and ongoing as instructed during the work shift. -The facility would provide appropriate personal protective equipment (PPE) including gloves, gowns, masks, goggles, shoe and hair covers when needed to all employees who may be exposed to blood or other potentially infectious material or contaminated surfaces. -All employees were required to use PPE as appropriate when in contact or when contact was possible (splashing) with bodily fluids or other potentially infectious material. -PPE was to be disposed of in a proper container prior to leaving the area of contact to prevent further spread. -Staff shall follow guidelines for diabetic testing/care to assure infection control was maintained. -Staff was to use disposable gloves when handling soiled laundry. The laundry should never touch the clothing of the staff. -Staff was to clean and decontaminate all surfaces that come into contact with infected bodily fluids during each shift as directed by the Health Department, using appropriate germicidal disinfectants according to the manufacturer's instructions. _____ The facility failed to implement an infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for Residents #3, #5, #9, #10, #12,#13,#14,#15, and facility staff were not properly trained or educated on the norovirus and using the PPE equipment, were not provided paper towels or bleach to complete task which required cleaning and disinfection to prevent the spread of the	D932		

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D932	Continued From page 116 norovirus. The facility failure to implement required infection prevention measures which resulted in substantial risk for serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/30/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 29, 2020.	D932		
D980	G.S. § 131D-25 Implementation 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 interviews and record reviews, the previous Administrator failed to ensure the management, operations, and policies of the facility were implemented and rules were maintained for personal care, referral and follow-up, medication administration, ACH infection prevention requirements, other staff requirements, and resident rights. The findings are:	D980		

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D980	Continued From page 117 Confidential telephone interview with a staff revealed: -There was no communication from the previous Administrator to the staff working on other shifts. -There were no stand-up meeting daily to discuss residents or staff concerns. -Residents went 2 weeks without having linens changed due to poor communication. -"Our jobs were threatened if we did not work extra hours or if we called in sick." -When we called the previous Administrator we were told, "I can't be there all day, when do you expect me to sleep." -The previous Administrator knew staff were sleeping on the job, she even was sent pictures, but did nothing to the staff. -The previous Administrator knew the resident's medications were not being administered as ordered because the medications were not in the facility. Confidential interview with another facility staff revealed: -The previous Administrator was responsible for ordering supplies for the facility. -"We ran out of bleach, paper towels, and toilet paper during the norovirus." -The previous Administrator told staff not to provide residents with showers during the norovirus. -"We worked long hours and were short staffed on several days." -The previous Administrator did not provide any education or infection prevention during the norovirus outbreak to the staff. -"We did not have face masks for two days after the norovirus outbreak in the facility was identified."	D980		

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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
D980	Continued From page 118 Interview with a resident in the facility on 01/30/20 at 11:27am revealed: -The previous Administrator told residents they could not take a shower. -Staff had rude attitudes with residents and the previous Administrator did nothing to the staff. Interview with a second resident in the facility on 01/30/20 at 11:38am revealed: -The previous Administrator told residents they could not take a shower because the facility was out of towels and the washer was broken, later residents found out it was because of the norovirus. -Residents were confined to their rooms with the norovirus outbreak and staff would not help them. -"I am blind and could not take a sponge baths at the sink, I needed help but could not get it." Interview with a third resident in the facility on 01/30/20 at 3:34pm revealed: -"We did not get showers or baths for a week." -The previous Administrator told residents to stay in their rooms. -All the residents ate in their rooms. Interview with a fourth resident in the facility on 01/30/20 at 3:39pm revealed: -The staff told the residents to stay in their rooms, but she would go out and smoke a cigarette when she wanted to. -The previous Administrator would not let her use the spa showers," I had no place to sit down when I showered." -She told the staff she was pissed. -They did not have a lot of staff working. -"We were lucky to get our clothes back if they washed them." -The facility staff had not washed her bedcovers in over a month.	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023045	A. BUILDING: _____ B. WING _____	R-C 01/31/2020

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D980	Continued From page 119 -"Half the time I did not have my medications because it was not in the building." Interview with the two local county Department of Social Services Adult Home Specialist on 01/29/20 at 1:00pm revealed: -There were no signs posted in the facility or on the outside door identifying the norovirus outbreak in the facility on 01/17/20 or on 01/19/20. -Staff were hard to locate on 01/17/20 except for 2 staff from another facility who were conducting medication cart audits. -The AHS needed to review medications and glucometers but could not locate a staff person with a key to the medication room for a while. -They waited for several minutes for someone from the facility to unlock the medication room, the 2 staff conducting the medication cart audits did not have a key to the medication room. -Staff were very limited that day. -The Administrator was not present in the facility but the staff who were conducting the medication cart audit called her to come to the facility. Telephone interview with the previous Administrator on 01/29/20 at 5:00pm revealed: -She was responsible for day to day operation in the facility before 01/27/20. -Her last day of employment at the facility was on 01/27/20. -She knew staff were sleeping on the job. -She knew staff had gotten in an argument and were yelling in the hallway disturbing residents while they were trying to sleep. -She contacted corporate about the staff issues and was told. "It is easier to keep staff than to retrain a new employee." -She was responsible for completing medication cart audits, but she did not do any in December	D980		

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D980	Continued From page 120	D980		

2019 or in January 2020.
-There was no other management team after 12/25/19 to assist her with managing the facility/staff or her responsibilities.
-Her previous Resident Care Director had quit in December 2019.
-"I contacted cooperate more than 10 times during December 2019 and January 2020 with concerns of the facility and staffing."
-She knew the facility was out of paper towels and out of toilet paper for a while during the norovirus but was not made aware the facility was out of bleach.
-She was responsible for ordering supplies for the facility.
-She was unsure how many residents were affected by the norovirus.
-She was responsible for keeping a log of the number of residents and staff affected by the norovirus for the local Health Department.
-She told the staff not to allow the residents to leave their rooms and to not provide showers to the residents due to the cross contamination possible by sharing the shower.
-She could not rely on housekeeping or the facility staff to assure the common shower spas or the showers in the resident's adjoining rooms were completely to prevent the spread of norovirus.

Interview with the Resident Care Coordinator (RCC) on 01/28/20 at 8:24am revealed:
-A new Resident Care Director (RCD) was hired 2-3 weeks ago but in the last week she and the new RCD were trained in the responsibilities for their new positions.
-She helped train the RCD and the RCD helped train her.
-"No one here fully knows what to do".
-"No one here is set in their job and what their responsibilities were".

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D980	Continued From page 121 -"No one was sure who to report to". Interview with the current Administrator on 01/30/20 at 1:10pm revelaed: -The previous Administrator was responsible for day to operations in the facility until 01/27/20. -The previous Administrator had not followed the standards of operations for the facility. -She did not know the previous Administrator told the residents they could not have showers during the norovirus. -She did not know the previous Administrator had not completed the excel spread sheet for the history of the residents and staff who contacted the norovirus in January 2020 for the local Health Department records. -She did not know the previous Administrator did not follow through on resident's medication that were not available in the facility. -She did not know the previous Administrator was not completing or had not assigned anyone to complete medication cart audits. Interview with the Interim Executive Director (ED) on 10/31/20 at 12:30pm revealed her first day was 01/28/20, she would be responsible for day to day operations as of that date. Non-compliance was identified at the violation level in the following rule areas: 1. Based on observations, interviews and record reviews the facility failed to assure the health care needs were met for 3 of 7 sampled residents related to timely primary care provider (PCP) notification of a painful itchy genital/buttock rash (Resident #1) and not notifying the psychiatric physician a resident's psychotropic medication was not available for administration for up to 28 days (Resident #16). [Refer to Tag D273 10A	D980		

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D980	Continued From page 122 NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 9 of 9 diabetic residents sampled (Residents #3, #5, #9, #10, #12, #13, #14, #15, and #17) with orders for blood sugar monitoring resulting in sharing of glucometers between residents and facility staff not properly trained or provided the supplies to complete their tasks and provide personal care to the residents during the norovirus outbreak. [Refer to Tag D932 GS 131D4.4A ACH Infection Preventions Requirements (Type A2 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure personal care was provided to 2 of 5 sampled residents (#1 and #18) related to a genital/buttock rash (#1) and a dried, soiled incontinent brief which had adhered to the resident's skin (#18). [Refer to Tag D269 10A NCAC 13F .0901(a) Personal Care (Type A1 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 2 of 4 residents (Residents #10 and #19) observed during the medication pass related to diuretics not available for administration (Residents #10 and #19), an antihistamine and a vitamin D3 not available for administration (Resident #10), and 2 of 5 sampled residents (Residents #3 and #16) related to a psychotropic medication not available	D980		

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D980	Continued From page 123 for administration (Resident #16), and 18 missed doses of magnesium chloride (Resident #3). [Refer to Tag D338 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 5. Based on interviews and record reviews, the facility failed to assure 1 of 5 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to Tag D137 10A NCAC 13F .0407(a)(5) Other Staff Requirements (Type B Violation)]. 6. Based on observations, record reviews and interviews, the facility failed to assure residents were treated with respect and dignity related to residents denied showers due to the norovirus outbreak in the facility. [Refer to Tag D338 10A NCAC 13F .0909 Residents' Rights (Unabated Type B Violation)]. _____ The previous Administrator's failure to assure responsibility for the overall operation of the facility resulted in significant noncompliance with state rules and regulations regarding: referral/ follow-up for Resident #1 who had multiple lesions on her vaginal area and the buttocks resulting in an ER/hospital admission with documentation the ER physician had concern for neglect due to the appearance of the skin; Resident #16, whose PCP and Mental Health provider were not notified his psychotropic medication was not filled for 6 weeks and resulted in an increase in hallucinations, agitation and insomnia, and Resident (#12) who had FSBS checks ordered every morning for 8 days that were not recorded to rule out further need for testing for diabetes. The facility failed to provide	D980		

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D980	Continued From page 124 personal care assistance for Resident #1 which resulted in not receiving bathing or completing a skin assessment preventing prompt notification to physician of a perineum/perianal skin rash, ER visit and hospital admission with documentation the lesions would have been observed during bathing and dressing, and Resident #18 who had diarrhea for 4 days and was found by staff wearing a brief soiled with dried feces which was stuck to her skin requiring staff to use warm wet washcloth soaks to prevent tearing the skin to her buttocks area. The facility failed to implement an infection control policy related to using a single dose glucometer for more than one resident with non-correlating FSBS on eMAR when compared to resident's glucometers; failed to provide staff with norovirus education on PPE equipment and maintain a supply of bleach, paper towels and toilet paper during the norovirus outbreak in the facility. HCPR checks related to a medication aide who was identified as having two HCPR substantiated findings of neglect of a resident; failed to assure residents were treated with dignity and respect regarding not providing residents with showers for 10 days to 2 weeks while the residents were quarantined to their rooms and not maintaining a supply of clean linens for residents use during the norovirus outbreak. The facility failed to assure the eMAR's were accurate resulting in resident's not receiving medications and staff documenting the medications were administered when the medicines were not in the facility. These failures of the previous Administrator to assure responsibility for the overall operation, administration, management and supervision of the facility resulted in serious physical harm and serious neglect of residents and constitutes a Type A1 Violation.	D980		

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D980	Continued From page 125 The facility provided a plan of protection in accordance with G.S. 131 D-34 on 01/30/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 29, 2020.	D980		

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D 000	Initial Comments The Adult Care Licensure Section and the Cleveland County Department of Social Services conducted a follow-up survey and a complaint investigation on 01/28/20 to 01/31/20. The complaint investigations were initiated by the Cleveland County Department of Social Services on 12/11/19, 12/30/19 and on 01/17/20.	D 000		
D 106	10A NCAC 13F .0311(b) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. This rule apply to new & existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the temperature in the dining room and in two of the resident's rooms (#12 and #13) were maintained at 75 degrees Fahrenheit under winter design conditions. The findings are: Observation on 01/28/20 between 6:30am and 8:00am of resident rooms #12 and #13 on the back hallway near the nurse's station revealed: -Upon entering two resident's rooms they were cold. -The doors were closed, and the thermostats could not be controlled in either room. -The resident in one room was laying wrapped under the covers on his bed. Interview on 01/28/20 between 6:30am and	D 106		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DeLetty C Brooks, RN, Divisional Director of Clinical Services 3-13-2020

Acknowledged and reviewed 03/17/20

Jeanne S Robinson RN

Plan of Correction
Cleveland House
March 13, 2020

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.

D 106-pg 1 **10A NCAC 13F .0311(b) Other Requirements**

Routine checks of room temperatures for both Resident rooms and Common Areas will be completed by the Maintenance Technician on a rotating, weekly basis, ensuring all rooms and common areas have a room temperature checked monthly, during winter months, to maintain room temperature at 75 degrees Fahrenheit. With any inclement weather or when outside temperatures are below 32 degrees Fahrenheit, the room temperature checks will be completed daily, ensuring all rooms are maintained at 75 degrees.

In the event a residents room temperature is found to be less than 75 degrees, all efforts will be made to correct the maintenance and heating issue, while providing an alternate space for that resident where the room temperature meets the required 75 degrees. In the event a Common area space is found to be less than 75 degrees, all efforts will be made to correct the heating issue, while providing Common area activities in another location where the room temperature meets the required 75 degrees.

Date of Completion 3-15-2020

D137-pg 3 **10A NCAC 13F .0407 (a) (5) Other Staff Qualifications—Type B**

An audit of all current employee personnel files was completed to ensure NC Health Care Personnel Registry (NC HCPR) checks have been completed as required and that there are no employees with any substantiated findings. Training was completed for the Executive Director and Business Office Manager on the importance of completion of the NC HCPR check prior to an offer of employment. All future prospective employees will have the NC HCPR check completed prior to an offer of employment and starting employment. Random audits of Personnel records will be completed by the Executive Director, Area Director of Operations and/or the Divisional Director Business Management at least quarterly.

Date of completion 3-1-2020

D 269-pg 6 **10A NCAC 13F .0901(a) Personal Care and Supervision—Type A1**

A comprehensive assessment will be completed on all new admissions. This assessment will determine the resident's ability to perform all ADL'S. The ability of the resident to perform ADL's will be included in the resident's plan of care. Each resident will have an assigned shower/bath schedule. The shower schedule will include the ability of the resident to perform his/her shower. Residents will receive showers on their assigned days. The shower will be documented in matrix care by the end of the shift. Any showers that were not completed will be reported to the SIC/Resident Care Director (RCD) before leaving the shift.

Staff have received training in assisting residents with ADL'S. This includes correct perineal care, incontinence care and assistance with showers. Residents will be assessed every two hours to determine incontinence. The incontinent resident will receive immediate perineal care.

All staff have been trained to accurately complete full body audits and skin evaluations. The staff performed return demonstrations to show mastery. The body audit/skin evaluation will be completed on each resident upon admission to the community, at their respective shower times, as well as return from a hospitalization, or a leave from the community. Any abnormal findings will be reported to the Resident Care Director, who will assess the resident. The Resident Care Director will notify the PCP immediately if warranted or upon his/her weekly visit to the community. The Resident Care Director will initiate any orders from PCP upon receipt. The Resident Care Director will evaluate the effectiveness or lack thereof and communicate findings to the PCP. At the time of hire/orientation, all care staff will receive body evaluation and ADL assistance training, including assistance with bathing and showering, incontinence care and dressing with return demonstrations as well, as part of orientation.

Date of Completion 2-29-2020

D 273 pg. 16 **10A NCAC 13F .0902(b) Health Care-Referral and Follow Up—Type A 2**

Body audits/skin evaluations will be completed on each resident upon admission to the community, at their respective shower times, as well as return from a hospitalization, or a leave from the community. Any abnormal findings will be reported to the Resident Care Director. The Resident Care Director will notify the PCP immediately if warranted or upon his/her weekly visit to the community. The Resident Care Director will initiate any orders from PCP upon receipt. The resident care director will evaluate the effectiveness or lack thereof to the PCP.

A medication inventory will be conducted upon admission of residents to the community. The Resident Care Director will compare the FL2 orders with any medications brought by the resident to the community. The Resident Care Director will contact PCP for any medications that residents brings to the facility that are not on the FL2 for clarification. Any medications that require an outside provider to prescribe said medication, the provider will be contacted and the order received. The Resident Care Director will review new orders the following morning to assure that all medications were received from the pharmacy. In the event any medication is not available for administration, the Med Aides will notify the Pharmacy and the Resident Care Director of the unavailability of the medication. The Resident Care Director will follow up with the Pharmacy to obtain the medication and with the PCP to notify of any missed medications. The Resident Care Director will complete daily audits of medication administration compliance review to determine any missing administration of medications. The Executive Director will complete weekly medication administration compliance reviews to assist with compliance of medication administration.

All Medication Aides were retrained on medication administration practice and expectations, including administration of all medications and completion of treatments as ordered. The training included process and procedure for notification of the Resident Care Director, Pharmacy and PCP in the event a medication is not available for administration and proper documentation of medications not administered.

Date of Completion 2-29-2020

D 338 pg. 36 **10A NCAC 13F .0909 Resident Rights—Unabated Type B**

Resident Rights retraining completed with all staff, including current Management employees, related to the rights of residents to receive appropriate care during an event such as a norovirus outbreak or other potentially infectious process requiring suspension of communal activities such as Dining and other group activities. Retraining included proper bathing, dressing, toileting and incontinence care of residents and use of measures to meet hygiene needs of all residents.

Upon notification that a contagious illness has been detected in the community, the local health department will be notified. The health department will provide instruction on the need for isolation and disinfection procedures. If there is concern regarding cross contamination between residents in semi- private rooms, the health department will provide guidance for disinfection procedures.

Date of Completion 2-29-2020

D 352-pg.42 **10A NCAC 13F .1003(a) Medication Labels**

All medications will be packaged in packaging with all required labeling information. If the Pharmacy providing medications is unable to label the Multi Dose Packaging with required information, the medication must be packaged in bottles with all required labeling information. Medication Aides will notify Resident Care Director of any discrepancies in medication packaging or labeling. Weekly medication cart audits will be completed by the Resident Care Director to ensure compliance with packaging and labeling. The Executive Director will complete random audits to assist with compliance.

Date of Completion 3-15-2020

D358 pg. 48 **10A NCAC 13F .1004(a) Medication Administration Type B**

All current Medication Aides have been re-trained on Medication Administration Policies and Procedures including expectations for administration of medications, as well as the process to follow when medications are not available. Process will include notification of the Pharmacy, the Executive Director and Resident Care Director, to determine why medication is not available and when medication will be delivered. The Resident Care Director will notify the PCP to inform of the unavailable medication and receive directions for administration or receive order to hold the medication until delivered by the Pharmacy. The re-training of the Med Aides included completion of the Medication Administration checklist by an RN.

The RCD or designee will complete Audits of the medication administration compliance record daily and review each pharmacy delivery for accuracy and delivery of reordered medications. The Executive Director will complete weekly medication administration compliance reviews to assist with compliance of medication administration. All discrepancies in administration and/or documentation of administration of medications will be immediately addressed and corrected.

In addition, the Resident Care Director, Executive Director and designated Medication Aide were re-trained on completing a weekly Medication Administration Record review/comparison against the weekly delivery of Multi Dose Packaging (MDP) medications, as well as medications not packaged in MDP. The Resident Care Director will review new orders the following morning to assure that all medications were received from the pharmacy. In the event any medication is not available for administration, the Med Aides will notify the Pharmacy and the Resident Care Director of the unavailability of the medication. The Resident Care Director will follow up with the Pharmacy to obtain the medication and with the PCP to notify of any missed medications.

Date of Completion 3-15-2020

D 367 pg. 69 **10A NCAC 13F .1004(j) Medication Administration**

The Resident Care Director (RCD) will review the electronic Medication Administration Records (MAR) weekly for accuracy by comparing the MAR against the Physician Orders. Any discrepancies with accuracy of orders will be addressed immediately with both the Pharmacy and the PCP and the MAR corrected. The collection of Finger Stick Blood Sugar (FSBS) results will be documented on the electronic MAR. If there is no place to document results, the RCD will immediately be notified and the MAR entry will be edited to include space for the FSBS results. All Residents with orders for scheduled FSBS collection will also have orders obtained from the PCP for PRN FSBS as needed for signs of low or high blood glucose (Hypo or Hyper Glycemia) or for resident request of PRN FSBS. There will be an entry and space for prn FSBS results.

Date of Completion 3-15-2020

D 451 pg. 74 and D 454 pg. 79 **10A NCAC 13F .1212 (a) (e) Reporting of Accident and Incidents**

Within 1 hour of ALL occurrences, all accidents or incidents will be reported directly to the Resident Care Director or designee via the designated "RCD /Med Tech Communication" crew app or a direct phone call.

13F 1212(a) For all accidents or incidents, the Med Tech/SIC will complete the electronic event report form located within the Matrix system as soon as possible after the occurrence but no later than the end of their shift on the date of occurrence. Within 24 hours of occurrence, the completed event report will be reviewed for accuracy by the Resident Care Director. The RCD will close the report, adding follow up information or initiating protocols, as the occurrence may require. Within 36 hours, the RCD will electronically send the closed report to Divisional Director of Clinical Services or designee, for review. Within 48 hours and upon, approval from the DDCS or designee, the Resident Care Director will fax all reportable incident reports to DSS. The fax confirmation page and printed report will be filed in the incident occurrence binder.

13F 1212 (e 1) Within 1 hour of an accident or incident that requires immediate/urgent medical attention the Med Tech/SIC will notify the resident's designated contact of the occurrence, via phone call. The name of the person spoken to and time of notification will be noted on the electronic report. Within 1 hour of an accident or incident that requires immediate/urgent medical attention the Med Tech/SIC will notify the resident's provider of the occurrence, via phone call. The name of the provider spoken to and time of notification will be noted on the electronic report.

10A NACA 13F 1212 (e 2) As soon as possible (but no later than 24 hours) any non-urgent or non-life threatening accident or incident, whether or not medical attention was provided, the Med Tech/SIC will notify the resident's designated contact of the occurrence, via phone call. The name of the person spoken to and time of notification will be noted on the electronic report. As soon as possible (but no later than 24 hours) of any non-urgent or non-life threatening accident or incident, whether or not medical attention was provided, the Med Tech/SIC will notify the resident's provider of the occurrence, via phone call. The name of the provider spoken to and time of notification will be noted on the electronic report.

Date of Completion 3-15-2020

D 912 pg. 83 **GS 131D-21(2) Declaration of Resident Rights**

D914 pg. 85 **GS 131D-21(4) Declaration of Resident Rights**

D 932 pg. 86 **GS 131D-4.4A(b) ACH Infection Prevention Requirements- Type A2**

Date of Completion 2-29-2020

All staff were retrained on Resident Rights to include the right to receive care and services which are adequate, appropriate and in compliance with federal and state laws and rules and regulations regarding Medication Administration, Infection Prevention Requirements, Other staff Requirements, Resident Rights, Implementation, Health Care, Personal Care, . Training was provided during all staff meetings and individual one to one trainings conducted by the company Medical Doctor, Dr. Guillermo Lesassier., the Divisional Directors of Clinical Services and the Divisional Quality Assurance Director. Trainings included group training, as well as competency trainings specific to each rule area identified. Specific trainings were also completed related to Infection Control including cleanliness of building, meeting hygiene needs of residents in all situations, and glucometer single use requirements.

D980 pg. 117 **GS 131D-25 Implementation-Type A1**

Training was provided to the Interim Executive Director by the Company Divisional Vice President of Operations and the Divisional Director of Clinical Services regarding all Regulatory Requirements for Adult Care Home facilities, as well as implementation and oversight of all Infection Control Policies and

Procedures, Residents Rights, Health Care, Personal Care and Medication Administration. On-site support has been provided on a daily basis for the Interim Executive Director by Divisional Directors of Clinical Services and Operations since the survey. Ongoing on-site support will be provided by the Divisional Directors at a minimum of a weekly basis.

Date of Completion 2-29-2020

Respectfully Submitted,
DeLeith C Brooks, RN
Divisional Director of
Clinical Services
Affinity Living Group, Inc
Cleveland House
HAL023-045

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023045	A. BUILDING: _____ B. WING _____	R-C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND HOUSE	950 HARDIN DRIVE SHELBY, NC 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Cleveland County Department of Social Services conducted a follow-up survey and a complaint investigation on 01/28/20 to 01/31/20. The complaint investigations were initiated by the Cleveland County Department of Social Services on 12/11/19, 12/30/19 and on 01/17/20.	D 000		
D 106	10A NCAC 13F .0311(b) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. This rule apply to new & existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the temperature in the dining room and in two of the resident's rooms (#12 and #13) were maintained at 75 degrees Fahrenheit under winter design conditions. The findings are: Observation on 01/28/20 between 6:30am and 8:00am of resident rooms #12 and #13 on the back hallway near the nurse's station revealed: -Upon entering two resident's rooms they were cold. -The doors were closed, and the thermostats could not be controlled in either room. -The resident in one room was laying wrapped under the covers on his bed. Interview on 01/28/20 between 6:30am and	D 106		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DeLetty C Brooks, RN, Divisional Director of Clinical Services 3-13-2020

Acknowledged and reviewed 03/17/20

Jeanne S Robinson RN

Plan of Correction
Cleveland House
March 13, 2020

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.

D 106-pg 1 **10A NCAC 13F .0311(b) Other Requirements**

Routine checks of room temperatures for both Resident rooms and Common Areas will be completed by the Maintenance Technician on a rotating, weekly basis, ensuring all rooms and common areas have a room temperature checked monthly, during winter months, to maintain room temperature at 75 degrees Fahrenheit. With any inclement weather or when outside temperatures are below 32 degrees Fahrenheit, the room temperature checks will be completed daily, ensuring all rooms are maintained at 75 degrees.

In the event a residents room temperature is found to be less than 75 degrees, all efforts will be made to correct the maintenance and heating issue, while providing an alternate space for that resident where the room temperature meets the required 75 degrees. In the event a Common area space is found to be less than 75 degrees, all efforts will be made to correct the heating issue, while providing Common area activities in another location where the room temperature meets the required 75 degrees.

Date of Completion 3-15-2020

D137-pg 3 **10A NCAC 13F .0407 (a) (5) Other Staff Qualifications—Type B**

An audit of all current employee personnel files was completed to ensure NC Health Care Personnel Registry (NC HCPR) checks have been completed as required and that there are no employees with any substantiated findings. Training was completed for the Executive Director and Business Office Manager on the importance of completion of the NC HCPR check prior to an offer of employment. All future prospective employees will have the NC HCPR check completed prior to an offer of employment and starting employment. Random audits of Personnel records will be completed by the Executive Director, Area Director of Operations and/or the Divisional Director Business Management at least quarterly.

Date of completion 3-1-2020

D 269-pg 6 **10A NCAC 13F .0901(a) Personal Care and Supervision—Type A1**

A comprehensive assessment will be completed on all new admissions. This assessment will determine the resident's ability to perform all ADL'S. The ability of the resident to perform ADL's will be included in the resident's plan of care. Each resident will have an assigned shower/bath schedule. The shower schedule will include the ability of the resident to perform his/her shower. Residents will receive showers on their assigned days. The shower will be documented in matrix care by the end of the shift. Any showers that were not completed will be reported to the SIC/Resident Care Director (RCD) before leaving the shift.

Staff have received training in assisting residents with ADL'S. This includes correct perineal care, incontinence care and assistance with showers. Residents will be assessed every two hours to determine incontinence. The incontinent resident will receive immediate perineal care.

All staff have been trained to accurately complete full body audits and skin evaluations. The staff performed return demonstrations to show mastery. The body audit/skin evaluation will be completed on each resident upon admission to the community, at their respective shower times, as well as return from a hospitalization, or a leave from the community. Any abnormal findings will be reported to the Resident Care Director, who will assess the resident. The Resident Care Director will notify the PCP immediately if warranted or upon his/her weekly visit to the community. The Resident Care Director will initiate any orders from PCP upon receipt. The Resident Care Director will evaluate the effectiveness or lack thereof and communicate findings to the PCP. At the time of hire/orientation, all care staff will receive body evaluation and ADL assistance training, including assistance with bathing and showering, incontinence care and dressing with return demonstrations as well, as part of orientation.

Date of Completion 2-29-2020

D 273 pg. 16 **10A NCAC 13F .0902(b) Health Care-Referral and Follow Up—Type A 2**

Body audits/skin evaluations will be completed on each resident upon admission to the community, at their respective shower times, as well as return from a hospitalization, or a leave from the community. Any abnormal findings will be reported to the Resident Care Director. The Resident Care Director will notify the PCP immediately if warranted or upon his/her weekly visit to the community. The Resident Care Director will initiate any orders from PCP upon receipt. The resident care director will evaluate the effectiveness or lack thereof to the PCP.

A medication inventory will be conducted upon admission of residents to the community. The Resident Care Director will compare the FL2 orders with any medications brought by the resident to the community. The Resident Care Director will contact PCP for any medications that residents brings to the facility that are not on the FL2 for clarification. Any medications that require an outside provider to prescribe said medication, the provider will be contacted and the order received. The Resident Care Director will review new orders the following morning to assure that all medications were received from the pharmacy. In the event any medication is not available for administration, the Med Aides will notify the Pharmacy and the Resident Care Director of the unavailability of the medication. The Resident Care Director will follow up with the Pharmacy to obtain the medication and with the PCP to notify of any missed medications. The Resident Care Director will complete daily audits of medication administration compliance review to determine any missing administration of medications. The Executive Director will complete weekly medication administration compliance reviews to assist with compliance of medication administration.

All Medication Aides were retrained on medication administration practice and expectations, including administration of all medications and completion of treatments as ordered. The training included process and procedure for notification of the Resident Care Director, Pharmacy and PCP in the event a medication is not available for administration and proper documentation of medications not administered.

Date of Completion 2-29-2020

D 338 pg. 36 **10A NCAC 13F .0909 Resident Rights—Unabated Type B**

Resident Rights retraining completed with all staff, including current Management employees, related to the rights of residents to receive appropriate care during an event such as a norovirus outbreak or other potentially infectious process requiring suspension of communal activities such as Dining and other group activities. Retraining included proper bathing, dressing, toileting and incontinence care of residents and use of measures to meet hygiene needs of all residents.

Upon notification that a contagious illness has been detected in the community, the local health department will be notified. The health department will provide instruction on the need for isolation and disinfection procedures. If there is concern regarding cross contamination between residents in semi- private rooms, the health department will provide guidance for disinfection procedures.

Date of Completion 2-29-2020

D 352-pg.42 **10A NCAC 13F .1003(a) Medication Labels**

All medications will be packaged in packaging with all required labeling information. If the Pharmacy providing medications is unable to label the Multi Dose Packaging with required information, the medication must be packaged in bottles with all required labeling information. Medication Aides will notify Resident Care Director of any discrepancies in medication packaging or labeling. Weekly medication cart audits will be completed by the Resident Care Director to ensure compliance with packaging and labeling. The Executive Director will complete random audits to assist with compliance.

Date of Completion 3-15-2020

D358 pg. 48 **10A NCAC 13F .1004(a) Medication Administration Type B**

All current Medication Aides have been re-trained on Medication Administration Policies and Procedures including expectations for administration of medications, as well as the process to follow when medications are not available. Process will include notification of the Pharmacy, the Executive Director and Resident Care Director, to determine why medication is not available and when medication will be delivered. The Resident Care Director will notify the PCP to inform of the unavailable medication and receive directions for administration or receive order to hold the medication until delivered by the Pharmacy. The re-training of the Med Aides included completion of the Medication Administration checklist by an RN.

The RCD or designee will complete Audits of the medication administration compliance record daily and review each pharmacy delivery for accuracy and delivery of reordered medications. The Executive Director will complete weekly medication administration compliance reviews to assist with compliance of medication administration. All discrepancies in administration and/or documentation of administration of medications will be immediately addressed and corrected.

In addition, the Resident Care Director, Executive Director and designated Medication Aide were re-trained on completing a weekly Medication Administration Record review/comparison against the weekly delivery of Multi Dose Packaging (MDP) medications, as well as medications not packaged in MDP. The Resident Care Director will review new orders the following morning to assure that all medications were received from the pharmacy. In the event any medication is not available for administration, the Med Aides will notify the Pharmacy and the Resident Care Director of the unavailability of the medication. The Resident Care Director will follow up with the Pharmacy to obtain the medication and with the PCP to notify of any missed medications.

Date of Completion 3-15-2020

D 367 pg. 69 **10A NCAC 13F .1004(j) Medication Administration**

The Resident Care Director (RCD) will review the electronic Medication Administration Records (MAR) weekly for accuracy by comparing the MAR against the Physician Orders. Any discrepancies with accuracy of orders will be addressed immediately with both the Pharmacy and the PCP and the MAR corrected. The collection of Finger Stick Blood Sugar (FSBS) results will be documented on the electronic MAR. If there is no place to document results, the RCD will immediately be notified and the MAR entry will be edited to include space for the FSBS results. All Residents with orders for scheduled FSBS collection will also have orders obtained from the PCP for PRN FSBS as needed for signs of low or high blood glucose (Hypo or Hyper Glycemia) or for resident request of PRN FSBS. There will be an entry and space for prn FSBS results.

Date of Completion 3-15-2020

D 451 pg. 74 and D 454 pg. 79 **10A NCAC 13F .1212 (a) (e) Reporting of Accident and Incidents**

Within 1 hour of ALL occurrences, all accidents or incidents will be reported directly to the Resident Care Director or designee via the designated "RCD /Med Tech Communication" crew app or a direct phone call.

13F 1212(a) For all accidents or incidents, the Med Tech/SIC will complete the electronic event report form located within the Matrix system as soon as possible after the occurrence but no later than the end of their shift on the date of occurrence. Within 24 hours of occurrence, the completed event report will be reviewed for accuracy by the Resident Care Director. The RCD will close the report, adding follow up information or initiating protocols, as the occurrence may require. Within 36 hours, the RCD will electronically send the closed report to Divisional Director of Clinical Services or designee, for review. Within 48 hours and upon, approval from the DDCS or designee, the Resident Care Director will fax all reportable incident reports to DSS. The fax confirmation page and printed report will be filed in the incident occurrence binder.

13F 1212 (e 1) Within 1 hour of an accident or incident that requires immediate/urgent medical attention the Med Tech/SIC will notify the resident's designated contact of the occurrence, via phone call. The name of the person spoken to and time of notification will be noted on the electronic report. Within 1 hour of an accident or incident that requires immediate/urgent medical attention the Med Tech/SIC will notify the resident's provider of the occurrence, via phone call. The name of the provider spoken to and time of notification will be noted on the electronic report.

10A NACA 13F 1212 (e 2) As soon as possible (but no later than 24 hours) any non-urgent or non-life threatening accident or incident, whether or not medical attention was provided, the Med Tech/SIC will notify the resident's designated contact of the occurrence, via phone call. The name of the person spoken to and time of notification will be noted on the electronic report. As soon as possible (but no later than 24 hours) of any non-urgent or non-life threatening accident or incident, whether or not medical attention was provided, the Med Tech/SIC will notify the resident's provider of the occurrence, via phone call. The name of the provider spoken to and time of notification will be noted on the electronic report.

Date of Completion 3-15-2020

D 912 pg. 83 **GS 131D-21(2) Declaration of Resident Rights**

D914 pg. 85 **GS 131D-21(4) Declaration of Resident Rights**

D 932 pg. 86 **GS 131D-4.4A(b) ACH Infection Prevention Requirements- Type A2**

Date of Completion 2-29-2020

All staff were retrained on Resident Rights to include the right to receive care and services which are adequate, appropriate and in compliance with federal and state laws and rules and regulations regarding Medication Administration, Infection Prevention Requirements, Other staff Requirements, Resident Rights, Implementation, Health Care, Personal Care, . Training was provided during all staff meetings and individual one to one trainings conducted by the company Medical Doctor, Dr. Guillermo Lesassier., the Divisional Directors of Clinical Services and the Divisional Quality Assurance Director. Trainings included group training, as well as competency trainings specific to each rule area identified. Specific trainings were also completed related to Infection Control including cleanliness of building, meeting hygiene needs of residents in all situations, and glucometer single use requirements.

D980 pg. 117 **GS 131D-25 Implementation-Type A1**

Training was provided to the Interim Executive Director by the Company Divisional Vice President of Operations and the Divisional Director of Clinical Services regarding all Regulatory Requirements for Adult Care Home facilities, as well as implementation and oversight of all Infection Control Policies and

Procedures, Residents Rights, Health Care, Personal Care and Medication Administration. On-site support has been provided on a daily basis for the Interim Executive Director by Divisional Directors of Clinical Services and Operations since the survey. Ongoing on-site support will be provided by the Divisional Directors at a minimum of a weekly basis.

Date of Completion 2-29-2020

Respectfully Submitted,
DeLeith C Brooks, RN
Divisional Director of
Clinical Services
Affinity Living Group, Inc
Cleveland House
HAL023-045

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023045	A. BUILDING: _____ B. WING _____	R-C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND HOUSE	950 HARDIN DRIVE SHELBY, NC 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Cleveland County Department of Social Services conducted a follow-up survey and a complaint investigation on 01/28/20 to 01/31/20. The complaint investigations were initiated by the Cleveland County Department of Social Services on 12/11/19, 12/30/19 and on 01/17/20.	D 000		
D 106	10A NCAC 13F .0311(b) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. This rule apply to new & existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the temperature in the dining room and in two of the resident's rooms (#12 and #13) were maintained at 75 degrees Fahrenheit under winter design conditions. The findings are: Observation on 01/28/20 between 6:30am and 8:00am of resident rooms #12 and #13 on the back hallway near the nurse's station revealed: -Upon entering two resident's rooms they were cold. -The doors were closed, and the thermostats could not be controlled in either room. -The resident in one room was laying wrapped under the covers on his bed. Interview on 01/28/20 between 6:30am and	D 106		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

DeLetty C Brooks, RN, Divisional Director of Clinical Services 3-13-2020

Acknowledged and reviewed 03/17/20

Jeanne S Robinson RN

Plan of Correction
Cleveland House
March 13, 2020

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.

D 106-pg 1 **10A NCAC 13F .0311(b) Other Requirements**

Routine checks of room temperatures for both Resident rooms and Common Areas will be completed by the Maintenance Technician on a rotating, weekly basis, ensuring all rooms and common areas have a room temperature checked monthly, during winter months, to maintain room temperature at 75 degrees Fahrenheit. With any inclement weather or when outside temperatures are below 32 degrees Fahrenheit, the room temperature checks will be completed daily, ensuring all rooms are maintained at 75 degrees.

In the event a residents room temperature is found to be less than 75 degrees, all efforts will be made to correct the maintenance and heating issue, while providing an alternate space for that resident where the room temperature meets the required 75 degrees. In the event a Common area space is found to be less than 75 degrees, all efforts will be made to correct the heating issue, while providing Common area activities in another location where the room temperature meets the required 75 degrees.

Date of Completion 3-15-2020

D137-pg 3 **10A NCAC 13F .0407 (a) (5) Other Staff Qualifications—Type B**

An audit of all current employee personnel files was completed to ensure NC Health Care Personnel Registry (NC HCPR) checks have been completed as required and that there are no employees with any substantiated findings. Training was completed for the Executive Director and Business Office Manager on the importance of completion of the NC HCPR check prior to an offer of employment. All future prospective employees will have the NC HCPR check completed prior to an offer of employment and starting employment. Random audits of Personnel records will be completed by the Executive Director, Area Director of Operations and/or the Divisional Director Business Management at least quarterly.

Date of completion 3-1-2020

D 269-pg 6 **10A NCAC 13F .0901(a) Personal Care and Supervision—Type A1**

A comprehensive assessment will be completed on all new admissions. This assessment will determine the resident's ability to perform all ADL'S. The ability of the resident to perform ADL's will be included in the resident's plan of care. Each resident will have an assigned shower/bath schedule. The shower schedule will include the ability of the resident to perform his/her shower. Residents will receive showers on their assigned days. The shower will be documented in matrix care by the end of the shift. Any showers that were not completed will be reported to the SIC/Resident Care Director (RCD) before leaving the shift.

Staff have received training in assisting residents with ADL'S. This includes correct perineal care, incontinence care and assistance with showers. Residents will be assessed every two hours to determine incontinence. The incontinent resident will receive immediate perineal care.

All staff have been trained to accurately complete full body audits and skin evaluations. The staff performed return demonstrations to show mastery. The body audit/skin evaluation will be completed on each resident upon admission to the community, at their respective shower times, as well as return from a hospitalization, or a leave from the community. Any abnormal findings will be reported to the Resident Care Director, who will assess the resident. The Resident Care Director will notify the PCP immediately if warranted or upon his/her weekly visit to the community. The Resident Care Director will initiate any orders from PCP upon receipt. The Resident Care Director will evaluate the effectiveness or lack thereof and communicate findings to the PCP. At the time of hire/orientation, all care staff will receive body evaluation and ADL assistance training, including assistance with bathing and showering, incontinence care and dressing with return demonstrations as well, as part of orientation.

Date of Completion 2-29-2020

D 273 pg. 16 **10A NCAC 13F .0902(b) Health Care-Referral and Follow Up—Type A 2**

Body audits/skin evaluations will be completed on each resident upon admission to the community, at their respective shower times, as well as return from a hospitalization, or a leave from the community. Any abnormal findings will be reported to the Resident Care Director. The Resident Care Director will notify the PCP immediately if warranted or upon his/her weekly visit to the community. The Resident Care Director will initiate any orders from PCP upon receipt. The resident care director will evaluate the effectiveness or lack thereof to the PCP.

A medication inventory will be conducted upon admission of residents to the community. The Resident Care Director will compare the FL2 orders with any medications brought by the resident to the community. The Resident Care Director will contact PCP for any medications that residents brings to the facility that are not on the FL2 for clarification. Any medications that require an outside provider to prescribe said medication, the provider will be contacted and the order received. The Resident Care Director will review new orders the following morning to assure that all medications were received from the pharmacy. In the event any medication is not available for administration, the Med Aides will notify the Pharmacy and the Resident Care Director of the unavailability of the medication. The Resident Care Director will follow up with the Pharmacy to obtain the medication and with the PCP to notify of any missed medications. The Resident Care Director will complete daily audits of medication administration compliance review to determine any missing administration of medications. The Executive Director will complete weekly medication administration compliance reviews to assist with compliance of medication administration.

All Medication Aides were retrained on medication administration practice and expectations, including administration of all medications and completion of treatments as ordered. The training included process and procedure for notification of the Resident Care Director, Pharmacy and PCP in the event a medication is not available for administration and proper documentation of medications not administered.

Date of Completion 2-29-2020

D 338 pg. 36 **10A NCAC 13F .0909 Resident Rights—Unabated Type B**

Resident Rights retraining completed with all staff, including current Management employees, related to the rights of residents to receive appropriate care during an event such as a norovirus outbreak or other potentially infectious process requiring suspension of communal activities such as Dining and other group activities. Retraining included proper bathing, dressing, toileting and incontinence care of residents and use of measures to meet hygiene needs of all residents.

Upon notification that a contagious illness has been detected in the community, the local health department will be notified. The health department will provide instruction on the need for isolation and disinfection procedures. If there is concern regarding cross contamination between residents in semi- private rooms, the health department will provide guidance for disinfection procedures.

Date of Completion 2-29-2020

D 352-pg.42 **10A NCAC 13F .1003(a) Medication Labels**

All medications will be packaged in packaging with all required labeling information. If the Pharmacy providing medications is unable to label the Multi Dose Packaging with required information, the medication must be packaged in bottles with all required labeling information. Medication Aides will notify Resident Care Director of any discrepancies in medication packaging or labeling. Weekly medication cart audits will be completed by the Resident Care Director to ensure compliance with packaging and labeling. The Executive Director will complete random audits to assist with compliance.

Date of Completion 3-15-2020

D358 pg. 48 **10A NCAC 13F .1004(a) Medication Administration Type B**

All current Medication Aides have been re-trained on Medication Administration Policies and Procedures including expectations for administration of medications, as well as the process to follow when medications are not available. Process will include notification of the Pharmacy, the Executive Director and Resident Care Director, to determine why medication is not available and when medication will be delivered. The Resident Care Director will notify the PCP to inform of the unavailable medication and receive directions for administration or receive order to hold the medication until delivered by the Pharmacy. The re-training of the Med Aides included completion of the Medication Administration checklist by an RN.

The RCD or designee will complete Audits of the medication administration compliance record daily and review each pharmacy delivery for accuracy and delivery of reordered medications. The Executive Director will complete weekly medication administration compliance reviews to assist with compliance of medication administration. All discrepancies in administration and/or documentation of administration of medications will be immediately addressed and corrected.

In addition, the Resident Care Director, Executive Director and designated Medication Aide were re-trained on completing a weekly Medication Administration Record review/comparison against the weekly delivery of Multi Dose Packaging (MDP) medications, as well as medications not packaged in MDP. The Resident Care Director will review new orders the following morning to assure that all medications were received from the pharmacy. In the event any medication is not available for administration, the Med Aides will notify the Pharmacy and the Resident Care Director of the unavailability of the medication. The Resident Care Director will follow up with the Pharmacy to obtain the medication and with the PCP to notify of any missed medications.

Date of Completion 3-15-2020

D 367 pg. 69 **10A NCAC 13F .1004(j) Medication Administration**

The Resident Care Director (RCD) will review the electronic Medication Administration Records (MAR) weekly for accuracy by comparing the MAR against the Physician Orders. Any discrepancies with accuracy of orders will be addressed immediately with both the Pharmacy and the PCP and the MAR corrected. The collection of Finger Stick Blood Sugar (FSBS) results will be documented on the electronic MAR. If there is no place to document results, the RCD will immediately be notified and the MAR entry will be edited to include space for the FSBS results. All Residents with orders for scheduled FSBS collection will also have orders obtained from the PCP for PRN FSBS as needed for signs of low or high blood glucose (Hypo or Hyper Glycemia) or for resident request of PRN FSBS. There will be an entry and space for prn FSBS results.

Date of Completion 3-15-2020

D 451 pg. 74 and D 454 pg. 79 **10A NCAC 13F .1212 (a) (e) Reporting of Accident and Incidents**

Within 1 hour of ALL occurrences, all accidents or incidents will be reported directly to the Resident Care Director or designee via the designated "RCD /Med Tech Communication" crew app or a direct phone call.

13F 1212(a) For all accidents or incidents, the Med Tech/SIC will complete the electronic event report form located within the Matrix system as soon as possible after the occurrence but no later than the end of their shift on the date of occurrence. Within 24 hours of occurrence, the completed event report will be reviewed for accuracy by the Resident Care Director. The RCD will close the report, adding follow up information or initiating protocols, as the occurrence may require. Within 36 hours, the RCD will electronically send the closed report to Divisional Director of Clinical Services or designee, for review. Within 48 hours and upon, approval from the DDCS or designee, the Resident Care Director will fax all reportable incident reports to DSS. The fax confirmation page and printed report will be filed in the incident occurrence binder.

13F 1212 (e 1) Within 1 hour of an accident or incident that requires immediate/urgent medical attention the Med Tech/SIC will notify the resident's designated contact of the occurrence, via phone call. The name of the person spoken to and time of notification will be noted on the electronic report. Within 1 hour of an accident or incident that requires immediate/urgent medical attention the Med Tech/SIC will notify the resident's provider of the occurrence, via phone call. The name of the provider spoken to and time of notification will be noted on the electronic report.

10A NACA 13F 1212 (e 2) As soon as possible (but no later than 24 hours) any non-urgent or non-life threatening accident or incident, whether or not medical attention was provided, the Med Tech/SIC will notify the resident's designated contact of the occurrence, via phone call. The name of the person spoken to and time of notification will be noted on the electronic report. As soon as possible (but no later than 24 hours) of any non-urgent or non-life threatening accident or incident, whether or not medical attention was provided, the Med Tech/SIC will notify the resident's provider of the occurrence, via phone call. The name of the provider spoken to and time of notification will be noted on the electronic report.

Date of Completion 3-15-2020

D 912 pg. 83 **GS 131D-21(2) Declaration of Resident Rights**

D914 pg. 85 **GS 131D-21(4) Declaration of Resident Rights**

D 932 pg. 86 **GS 131D-4.4A(b) ACH Infection Prevention Requirements- Type A2**

Date of Completion 2-29-2020

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D980 pg. 117 **GS 131D-25 Implementation-Type A1**

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Procedures, Residents Rights, Health Care, Personal Care and Medication Administration. On-site support has been provided on a daily basis for the Interim Executive Director by Divisional Directors of Clinical Services and Operations since the survey. Ongoing on-site support will be provided by the Divisional Directors at a minimum of a weekly basis.

Date of Completion 2-29-2020

Respectfully Submitted,
DeLeith C Brooks, RN
Divisional Director of
Clinical Services
Affinity Living Group, Inc
Cleveland House
HAL023-045