Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: ______ B. WING ______	12/13/2019

RECEIVED
APR 0 2 2020
ADULT CARE LICENSURE SECTION
RALEIGH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 Davie County Department of Social Services conducted an annual survey and a complaint investigation on 12/03/19 through 12/06/19 and 12/10/19 through 12/13/19. The complaint investigation was intiated by the Davie County Department of Social Services on 11/07/19.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, record reviews, and observations, the facility failed to ensure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled residents (Resident #5) who was constantly disorientated, had wandering behaviors and eloped from the facility without staff's knowledge.	D 067		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Managing Member (X6) DATE 3/30/20

Received and Accepted Keisha Banks 06/10/20

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The findings are:

Observations during the tour of the facility on 12/03/19 between 9:45am and 11:15am revealed:
-At 9:45am, the front door of the main entrance was unlocked and did not sound upon entering the facility.
-The front door led to a large lobby area and there was another unlocked door in the large lobby area which led to a smoking area for residents.
-There was a third door in the large lobby area which led to a smaller lobby area and this door was propped open with a door stopper.
-Residents were observed going in and out of the main entrance door, the door which led to the smoking area, and the door which led from the large lobby area to the smaller lobby are and there was no sound heard when either door was opened.
-There was also a door at the end of each resident hallway in the facility which had a sign that read, "Emergency exit alarm will sound."
-There was no sign related to an alarm on either of the other 3 doors at the front of the building.

Observations of the facilty at various times between 12/03/19 and 12/12/19 revealed:
-There was no sounding device on the door leading from the outside of the facilty to the large lobby.
-There was no sounding device on the door in the large lobby leading to the outside smoking area.
-The door between the large lobby area and the small lobby area remained propped open and there was no sounding device.
-Residents entered and exited all three doors.

Observations of the facility on 12/04/19 at 5:58am

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revealed:
-There was a staff member outside at his car.
-The side door to one of the resident hallways was propped open with a coat hanger and there was no alarm sounding with the door being open.
-The main door to the facility (large lobby area) was unlocked from the outside and there was no sound when the door was opened.
-The door between the large lobby area and the smaller lobby area was propped open with a door stopper and there was no alarm sounding when the door was propped open.
-There was an alarm keypad on the wall at the medication aide (MA) work station.

Interview with a third shift medication aide (MA) on 12/04/19 at 6:15am revealed:
-The main door to the facility (large lobby area) was never locked.
-The door leading from the large lobby area to the smaller lobby area was closed at night between 3:00am and 5:00am.
-Once the door leading from the large lobby area to the smaller lobby area was closed, the door automatically locked from the outside and the alarm was automatically activated.
-Once the door was shut, no one could get in, but staff and residents could go out of the door and the alarm would sound if anyone went out.
-The only way to deactivate the alarm was from the alarm keypad at the MA station.
-She left the door between the large and small lobby areas open at night because residents liked to go outside to smoke.

Interview with a third shift personal care aide (PCA) on 12/04/19 at 6:20am revealed:
-The PCA was found at his car at 5:58am because his keys for the facility were in his car so he decided to get them when he took the trash

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D 067	Continued From page 3 out. -He had taken the trash out using the side door, so he propped a coat hanger in the side door to keep it from locking back and to prevent the alarm from being activated. -He propped the door open every night he worked when it was time to take the trash out because it saved him time. -When he propped the side door open with a coat hanger, he had the MA to turn off the alarm while it was propped open. -No resident had ever left the building by going out the side door. -One resident (#5) had left out the front door and was brought back by police. -The interior front door between the large and small lobby areas had an alarm on it, but it stayed propped open until the MA came in between 12:00am and 1:30am, at which time the door was closed and automatically locked and alarmed. Interview with the third shift MA on 12/12/19 at 4:50pm revealed: -She recalled when Resident #5 left the facility. -She was not sure how he got out but stated sometimes staff left the door open while they dumped the trash. Interview with a second shift MA on 12/05/19 at 7:33 pm revealed: -There were residents in the facility who had a diagnosis of dementia. -There was no sounding device on the door to the large lobby area (when the door was open), the small lobby area, or the door to the outside smoking area. -The door between the large and small lobby areas was alarmed by staff at 8:00pm and deactivated at 7:00am. -Residents went out to smoke at night, but staff	D 067		

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D 067	Continued From page 4 was usually with them. Review of Resident #5's current FL2 dated 10/04/19 revealed: -Diagnoses included fracture of left ankle, bipolar, gastroesophageal reflux disease (GERD), and anemia. -Resident #5 was constantly disoriented. -The resident had inappropriate behavior, wandered and was verbally abusive at times. Review of Resident #5's Care Plan dated 08/23/19 revealed Resident #5 required limited assistance with eating, toileting, ambulation, and transfers. Review of a report from the local police department dated 10/01/19 revealed: -Resident #5 was found by police officers on a dark street, almost two blocks from the facility. -The resident was found at 3:13 am and the resident appeared disoriented. -The resident told the police officers that he was having chest pains and pain in his left arm, but facility staff would not call medical assistance for him. -The resident was transported back to the facility by the police. -The staff at the facility did not know the resident had left the building. -The door was observed being held open by a door stop, which caused the alarm to be deactivated, which was how Resident #5 left the building. -No staff at the facility could advise when Resident #5 left the facility. Review of Resident #5's Incident/Accident reports revealed there were no Incident/Accident reports.	D 067		

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D 067	Continued From page 5 Interview with Resident #5's guardian on 12/05/19 at 12:13 pm revealed: -The Administrator at the facility called her on 10/02/19, the next morning after Resident #5 eloped. -She told the Administrator the facility needed a better system to identify when residents left the building. -Resident #5 told her that he left the facility because he needed an ambulance and the staff would not call the ambulance for him. -No one at the facility had called to inform her about anything involving Resident #5. Interview with Resident #5 on 12/05/19 at 9:11am revealed: -He had told staff on 10/01/19 that he did not feel good and he wanted to go to the hospital. -The staff ignored him and told him there was nothing wrong with him. -He left and was later found by the police and they brought him back to the facility. Interview with 4 residents on 12/12/19 5:56pm and 6:10pm revealed: -The door between the large lobby area and the small lobby area was usually closed, locked, and alarmed around 11:00pm. -One of the resident heard the alarm sounding every night around 12:00pm. -People came in and out of the facility all throughout the night. -Residents never heard a sounding device on the main door to large lobby or the exit door to the smoking area. -The door between the the large and small lobby stayed propped open during the day and only alarmed if it was opened after being closed. -Residents who smoked were able to go out to smoke during the night.	D 067		

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-Sometimes the door between the large and small lobbies was closed and alarmed and sometimes the door was not closed and alarmed.

Interview with the Administrator on 12/12/19 at 9:37 am revealed:
-She was aware Resident #5 eloped from the facility.
-She thought staff left the alarmed door open.
-She talked with staff and notified Resident #5's guardian.
-She had informed staff to watch all the residents , especially the residents that were easily agitated.

Second interview with the Administrator on 12/12/19 at 6:20pm.
-There was an alarm on the door at the end of each resident hallway at all times which sounded when the door was opened.
-There was an alarm on the door between the large lobby area and the smaller lobby area, but it was only activated when the door was closed.
-The door between the large and small lobby area was usually open throughout the day and did not have any sounding device while it was open.
-The door leading from the outside of the facility to the large lobby and the door leading from the large lobby area to the outside smoking area did not have a sounding device and were never alarmed.
-There were residents in the facility with a diagnosis of dementia and disorientation.
-She did not know of any residents in the facility with any wandering behaviors.
-She did not know there needed to be a sounding device on all exit doors accessible by residents when there was at least one resident in the facility who had wandering behaviors or disorientation.

____

The facility failed to assure all exit doors were

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D 067	Continued From page 7 alarmed when there was at least one identified resident who wandered or was disoriented resulting in Resident #5 eloping from the facility without staff's knowledge. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ______________________________ The facility provided a plan of protection in accordance with G. S. 131D-34 on 12/07/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D 067	ATTACHED IS OUR LONG STANDING POLICY REGARDING DOOR ALARMS AND WANDERING RESIDENTS. THIS IS CONTAINED IN OUR POLICY AND PROCEDURE MANUAL. THE ADMINISTRATOR AND STAFF INEXPLICABLY, DID NOT FOLLOW THIS PROCEDURE. THE HOME WAS CLOSED ON 2/7/2020 AND THE RESIDENTS WERE RELOCATED TO APPROPRIATE LEVELS OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S.	
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all residents had a readily accessible supply of bath soap, toilet paper, clean towels and clean washcloths on hand for use at all times. The findings are: Observation on 12/03/19 and 12/04/19 revealed the facility had a census of 31 residents.	D 080		

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Interview with second shift housekeeper on 12/03/19 at 4:36pm revealed:
-Resident supplies of toilet paper, soap, and paper towels were kept in a locked utility closet directly beside the laundry room and was accessible by staff.
-Bulk paper towels, toilet paper, and soap were kept in another locked utility closet by the laundry room and was accessible only by the Administrator due to these supplies "getting missing from the staff utility closet."
-This had stopped the theft of the supplies.

Observation of the locked utility closet accessed by the Administrator on 12/03/19 at 5:02pm revealed:
-There were no bars of soap.
-There were no paper towels.

Interview with the Administrator on 12/03/19 at 5:02pm revealed supplies (toilet paper, paper towels, and soap) were delivered to the facility every Thursday.

Observation of residents' rooms on 12/04/19 between 9:15am and 10:12am revealed:
-The men's bathroom had no hand soap.
-There was one resident in room 204, there were no towels in the room.
-There were 2 residents in room 103, there were no towels in the shared bathroom.
-There were 2 residents in room 107, there were no soap or towels in the shared bathroom.

Observation of the laundry room on 12/04/19 at 10:15am revealed:
-There was one bath towel folded on the shelf behind the door of the laundry room.
-There were 7 washcloths folded and on the shelf behind the door of the laundry room.

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D 080	Continued From page 9 Interview with a first shift housekeeper on 12/04/19 at 10:15am revealed: -The facility had 24 to 36 towels and about 50 washcloths. -She did not know where the remaining towels and washcloths were. Observation of the laundry room on 12/05/19 at 4:00pm revealed that the facility had a supply of3 washcloths and 2 towels on the shelf behind the door of the laundry room. Observation of the housekeeping cart on 12/05/19 at 4:05pm revealed that there were 2 towels and 2 washcloths. Observation of the shower room on the 100 hall shower room on 12/05/19 at 4:08pm revealed that there was 1 towel and 4 washcloths. Interview with a second shift PCA on 12/05/19 at 4:00pm revealed: -The facility had a supply of about 20 washcloths and 25 towels. -She did not know where the missing towels were. Interview with the Administrator on 12/06/19 at 9:21am revealed: -She ordered all the supplies for the building, including toilet paper, paper towels, and soap, per the instructions of the owner. -At one time, the facility had around 75-100 towels and washcloths. -She had ordered more towels and washcloths, but she did not indicate when. -She had purchased some towels and washcloths and "they have disappeared."	D 080		

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D 080	Continued From page 10 Interview with the Supervisor on 12/06/19 at 10:00am revealed: -The Administrator was responsible for ordering the cleaning and other supplies. -There was "not always plenty of soap or towels." -There were 4 stacks of towels and 5 stacks of washcloths ordered in June or July 2019. -Staff was washing laundry as quickly as they could to make sure residents had clean washcloths and towels. Observation of the laundry room on 12/06/19 at 10:58am revealed: -There were 2 washcloths and 3 towels folded on the shelf behind the door. -There were 2 soiled washcloths waiting to be washed. Observation on 12/11/19 at 9:02am of the laundry room revealed that there were 7 washcloths and 4 towels folded on the shelf behind the door. Interview with a housekeeper on 12/11/19 at 9:02am revealed: -She was responsible for the laundry. -Laundry was also completed on 2nd and 3rd shifts. -She thought the facility may have had a total of 6 towels and 6 washcloths on hand. -The Administrator recently bought around 3 dozen new towels and washcloths but "they have disappeared." Interview with two residents on 12/11/19 at 9:23am and 9:25am revealed: -"I have never been given a towel so I bought one." -"I have 4 personal towels and 2 personal hand towels and I decide when they need to be washed."	D 080		

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D 080	Continued From page 11 -The residents did not use the soap in the dispenser because the soap was old. Interview with the Administrator on 12/11/19 at 9:36am revealed: -She did not know what was happening with the towels and washcloths. -Residents may have tossed the towels and wash cloths in the trash. -She purchased 50 towels and 100 washcloths last week and they has all "disappeared." Observation of the laundry room on 12/12/19 at 8:15am revealed that there were 8 towels and 16 washcloths folded on the shelf behind the door. Observation of room #207 on 12/11/19 at 12:15pm revealed: -There were 2 residents in the room. -There was no toilet paper, paper towels, soap, or other towels in the shared bathroom.	D 080	ATTACHED ARE INVENTORY SHEETS SHOWING THAT ADMINISTRATOR IS SUPPOSED TO CONDUCT MONTHLY CHECK OF INVENTORY AND STOCK TO APPROPRIATE LEVELS. ACTUAL INSPECTION OF OWNER, INTO A LOCKED UTILITY ROOM REVEALED ONE UNOPENED CASE OF HAND SOAP AND TWO CASES OF TOILET PAPER. OWNER HAS NO EXPLANATION AS TO WHY ONSITE MANAGEMENT DID NOT SHOW THIS TO SURVEY TEAM.	
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION	D 131		

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Based on record reviews and interviews, the facility failed to assure 9 of 12 sampled staff (Staff A, B, C, E, F, G, I, J, and K) were tested for Tuberculosis (TB) disease upon hire.

The findings are:

1. Review of Staff E's, medication aide (MA), personnel record revealed:
-Staff E was hired on 06/27/19.
-There was no documentation of any TB skin tests.

Interview with Staff E on 12/12/19 at 10:37 am revealed:
-She was originally hired in June 2019, she left the facility in July 2019, and was re-hired on 09/05/19.
-She could not recall the last time she had a TB skin test.
-She did not know she needed a TB skin test upon hire.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She was responsible for hiring Staff E and ensuring Staff E had a TB skin test upon hire.
-The Licensed Health Professional Support (LHPS) nurse placed and read the TB skin tests for staff at the facility.

Telephone interview with the LHPS nurse on 12/12/19 at 8:35pm revealed the facility staff did not request a TB skin test for Staff E.

Refer to the interview with the Administrator on 12/12/19 at 5:25pm.

2. Review of Staff A's, personal care aide (PCA),

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 131	Continued From page 13 personnel record revealed: -Staff A was hired on 01/02/17. -There was no documentation of any TB skin tests. Interview with Staff A on 12/12/19 at 8:38 am revealed: -She was hired as a personal care aide and housekeeper 3 years ago. -She had two TB skin tests when she was hired 3 years ago. -Both the first and the secondTB skin tests were read as negative. Interview with the Administrator on 12/12/19at 5:35pm revealed: -The corporate office was in the process of transitioning personnel records to electronic files and some staff members' paperwork had been sent to the corporate office for scanning into electronic records. -She did not have Staff A's TB skin test documentation onsite and she was unable to retrieve Staff A's TB test documentation from the electronic record. -She knew Staff A needed to have documentation of TB skin tests in order to be compliant or Staff A needed to repeat her TB skin tests. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. 3. Review of Staff B's, PCA, personnel record revealed: -Staff B was hired inAugust 2019. -Staff B had aTB skin test placed on 09/03/19 and read as negative on 09/05/19. -There was no documentation of a second TB skin test.	D 131		

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D 131	Continued From page 14 Interview with Staff B on 12/11/19 at 4:29pm revealed: -She was hired as a PCA at the end of July 2019. -The Licensed Health Professional Support (LHPS) nurse placed and read the first TB skin test and the skin test was negative. -She did not have a second TB skin test. Interview with the Administrator on 12/12/19 at 5:35pm. -She was responsible for completing Staff B's paperwork when she was hired. -She was responsible for ensuring Staff B's TB skin test was completed upon hire. -The LHPS nurse placed and read the TB skin tests for Staff B. Telephone interview with the LHPS nurse on 12/12/19 at 8:35pm revealed: -She placed Staff B's TB skin test on 09/03/19 and the TB skin test read negative on 09/05/19. -She had not placed a second TB skin test for Staff B. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. 4. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired on 08/27/18. -There was no documentation of any TB skin tests. Telephone interview with Staff C on 12/12/19 at 4:20pm revealed: -She worked off and on at the facility since 2010 and she recently came back to work at the facility in January 2019. -She had a TB skin test completed right after she was hired and she had a second TB skin test	D 131		

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D 131	Continued From page 15 done (date unknown). -Both TB skin tests were read as negative in 2019. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -The corporate office was in the process of transitioning personnel records to electronic files and some staff members' paperwork had been sent to the corporate office for scanning into electronic records. -She did not have Staff C's TB skin test documentation onsite and she was unable to retrieve Staff C's TB test documentation from the electronic record. -She knew Staff C needed documentation of a TB skin test upon hire. -The Resident Care Coordinator (RCC) was responsible for hiring Staff C and ensuring Staff C had completed TB skin tests; the facility had not had a RCC since late April 2019. -She was responsible for assuring Staff C had documentation of TB skin tests in order to be compliant, or Staff C needed to repeat her TB skin tests. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. 5. Review of Staff F's, medication aide (MA), personnel record revealed: -Staff F was hired on 08/16/19. -Staff F had a TB skin test placed on 09/03/19 and was read as negative on 09/05/19. -There was no documentation of a second TB skin test. Interview with Staff F on 12/11/19 at 5:00pm revealed: -She was hired as a MA on 08/16/19.	D 131		

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D 131	Continued From page 16 -The Licensed Health Professional Support (LHPS) nurse placed and read her TB skin test and the TB skin test was negative. Interview with the Administrator on 12/12/19 at 5:35pm. -She was responsible for completing Staff F's paperwork when she was hired. -She was responsible for ensuring Staff F's TB skin test was completed upon hire. -The LHPS nurse placed and read the TB skin tests for Staff F. Telephone interview with the LHPS nurse on 12/12/19 at 8:35pm revealed she placed Staff F's TB skin test on 09/03/19 and the TB skin test read as negative on 09/05/19. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. 6. Review of Staff G's, a cook, personnel record revealed: -Staff G was hired on 10/15/19. -Staff G had a TB skin test placed on 11/07/19 and read as negative on 11/09/19. -There was no documentation of a second TB skin test. Interview with Staff G on 12/12/19 at 8:30pm revealed: -She was hired as a cook in October 2019. -She had a TB skin test in November 2019. Interview with the Administrator on 12/12/19 at 5:35pm. -She was responsible for completing Staff G's paperwork when she was hired. -She was responsible for ensuring Staff G's TB skin test was completed upon hire.	D 131		

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D 131	Continued From page 17 -The Licensed Health Professional Support (LHPS) nurse placed and read the TB skin tests for Staff G. Telephone interview with the LHPS nurse on 12/12/19 at 8:35pm revealed she placed Staff G's TB skin test on 11/07/19 and the TB skin test read as negative on 11/09/19. Refer to the interview with the Administrator on 12/13/19 at 5:25pm. 7. Review of Staff I's, medication aide (MA), personnel record revealed: -Staff I was hired on 03/13/19. -There was documentation a TB skin test was placed on 04/12/19; the TB skin test was not read and there was no signature by a Registered Nurse (RN). -There was no additional documentation of a TB skin test. Interview with Staff I on 12/11/19 at 4:38 pm revealed: -She was hired as the Activity's Director on 03/13/19 and she then transitioned to a MA. -She had a TB skin test completed upon hire at the facility and she had a second TB skin test done (date unknown). Interview with the Administrator on 12/12/19 at 5:35pm. -The corporate office was in the process of transitioning personnel records to electronic files and some staff members' paperwork had been sent to the corporate office for scanning into electronic records. -She did not have Staff I's TB skin test documentation onsite and she was unable to retrieve Staff I's TB test documentation from the	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 131	Continued From page 18	D 131		

electronic record.
-At the time Staff I was hired, the Resident Care Coordinator (RCC) was responsible for completing the paperwork for staff; the facility had not had a RCC since late April 2019.
-There were 3 to 4 Licensed Health Professional Support (LHPS) nurses since Staff I was hired and she did not have additional documentation on Staff I's TB skin test placed on 04/12/19.
-She was responsible for assuring Staff I had documentation of her TB skin tests in order to be compliant, or she needed to repeat her TB skin tests.

Refer to the interview with the Administrator on 12/12/19 at 5:25pm.

8. Review of Staff J's, medication aide (MA), personnel record revealed:
-Staff J was hired on 03/13/19.
-There was documentation a TB skin test was placed on 04/12/19; the TB skin test was not read and there was no signature by a RN.
-There was no additional documentation of a TB skin test.

Telephone interview with Staff J on 12/12/19 at 9:35am revealed:
-She worked at the facility as a MA for almost a year.
-She was hired by the Resident Care Coordinator (RCC).
-The facility's Licensed Health Professional Support (LHPS) nurse placed and read the first TB skin test and the LHPS nurse did not return to place the second TB skin test.
-She repeated the first and second TB skin tests with another LHPS nurse, and the TB skin tests results were negative (date unknown).

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D 131	Continued From page 19	D 131		

Interview with the Administrator on 12/12/19 at 5:35pm.
-The corporate office was in the process of transitioning personnel records to electronic files and some staff members' paperwork had been sent to the corporate office for scanning into electronic records.
-She did not have Staff J's TB skin test documentation onsite and she was unable to retrieve Staff J's TB test documentation from the electronic record.
-The RCC was responsible for ensuring Staff J's TB skin tests were completed and in Staff J's record.
-There have been 3 to 4 LHPS nurses since Staff J was hired and she did not have additional documentation for Staff J's TB skin test placed on 04/12/19.
-She was responsible for assuring Staff J had documentation of TB skin tests in order to be compliant, or she needed to repeat her TB skin tests.

Refer to the interview with the Administrator on 12/12/19 at 5:25pm.

9. Review of Staff K's, medication aide (MA), personnel record revealed:
-Staff K did not have a documented hire date.
-There was no documentation of any TB skin tests.

Telephone interview with Staff K on 12/12/19 at 4:38 pm revealed:
-She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a MA.
-When she was hired, she provided documentation of the first and second TB skin tests and both TB skin tests were read as

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D 131	Continued From page 20 negative; she did not know when the TB skin test were administered or read. Interview with the Administrator on 12/12/19 at 5:35pm. -The corporate office was in the process of transitioning personnel records to electronic files and some staff members' paperwork had been sent to the corporate office for scanning into electronic records. -She did not have Staff K's TB skin test documentation onsite and she was unable to retrieve Staff K's TB test documentation from the electronic record. -She was responsible for assuring Staff K had documentation of her TB skin tests in order to be compliant, or Staff K needed to repeat her TB skin tests. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. ______________________ Interview with the Administrator on 12/12/19 at 5:25pm revealed: -The Resident Care Coordinator (RCC) was responsible for personnel records and for auditing personnel records; the facility had not had a RCC since late April 2019. -She was responsible for assuring personnel records were completed since there was currently no RCC at the facility. -There was a high turnover rate for staffing and ensuring all new staff met the necessary requirements, while also maintaining personnel records, was difficult to manage. -She was responsible for auditing personnel records and she had not audited staffs' personnel records because of time constraints. -The "obligation for staffing duties interfered with her administrative duties" and her responsibility	D 131	ATTACHED IS A COPY OF OUR NEW HIRE CHECKLIST CONTAINED IN OUR POLICY & PROCEDURE MANUAL. THIS INCLUDES THE PROCEDURE FOR THE TWO-STEP TB TEST. THE RESPONSE OF ADMINISTRATOR IS INCORRECT. WE DO NOT "REMOVE RECORDS" OF ANY KIND TO OUR CORPORATE OFFICE. WE MAY FROM TIME TO TIME, REQUEST AN ELECTRONIC COPY BUT, THAT IS ALL. THE HOME WAS CLOSED ON 2/7/2020 AND THE RESIDENTS WERE RELOCATED TO APPROPRIATE LEVELS OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S.	

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D 131	Continued From page 21 for ensuring staffs' TB skin tests were completed, in the personnel files, and up to date. ______________ The facility failed to assure 9 of 12 sampled staff (Staff A, B, C, E, F, G, I, J, and K) were tested for tuberculosis disease which increased the risk of the transmission of TB disease. The facility's failure to assure testing for tuberculosis was completed, was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. ______________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/10/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D 131		
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: Based on observations, interviews and record reviews, the facility failed to assure 3 of 12 sampled staff (Staff B, I and the Administrator) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR)	D 137		

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D 137	Continued From page 22	D 137		

upon hire.

The findings are:

1. Review of Staff B's, a personal care aide (PCA), personnel record revealed:
-Staff B was hired inAugust 2019.
-There was no documentation a HCPR check was completed.

Interview with Staff B on 12/11/19 at 4:29pm revealed:
-She had worked at the facility for three months.
-She was a PCA and provided resident care including bathing, feeding, and toileting assistance.

Interview with a resident on 12/12/19 at 4:00pm revealed:
-Staff B was a PCA at the facility.
-Staff B assisted the resident with transferring, bathing, changing incontinence briefs, and getting dressed.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She was responsible for ensuring Staff B had a HCPR check upon hire.
-She did not know why Staff B's HCPR check was not in her personnel record and Staff B's HCPR needed to be checked in order to be compliant.
-She did not know if Staff B had a HCPR check when she was hired.
-Staff B's HCPR check from hire was unavailable for review, and she did not know where the HCPR check was located at the present time.

Refer to the interview with the Administrator on 12/12/19 at 5:25pm.

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D 137	Continued From page 23 2. Review of Staff I's, medication aide (MA), personnel record revealed: -Staff I was hired on 03/13/19. -There was no documentation a HCPR check was completed. Interview with Staff I on 12/11/19 at 4:38 revealed: -In March 2019, she was hired as the Activity's Director and she then transitioned to a MA. -She passed medications to residents, and when needed, she provided personal care to residents, like bathing and transferring assistance. Observation of Staff I on 12/12/19 from 8:00am to 12:00pm revealed Staff I administered medications to residents at the facility. Interview with a resident on 12/12/19 at 3:32 pm revealed Staff I was a MA and administered her medications. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -In March 2019, the Resident Care Coordinator (RCC) was responsible for hiring Staff I and ensuring Staff I had a HCPR check upon hire. -She did not know Staff I's HCPR check was not in her personnel record and Staff I needed a HCPR check in order to be compliant. -Staff I's HCPR check from hire was unavailable for review, and she did not know where Staff I's HCPR check was located at the present time. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. 3. Review of the Administrator's personnel record revealed: -There was no documented date of hire.	D 137		

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D 137	Continued From page 24 -There was no documentation a HCPR check was completed. Interview with a resident on 12/12/19 at 3:32 pm revealed the Administrator was a medication aide and administered her medications. Interview with the Administrator on 12/12/19 at 5:25pm revealed she was able to provide documentation of her HCPR check. Review of the Administrator's HCPR documentation revealed the Administrator's HCPR check was completed on 12/11/19 with no substantiated findings. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She was hired on 11/01/18 and started working at the facility in January 2019. -She did not know if the corporate office had documentation of her HCPR check upon hire; her HCPR check from hire was unavailable for review. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. ___ Interview with the Administrator on 12/12/19 at 5:25pm revealed: -She was responsible for maintaining personnel records. -The corporate office was in the process of transitioning personnel records to electronic files and some of staff members' paperwork had been sent to the corporate office for scanning into electronic records. -There was a high turnover rate for staffing at the facility and ensuring all new staff met the necessary requirements, while also maintaining	D 137	ATTACHED IS A COPY OF OUR NEW HIRE CHECKLIST. IT INCLUDES A "REGISTRY"CHECK FOR ALL POSITIONS. THE HOME OFFICE IS NOT RESPONSIBLE FOR THESE CHECKS. IT IS THE RESPONSIBILITY OF THE ADMINISTRATOR TO DO THESE CHECKS. THE COMMENT REGARDING "ELECTRONIC RECORDS WERE TRANSITIONING TO HOME OFFICE" IS INCORRECT.	

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D 137	Continued From page 25 personnel records was difficult to manage. -She was responsible for auditing personnel records and she had not audited personnel record because of time constraints.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall : (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K) had a criminal background check completed prior to hire. The findings are: 1. Review of Staff B's, personal care aide (PCA) personnel record revealed: -Staff B was hired in August 2019. -There was no documentation a criminal background check was completed on Staff B. -There was no documentation of a consent for a criminal background check. Interview with Staff B on 12/11/19 at 4:29pm revealed: -She had worked at the facility for three months. -She was a PCA and provided personal care to residents including bathing, feeding, and toileting assistance.	D 139	ATTACHED IS OUR NEW HIRE CHECKLIST WHICH INCLUDES DOING THE CRIMINAL BACKGROUND CHECK. THE PROCEDURES FOR THIS ARE ALSO ATTACHED. THE ADMINISTRATOR FAILED TO FOLLOW THIS PROCEDURE. WHEN THE OWNER RECEIVED THIS HAD NOT BEEN PROPERLY DONE, THESE WERE COMPLETED BY THE HOME OFFICE. A COPY OF THIS IS ATTACHED. THE HOME WAS CLOSED ON 2/7/2020 AND ALL RESIDENTS WERE RELOCATED TO APPROPRIATE LEVELS OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S.	

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D 139	Continued From page 26 -The Administrator completed her paperwork when she was hired, and she signed a consent for a criminal background check when she was hired. -She did not know why her criminal background check was not in her personnel record. Interview with a resident on 12/12/19 at 4:00pm revealed Staff B was a PCA and Staff B assisted the resident with transferring, bathing, changing incontinence briefs, and getting dressed. Interview with the Administrator on 12/12/19 at 5:40pm revealed: -She did not know Staff B did not have a criminal background check in her personnel record. -The corporate office was in the process of transitioning personnel records to electronic files and some of the staffs' paperwork had been sent to the corporate office for scanning into electronic files. -She did not have Staff B's criminal background check onsite and she was unable to retrieve Staff B's criminal background check from the electronic file. -She was responsible for hiring Staff B and ensuring Staff B had a criminal background check prior to hire. Refer to interview with the Administrator on 12/12/19 at 5:25pm. 2. Review of Staff E's, medication aide (MA) personnel record revealed: -Staff E was hired on 06/27/19. -There was documentation presented as a background check for Staff E that was void of any identifying title, could not be determined if it was statewide, and did not meet requirements for a criminal background check.	D 139		

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-There was no documentation of a consent for a criminal background check.

Interview with Staff E on 12/12/19 at 10:37 am revealed:
-She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19.
-She worked as a medication aide and administered medications to residents.
-She never had a criminal background check at the facility.
-She did not sign a consent for a criminal background check.
-She did not know a criminal background check was a requirement for her job.

Interview with a resident on 12/12/19 at 4:00pm revealed Staff E was a MA at the facility and Staff E administered medications to the resident.

Interview with the Administrator on 12/12/19 at 5:40pm revealed:
-She did not know the document presented as a background check for Staff E did not meet the requirements for a criminal background check regarding not indicating what records were checked, and for covering "statewide".
-She did not have additional documentation for Staff E's criminal background check.
-She was responsible for hiring Staff E and ensuring Staff E had a criminal background check prior to hire.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

3. Review of Staff F's, medication aide (MA) personnel record revealed:
-Staff F was hired on 08/16/19.

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-There was no documentation a criminal background check was completed for Staff F.
-There was no documentation of a consent for a criminal background check.

Interview with Staff F on 12/11/19 at 5:00pm revealed:
-She worked as a MA at the facility since 08/16/19.
-She administered medications to residents at the facility.
-She never had a criminal background check completed.
-She did not sign a consent for a criminal background check.
-She did not know a criminal background check was a requirement for her job.

Interview with a resident on 12/12/19 at 4:00pm revealed Staff F was a MA at the facility and Staff F administered medications to the resident.

Interview with the Administrator on 12/12/19 at 5:40pm revealed:
-She did not know a criminal background check was not completed for Staff F.
-She was responsible for hiring Staff F and ensuring Staff F had a criminal background check prior to hire.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

4. Review of Staff G's, a cook, personnel record revealed:
-Staff G was hired on 10/15/19.
-There was no documentation a criminal background check was completed on Staff G.
-There was no documentation of a consent for a criminal background check.

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Interview with Staff G on 12/12/19 at 8:30am revealed:
-She was hired as a cook and had worked in the kitchen at the facility since October 2019.
-The Administrator completed her paperwork when she was hired, and she signed a consent for a criminal background check when she was hired.
-She did not know why her criminal background check was not in her personnel record.

Observation of Staff G in the kitchen on 12/12/19 from 8:30am to 9:00am revealed Staff G was preparing food and serving the residents' their breakfast meal in the dining room.

Interview with the Administrator on 12/12/19 at 5:40pm revealed:
-She did not know Staff G did not have a criminal background check in her personnel record.
-The corporate office was in the process of transitioning personnel records to electronic files and some of the staffs' paperwork had been sent to the corporate office for scanning into electronic files.
-She did not have Staff G's criminal background check onsite and she was unable to retrieve Staff G's criminal background check from the electronic file.
-She was responsible for hiring Staff G and ensuring Staff G had a criminal background check prior to hire.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

5. Review of Staff I's, medication aide (MA) personnel record revealed:
-Staff I was hired on 03/13/19.

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-There was documentation presented as a background check for Staff I that was void of any identifying title, could not be determined if it was statewide, and did not meet requirements for a criminal background check.
-There was no documentation of a consent for a criminal background check.

Interview with Staff I on 12/11/19 at 4:38 pm revealed:
-In March 2019, she was originally hired as the Activity's Director and she then transitioned to a MA.
-She "remembered signing papers" but she did not know if she signed a consent for a criminal background check.
-The Administrator was responsible for personnel records and assuring the criminal background check was in her record.
-She did not know why the Administrator did not have documentation of criminal background check in her personnel record.

Observation of Staff I on 12/11/19 from 8:00am to 12:00pm revealed Staff I administered medications to residents at the facility.

Interview with the Administrator on 12/12/19 at 5:40pm revealed:
-She understood that the document presented as a background check for Staff I did not meet the requirements for a criminal background check.
-At the time Staff I was hired, the Resident Care Coordinator (RCC) was responsible for ensuring criminal background checks were completed prior to hire.
-She did not have additional documentation for Staff I's criminal background check.
-She was responsible for assuring Staff I had a criminal background check prior to hire.

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D 139	Continued From page 31 Refer to interview with the Administrator on 12/12/19 at 5:25pm. 6. Review of Staff J's, medication aide (MA) personnel record revealed: -Staff J was hired on 03/13/19. -There was documentation presented as a background check for Staff J that was void of any identifying title, could not be determined if it was statewide, and did not meet requirements for a criminal background check. -There was no consent for a criminal background check. Telephone interview with Staff J on 12/12/19 at 9:35am revealed: -She was hired as a MA in February 2019. -She was hired by the Resident Care Coordinator (RCC), and currently the Administrator was responsible for personnel records since there was no longer a RCC at the facility. -She never had a criminal background check at the facility. -She did not sign a consent for a criminal background check. Interview with a resident on 12/12/19 at 4:00pm revealed Staff J was a MA at the facility, and Staff J administered medications to the resident. Interview with the Administrator on 12/12/19 at 5:40pm. -She understood that the document presented as a background check for Staff J did not meet the requirements for a criminal background check. -At the time Staff J was hired, the RCC was responsible for ensuring criminal background checks were completed prior to hire. -She did not have additional documentation for	D 139		

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Staff J's criminal background check.
-She was responsible for assuring Staff J had a criminal background check prior to hire.

Refer to the interview with the Administrator on 12/12/19 at 5:25pm.

7. Review of Staff K's, medication aide (MA) personnel record revealed:
-Staff K did not have a hire date in her personnel record.
-There was no documentation a criminal background check was completed for Staff K.
-There was no documentation of a consent for a criminal background check.

Telephone interview with Staff K on 12/12/19 at 4:38 pm revealed:
-She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a MA.
-She could not remember if she signed a consent for a criminal background check.

Interview with the Administrator on 12/12/19 at 5:40pm.
-She did not know a criminal background check was not completed for Staff K.
-She was responsible for hiring Staff K and ensuring Staff K had a criminal background check prior to hire.

Refer to the interview with the Administrator on 12/12/19 at 5:25pm.

____

Interview with the Administrator on 12/12/19 at 5:25pm revealed:
-She was responsible for personnel records and ensuring records were complete.
-She was responsible for auditing personnel

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D 139	Continued From page 33 records and she had not audited personnel records because of time constraints. -There was a high turnover rate for staffing at the facility and ensuring all staff had a criminal background screen prior to hire, while also maintaining personnel records was difficult to manage. _______________ The facility failed to obtain a criminal background check for 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K). The facility's failure of not knowing if Staff B, E, F, G, I, J, and K had a criminal record history was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _______________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/12/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D 139		
D 150	.0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and	D 150		

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D 150	Continued From page 34 mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 4 of 11 sampled staff (Staff C, D, I, and J) who provided personal care to residents had documentation of successful completion of an 80 hour personal care training and competency evaluation program. The findings are: 1. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired on 08/27/18. -There was no documentation Staff C had completed an 80 hour personal care training and competency evaluation program. Interview with Staff C on 12/12/19 at 4:20pm revealed: -She was rehired on 01/02/19 -She had worked at the facility off and on since 2010. -She supervised personal care aides (PCA) when she worked at the facility.	D 150	ATTACHED ARE OUR COMPANY POLICIES USED FOR EMPLOYEES THAT ARE HIRED TO WORK IN PCS AND/OR MED TECH AREAS. ADMINISTRATOR FAILED TO FOLLOW THESE PROCEDURES. THE OWNER CONTRACTED WITH A NURSE TO COME IN AND REVIEW & SIGN OFF ON EMPLOYEES THAT HAD MET THE REQUIREMENTS, THIS WAS COMPLETED ON JANUARY 23, 2020.	

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-She had assisted with bathing residents, transferring residents, and any other personal care tasks residents needed assistance with.
-She thought she had taken the 80 hours of personal care training on two different occasions , but she did not have documentation available.
-The facility should have the documentation for her 80 hours of personal care training on file.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She was responsible for ensuring Staff C completed an 80 hour personal care training and competency evaluation program.
-The corporate office was in the process of transitioning personnel records to electronic files and some of the staffs' paperwork had been sent to the corporate office for scanning into electronic files.
-She did not have documentation of Staff C's 80 hour personal training onsite and she was unable to retrieve Staff C's 80 hour personal training documentation from the electronic file.

[Refer to Tag D 269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to interview with the Licensed Health Professional Support (LHPS) nurse on 12/12/19 at 8:30pm.

2. Review of Staff D's, personal care aide (PCA), personnel record revealed:
-Staff D was hired on 10/12/16.
-There was no documentation Staff D had completed an 80 hour personal care training and

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competency evaluation program.

Attempted telephone interview with Staff D on 12/12/19 at 2:00pm was unsuccessful.

[Refer to Tag D 269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to interview with the Licensed Health Professional Support (LHPS) nurse on 12/12/19 at 8:30pm.

3. Review of Staff I's, medication aide (MA), personnel record revealed:
-Staff I was hired on 03/13/19.
-There was no documentation Staff I had completed an 80 hour personal care training and competency evaluation program.

Interview with Staff I on 12/11/19 at 4:40pm revealed:
-She had worked several years as a traveling nursing assistant.
-She had personal care training in the past.
-She did not know where her paperwork may be in the facility.
-She assisted residents with personal care tasks like bathing and assisting residents with transfers.
-The facility should have the paperwork and documentation for her 80 hours of personal care training on file.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She was responsible for ensuring Staff I completed an 80 hour personal care training and

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competency evaluation program.
-She did not have documentation that Staff I completed an 80 hour personal care training and competency evaluation program.
-The corporate office was in the process of transitioning personnel records to electronic files and some of the staffs' paperwork had been sent to the corporate office for scanning into electronic files.
-She did not have documentation of Staff I's 80 hour personal training onsite and she was unable to retrieve Staff I's 80 hour personal training documentation from the electronic file.

[Refer to Tag D 269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to interview with the Licensed Health Professional Support (LHPS) nurse on 12/12/19 at 8:30pm.

4. Review of Staff J's, medication aide (MA), personnel record revealed:
-Staff J was hired on 03/13/19.
-There was no documentation Staff J had completed an 80 hour personal care training and competency evaluation program.

Interview with Staff J on 12/12/19 at 9:35am revealed:
-She had been employed at the facilty for less than one year.
-She had not performed a lot of personal care assistance for the residents, but she helped with transferring residents.
-She took 80 hours of personal care training in

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the past, maybe December 2018 or January 2019, and she had not complete a Certified Nursing Assistant course.
-She did not turn in documentation for completing the 80 hour personal care training and competency evaluation program to the facility when she was hired because she was not able to obtain documentation from the facility where she took the course.
-She supervised personal care aides (PCAs) when she worked.
-She did not know she needed documentation for 80 hours of personal care training to supervise PCAs.
-She routinely worked Friday, Saturday, and Sunday on the 7:00am to 7:00pm shift.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She was responsible for ensuring Staff J completed an 80 hour personal care training and competency evaluation program.
-She did not have documentation that Staff J completed an 80 hour personal care training and competency evaluation program.
-She would contact Staff J and work on getting documentation for her 80 hour personal training.

[Refer to Tag D 269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to interview with the LHPS nurse on 12/12/19 at 8:30pm.

Interview with the Administrator on 12/12/19 at 5:25pm revealed:

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D 150	Continued From page 39 -She was responsible for maintaining personnel records and ensuring they were complete and up to date. -She was responsible for auditing personnel records and she had not audited any personnel records because of time constraints. -There was a large staff turnover at the facility, and there had not been a Resident Care Coordinator (RCC) since April 2019, therefore, it was difficult for her to manage personnel records . -She was responsible for ensuring staff that provided residents' personal care completed the 80-hour personal care training and competency evaluation program within 6 months of employment. -The LHPS nurse conducted PCA trainings at the facility. Interview with the LHPS nurse on 12/12/19 at 8:30pm revealed: -She had been the facility's LHPS nurse for 3 months. -She did not conduct any in-service or personal care trainings at the facility. -The Administrator did not request for her to complete any trainings at the facility. ______________________ The facility failed to ensure 80-hour personal care training and competency evaluation program was completed for 4 of 7 sampled medication aides (Staff C, D, I, and J) prior to the staff providing personal care to the residents and prior to the staff directly supervising PCAs which increased the risk for improper personal care provided including not transferring a resident who required two person transfer, incontinent care not provided resulting in a second resident developing skin breakdown and bedsores, and residents not being bathed according to the bathing schedule regularly resulting in a third resident developing a	D 150	ATTACHED IS A CHECKLIST OF ITEMS REQUIRED FOR ANY EMPLOYEE THAT NEEDS THE PCS TRAINING PROGRAM AND/OR FOR MED TECHS. ALSO, ATTACHED IS OUR POLICIES REGADING THE TRAINING AND THE SKILLS CHECKLIST. THIS IS A REQUIREMNT OF OUR ADMINISTRATOR TO ASSURE THAT THIS IS PROPERLY COMPLETED AND DOCUMENTED PER STATE REQUIREMENTS. OUR ADMINISTRATOR FAILED TO DO THIS DEPSITE ALL OF THESE PROCEDURES BEING IN PLACE.	

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D 150	Continued From page 40	D 150		
	foot sore. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation.			
	The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation.			
	CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2019.			
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks	D 161		
	10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.			
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 3 of 11 sampled staff (Staff B, C, and F) were competency validated for			

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D 161	Continued From page 41 Licensed Health Professional Support (LHPS) tasks including ambulation with assistive device, transferring, finger stick blood sugars and insulin administration. The findings are: 1. Review of Staff B's, personal care aide (PCA), personnel record revealed: -Staff B was hired in August 2019. -There was no documentation of a LHPS competency validation. Interview with a resident on 12/12/19 at 4:00pm revealed Staff B assisted the resident with transferring, bathing, changing incontinence briefs, and getting dressed. Interview with Staff B on 12/11/19 at 4:29pm revealed: -She had worked at the facility for three months. -She was a PCA and provided resident care including toileting and bathing for residents who required assistance with transfers. -She had not been competency validated for LHPS tasks. Interview with the Administrator on 12/12/19at 5:35pm revealed she did not know Staff B was not LHPS competency validated. Telephone interview with the LHPS nurse on 12/12/19 at 8:30pm revealed: -She had not completed a LHPS competency validation for Staff B. -The Administrator had not requested for her to complete Staff B's LHPS competency validation. Refer to the interview with the Administrator on 12/12/19 at 5:25pm.	D 161		

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D 161	Continued From page 42 Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 2. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired on 08/27/18. -There was no documentation of a LHPS competency validation. -There was no documentation of a Medication Administration Skills Validation checklist. Review of residents' electronic Medication Administration Records (eMARs) revealed there was documentation Staff C obtained finger stick blood sugars and administered insulin 21 times in October 2019, 13 times in November 2019, and 7 times in December 2019. Telephone interview with Staff C on 12/12/19 at 4:20pm revealed: -She worked off and on at the facility since 2010 and she recently came back to work at the facility in January 2019. -She administered residents' medications including insulin and she obtained residents' finger stick blood sugars. -She assisted residents with bathing, transferring with an assistive device, and other personal needs (incontinent care and ambulation). -She had not been competency validated for LHPS tasks. Interview with the Administrator on 12/12/19at 5:35pm revealed she did not know Staff C was not LHPS competency validated. Telephone interview with the LHPS nurse on 12/12/19 at 8:30pm revealed: -She had not completed LHPS competency	D 161		

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D 161	Continued From page 43	D 161		

validation for Staff C.
-The Administrator had not requested for her to complete Staff C's LHPS competency validation.

Refer to the interview with the Administrator on 12/12/19 at 5:25pm.

Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.

3. Review of Staff F's, medication aide (MA), personnel record revealed:
-Staff F was hired on 08/16/19.
-There was no documentation of a LHPS competency validation.
-There was no documentation of a Medication Administration Skills Validation checklist.

Review of residents' electronic Medication Administration Records (eMARs) revealed there was documentation Staff F obtained finger stick blood sugars and administered insulin 12 times in October 2019, 11 times in November 2019, and FSBS 3 times and insulin 7 times in December 2019.

Interview with Staff F on 12/11/19 at 5:00pm revealed:
-Staff F was hired as a MA on 08/16/19.
-She obtained residents' finger stick blood sugars and administered insulin injections.
-She assisted residents with transfers, and applied anti-thrombotic hose for residents.
-She had not been competency validated for LHPS tasks.

Refer to the interview with the Administrator on 12/12/19 at 5:25pm.

Refer to the telephone interview with the LHPS

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D 161	Continued From page 44 nurse on 12/12/19 at 8:30pm. ______ Interview with the Administrator on 12/12/19 at 5:25pm revealed: -The Resident Care Coordinator (RCC) had been responsible for ensuring staff qualifications including LHPS competency validations were completed. -The RCC position had been vacant since April 2019 and now she (Administrator) was responsible for ensuring staff were LHPS competency validated. -There was currently no process in place to assure staff were LHPS competency validated. -The obligation for staffing duties interfered with her administrative duties and interfered with her responsibility of ensuring staff were were competency validated by a nurse for LHPS tasks prior to staff performing tasks. -She had not audited staff records due to staffing duties and time constraints. -The LHPS nurse was responsible for completing the LHPS competency validations. Telephone interview with the LHPS nurse on 12/12/19 at 8:30pm revealed: -She had been the LHPS nurse at the facility for 3 months. -She had completed LHPS competency validation for two MAs at the facility. -The Administrator did not request for her to complete any additional LHPS competency validations for staff.	D 161		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents	D 164		

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D 164	Continued From page 45 An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic resident prior to the administration of insulin. The findings are: 1. Review of Staff F's, medication aide (MA)	D 164	ATTACHED IS A COPY OF OUR POLICIES AND PROCEDURES THAT WERE IN PLACE AT THE TIME OF THE STATE SURVEY. THE BOOK THAT CONTAINS THIS, AND ALL OF OUR PROCEDURES, WERE IN THE ADMINISTRATOR'S OFFICE AT THE TIME OF SURVEY. THEY ARE CONSTANTLY REMINDED TO MAKE USE OF THIS BOOK AS MUCH AS NEEDED. THE ADMINISTRATOR FAILED TO FOLLOW THESE PROCEDURES. THE HOME WAS CLOSED ON 2/7/20 WITH THE ASSISTANCE OF DAVIE COUUNTY D.S.S. AND THE RESIDENTS WERE PLACED IN APPROPRIATE LEVELS OF CARE.	

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D 164	Continued From page 46	D 164		

personnel record revealed:
-Staff F was hired on 08/16/19.
-There was no documentation Staff F completed training on care of the diabetic resident.

Review of residents' electronic Medication Administration Records (eMARs) revealed there was documentation Staff F obtained finger stick blood sugars and administered insulin 12 times in October 2019, 11 times in November 2019, and FSBS 3 times and insulin 7 times in December 2019.

Interview with Staff F on 12/11/19 at 5:00pm revealed:
-Staff F was hired as a MA on 08/16/19.
-She administered residents' insulin and she obtained residents' finger stick blood sugars.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-Staff F was a MA and was responsible for checking finger stick blood sugars and administering insulin injections to residents.
-She had a notebook that contained staffs' diabetic training and she did not have documentation that Staff F completed training on care of the diabetic resident.
-Staff F needed to complete the training on care of the diabetic resident in order to be compliant.

Second interview with Staff F on 12/11/19 at 6:05pm revealed:
-She had training on insulin administration when she started working at the facility but did not say who trained her.
-She did not have documentation for the training.
-The Administrator reviewed insulin administration recently with the staff, including herself.

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Review of a signed diabetic administration and documentation form on 12/11/19 revealed a diabetic in-service for staff was conducted on 11/21/19 by the Administration in response to the Administrator's audit of resident electronic Medication Administration Records (eMARs) and errors that were detected on the eMARs.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4 ACH Infection Prevention Requirements (Type B Violation)].

Refer to interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

2. Review of the Administrator's personnel record revealed:
-The Administrator did not have a documented hire date.
-The Administrator had a Medication Clinical Skills validation dated 12/27/18.
-The Administrator passed the State medication aide test on 01/10/19.
-There was no documentation the Administrator had completed training on care of the diabetic resident.

Review of residents' electronic Medication Administration Records (eMARs) revealed there was documentation the Administrator obtained finger stick blood sugars and administered insulin 4 times in November 2019, and checked FSBS 3 times and administered insulin 4 times in December 2019.

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D 164	Continued From page 48 Interview with the Administrator on 12/12/19at 5:35 revealed: -She was hired as the Administrator in November 2018 and started working at the facility in January 2019. -She administered medications to residents, including insulin, and she obtained residents' finger stick blood sugars. -She completed trainings, but she did not have diabetic care training documentation onsite because the corporate office was in the process of transitioning personnel records to electronic files and her paperwork had been sent to the corporate office for scanning into electronic files . [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. [Refer to Tag D932 G.S. 131D-4.4 ACH Infection Prevention Requirements (Type B Violation)]. Refer to interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. ____________________ Telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am revealed: -The pharmacy offered facility staff an online training on care of the diabetic resident. -There was no training with return demonstration completed with the online class. Interview with the Administrator on 12/12/19 at 5:25pm revealed: -The Resident Care Coordinator (RCC) was responsible for staff training, including training on the care of the diabetic resident, until she left in	D 164		

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April 2019.
-The facility's contracted pharmacy offered facility staff an online training on care of the diabetic resident.
-She was responsible for scheduling MA training and ensuring MAs completed the training on care of the diabetic resident.
-She was responsible for personnel records and ensuring they were complete and up to date.
-There was a large staff turnover at the facility, and she did not have a RCC therefore, it was difficult for her to manage personnel records.
-The obligation for staffing duties interfered with her administrative duties and interfered with her responsibility of ensuring staff were trained on the care of the diabetic resident.
-The corporate office was in the process of transitioning personnel records to electronic files and some of the staffs' paperwork had been sent to the corporate office for scanning into electronic files.
-She did not have some staff information onsite , and she was unable retrieve all staff diabetic training documentation from the electronic file.
-She did not audit personnel records to ensure all training had been completed, including training on the care of the diabetic resident because of time constraints.
-In November 2019, she identified that MAs were administering insulin incorrectly and she had an in-service on insulin with the MAs.

The facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin completed training on care of diabetic residents resulting in two residents administered incorrect dosages of insulin placing the residents at risk for hypoglycemia and hyperglycemia and staff sharing glucometers between residents with orders for finger stick blood sugar testing, placing

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the residents at risk for transmission and development of bloodborne infectious diseases and increasing the risk for medication errors. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/12/19 for this violation.

CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.

D 167 | 10ANCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation | D 167

10ANCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation
Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

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

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D 167	Continued From page 51 Based on observations, record reviews and interviews, the facility failed to assure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 27 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. The findings are: Review of 13 staff personnel records revealed: -Staff A, D, H, I, J, L, and M had documentation of CPR certification within the past 24 months. -Staff B, C, E, F, H, and K had no documentation of completing a course in CPR in the past 24 months. Review of the staffing schedule and the punch time detail reports for 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019 revealed: -Staff A, D, H, I, J, L, and M did not work or worked partial shifts for 27 of 69 shifts. -Staff B, C, E, F, H, and K worked various shifts for the 23 sampled days. -There was 1 of 23 days for first shift when there was no CPR certified staff on the premises. -On 11/18/19 from 7:00am to 1:15pm, there was no CPR certified staff on the premises. -There were 19 of 23 days for second shift when there was no CPR certified staff on the premises. -Examples of second shifts when there was no CPR certified staff on the premises included: 09/23/19, 09/24/19, 09/25/19, 10/04/19, 11/04/19, and 11/14/19 from 7:00pm to 11:00pm. -There were 7 of 23 days for third shift when there was no CPR certified staff on the premises. -Examples of third shifts when there was no CPR certified staff on the premise included: 09/21/19, 09/22/19, and from 11:00pm to 7:00am, on	D 167	WITHOUT KNOWING SPECIFICALLY WHOSE RECORDS THAT WERE CHECKED, I CANNOT FULLY VERIFY THIS. I DO KNOW THAT UPON REVIEW, THERE WAS A NOTEBOOK THAT THE SURVEY TEAM DID NOT SEE, (COPIES OF TRAINING ATTACHED) THAT CONTAINED NINE, CURRENT STAFF MEMBERS THAT HAD UP-TO-DATE CPR TRAINING. THERE IS ALSO A LIVE-ON STAFF MEMBER THAT LIVES ON THE PROPERTY WITHIN 50 FEET OF THE BUILDING, THAT IS ON PREMISES EVERY NIGHT, EXCEPT FOR VACATIONS AFTER 11 PM. HER CPR TRAINING WAS CURRENT AS OF THE STATE SURVEY. I CANNOT EXPLAIN WHY ADMINISTRATOR DID NOT SHOW THIS TO SURVEY TEAM. IT WAS IN HER OFFICE ON HER DESK. AS OF 2/7/2020, All RESIDENTS HAVE BEEN PLACE IN AN APPROPRIATE LEVEL OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE FACILITY HAS BEEN CLOSED.	

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D 167	Continued From page 52 10/05/19, 11/03/19, and 11/19/19 from 1:00am to 7:00am. Confidential interview with a facility staff revealed : -Not all staff were CPR certified. -Not every shift had at least one staff certified in CPR. -Staff H, personal care aide (PCA), and Staff M, medication aide (MA), had their CPR certification, and they lived within 500 feet of the facility, therefore, the Administrator believed that Staff H and Staff M met the staffing requirements for the facility's CPR coverage. Interview with Staff F, MA, on 12/11/19 at 8:38am revealed: -The Administrator was responsible for the staffing schedule. -She was not CPR certified. Interview with Staff H, PCA, on 12/11/19 at 4:50pm revealed: -She worked at the facility for 17 years and she lived next door to the facility. -She was CPR certified. -She was never told she was expected to cover shifts where there was no staff working who had not completed CPR certification. -Staff M was no longer employed at that facility and left in October 2019. -She did not know which staff had CPR certification or the shifts that did not have CPR coverage. Interview with Staff C, MA, on 12/12/19 at 4:20pm revealed: -She had not provided documentation of CPR certification to the facility. -She did not know where her CPR certification	D 167		

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D 167	Continued From page 53 card was located, and she did not know when her CPR certification expired. -She thought she took CPR in February 2018. Interview with the Administrator on 12/12/19 at 5:25pm revealed: -The Resident Care Coordinator (RCC) was responsible for personnel records and for auditing personnel records to assure staff had all qualifications including CPR. -She was responsible for ensuring personnel records were completed since there was currently no RCC at the facility. -She was responsible for auditing personnel records and she had not audited staff records because of time constraints. -The obligation for regular staffing interfered with her administrative duties; she was responsible for ensuring staff with CPR were appropriately scheduled. -She was responsible for the schedule and assuring staff with CPR certification were always on the premises in the absence of the RCC. -When she completed the schedule, she scheduled staff with CPR on each shift from memory. -The CPR cards in the personnel records were all the CPR cards she had available onsite at the facility. -She had seen certification cards for the staff that had CPR certification, except for Staff C. -She did not know where Staff C's CPR certification card was located. -Staff H and Staff M had CPR and they resided within 500 feet of the facility; she thought Staff H and Staff M residing within 500 feet would meet the CPR staffing requirements for the facility. -Staff M no longer worked at the facility since the beginning of October 2019. -She did not know that one staff with CPR	D 167		

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D 167	Continued From page 54 completed within the last 24 months needed to always be on the premise. ________________ The facility failed to assure staff on duty for 27 shifts had completed a course on CPR within the last 24 months which resulted in no staff available who had completed CPR certification, in case of an emergency requiring cardio-pulmonary resuscitation of a resident. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. ________________ The facility provided a plan of protection in accordance with G.S. 131D-21 on 12/10/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D 167		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census	D 188		

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or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)
(D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

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

Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing at the facility for 8 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019.

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D 188	Continued From page 56 The findings are: Review of the facility's 2019 license revealed the facility was licensed for an Assisted Living with a capacity of 40 beds. Review of the resident census report dated 09/21/19 revealed there was a census of 31 residents, which required 20 staff hours on first and second shift. Review of the staff time cards dated 09/21/19 revealed: -There were 14 total personal care aide (PCA) hours provided on first shift. There was a shortage of 6 aide hours. -There were 19 total PCA hours provided on second shift. There was a shortage of 1 aide hour. Review of the resident census report dated 09/23/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift. Review of the staff time cards dated 09/23/19 revealed there were 15 total staff hours provided on third shift. There was a shortage of 1 aide hour. Review of the resident census report dated 10/05/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift. Review of the staff time cards dated 10/05/19 revealed there were 19.5 total staff hours provided on third shift. There was a shortage of 4.5 supervisor hours (There was no Supervisor/medication aide (MA) within 500 feet	D 188		

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D 188	Continued From page 57 of the facility). Review of the resident census report dated 11/03/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift. Review of the staff time cards dated 11/03/19 revealed there were 17.5 total staff hours provided on third shift. There was a shortage of 6.5 aide hours. Review of the resident census report dated 11/06/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift. Review of the staff time cards dated 11/06/19 revealed there were 7 total staff hours provided on third shift. There was a shortage of 9 aide hours and 6 supervisor hours (There was no Supervisor/MA within 500 feet of the facility). Review of the resident census report dated 11/14/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift. Review of the staff time cards dated 11/14/19 revealed there were 15 total staff hours provided on third shift. There was a shortage of 9 aide hours. Review of the resident census report dated 11/15/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift. Review of the staff time cards dated 11/15/19 revealed there were 15 total staff hours provided	D 188		

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on third shift. There was a shortage of 9 aide hours. (There was no Supervisor/MA) within 500 feet of the facility).

Review of the resident census report dated 11/16/19 revealed there was a census of 31 residents, which required 20 staff hours on second shift.

Review of the staff time cards dated 11/16/19 revealed there were 9.75 total staff hours provided on second shift. There was a shortage of 8 aide hours and 2.25 supervisor hours. (There was no Supervisor/MA within 500 feet of the facility).

Review of the resident census report dated 11/18/19 revealed there was a census of 31 residents, which required 20 staff hours on first shift and 24 hours on third shift.

Review of the staff time cards dated 11/18/19 revealed:
-There were 15 total staff hours provided on first shift. There was a shortage of 3 aide hours and 2 Supervisor hours (There was no Supervisor/MA within 500 feet of the building).
-There were 16 total staff hour provided on third shift. There was a shortage of 8 aide hours.

Review of the resident census report dated 11/19/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift.

Review of the staff time cards dated 11/19/19 revealed there were 10.75 total staff hours provided on third shift. There was a shortage of 10.25 aide hours and 3 supervisor hours. (There was no Supervisor/MA within 500 feet of the

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facility).

Review of the resident census report dated 11/20/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift.

Review of the staff time cards dated 11/20/19 revealed there were 16 total staff hour provided on third shift. There was a shortage of 8 aide hours.

Confidential interview with a staff revealed the Administrator tried to have every shift covered, but there were shifts, specifically 3rd shift, that were short staffed.

Confidential interview with a second staff revealed:
-Overall, there were shifts that did not have enough staff.
-There were nights when there was no MA available at the facility.

Confidential interview with a third staff revealed :
-The Administrator was responsible for the schedule and the schedule was usually made a week in advance.
-There was not enough staff on every shift and staffing was short on the weekends.
-On Saturdays and Sundays, there were times when there were only 2 staff, 1 PCA and 1 MA.

Confidential interview with a fourth staff revealed :
-The schedule was completed by the Administrator.
-The Administrator changed the schedule to reflect there was enough staffing to meet minimum staffing requirements.

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-The Administrator documented on the time cards to show there was enough staffing at the facility.

Confidential interview with a resident revealed:
-There were nights when there was only one PCA and one MA.
-The resident did not need any assistance with activities of daily living, but they were told in the past there was no MA to administer medications during the night.

Confidential interview with a second resident revealed:
-Staff told the resident they could not transfer the resident in and out of the bed and the staff could not change the resident's incontinence briefs because there was "not enough staff".
-The "morning and night need help" with staffing.
-The resident did not complain to the staff because there was "nothing [the resident] could do about it" because the resident had to rely on staff to assist with personal care.

Interview with a MA on 12/11/19 at 5:00pm revealed the Administrator was responsible for the staffing schedule.

Interview with the Administrator on 12/12/19 at 8:50am revealed:
-She covered some shifts that were short of aide hours.
-She was a medication aide and could administer "as needed" medications.
-Her staff time card was current, and the time cards had been filled in for missed punches.
-If she was not listed on the time card as working, she "must not have been [there]".

Interview with the Administrator on 12/12/19 at 5:25pm revealed:

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-She was responsible for the schedule and assuring staffing needs were met.
-If staff did not use the time card, then they were not accounted for and the staff were technically not at the facility.
-She knew the time cards were the documents used to support staffing requirements.
-She did not know there were shifts that were short staffed.
-There had been a large turnover rate in the facility in the past year.
-The "obligation for staffing duties interfered with her administrative duties" and her responsibility for ensuring the shifts was adequately staffed .
-When there was no MA either scheduled or was on approved leave, she would "cover or a person [staff] that lived close by would come in" to the facility and administer medications to residents.

Attempted telephone interview with a 3rd shift PCA on 12/12/19 at 5:07pm was unsuccessful.

[Refer to Tag D269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)].

____

The facility failed to assure the minimum number of staff were present at all times to meet the needs of residents for 8 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019 resulting in an increased risk for improper personal care provided including not transferring a resident who required two person transfer, incontinent care not provided resulting in a second resident developing skin breakdown and bedsores, and residents not being bathed according to the bathing schedule regularly resulting in a third resident developing a foot sore. This failure was detrimental to the health, safety and welfare of the residents and

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D 188	Continued From page 62 constitutes a Type B Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/23/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D 188		
D 214	10A NCAC 13F .0605 (c) Staffing Of Personal Care Aide Supervisor 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (c) On third shift in facilities with a capacity or census of 31 to 60 residents, the supervisor shall be in the facility or within 500 feet and immediately available, as defined in Rule .0601 of this Subchapter. In facilities sprinklered for fire suppression with a capacity or census of 31 to 60 residents, the supervisor's time on duty in the facility on third shift may be counted as required aide duty. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record review, the facility failed to assure first and second shifts were staffed with a minimum of 20 hours including 16 hours of personal care staff and 8 hours of supervision with up to 4 hours counted toward personal care hours, and third shift was staffed with 16 hours of personal care aide and 8 supervisor hours when there was not a supervisor within 500 feet of the facility for 5 of 69 sampled shifts when there was a census of 31 residents in	D 214		

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D 214	Continued From page 63 an unsprinkled facility. The findings are: Review of the facility's 2019 license from the Division of Health Service Regulation revealed the facility was licensed for an Assisted Living with a capacity of 40 beds. Interview with the Administrator on 12/12/19 at 5:20pm revealed: -The current facility census was 31 and the facility was not sprinklered. -There was a Supervisor who was a medication aide (MA) living within 500 feet of the building until 10/30/19. -There was not currently a staff living within 500 feet of the facility meeting the qualifications of a MA and personal care aide(PCA) Supervisor as of November 2019. Review of the resident census report and Staff time cards dated 10/05/19 revealed: -There was a census of 31 residents in the facility, which required 24 staff hours on third shift. -There were 19.5 total staff hours provided on third shift. -There was a shortage of 4.5 Supervisor hours (from 2:30am to 7:00am). Review of the resident census report and Staff time cards dated 11/06/19 revealed: -There was a census of 31 residents in the facility, which required 24 staff hours on third shift. -There were 7 total staff hours provided on third shift. -There was a shortage of 9 aide hours and 6 Supervisor hours (from 12:00am to 6:00am).	D 214		

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Review of the resident census report and Staff time cards dated 11/16/19 revealed:
-There was a census of 31 residents in the facility, which required 20 staff hours on first and second shift.
-There were 24.5 total staff hours provided on first shift. There was a shortage of 2.0 Supervisor hours.
-There were 9.75 total staff hours provided on second shift. There was a shortage of 8.00 aide hours and 2.25 Supervisor hours (from 7:45pm to 11:00pm)

Review of the resident census report and Staff time cards dated 11/18/19 revealed:
-There was a census of 31 residents in the facility, which required 20 staff hours on first shift.
-There were 15 total staff hours provided on first shift. There was a shortage of 3 aide hours and 2 Supervisor hours (from 1:00pm to 3:00pm).

Review of the resident census report and Staff time cards dated 11/19/19 revealed:
-There was a census of 31 residents in the facility, which required 24 staff hours on third shift.
-There were 10.75 total staff hour provided on third shift. There was a shortage of 10.25aide hours and 3 Supervisor hours (from 4:00am to 7:00am).
Confidential interview with a staff revealed:
-The Administrator tried to have every shift covered, but there were shifts, especially 3rd shift, that were short staffed.
-There were nights on 3rd shift when MAs were not at the facility.

Confidential interview with a second staff revealed:

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-Third shift did not always have a MA.
-The PCA did not know who was responsible for administering medications if a MA was not at the facility.
-PCAs were given the medication cart keys when there was no MA, but PCAs "did not mess with the medication cart".
-The PCAs held onto the keys until a MA came to get the keys.

Confidential interview with a third staff revealed :
-MAs on first shift were not "normally" short staffed.
-Third shift usually had one MA and one PCA.
-"There were no MAs" a "couple times" on 2nd shift and there were no MAs "a lot" on 3rd shift.
-"Nobody [passed] medications if there was no MA".
-When there was no MA on the shift, the previous shift MA administered the medications before they left the facility and the MA working the next shift would be expected to come in early to administer the medications that were due.
-Residents' medications were administered in advance so the MA was able to leave the facility.
-In the past, the PCA was responsible for the medication cart keys when a MA was not working; MAs were handed the medication cart keys by a PCA when a MA was not at the facility.
-The Administrator was responsible for the schedule and knew there were shifts when there were no MAs; the Administrator told the MA that "some days she [had] someone, and some days she [didn't]".

Confidential interview with a fourth staff revealed first shift was staffed with a MA and second and third were not always staffed with a MA.

Confidential interview with a resident on 12/12/19

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revealed:
-A MA administered the resident's medication four times a day.
-They were told in the past that there was no MA to administer medications.
-When they first arrived at the facility, there was a period of 6 nights in a row that there was "no one here to give medicine" including pain medications that were ordered "as needed".
-In the past 3 months, there were "sporadic times that a [MA] didn't show up at night" and they were told they could not receive their medication.
-When the resident did not receive pain medication as scheduled, they would have to lay in pain unable to sleep, and if they did fall asleep, the pain would be so bad it would wake them up.
-When the resident did not receive their pain medication, they voiced their concerns to the MA and to the Administrator the next day and the MA and Administrator both apologized and said they would "try to see if they could do better".

Interview with a MA on 12/11/19 at 4:38pm revealed she supervised personal care aides (PCA) when she worked at the facility.

Interview with a PCA on 12/11/19 at 4:50pm revealed:
-She worked at the facility for 17 years and she lived next door to the facility.
-She was a PCA, a housekeeper, and a cook at the facility.
-She supervised PCAs, housekeeping staff, and kitchen staff when there was no other staff available to supervise.
-She was not a MA, she did not have the MA training, and "never passed medications".
-There was a MA that had lived next door to the facility, but since October 2019, he was no longer employed at the facility.

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Interview with a second MA on 12/11/19 at 5:00pm revealed:
-She worked as a MA at the facility since 08/16/19.
-The Administrator was responsible for the staffing schedule.
-She was a MA and supervised staff when she worked at the facility.

Interview with a third MA on 12/12/19 at 9:35am revealed:
-She worked as a MA and Supervisor at the facility for almost a year.
-She supervised staff when she worked at the facility.

Interview with a fourth MA on 12/12/19 at 10:37am revealed:
-She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19.
-She worked as a MA and administered medications to residents.
-She supervised PCAs at the facility when there was no other staff available to be a Supervisor.

Interview with the Administrator on 12/12/19 at 5:25pm revealed:
-She was responsible for the schedule and ensuring the Supervisor staffing needs were met .
-She did not know there were shifts that did not have a Supervisor or MA.
-There had been a large turnover rate in the facility in the past year.
-The facility did not currently have a Resident Care Coordinator (RCC); the Administrator had assumed the RCC duties since the RCC left in April 2019.
-The obligation for staffing duties interfered with

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her administrative duties and her responsibility for ensuring the shifts was adequately staffed .
-There was a PCA that lived within 500 feet of the facility.
-There was a MA and Supervisor that had lived within 500 feet of the facility, but he no longer worked at the facility since the beginning of October 2019.
-When there was no MA, she would "cover or a person that lived close by would come in" to the facility and administer medications to residents.
-She was aware medications were missed occasionally due to staffing; "possibly the person wasn't here or if the person came in late, then it was too late to administer the medications".
-She did not know PCAs were given the medication cart keys.
-MAs had a process and were to store the keys in a secure location at the end of their shift if a MA was late or was not in the building.

Attempted telephone interview with Staff D, a third shift PCA, on 12/12/19 at 5:07pm was unsuccessful.

[Refer to Tag D269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)].

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

____

The facility failed to assure all shifts were adequately staffed with a Supervisor present at all times to meet the needs of residents for 5 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019, which increased the risk for improper personal care provided including not transferring a resident who required two person transfer, incontinent care not

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D 214	Continued From page 69 provided resulting in a second resident developing skin breakdown and bedsores, and residents not being bathed according to the bathing schedule regularly resulting in a third resident developing a foot sore. There were 5 residents not administered medications as ordered resulting in a resident not administered lovenox for 3 days which resulted in the resident having to be transported to the hospital for an injection and placed the resident at risk for blood clotting; a resident not administered a narcotic pain medication resulting in the resident experiencing severe pain for extended amounts of time; two residents administered incorrect dosages of insulin placing the residents at risk for hypoglycemia and hyperglycemia; a resident not administered a topical antiseptic to a wound for 3 days placing the resident at risk for further skin breakdown and infection; a resident not administered a diuretic placing the resident at risk for continued swelling in his feet; and a resident with multiple missed doses of a gastric acid reducer placing the resident at risk for having chest pain (#1). This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/23/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D 214		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical	D 234		

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Examination & Immunizations
(a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 1 of 5 residents sampled (#4) was tested for tuberculosis (TB) disease upon admission.

The findings are:

Review of Resident #4's current FL2 dated 10/02/19 revealed diagnoses included hyponatremia, chronic diastolic congestive heart failure, protein calorie malnutrition, and mass of small intestine.

Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 09/25/19.

Review of Resident #4's admissions documents revealed:
-Resident #4 was admitted to the facility from a local hospital.
-There was no documentation of a TB skin test.

Interview with a first shift medication aide (MA) on 12/12/19 at 11:46am revealed she was not sure

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who was responsible for ensuring TB skin tests were completed, but thought the facility's contracted nurse completed the TB skin tests.

Interview with the Supervisor on 12/12/19 at 3:47pm revealed:
-The Administrator was responsible for ensuring TB skin tests were completed for residents.
-The first TB test for a resident should have been completed upon admission to the facility.
-She thought Resident #4 had a TB skin test completed and it should be in her resident record.

Interview with the facility's contracted nurse on 12/12/19 at 8:24pm revealed:
-She had not completed a TB skin test for Resident #4.
-She thought Resident #4 may have had her first step TB skin test already.

Interview with the Administrator on 12/12/19 at 6:20pm revealed:
-The facility's contracted nurse was responsible for completing TB skin tests.
-She or the Supervisor were responsible for contacting the nurse to schedule the TB tests for residents.
-Residents should have their first TB skin test prior to being admitted to the facility and the second TB skin test should be completed a couple of weeks later.
-She thought Resident #4 had her first and second TB tests documented in her hospital reports.

Resident #4 was not available for interview.

A first and second step TB skin test were not provided during the survey.

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D 269	Continued From page 72	D 269	MED TECH SHIFT REPORTS (COPY OF POLICY ATTACHED) SHOULD HAVE BEEN COMPLETED AT THE END OF EACH SHIFT. ANY CONCERNS OF RESIDENTS, INCLUDING BEHAVIOR, REFUSAL OF SHOWER/BATH, INFECTIONS, ETC. SHOULD HAVE BEEN DOCUMENTED. THIS IS THEN GIVEN TO THE SUPERVISOR/RCC AND ULTIMATELY TO BE FOLLOWED UP ON, BY ADMINISTRATOR. OUR POLICY IS FOR THERE TO BE ONE PCS STAFF MEMBER FOR EVERY 20 RESIDENTS. AT THE TIME OF THE SURVEY, THE HOME HAD 31 RESIDENTS AND WAS SCHEDULING TWO PCS WORKERS FOR 1ST AND 2ND SHIFTS. THE SUPERVISOR WAS ALSO A LICENSED MED TECH AND CNA. IT WAS HER RESPONSIBILITY TO ASSIST AND ASSURE ALL PERSONAL CARE TASKS HAD BEEN COMPLETED ON A DAILY BASIS AND TO CHECK WEEKLY FOR ACCURACY IN CHARTING AND CHANGES IN LEVEL OF CARE. ADMINISTRATORWAS TO SIGN OFF AT THE END OF EACH MONTH AS CERTIFICATION OF COMPLETED TASKS. ONCE THE STATE COMPLETED THE SURVEY ON 12/13/19, THE OWNER'S CAME IN ON 12/16/19 AND BEGAN SUPERVISING AND ASSISTING IN CORRECTING PROBLEMS THAT HAD BEEN IDENTIFIEDBY THE SURVEYORS. ALL RESIDENTS WERE SEEN BY EITHER THE FACILITY DOCTOR OR THEIR PERSONAL PHYSICIAN WITHIN A FOUR WEEK PERIOD. FACILITY WAS CLOSED ON 2/14/2020 AND ALL RESIDENTS WERE RELCOATED TO APPROPRIATE LEVELS OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S.	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure personal care was provided to 8 of 11 sampled residents (#1, #5, #7, #8, #11, #12, #18, and #20) including foot care to three residents (#5, #12, and #18,); residents having to wait for incontinence care (#7, #8, and #20), and residents with a yeast rash (#1 and #11). The findings are: 1. Review of Resident #5's current FL2 dated 10/04/19 revealed: -Diagnoses included fracture of left ankle, bipolar, gastroesophageal reflux disease (GERD), and anemia. -Resident #5 was constantly disoriented. -The resident had inappropriate behavior,	D 269		

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wandering behavior and was verbally abusive at times.

Review of Resident #5's Care Plan dated 08/23/19 revealed:
-Resident #5 required extensive assistance with bathing, dressing and grooming.
-Resident #5 required limited assistance with eating, toileting, ambulation, and transfers.

Review of the facility's November 2019 Personal Care Record shower record for Resident #5 revealed:
-Resident #5 was independent with showers and skin care.
-Resident #5 should receive a shower two times per week.
-Resident #5 was scheduled for a shower on 11/01/19, 11/04/19, 11/08/19, 11/11/19, 11,15/19, 11/18/19, 11/22/19, 11/25/19, and 11/29/19.
-Resident #5 received a shower on 11/14/19 and 11/15/19 with skin care.
-There was no documentation the resident had a shower in December 2019.

Review of the Personal Care Record for Resident #5 for December 2019 revealed there was no documentation of care provided.

Observation of Resident #5 on 12/05/19 at 8:53am revealed:
-The resident's feet were white with grayish patches of dry skin.
-There were loose flakes like a chalky substance that fell to the floor from both the resident's feet.
-The resident's toenails on the first three toes were black and had a thick build up that could not be determined if it was the resident's toe nail or dirt.
-There was a black substance scattered

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throughout the bottom of the resident's left foot.

Interview with Resident #5 on 12/05/19 at 8:53am revealed:
-He was unable to recall the last time he had a shower.
-He put socks on himself, staff helped him get dressed.
-He did not have lotion to put on his feet.
-He had not asked for lotion because he did not think to ask.

Interview with Resident #5's guardian on 12/05/19 at 12:13pm revealed:
-She did not know how often Resident #5 received personal care services at the facility.
-She expected facility staff to ensure the resident's personal care the properly maintained and the resident was kept clean.
-The shoes that Resident #5 currently had were brand new.
-She gave them to the resident last month.
-Facility staff should have called to tell her the shoes were too little, and she could have ordered the resident a larger shoe size.
-She did not know Resident #5 had swollen legs, ankles and feet.

Interview with a second shift personal care aide (PCA) on 12/10/19 at 6:00pm revealed:
-Resident #5 usually did not get showers because the resident complained about his feet and legs hurting.
-The last time she showered Resident #5 was around Thanksgiving.
-She did not continue asking Resident #5 about taking a shower because he usually cursed and said, "you can't tell me to do a [expletive]thing."

Interview with another PCA on 12/12/19 at

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D 269	Continued From page 75 10:15am revealed: -Resident #5 dressed himself and did not allow staff to dress him. -She did not provide showers for Resident #5 because he usually refused. -She had not observed the resident's feet. -Resident #5 was sometimes combative. -Personal care was provided only if the resident allowed. Interview with the Administrator on 12/12/19 at 9:37am revealed: -She was not aware Resident #5 was combative and refused showers. -If the resident was becoming combative and refused showers the PCA needed to make the medication aide (MA) aware. -The MA needed to assess what was going on and figure out the best way to address the issues. -If the MA was unable to figure out or resolve the issue, she needed to report the problem to the resident's PCP or consider changing the shower times. Interview with the Mental Health Provider (MHP) on 12/06/19 at 3:50pm revealed: -If Resident #5 refused showers due to anxiety he expected to be notified. -He had not received any pages or phone calls regarding Resident #5's behaviors. Interview with the podiatrist on 12/13/19 at 1:43pm revealed: -The facility staff sent residents to see him. -He did not specifically remember Resident #5. -In general, the facility staff should make a practice of moisturizing residents' skin after showers and as needed. 2. Review of Resident #12's current FL2 dated	D 269		

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10/21/19 revealed:
-Diagnoses included diabetes mellitus, psychotic disorder, and deep vein thrombosis.
-Resident #12 was intermittently disoriented.
-The resident was semi-ambulatory with a wheelchair.
-Resident #12 was incontinent of bladder/bowel and wore incontinent briefs.

Review of Resident #12's Care Plan dated 03/20/18 revealed:
-Resident #12 required limited assistance with eating, toileting and dressing.
-Resident #12 required extensive assistance with ambulation, bathing, and transferring.
-Resident #12 groomed himself and required supervision with eating.
-Resident #12 was disruptive with behaviors.

Review of the Personal Care Record for Resident #12 for November 2019 shower schedule revealed:
-Resident #12 required limited assistance with showers.
-Resident #12 was scheduled for showers three days per week.
-The showers were documented as scheduled for Resident #12 on 11/04/19, 11/06/19, 11/08/19, 11/11/19, 11/13/19, 11/15/19, 11/8/19, 11/20/19, 11/22/19, 11/25/19, 11/27/19 and 11/29/19.
-The documented days the resident showered were 11/14/19, 11/15/19 and 11/20/19.

Review of the Personal Care Record for Resident #12 for December 2019 revealed there was no documentation of care provided.

Observation of Resident #12's feet on 12/04/19 at 11:04am revealed:
-The resident's feet were white with grayish

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patches.
-The dryness was white grayish patches that extended the entire length of both the resident's feet.

Review of Resident #12's record revealed he was last seen by podiatry on 07/08/19.

Interview with Resident #12 on 12/04/19 at 11:06am revealed:
-His feet hurt, and he did not like staff touching his feet.
-He took showers but was unable to recall the last time he had a shower.
-He would let staff touch his feet if they were very gentle.
-No staff asked to put lotion on his feet.

Interview with the Mental Health Provider (MHP) on 12/11/19 at 3:13pm revealed:
-He wanted to be notified when Resident #12 had behaviors and was refused showers.
-If the facility staff had contacted him, he would have suggested to give the resident anxiety medication at least thirty minutes prior to the shower to help with anxiety/agitation.
-He had no documentation the resident refused showers.

Interview with a personal care aide (PCA) on 12/10/19 at 5:20pm revealed:
-The last time she provided shower and foot care to Resident #12 was one and one-half weeks ago.
-She did not provide foot care to Resident #12 because he often complained about his feet and legs hurting when touched.
-The Administrator and the Supervisor were aware the resident's feet hurt.

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D 269	Continued From page 78 Interview with a second PCA on 12/12/19 at 9:38am revealed: -Resident #12 had never refused personal care from her. -Sometimes he did not want to take a full shower, so he got a bed bath. -He did not get his feet washed with a bed bath. -Resident #12's feet did not get cleaned unless he had a shower. Interview with the Administrator on 12/12/19 at 10:09am revealed: -She was not aware staff had problems with Resident #12 refusing personal care, like showers. -After a week of refusing showers she wanted the Primary Care Provider (PCP) to be notified. -Staff should offer a bed bath as an option if a resident refused a shower. 3. Review of Resident #18's current FL2 dated 05/19/19 revealed: -Diagnoses included dementia, acute encephalopathy and schizoaffective disorder . -Resident #18 was intermittently disoriented. -Resident #18 was semi-ambulatory, with functional limitations of hearing and sight. -Resident #18 required personal care assistance with bathing, dressing, feeding and verbal communication. Review of Resident #18's Care Plan dated 01/22/19 revealed: -Resident #18 required limited assistance with eating, toileting, ambulation, dressing and transferring. -Resident #18 required extensive assistance with bathing and grooming. -Resident #18 had disruptive inappropriate behaviors.	D 269		

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-Resident #18 had a history of mental illness and was currently being seen by mental health.

Observation of Resident 18's feet on 12/03/19 at 3:55pm revealed:
-The resident's feet were chalky white with ashy skin.
-The white ashiness covered the resident's feet from his toes to the heel of his feet, and partway up the resident's ankle.

Review of the Personal Care Record for Resident #18 for November 2019 shower schedule revealed:
-Resident #18 required extensive assistance with showers.
-Resident #18 had scheduled for showers and "bed-baths."
-On the bed-bath days at some point staff were to "wash off the resident and apply powers and creams."
-The staff documented for this task were the MA and PCA.
-The showers and bed-baths were documented as scheduled for Resident #18 on 11/01/19 (shower/first shift), 11/05/19 (bed-bath), 11/06/19 (bed-bath),11/07/19 (shower/first shift), the rest of the week there was no documentation.
-There was no documentation the above schedule had completed for Resident #18.

Review of the Personal Care Record for Resident #18 for December 2019 revealed there was no documentation of care provided

Interview with a personal care aide (PCA) on 12/10/19 at 5:20pm revealed:
-Her duties and responsibilities were specifically showers.
-There was a shower schedule, however she

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D 269	Continued From page 80 showered residents as needed. -Although Resident #18 showers werescheduled for first shift, she tried to give him a shower on the second shift. -When she attempted to shower Resident #18, he usually refused the shower, became combative and fought a lot. -She attempted three to four times to get Resident #18 to take a shower, then she left him alone. -Sometimes she gave Resident #18 a bed-bath if he allowed her. -Most of the times a bed-bath excluded washing the resident's feet. -She only provided foot care when she was able to catch Resident #18 in a good mood. -When Resident #18 was agitated he hit walls, tables and threw chairs. -Dealing with Resident #18's agitation and combativeness were a daily issue. -She had heard the medication aide (MA) say as needed medications did not work for Resident #18. -She did not know if the resident's Primary Care Provider (PCP) was notified. Interview with a first shift PCA on 12/12/19 at 10:01am revealed: -She had to do everything except feed Resident #18. -She had to assist with getting the resident dressed. -The staff getting Resident #18 dressed was responsible for providing personal care like: shaving, trimming fingernails and applyinglotion to the resident's feet. -Sometimes Resident #18 becamecombative and would fight staff. -When he became combative "we just put him in the room and left him alone until he calmed	D 269		

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down."
-She did not tell the MA every time Resident #18 was combative and refused personal care.
-She did not know if the resident's PCP or mental health provider was notified.

Interview with the Mental Health Provider (MHP) on 12/11/19 at 3:13pm revealed:
-He was aware Resident #18 had behaviors with agitation, but he did not know the resident refused showers.
-He had previously suggested to staff that they should use the as needed anxiety medications and if the anxiety medication it did not work, they were supposed to contact him.

Interview the Administrator on 12/12/19 at 9:49am revealed:
-She expected staff to provide personal care like putting lotion on the residents, even when it was not the resident's shower day.
-She did not know Resident #18 refused personal care (showers) and was combative.
-She had been verbalizing to staff to use Resident #18's as needed medications when he was combative.
-She did not tell staff to document when Resident #18 had behaviors or when they notified the Primary Care Provider (PCP).

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

4. Review of Resident #7's current FL2 dated 10/04/19 revealed:
-Diagnoses included anxiety, diabetes mellitus type II, gastroesophageal reflux disease, hypertension, schizophrenia, and mental retardation.

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D 269	Continued From page 82 -Resident #7 was semi-ambulatory with a walker -Resident #7 was incontinent of bladder and bowels at times and wore incontinence briefs. -Resident #7 needed assistance by staff with bathing and dressing, ambulation, and transferring. Review of Resident #7's care plan dated 10/04/19 revealed: -Resident #7 was ambulatory with a walker. -Resident #7 needed supervision with toileting and limited assistance by staff with bathing and dressing. Observation of Resident #7 on 12/06/19 at 3:15pm revealed: -Resident #7 was seated in a chair in her room. -There was a strong odor of urine in Resident #7's room. Interview with Resident #7 on 12/06/19 at 3:15pm revealed: -She needed assistance by staff with changing her incontinence briefs and with bathing. -She sometimes did not get a bath weekly. -She sometimes had to wait for staff to assist her with incontinence care. -Staff changed her sheets, but she did not know how often. -She did not know what the odor was in her room. Review of the facility incontinence care sheets revealed: -Resident #7 provided her own incontinence care on 11/29/19, 11/30/19, 12/01/19, 12/02/19, 12/03/19, 12/04/19, and 12/05/19. -Resident #7 was provided incontinence care 3 times on 12/02/19 and 12/03/19. Review of the Personal Care Record for Resident	D 269		

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#7 for November 2019 revealed:
-Resident #7 required extensive assistance by staff with bathing and had the option of receiving a shower, shower/bath, bed bath, or sponge bath.
-There were days highlighted which indicated when Resident #7 should have had a bath.
-Resident #7 should have had a bath twice a week on 11/05/19, 11/07/19, 11/12/19, 11/14/19, 11/19/19, and 11/21/19 totaling 6 baths in the month of November 2019.
-There was documentation Resident #7 received a sponge bath on 11/16/19, 11/20/19, and 11/22/19.
-There was no documentation regarding refusals.

Review of the Personal Care Record for Resident #7 for December 2019 revealed:
-Resident #7 required extensive assistance by staff with bathing and had the option of receiving a shower, shower/bath, bed bath, or sponge bath.
-There were days highlighted which indicated when Resident #7 should have had a bath.
-Resident #7 should have had a bath twice a week on 12/03/19 and 12/05/19, but there was no documentation Resident #7 was given a bath.
-There was no documentation regarding refusals.

Interview with a second shift personal care aide (PCA) on 12/06/19 at 5:01pm revealed:
-She checked on residents every 2 hours and as needed for incontinence care.
-She usually gave residents a bed bath unless they needed a shower.
-She did not document on the Personal Care Record, but tried to document on the incontinence care sheets.
-She physically checked residents at the beginning of her shift to see if they needed incontinence care.
-She was sometimes told by other PCAs a

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resident "wanted her" which meant there was no incontinence care provided to the resident.
-Resident #7 usually needed incontinence care when she started her shift, but she had not noticed any skin breakdown.

Interview with another second shift PCA on 12/06/19 at 5:36pm revealed:
-She started each shift by checking residents to see if they needed incontinence care.
-She had found residents many times soaked and "got mad about it."
-She told the Administrator who told her she would look to see who worked the previous shift and would correct the issue.
-First shift was usually responsible for giving baths.

Interview with a first shift medication aide (MA) on 12/12/19 at 11:46pm revealed:
-When she started her shift residents were soaked with urine and their linens were soiled.
-Residents were found lacking personal care and linens were more soiled on Mondays due to personal care not being provided over the weekend.
-Resident #7 had multiple incontinence episodes and the resident was almost always drenched at the start of her shift.
-Resident #7 needed assistance with bathing and incontinence care.
-She had informed the Administrator incontinence care was not being provided on third shift.
-Resident #7 needed assistance with bathing and incontinence care.

Interview with a Supervisor on 12/12/19at 12:48pm revealed:
-Staff should check residents for incontinence care every 2 hours.

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D 269	Continued From page 85 -She had received complaints from PCAs that residents had been left soaked by staff on the previous shift. -Resident #7 had multiple incontinence episodes and required assistance with changing her incontinence briefs. -Residents who had multiple incontinence episodes should have been provided incontinence care more often than every 2 hours if needed. Interview with the Administrator on 12/06/19 at 6:15pm revealed: -The PCAs were supposed to document on the Personal Care Records each time a resident was given a bath. -She knew the Personal Care Records had not been completed, but she had instructed staff to complete when baths were given. -Baths were usually given either 2 days a week or 3 days a week. -She did not know of any resident regularly refusing a bath or incontinence care. -If a resident did refuse a bath or incontinence care, the resident should not be left without staff providing personal care. -Staff should re-approach the resident for assistance with incontinence care. -She had received complaints from staff on all shifts that they were finding residents needing incontinence care at the beginning of their shifts. -She suggested to staff to round together at the change of shifts to make sure all residents had been provided incontinence care by staff on the previous shift. -She would like for staff to check residents for incontinence care every 2 hours and more often for residents who had multiple incontinence episodes. -There should be documentation of incontinence	D 269		

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care at least every 2 hours on the incontinence care sheets.
-Resident #7 had multiple incontinence episodes and should be checked on more frequently than every 2 hours for incontinence care.

5. Review of Resident #8's current FL2 revealed:
-Diagnoses included diabetes mellitus, gout, vitamin D deficiency, anemia, heart failure, accelerated hypertension, vascular dementia, acute renal failure, and acute encephalopathy.
-Resident #8 was semi-ambulatory with a walker.
-Resident #8 was incontinent of bowel and bladder and wore incontinence briefs.

Review of Resident #8's Care Plan dated 04/24/19 revealed:
-Resident #8 refused personal care at times.
-Resident #8 was confused and forgetful at times.
-Resident #8 needed limited assistance with toileting, extensive assistance with bathing, limited assistance with dressing, and extensive assistance with grooming/personal hygiene.

Review of Resident #8's licensed health professional support evaluation and review dated 09/25/19 revealed Resident #8 remained incontinent and was on a bowel and bladder training program.

Review of the facility incontinence care sheets revealed:
-Resident #8 was checked 6 times for incontinence care on 11/29/19 and was documented as unsoiled 5 times and soiled 1 time.
-Resident #8 was checked 3 times for incontinence care on 11/30/19 and was documented as unsoiled 2 times and soiled 1 time.

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-Resident #8 was checked 4 times for incontinence care 12/01/19 and was documented as "BR" 1 time. (There was no documentation of what BR meant.)
-On 12/02/19, there were 4 entries documented as "Bed." (There was no documentation of what Bed meant.). There was a second incontinence care sheet dated 12/02/19 revealing Resident #8 was checked 2 times for incontinence care and was unsoiled both times.
-On 12/03/19, there were 4 entries documented as "Bed." (There was no documentation of what Bed meant.). There was a second incontinence sheet dated 12/03/19 revealing Resident #8 was checked 1 time for incontinence care and was unsoiled.
-On 12/04/19, there were 3 entries documented as "Bed." (There was no documentation of what Bed meant.). There was documentation Resident #8 was checked for incontinence care 1 time and was soiled.
-Resident #8 was checked 2 times for incontinence care on 12/05/19 and was unsoiled both times. There was a second incontinence care sheet dated 12/05/19 revealing Resident #8 was checked 2 times for incontinence care and was soiled 2 times.

Review of the Personal Care Record for Resident #8 for November 2019 revealed:
-Resident #8 was scheduled to receive a shower 3 times a week on Mondays, Wednesdays, and Fridays and had the option of receiving a shower, shower/bath, bed bath, or sponge bath.
-Resident #8 should have had a bathon 11/01/19, 11/04/19, 11/06/19, 11/08/19, 11/11/19,11/13/19, 11/15/19, 11/18/19, 11/20/19, 11/22/19, 11/22/19, 11/25/19, 11/27/19, and 11/29/19 totaling 14 baths in the month of November 2019.
-Resident #8 showered independently with no

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assistance on 11/14/19, 11/15/19, 11/18/19, and 11/20/19.
-Resident #8 was independent with providing her own skin care (wash face/hands/foot care) on 11/14/19, 11/15/19, 11/16/19, 11/17/19, 11/18/19, 11/19/19, and 11/20/19.
-There was no documentation regarding refusals of personal care.

Review of the Personal Care Record for Resident #8 for December 2019 revealed there was no documentation of care provided.

Observation of Resident #8 on 12/05/19 at 11:03am revealed:
-Resident #8 was seated on her bed in her room.
-Resident #8 was dressed for the day and her bed was made.
-Resident #8's walker was within arm's reach.

Interview with Resident #8 on 12/05/19 at 11:03am revealed:
-She was usually soiled when she woke up in the morning and her sheets were usually wet.
-She went to sleep between 10:00pm and 11:00pm and woke up around 12:00pm.
-She did not receive incontinence care during the night.
-"I try not to bother them."
-"A lot of times, I don't think they have anybody working."
-She sometimes had to get up from her bed or chair to go tell staff she needed to be changed .
-She had been told by staff, "We don't have time to change you or your bed."
-She had multiple incontinence episodes and needed assistance with incontinence care.
-She needed assistance with incontinence care, but she sometimes changed her incontinence briefs herself.

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D 269	Continued From page 89 -Her briefs were very wet when she changed them and she disposed of the briefs in the trashcan in her room. -She gave herself a bed bath sometimes. -She did not remember ever refusing to have a bath or shower. Interview with Resident #8's roommate on 12/05/19 at 10:12am revealed: -Resident #8 had incontinence episodes during the night and sometimes had to wait hours during first shift for her incontinence briefs to be changed. -Resident #8 always had to wait long periods of time for incontinence care on second and third shifts. -Resident #8 had missed breakfast numerous times due to her incontinence briefs being "soaking wet." -Resident #8 sometimes had to wait until dinner for staff to change her soiled sheets from the night before. -Staff offered Resident #8 a shower or bath about once every two weeks. Interview with a personal care aide (PCA) on 12/05/19 at 5:35pm revealed: -She checked on residents every 2 hours to see if incontinence care was needed. -Resident #8 required assistance with all personal care. -She had found Resident #8 soiled at times at the beginning of her shift. -Resident #8 changed her own incontinence briefs sometimes and was hardly ever soiled when she checked her. -She documented on the incontinence care sheets every time incontinence care was provided for residents. -She doubted the incontinence care sheets and	D 269		

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the Personal Care Records were correct for residents because sometimes the PCAs forgot to fill them out or just did not fill them out.

Interview with a second PCA on 12/06/19 at 5:01pm revealed:
-Baths were usually given on first shift.
-She provided a bed bath as needed unless she felt a resident needed a shower.
-She did not document personal care on the Personal Care Records, but she tried to document on the incontinence care sheets.
-She checked on residents every 2 hours and as needed for incontinence care.
-She physically checked residents to see if they needed incontinence care.
-She found residents wet each day when she started her shift.
-She was sometimes told by other PCAs on previous shifts a resident "wanted her" which meant there was no incontinence care provided to the resident.
-She did not really check on Resident #8 because she "was okay."
-Another PCA started helping Resident #8 and took away her independence so Resident #8 decided she was not going to the bathroom anymore.
-Resident #8 could provide her own incontinence care and did not need any help.

Interview with third PCA on 12/06/19 at 5:36pm revealed:
-She started each shift by checking residents to see if they needed incontinence care.
-She had found residents many times soaked and "got mad about it."
-She had found Resident # 8 soiled and her linen soiled before when she started her shift.
-She told the Administrator who told her she

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would look to see who worked the previous shift and would correct the issue.
-First shift was usually responsible for giving baths.

Interview with a fourth PCA on 12/06/19 at 5:57pm revealed:
-She assisted with personal care including baths, showers, and incontinence care.
-If Resident #8 had food in her personal refrigerator, she would stay in her room during meal times and not get out of bed or allow staff to assist with incontinence care.
-Resident #8 refused to be assisted with incontinence care more often than she refused assistance with baths.
-Resident #8 refused baths about 4 days out of 7 days a week.
-When Resident #8 refused a bath or shower, she let the oncoming shift PCA know.
-She did not document refusals on the incontinence care sheets or on Personal Care Records and did not know if other PCAs were documenting.
-She wrote on a sheet of paper who she provided showers to and left the paper at the medication aide (MA) desk for the oncoming staff.

Interview with the Administrator on 12/06/19 at 6:15pm revealed:
-The PCAs were supposed to document on the Personal Care Records each time a resident was given a bath.
-She knew the Personal Care Records had not been completed, but she had instructed staff to complete when baths were given.
-Baths were usually given either 2 days a week or 3 days a week.
-She did not know of anyone regularly refusinga bath or incontinence care.

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D 269	Continued From page 92 -She did know about of a few times when Resident #8 refused personal care and she personally spoke to Resident #8 and encouraged her to allow staff to provide care. -If a resident did refuse a bath or incontinence care, the resident should not be left without staff providing personal care. -Staff should re-approach the resident for assistance with incontinence care. -She had received complaints from staff on all shifts that they were finding residents needing incontinence care at the beginning of their shifts. -She suggested to staff to round together at the change of shifts to make sure all residents had been provided incontinence care by the previous shift. -She would like for staff to check residents for incontinence care every 2 hours and more often for residents who had multiple incontinence episodes. -Resident #8 had multiple incontinence episodes. -There should be documentation of incontinence care at least every 2 hours on the incontinence care sheets. 6. Review of Resident #11's current FL2 dated 01/25/19 revealed: -Diagnoses included psychosis, hypertension, hyperlipidemia, and syncope. -Resident #11 was ambulatory and required assistance with bathing and dressing. -Resident #11 was incontinent of bladder and bowels and wore incontinence briefs. Review of Resident #11's care plan dated 01/22/19 revealed: -Resident #11 had daily incontinence of the bladder and occasional incontinence of the bowel. -Resident #11 refused care, but there was no	D 269		

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documentation how often care was refused.
-Resident #11's skin was normal.
-Resident #11 needed supervision with toileting, extensive assistance with bathing, and limited assistance with dressing.

Review of the Personal Care Record for Resident #8 for December 2019 revealed there was no documentation regarding personal care provided.

Observation of Resident #11 on 12/11/19 at 5:26pm revealed:
-Resident #11 was laying in bed in her room.
-A (PCA) pulled Resident #11's shirt up to reveal a red area with a thin white layer under Resident #11's left breast and Resident #11 also had red areas on her abdomen.
-There was an odor emitted when the PCA revealed the red areas.

Interview with Resident #11 on 12/12/19 at 6:12pm revealed:
-She needed assistance with bathing.
-She did not know if she had any issues with her skin.
-She thought she received a bath regularly, but did not know how many times a week.

Interview with the PCA on 12/11/19 at 5:26pm revealed:
-Resident #11's skin looked better than what it had been looking.
-She applied cream to Resident #11 when she provided personal care, but she was not sure other PCAs were applying cream to the areas.
-"They must have started putting something on it this week."

Telephone interview with a first shift medication aide (MA) on 12/12/19 at 9:50am revealed:

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-Resident #11 had rash in the folds of her skin under her breast and in her groin area.
-She had been having issues with rash since February 2019.
-Resident #11 was prescribed Diflucan a few months ago for 5 days to treat the rash.
-The Diflucan helped the rash, but it did not clear it up.

Review of Resident #11's electronic Medication Administration Record for October 2019 revealed:
-There was an entry for fluconazole (Diflucan)100mg tablet 1 tablet daily for 6 days for yeast dermatitis.
-Diflucan 100mg was documented as administered on 4 of 6 opportunities on 10/08/19, 10/09/19, 10/10/19, and 10/11/19.
-There was no documentation why the other 2 tablets were not administered to Resident #11 to complete the order for Diflucan.

Interview with a second first shift MA on 12/12/19 at 11:46am revealed Resident #11 had rash under her breast and in her groin area.

Interview with the Administrator on 12/06/19at 6:15pm revealed:
-She had gotten complaints regardingpersonal care from staff reporting previous shifts.
-Baths should have been given either 2 or 3 days a weeks and incontinence care should have been provided at least every 2 hours.
-She did not know of anyone regularly refusing a bath or incontinence care, but she had witnessed Resident #11 refusing a bath before.
-If a resident did refuse a bath or incontinence care, the resident should not be left without staff providing personal care.
-Staff should re-approach the resident for assistance with incontinence care.

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Interview with Resident #11's primary care physician (PCP) on 12/12/19 at 3:47pm revealed:
-She knew about the rash under Resident #11's breast and in her abdomen area.
-She had to treat Resident #11 several times for rash under her breast.
-The smell was "overwhelming."
-Resident #11 had physician's orders for calazime paste and she ordered Diflucan on 10/04/19 for 6 days and on 10/31/19 for 10 days.
-To her knowledge, the calazime paste and Diflucan were being used as ordered.
-She did not know Resident #11 did not receive Diflucan for 2 days of the 6 days ordered.
-She did not think Resident #11 missing 2 days of Diflucan contributed to Diflucan having to be reordered on 10/31/19 for 10 days.
-She thought Resident #11 might continue to have rash under her breast and groin area due to staff not thinking to make sure Resident #11 was dry in the folds of her skin under her breast and abdomen.

7. Review of Resident #1's FL2 dated 10/04/19 revealed:
-Diagnoses included Cerebral Palsy, seizure disorder, hypothyroidism, and arthritis.
-Resident #1 was non-ambulatory.
-Resident #1 was incontinent of her bladder and bowels and wore incontinent briefs.
-Resident #1 needed assistance by staff with bathing and dressing.

Review of Resident #1's care plan dated 01/22/19 revealed:
-Resident #1 was ambulatory with a wheelchair.
-Resident #1 had limited range of motion of her upper extremities.
-Resident #1 had daily incontinence of her

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D 269	Continued From page 96 bladder and bowels. -Resident #1 needed supervision with grooming and personal hygiene. -Resident #1 needed limited assistance by staff with getting dressed. -Resident #1 needed extensive assistance by staff with toileting and bathing. Observation of Resident #1 on 12/03/19 at 10:42am revealed: -Resident #1 was seated in a wheelchair in her room. -Resident #1's hair was unkempt and greasy. -A personal care assistant (PCA) assisted Resident #1 to lift her left breast; there was a trace of yellowish powder residue in the front and to the far side of her left breast with her skin being bright red and inflamed with red blistered areas. -A PCA assisted Resident #1 to lift her right breast; the skin under her right breast had a very foul odor and had sticky, yellowish, clumpy powder under her right breast and her skin was bright red and inflamed. Review of the facility incontinence care sheets dated 11/29/19 through 12/05/19 revealed: -In the right-hand column, her assistance code was listed as "EA" (meaning extensive assistance). -On 11/29/19 Resident #1 provided her own incontinence care twice. -On 11/30/19 Resident #1 provided her own incontinence care once. -On 12/01/19 Resident #1 provided her own incontinence care once. -On 12/02/19 Resident #1 was provided incontinence care 3 times on 12/02/19; however, a second facility incontinence care sheet dated 12/02/19 revealed Resident #1 provided her own	D 269		

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incontinence care.
-On 12/03/19 Resident #1 was provided incontinence care once; however, a second facility incontinence care sheet dated 12/03/19 revealed Resident #1 provided her own incontinence care.
-On 12/04/19 Resident #1 provided her own incontinence care once.
-On 12/05/19 Resident #1 provided her own incontinence care once.

Review of the Personal Care Record for Resident #1 for November 2019 revealed:
-Resident #1 required extensive assistance by staff with bathing and had the option of receiving a shower, shower/bath, bed bath, or sponge bath.
-Resident #1's bath days were highlighted in pink.
-Resident #1 should have had a bath three times a week on 11/01/19, 11/04/19, 11/06/19, 11/08/19, 11/11/19, 11/13/19, 11/15/19, 11/18/19, 11/20/19, 11/22/19, 11/25/19, 11/27/19, and 11/29/19 totaling 13 baths in the month of November 2019.
-Resident #1 received a shower on 11/14/19, 11/15/19, 11/18/19 and 11/20/19.
-There was no documentation regarding refusals.
-Resident #1 needed extensive assistance with providing her own skin care (wash face/hands/foot care) on 11/14/19, 11/15/19, 11/18/19, and 11/20/19.

Review of the Personal Care Record for Resident #1 for December 2019 revealed:
-Resident #1 required extensive assistance by staff with bathing and had the option of receiving a shower, shower/bath, bed bath, or sponge bath.
-Resident #1's bath days were highlighted in pink.
-Resident #1 should have had a bath three times a week on 12/02/19, 12/04/19, and 12/06/19, but there was no documentation Resident #1 was given a bath.

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D 269	Continued From page 98 -There was no documentation regarding refusals. -Resident #1 was provided skin care (wash face/hands/foot care). Interview with Resident #1 on 12/03/19 at 10:22am revealed: -The facility staff sometimes helped her with a bath. -The staff would not help her get dressed. -The skin under her breasts burned and was painful. -The staff did not put her powder under her breast daily. Second observation of Resident #1 on 12/06/19 at 9:15am revealed: -Resident #1 was seated in a wheelchair in her room. -Resident #1's hair was unkempt and greasy hair. -Resident #1 had an odor of urine and feces with feces on the bed sheet and on the floor. -A PCA covered the dirty linen with clean linen and assisted the resident onto the bed and provided incontinent care for her. -Resident #1's skin was red on the bottom 4 inches of her buttocks. -The PCA got Resident #1 back to her wheelchair, assisted her to lift her shirt and left breast. There was a small amount of sticky powder present with the skin red, inflamed and an odor present. -The PCA got a wet washcloth with a drop of no rinse soap on it and made 1 swipe under the left breast. -She did not rinse or dry under the resident's left breast or place a cloth to prevent the skin from touching. -The PCA then assisted to lift Resident #1's right breast; the skin was red and inflamed. -The PCA used the same washcloth and made 1	D 269		

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swipe under her right breast.
-She did not rinse or dry under the resident's right breast or place a cloth to prevent the skin from touching.
-Resident #1 did not have shoes on; both her feet were edematous and had dry, flaky, cracked scaling.
-Resident #1's toes on both feet had a thick scaly yellowish white coating on them with longtoenails and the left great toe had a broken, jagged nail.

Second interview with Resident #1 on 12/06/19 at 9:06am revealed:
-Resident #1 did not know when she last had a bath.
-Sometimes, she declined a bath.
-She still burned and hurt under her breast's.
-She sometimes had to wait for staff to assist her with incontinence care.
-She did not know when she saw a foot doctor but she had to wait in line too long when the foot doctor came to the facility.
-She did not know how long her feet had been dry and scaly.
-Her feet only got cleaned when she took a shower.
-No one ever put lotion on her feet.
-She would like lotion on her feet, but no one would assist her.

Third observation of Resident #1 on 12/11/19 at 9:30 am revealed:
-A PCA assisted Resident #1 to lift her left breast; her skin was reddened without odor, but had improved, with a light powder residue.
-A PCA assisted Resident #1 to lift her right breast; her skin was reddened, without odor, but had improved.
-Resident #1's feet were edematous with dry, flaky cracked scaling and her toes had a thick,

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scaly yellowish white coating on them.

Third interview with Resident #1 on 12/1/19 at 9:23am revealed:
-Resident #1's breast had improved.
-Staff had been putting her powder on her and had placed a a cloth under her breasts.
-She had a bath yesterday.

Interview with a PCA on 12/06/19 at 8:50am revealed:
-She made rounds every 2 hours, but some residents required rounds more frequently.
-She rounded on Resident #1 every 4 hours because the resident would let her know if she needed to be changed.
-Resident #1 changed herself at times.

Interview with another PCA on 12/10/19 at 5:55pm revealed;
-She started her shift off by checking the residents who were usually incontinent, first.
-She made rounds on the residents every 2 hours to make sure they were dry.
-A lot of residents required assistance with incontinent care.
-She bathed residents when they smelled like they needed a bath.
-Resident baths were documented on the flow sheets located at the desk.
-She had not bathed Resident #1.
-She had only aided with personal care for Resident #1 one time because she usually did her own care.
-She knew Resident #1 had a rash under her breast but had not reported the rash because "basically everyone knew".
-The Administrator knew Resident #1 had the rash under her breast since she was hired as the Administrator.

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D 269	Continued From page 101 -Resident#1's feet were not bad but she "could not specify" as she did not work much with Resident #1. Interview with a medication assistant (MA) on 12/12/19 at 3:29pm revealed: -Resident #1 required assistance with her bath. -When Resident #1 refused her bath, her rash flared up. -MAs were responsible for ensuring the residents had a bath. -Sometimes, there was only one shower room available for the residents use. -Most of the time there would only be 1 PCA on first shift so the MAs had to assist her with the residents' care. Interview with a third PCA on 12/12/19 at 4:33 pm revealed: -The MAs were responsible for ensuring that personal care tasks were completed each shift by the PCAs. -She made rounds every 2 hours for each resident, and every hour for residents that "have frequent urination." -There was a sheet at the nurses' station showing which residents got showers on each day. Interview with a second MA on 12/12/19 at 4:45pm revealed: -The PCAs were responsible for providing personal care for the residents. -Resident #1 had a rash under her breast for a few weeks. -She tried to keep a soft cloth under her breast so her skin did not rub but the resident would remove it. Interview with a fourth PCA on 12/12/19 at 4:46 pm revealed:	D 269		

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-The MAs were responsible for ensuring that personal care tasks were completed each shift by the PCAs.
-She made rounds every 2 hours for each resident, or more if needed.
-She and another PCA may give a shower when we feel like they need one, like if they had a bowel movement.
-Resident #1 changes herself at times.

Interview with a fifth PCA on 12/12/19 at 5:08 pm revealed:
-She made rounds every hour for each resident.
-Showers and baths were given to the residents as needed but she felt like they needed showers every other day.

Interview with Resident #1's Primary Care Provider (PCP) on 12/06/19 at 11:16am revealed:
-She had not checked Resident #1's skin recently.
-Resident #1's rash had not been reported.
-Facility staff used to keep Resident #1 bathed and her hair washed, now she hardly ever saw Resident #1 clean.
-It had been over a week since Resident #1 had her hair washed which was why it was so greasy.
-She had tried to teach staff how to dry Resident #1 after her bath to help prevent a rash.
-She placed Resident #1 on the list to see podiatry and applied lotion to Resident #1's feet that day.

Interview with the Administrator on 12/10/19 at 5:00pm revealed:
-Rounds were supposed to be made by staff every 2 hours at a minimum.
-Residents with behaviors should be rounded on at least hourly.
-Staff knew the residents routine, so she did not

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create to have have staff complete any documentation showing the residents had been seen every 2 hours at a minimal.
-Residents were provided incontinent care every 2 hours and residents had baths 2-3 times per week with some residents getting them more often.
-She expected rounds to be made no less than every 2 hours and expected to know the habits of each resident.

Interview with the Administrator on 12/12/19 at 6:55pm revealed:
-Resident #1 required assistance from staff to get her bath.
-She knew Resident #1 had a problem with yeast since 10/31/19 when she saw an order to use a soft cloth to place under the resident's breast.
-MAs and PCAs were suppose to ensure a soft cloth was under Resident #1's breasts.
-She had not seen any documentation regarding the yeast on Resident #1's breast.
-She expected Resident #1 to have a bath regularly and if refusals became an issue, staff would let the physician know.
-Resident #1's skin should be checked when she got a bath.
-The PCAs were supposed to document on the Personal Care Records each time a resident was given a bath.
-She knew the Personal Care Records had not been completed, but she had instructed staff to complete when baths were given.
-Baths were usually given either 2 days a week or 3 days a week.
-She did not know of any resident regularly refusing a bath or incontinence care.
-If a resident did refuse a bath or incontinent care, the resident should not be left without staff providing personal care. A second staff should

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offer to assist with care.
-She had received complaints from staff on all shifts that they were finding residents needing incontinence care at the beginning of their shifts.
-At shift change, it was the responsibility of the oncoming PCA to make rounds with the off-going PCA to check the residents to ensure they were dry.
-If the on-coming PCA failed to communicate with the off-going PCA, then it became their responsibility to provide incontinent care for the residents who were soiled.
-She would like for staff to check residents for incontinence care every 2 hours and more often for "heavy wetters".
-Incontinent care should be documented every 2 hours on the incontinence care sheets.
-Staff tried to keep the bath/shower list up to date but it was not currently up to date, and all the residents were not listed on the bath/shower list.
-MAs were responsible for updating the shower list.
-Baths were supposed to be documented on the PCA sheets.
-No one currently audited the PCA sheets.
-She was responsible for ensuring the PCA sheets were completed.

Interview with the Supervisor on 12/13/19 at 11:09 am revealed the bath schedule was currently not up to date and did not have all the residents listed on it.

8. Review of Resident #20's FL2 dated 01/23/19 revealed:
-Diagnoses included dementia, hypertension, anxiety, and degenerative joint disease of the lumbar spine.
-Resident #20 was intermittently disoriented.
-Resident #20 was semi-ambulatory with use of a

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cane or wheelchair.
-Resident #20 was incontinent of her bladder and bowels and wore incontinent briefs.
-Resident #20 required assistance with bathing and dressing herself.

Review of Resident #20's care plan dated 01/22/19 revealed:
-Resident #20 was ambulatory with aide of a device.
-Resident #20 had limited range of motion of her upper extremities.
-Resident #20 had daily incontinence of her bladder and bowels.
-Resident #20 was forget and needed reminders.
-Resident #20 needed limited assistance with grooming, personal hygiene, getting dressed, and toileting.
-Resident #20 needed extensive assistance by staff with bathing.

Review of the facility incontinence care sheets dated 11/29/19 through 12/05/19 revealed:
-In the right-hand column, her assistance code was listed as "EA" (meaning extensive assistance).
-On 11/29/19 Resident #20 was provided incontinent care once time.
-On 11/30/19 Resident #20 was provided incontinence care one time.
-On 12/01/19 Resident #20 was not provided incontinence care.
-On 12/02/19 Resident #20 was not provided incontinence care; Review of a second facility incontinence care sheet dated 12/02/19 revealed Resident #20 was not provided incontinence care.
-On 12/03/19 Resident #20 was not provided incontinence care; Review of a second facility incontinence care sheet dated 12/03/19 revealed

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D 269	Continued From page 106 Resident #20 was not provided incontinence care. -On 12/04/19 Resident #20 was not provided incontinence care. -On 12/05/19 Resident #20 was not provided incontinence care. Review of the Personal Care Record for Resident #20 for November 2019 revealed: -Resident #20 required extensive assistance by staff with bathing and had the option of receiving a shower, shower/bath, bed bath, or sponge bath. -Resident #20's bath days were highlighted in pink. -Resident #20 should have had a bath three times a week on 11/01/19, 11/04/19, 11/06/19, 11/08/19, 11/11/19, 11/13/19, 11/15/19, 11/18/19, 11/20/19, 11/22/19, 11/25/19, 11/27/19, and 11/29/19 totaling 13 baths in the month of November 2019. -Resident #20 received a shower on 11/16/19, 11/20/19, and 11/22/19. -There was no documentation regarding refusals. -Resident #20 needed extensive assistance with providing her own skin care (wash face/hands/foot care) on 11/16/19, 11/20/19, and 11/22/19. Review of the Personal Care Record for Resident #20 for December 2019 revealed: -Resident #20 required extensive assistance by staff with bathing and had the option of receiving a shower, shower/bath, bed bath, or sponge bath. -Resident #20's bath days were highlighted in pink. -Resident #20 should have had a bath three times a week on 12/02/19, 12/04/19, and 12/06/19, but there was no documentation Resident #20 was given a bath. -There was no documentation regarding refusals.	D 269		

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-There was no documentation Resident #20 was provided skin care (wash face/hands/foot care)

Observation of Resident #20 on 12/06/19 at 2:37pm revealed:
-Resident #20 was in a wheelchair, rolling down the hallway, looking in each room.
-Resident #20 was wearing only a shirt and was carrying a wet pull-up and a wet pair of pants.
-Resident #20's shirt was stretched over her knees to cover herself.
-Resident #20 placed the wet pull-up and her wet pants by the doorway to the breakroom.

Interview with Resident #20 on 12/06/19 at 2:37pm revealed:
-She had rolled down the hallway to look for staff to assist her, but she was not able to find anyone.
-She needed help washing up and putting on clean clothes.
-No one had assisted her to the bathroom today.

Interview with a personal care assistant (PCA) on 12/10/19 at 5:55pm revealed;
-She started her shift off by first checking the residents who were usually incontinent.
-She made rounds on the residents every 2 hours to make sure they were dry.
-A lot of residents required assistance with incontinent care.
-She bathed residents when they smelled like they needed a bath.
-Resident baths were documented on the flow sheets located at the desk.
-She had not bathed Resident #20.
-She had never assisted Resident #20 with personal care until earlier today because she was still in her night gown.
-She worked on 12/06/19 when Resident #20 had removed her soiled clothes, but she was assisting

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D 269	Continued From page 108 another resident. -She applied lotion to Resident #20 weekly because she had dry skin. -She told theAdministrator Resident #20 had dry skin on her legs and feet; the Administrator gave her some lotion to apply. Interview with a medication aide (MA) on 12/12/19 at 3:29pm revealed: -MAs were responsible for ensuring the residents had a bath. -If she did not know what a resident's level of care was, she reviewed the care plan. -Resident #20 removed her clothing at times, when she was soiled. -The bath/shower list was outdated as some of the residents were no longer at the facility and new residents were not on the list. -She updated the bath/shower list, but the Administrator would not accept it. -Sometimes, boxes were stacked in one of the shower rooms so residents were not able to have their bath as scheduled. -Most of the time there would only be 1 PCA on first shift so the MAs had to assist her with the residents' care. Interview with a second PCA on 12/12/19 at 4:33 pm revealed: -The MAs were responsible for ensuring that personal care tasks were completed each shift by the PCAs. -She made rounds every 2 hours for each resident, and every hour for residents that "have frequent urination." -There was a sheet at the nurses' station to document when residents were assisted with incontinent care. -Resident #20 told staff when she needed to be changed.	D 269		

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Interview with a second MA on 12/12/19 at 4:45pm revealed:
-The PCAs were responsible for providing personal care for the residents.
-Resident #20 removed her clothes when she was hot.
-Resident #20 was checked every 2 hours and as needed.

Interview with a third PCA on 12/12/19 at 4:46 pm revealed:
-The MAs were responsible for ensuring that personal care tasks were completed each shift by the PCAs.
-She made rounds every 2 hours for each resident, or more if needed.
-She and another PCA may give a shower when we feel like they need one, like if they have an incontinent episode.
-She checked Resident #20 every 2 hours.

Interview with a fourth PCA on 12/12/19 at 5:08 pm revealed:
-She made rounds every hour for each resident.
-Showers and baths were given to the residents as needed but she felt like they needed showers every other day.

Interview with Resident #20's Primary Care Provider (PCP) on 12/12/19 at 4:50pm revealed:
-Facility staff had never reported to her that Resident #20 had removed her clothing and went into the hallway.
-She was concerned that Resident #20 removed her clothing and went into the hallway to find staff to assist with care.
-Resident #20 required assistance with personal care and toileting.
-Residents should be provided with incontinence

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care every 2 hours at a minimal.

Interview with the Administrator on 12/12/19 at 6:55pm revealed:
Resident #20 required assistance from a staff to get her bath.
-The PCAs were supposed to document on the Personal Care Records each time a resident was given a bath.
-She knew the Personal Care Records had not been completed, but she had instructed staff to complete when baths were given.
-Baths were usually given either 2 days a week or 3 days a week.
-She did not know of any resident regularly refusing a bath or incontinence care.
-If a resident did refuse a bath or incontinent care, the resident should not be left without staff providing personal care.
-Staff should re-approach the resident for assistance with incontinence care.
-She had received complaints from staff on all shifts that they were finding residents needing incontinence care at the beginning of their shifts.
-At shift change, it was the responsibility of the oncoming PCA to make rounds with the off-going PCA to check the residents to ensure they were dry.
-If the on-coming PCA failed to communicate with the off-going PCA, then it became their responsibility to provide incontinent care for the residents who were left soiled.
-She would like for staff to check residents for incontinence care every 2 hours and more often for "heavy wetters".
-There should be documentation of incontinence care at least every 2 hours on the incontinence care sheets.
-Staff tried to keep the bath/shower list up to date but it was not currently up to date, and all the

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residents were not listed on the bath/shower list.
-Baths were supposed to be documented on the PCA sheets.
-No one currently audited the PCA sheets.
-The Administrator was responsible for ensuring the PCA sheets were completed.

Interview with a Supervisor on 12/13/19 at 11:09 am revealed:
-The bath schedule was currently not up to date and did not have all the residents listed on it.
-There was not usually staff at the desk because the was only 1 PCA scheduled to work on first shift and she stayed busy assisting residents.

____

The facility failed to provide personal care assistance for 8 of 11 sampled residents which resulted in four residents not getting proper foot care (#1, #5, #12 and #18) resulting in discoloration and thick buildup on residents' feet and toenails, residents not provided proper incontinence care (#1, #7, #8, and #20) resulting in residents having to wait for incontinence care and a resident pulling her pants and briefs off in the hallway, and residents not provided appropriate skin care (#1 and #11) resulting in a rash causing pain, burning, and foul odors. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/19 for this violation.

THE CORRECTION DATE FOR THIS TYPE BE VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews, observation and interviews the facility failed to provide supervision to meet the needs of 2 of 5 sampled residents (Residents #5 and #12) who had muscle weakness causing him to repeatedly fall (#12) and a resident who eloped without staff's knowledge (#5). The findings are: 1. Review of Resident #5's current FL2 dated 10/04/19 revealed: -Diagnoses included fracture of left ankle, bipolar, gastroesophageal reflux disease (GERD), and anemia. -Resident #5 was constantly disoriented. -There was documentation the resident had inappropriate behavior, wandered and was verbally abusive at times. Review of a report from the local police	D 270	IT IS NOT OUR POLICY(OUR POLICIES ARE ATTACHED) TO PROP ANY DOOR OPEN TO AVOID ALARMS GOING OFF. OWNER WAS NEVER MADE AWARE (UNTIL THIS SURVEY) THAT INCIDENT WITH RESIDENT #5 EVER OCCURRED. WHEN ISSUE WAS CITED, EMPLOYMENT OF EMPLOYEE RESPONSIBLE FOR THIS ACTION WAS TERMINATED. POLICIES WERE IN PLACE (SEE ATTACHMENT) FOR FALL PREVENTION. STAFF HAD SIGNED THAT THEY UNDERSTOOD POLICY. THIS ISSUE SHOULD HAVE BEEN ADDRESSED BY PCS STAFF AND ADMINISTRATOR. AS OF 12/16/19, OWNERS WERE ACTIVELY INVOLVED IN SEEING THAT RESIDENTS WERE BEING CARED FOR AND PROPERLY SUPERVISED. AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN RELOCATED TO APPROPRIATE LEVELS OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S.	

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department dated 10/01/19 revealed:
-Resident #5 was found by the police officers on dark street.
-The location where the resident was found was almost two blocks from the facility.
-It was 3:13am and the resident appeared disoriented.
-The resident told the police officers that he was having chest pains and pains in his left arm, but facility staff would not call medical assistance for him.
-The police officers transported the resident back to the facility.
-The staff at the facility did not know theresident had left the building.
-The door to the facility was observed as being held open by a "door stop," which caused the alarm to be deactivated.
-The officer documented the door open was how Resident #5 left the building.
-No staff at the facility could advise the police officer when and how Resident #5 left the facility.

Interview with Resident #5's guardian on 12/05/19 at 12:13pm revealed:
-The Administrator at the facility called her later in the morning on 10/01/19 after Resident #5 eloped.
-She told the Administrator the facility needed a better system to identify when resident's leave the building.
-Resident #5 told her that he left the facility because he needed an ambulance and the staff would not call the ambulance for him.

Interview on 12/05/19 at 9:11am with Resident #5 revealed:
-A few months ago, he left the facility because he wanted to go to the hospital.
-He had been telling staff that he did not feel

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good and was in pain.
-The staff refused to send him to the hospital.
-The staff continued to ignore his request to go to the hospital and staff told him there was nothing wrong with him.
-He left the facility to take himself to the hospital.
-The police stopped on the street and the police transported him back to the facility.
-He still never got to go to the hospital.

Telephone interview with the Mental Health Provider (MHP) on 12/06/19 at 3:50pm revealed:
-Resident #5 was confused and needed continual supervision.
-The resident was unable to make good judgement decisions when a situation was dangerous.
-If the resident complained about a non-factual illness the facility staff should have notified him .
-He had not received any pages or phone calls regarding Resident #5 stating he was sick and wanted to go to the hospital.

Interview with the third shift medication aide (MA) on 12/12/19 at 4:50pm revealed:
-She recalled when Resident #5 left the facility.
-She was not sure how he got out but stated sometimes staff left the door open when they dumped the trash, that could possibly be how Resident #5 got out.
-They checked on residents every two hours.
-She did not know how long Resident #5 was gone before the police brought the resident back to the facility.
-She did not contact the resident's Primary Care Practitioner (PCP) or mental health.
-She had not completed an incident report, but she did notify the Administrator of the incident.

Interview with theAdministrator on 12/12/19 at

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9:37am revealed:
-She was aware Resident #5 eloped from the facility.
-She thought staff left the door open.
-She had talked with staff and notified Resident #5's guardian.
-She had informed staff to watch all the residents , especially the residents that were easily agitated.
-The facility's policy was to provide supervision every two hours when providing incontinent care to the residents.
-Staff should observe the residents more often than every two hours, but she had no specific time when staff should monitor the residents.
-Staff should call the PCP, however she found out one month ago, that mental health wanted to be called when a resident was agitated.

2. Review of Resident #12's current FL2 dated 10/21/19 revealed:
-Diagnoses included diabetes mellitus, hypertension, psychotic disorder, deep vein thrombosis, esophageal reflux, and hypothyroidism.
-Resident #12 was intermittently disoriented.
-Resident #12 was semi ambulatory with a wheelchair.

Review of Resident #12's Care Plan dated 03/20/18 revealed:
-Resident #12 required limited assistance with eating, toileting and dressing.
-Resident #12 required extensive assistance with ambulation, bathing, and transferring.

Review of the contracted nurse's note dated 09/03/19 revealed:
-Resident #12 had increased weakness to both lower extremities.
-Resident #12 was observed in the hallway on his

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D 270	Continued From page 116 hands and knees due to not being able to hold himself up using a walker. Review of the contracted nurse's note dated 10/01/19 revealed the resident had a decline in mobility. Review of the Licensed Health Professional Support (LHPS) evaluation dated by the contracted nurse 11/14/19 revealed: -The report was completed by a Registered Nurse (RN). -Staff told her that Resident #12 had fallen twice today. -The resident's blood sugar was 113. -The resident had recently returned from the hospital. -The RN noted under recommendations that Resident #12 was a high risk for falls due to psychosis. Observation of Resident #12 on 12/04/19 at 11:04am revealed: -The resident was sitting in a wheelchair. -The resident was facing the bed. -The resident was leaned forward with his head lying on the bed. -The resident appeared weak and unable to hold his head up for one minute to talk. -When the resident talked, he had his head down and was holding his head in his hands. Interview with Resident #12 on 12/04/19 at 11:06am revealed: -He always leaned forward and was unable to hold the upper part of his body up. -When he leaned forward, he just kept going and sometimes fell to the floor. -He fell to the floor at least once daily, and some days more than once.	D 270		

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-It hurt when he fell to the floor and sometimes, he received scratches and bruises.
-He had never been to the hospital as a result of a fall.
-Sometimes he fell out of bed onto the floor, and staff left him on the floor all night
-Staff had to help him out of bed and into the wheelchair.
-When in the wheelchair he was weak and unable to sit up straight, so he leaned forward which caused him to fall to the floor.
-Some days staff put his wheelchair close to the bed so when he learned forward and was able to rest his head on the bed, but not all staff.
-When in the bed he sometimes rolled out of the bed onto the floor due to muscle weakness.
-The staff on the mid-night shift left him on the floor all night, they covered him up with a blanket.
-In the morning the day shift staff got him off the floor.

Interview with a resident on 12/11/19 at 5:35pm revealed:
-Within the past 3-4 months she had observed Resident #12 on the floor several times.
-She observed Resident #12 sitting on the bed, then he will fall to the floor.
-Resident #12 fell to the floor because he was bent over and was unable to sit up straight.
-When she observed the resident on the floor, she informed staff.

Interview with a first shift personal care aide (PCA) on 12/04/19 at 9:46am revealed:
-Two weeks ago, Resident #12 complained he could not move his lower limbs and had pain when touched his (legs and feet).
-Last month emergency medical services (EMS) were called because Resident #12 had symptoms of a stroke with weakness and he was unable to

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THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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move his limbs.
-The resident had been to the hospital at least two times with the same stroke like symptoms.
-Resident #12 had fallen at least ten times within the past two weeks due to the resident being unstable and unable to sit up in his wheelchair.
-She had come to work many days on the first shift and found Resident #12 lying on the floor.
-When Resident #12 was found on the floor she assisted the resident to the bed or to the wheelchair.
-The third shift staff left the resident on the floor.

Interview with the Supervisor on 12/12/19 at 12:15pm revealed:
-Resident #12's falls used to be worse.
-Her way of correcting the issue of the resident's falls was that she asked the Primary Care Provider (PCP) to check and change some of the resident's medications, which decreased the resident's falls.
-She was aware Resident #12 still had falls.
-No supervision or monitoring system had been put in place.
-She had no control over the staff schedule and if there was not enough staff to continually watch Resident #12 it was not her fault.

Interview with another first shift personal care aide (PCA) on 12/12/19 at 9:38am revealed:
-Due to Resident #12 decline he has had a couple of falls that she witnessed.
-Resident #12 was weak and he tended to lean forward in his wheelchair causing him to fall forward out of the chair onto the floor.
-As far as she knew the resident had not sustained any injuries due to the falls.
-However, it was very common to see Resident #12 on the floor because he fell out of his wheelchair.

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D 270	Continued From page 119 -It was the facility's policy when a resident fell to notify the medication aide (MA) on duty to assess the resident. -The MA assessed the resident and gave the information to the Administrator. -The Administrator had been made aware the resident had many falls because the MA had completed documentation and notified the Administrator. -Also, the Administrator had witnessed the resident on the floor (unable to recall specific date), and she knew the resident did not intentionally put himself on the floor. -She recalled an incident that happened a couple of months ago (unable to recall the specific date) when the resident was in the dining room and he leaned forward at the table, which caused him to fall to the floor. -While falling, Resident #12 knocked all the food that was on the table to the floor. -The resident did not have any visible injuries, but the fall was noted in the resident's progress notes. -After the incident she tried to put the resident's wheelchair far enough under the table so that when the resident leaned forward, he would not fall to the floor. -To prevent the resident from falling on the floor in his room, she also tried to push the resident's wheelchair close to the bed, so when the resident leaned forward, he fell onto the bed. -Most of the time this worked, and the resident did not fall on the floor. -Resident #12's last fall was about one week ago. -She came into work that morning and Resident #12 was in the bed. -She later that day she walked by the room and the resident was on the floor. -To her knowledge no system had been put in place to monitor Resident #12 to ensure he did	D 270		

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not fall.
-The Administrator had not given instructions regarding suggestions on how to keep Resident #12 from falling.
-She did not know if Resident #12's PCP was aware the resident had falls or not.

Interview with a first shift MA on 12/12/19 at 11:37am revealed:
-Resident #12 had frequent falls and almost daily was usually found on the floor.
-A third shift PCA left the resident on the floor or in the bed sick.
-She often found the resident slumped over in the chair.
-The Administrator and the supervisor were both made aware the resident was frequently found on the floor because she reported it to them both.
-Also, Administrator and the supervisor both had witnessed the resident on the floor.
-Resident #12 had slowed down and no longer was able to get himself out of bed.
-Within the past month she had witnessed at least six times when Resident #12 had fallen on her shift.
-She documented each time she had seen the resident on the floor, and she documented the resident's condition.
-The book with her documentation was previously at the nurses' desk, but now had disappeared.
-The Administrator had never said anything to staff regarding supervising or monitoring Resident #12 more frequently, so he did not fall out of his wheelchair.
-She had not observed any bruises or injuries that resulted from the resident's fall.
-She administered medications all day and was unable to monitor Resident #12 to prevent the resident from falling.

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D 270	Continued From page 121 Telephone interview with a third shift medication aide (MA) on 12/12/19 at 4:50pm revealed: -Resident #12 often slid out of bed onto the floor. -She told the Administrator about the resident sliding out of the bed. -The Administrator did not tell them anything to do regarding monitoring or supervising the resident, so he did not slide out of bed. -Within the past month she found the resident on the floor two to three times. Interview with Resident #12's Primary Care Provider (PCP) on 12/12/19 at 4:30pm revealed: -Three to four months ago Resident #12 was walking and was able to get out of bed without assistance. -She had observed the resident on the floora couple of times during her visit. -The resident needed to be monitored more frequently due to the weakness he was currently experiencing but did not know if the facility provided continual supervision. -She had a great concern about the residents in general, and it was difficult not being able to do anything to help the residents. -Her concern was the residents were notbeing cared for. Review of the facility's nurse notes, incident reports and documentation in Resident #12's records revealed there were no documented incidents or hospital reports related to Resident #12 falls. Interview with the Administrator on 12/12/19 at 10:09am revealed: -She did not know Resident #12 was falling every day. -She had seen the resident on the floor on his hands and knees, but to her Resident #12 did not	D 270		

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D 270	Continued From page 122 appear that he had fallen on the floor. -She thought the resident was on the floor on his hands and knees trying to stand up. -She knew the resident had declined in his ability to walk and stand but had not put any interventions in place because she did not know the resident had falls every day. ______ The facility failed to provide supervision for 2 of 5 sampled residents (#5 and #12) regarding a resident that had multiple falls due to a decline in health and weakness of the lower extremities (#12) and a resident that eloped from the facility without staff's knowledge (#5). This failure was detrimental to the health safety and welfare of the residents and constitutes a Type B Violation. ______ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/12/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

Division of Health Service Regulation

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D 273	Continued From page 123 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews, observations and interviews the facility failed to contact the health care and mental health providers and specialty health care providers for 7 of 11 sampled residents (Residents #1, #3, #5, #9, #12, #14, and #18) regarding a resident with a pressure ulcer (#3), a resident with extreme muscle weakness resulting in falls who missed a nerve conduction study and two MRI appointments (#12), a resident with swollen lower extremities that caused pain when walking (#5), a resident with aggressive/agitated behaviors that yelled at other residents, beat on the walls and threw chairs (#18), two residents with rashes which made the residents uncomfortable (#1 and #9) and a glucometer which did not work properly (#14). The findings are: 1. Review of Resident #12's current FL2 dated 10/21/19 revealed: -Diagnoses included diabetes mellitus, psychotic disorder, and deep vein thrombosis. -Resident #12 was intermittently disoriented. -The resident was semi-ambulatory with a wheelchair. -Resident #12 was incontinent of bladder/bowel and now wore incontinent briefs. Review of Resident #12's Care Plan dated 03/20/18 revealed: -Resident #12 required limited assistance with eating, toileting and dressing. -Resident #12 required extensive assistance with ambulation, bathing, and transferring.	D 273	REFERRALS TO OTHER APPOINTMENTS AND/OR TREATEMENTS ARE SUPPOSED TO BE ADDRESSED BY MED TECHS AND RCC. IT IS THE ADMINISTRATOR'S RESPONSIBILITY TO SEE THAT THESRE ARE COMPLETED PROMPTLY. (POLICY ATTACHED) AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN RELOCATED TO APPROPRIATE LEVELS OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S.	

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D 273	Continued From page 124 -Resident #12 groomed himself and required supervision with eating. -Resident #12's was disruptive with behaviors. a. Review of a local Emergency Medical Services (EMS) report dated 07/17/19 revealed: -Staff informed EMS that Resident #12 was "not acting like his normal self." -Resident #12 stated he didn't feel like his normal self, he felt weak. -Resident #12 was assessed as being weak and transported to the hospital. Review of a physician's order for Resident #12 dated 07/26/19 revealed the Primary Care Provider (PCP) ordered a neurology consult to evaluate and treat Resident #12's abnormal gait with tremors. Review of a physician's office visit note for Resident #12 dated 08/13/19 revealed: -Resident #12 was seen by the neurologist. -There was a procedure (nerve conduction study) scheduled for 10/10/19 at 11:00am. Review of contracted nurse's notes for Resident #12 dated 09/03/19 revealed: -Resident #12 had increased weakness to both lower extremities. -Resident #12 was observed in the hallway on his hands and knees due not being able to hold himself up using a walker. Review of a physician's report from Resident #12's mental health provider (MHP) dated 09/07/19 revealed: -Resident #12 had experienced functional health decline over the past month. -Resident #12 had been referred to neurology to assess due to increased gait issues.	D 273		

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Review of a hospital discharge summary report dated 09/07/19 revealed Resident #12 was seen for muscle weakness, generalized weakness and muscle spasm. It was recommended neurology be contacted.

Review of a local EMS report dated 11/19/19 revealed:
-Resident #12's chief complaint was altered mental status.
-Resident #12 had low oxygen levels, with identified weakness on the right and left sides of his body. The weakness caused the resident to have "diminished grip strength."

Review of a second contracted nurse's notes for Resident #12 dated 10/01/19 revealed the resident had a decline in mobility.

Review of Resident #12's record revealed there was no documentation the resident had completed the nerve conduction study that was scheduled for 10/10/19.

Interview with a representative from the neurologist office on 12/11/19 at 9:59am revealed:
-Resident #12 had seen the neurologist on 08/13/19.
-At that appointment a nerve conduction study was scheduled for 10/10/19.
-Resident #12 was a "no show" for the appointment.
-As of today's, date (12/11/19) no one had called to reschedule Resident #12 for the appointment.

Interview with a second first shift medication aide (MA) on 12/12/19 at 11:37am revealed:
-She did not know Resident #12 had an

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D 273	Continued From page 126 appointment for a nerve conduction study. -A lot of residents missed their appointments because staff forgot about the appointment or there was no one to drive the transportation van. Interview with the Supervisor on 12/12/19 at 12:13pm revealed: -She did not know that Resident #12 had a nerve conduction study scheduled on 10/10/19. -The staff that took Resident #12 to his neurology appointment in August 2019 should have given her the paperwork for her to put the appointment date on her calendar. -She did not recall asking the staff if there had been paperwork resulting from the visit with the neurologist in August 2019. -Now, there was no way to identify the staff that took Resident #12 to his initial neurology appointment back in August 2019. -The Administrator was responsible for ensuring transportation was provided for residents to and from doctor appointments. -The issue with scheduling transportation was insurance coverage for the person driving the van. -The Administrator was the only person allowed to add staff to the insurance giving them access to drive the van. Interview with Resident #12's PCP on 12/12/19 at 4:30pm revealed: -Three to four months ago Resident #12 was walking and was able to get out of bed without assistance. -It was frustrating, because she had ordered consults for residents and they were not completed. -She ordered a neurology consult in July 2019 for Resident #12. -The resident had a decline in his motor skills,	D 273		

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which caused her to believe the resident had lumbar stenosis (causes symptoms of pain, tingling, numbness, weakness and cramping in the legs and feet).
-Without the proper test diagnoses could not be determined.
-It was important for Resident #12 to have tests done for her to provide proper treatment.
-Previously, she made referral appointments for the residents because the facility did not make the appointments as she requested.
-The falls were an example of why it was important for Resident #12 to have tests completed.
-Due to the resident's fast decline she expected facility staff to ensure the resident was present for scheduled test and appointments.

Interview with the Administrator on 12/12/19 at 10:29am revealed:
-The Supervisor was responsible for making and scheduling appointments.
-The Supervisor was also responsible for ensuring the residents had a secure means of transportation available to all their appointments.
-She did not know the resident had missed a nerve conduction study on 10/10/19.

b. Review of a follow-up note dated 10/04/19 from Resident #12's PCP revealed she had previously ordered a Magnetic Resonance Imaging (MRI) for Resident #12 and was waiting for the results.

Review of Resident #12's record revealed there was no documentation Resident #12 had an MRI.

Interview with a representative from the MRI office on 12/11/19 at 9:38am revealed:
-Resident #12 was initially scheduled for an MRI in October 2019.

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D 273	Continued From page 128 -The Administrator at the facility called and canceled the appointment, stating she would have transportation call back and schedule another appointment. -A second appointment was scheduled for 11/08/19. -The resident did not show up for the appointment on 11/08/19, and no one at the facility called to cancel the appointment. -As of today's, date (12/11/19), there was no MRI appointment scheduled for Resident #12. Interview with the Supervisor on 12/12/19 at 12:13pm revealed: -She was aware that Resident #12 missed one of his MRI appointments due to the housekeeper having a death in her family. -She did not know the resident had missed two MRI appointments. -The Administrator was responsible for ensuring transportation was provided for residents to and from doctor appointments. -The issue with scheduling transportation was the insurance. -The Administrator was the only person allowed to add staff to the insurance giving them access to drive the van. Interview with a second first shift medication aide (MA) on 12/12/19 at 11:37am revealed: -Within the past three to four months Resident #12 had declined in his ability to ambulate and transfer himself. -Resident #12 was now totally dependent upon staff for all his activities of daily living needs. -She had heard that Resident #12 had an MRI scheduled, but she did not know the exact date of the appointment. -She was not surprised the resident missed an appointment.	D 273		

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-A lot of residents missed their appointments because staff forgot about the appointment or there was no one to drive the transportation van.

Interview with Resident #12's PCP on 12/12/19 at 4:30pm revealed:
-Three to four months ago Resident #12 was walking and was able to get out of bed without assistance.
-She ordered a MRI in July 2019 for Resident #12.
-The resident had a decline in his motor skills, which caused her to believe the resident had lumbar stenosis.
-Without the proper test diagnoses could not be determined.
-It was important for Resident #12 to have tests done in order to provide proper treatment.
-Previously, she made referral appointments for the residents because the facility did not make the appointments as she requested.
-The falls were an example of why it was important for Resident #12 to have tests completed.
-The tests would help to determine the proper treatment to provide Resident #12.
-Due to the resident's fast decline she expected facility staff to ensure the resident was present for scheduled appointments.

Interview with the Administrator on 12/12/19 at 10:29am revealed:
-She was unaware Resident #12 had missed two MRI appointments in October 2019 and November 2019.
-She did not recall that she had called to cancel the MRI appointment in October 2019.
-The Supervisor was responsible for making and scheduling appointments.
-The Supervisor was also responsible for

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ensuring the residents had a secure means of transportation available to all their appointments.

c. Observation of Resident #12 on 12/04/19 at 11:04am revealed:
-The resident was sitting in a wheelchair.
-The resident's front was facing the bed.
-The resident was leaned forward with his head lying on the bed.
-When the resident talked, he used his hands to hold his head up.

Interview with Resident #12 on 12/04/19 at 11:06am revealed:
-He always leaned forward.
-He was unable to hold the upper part of his body up.
-When he leaned forward, he just kept going and sometimes fell to the floor.
-He fell to the floor at least once daily, and some days more than once.
-It hurt when he fell to the floor.
-Sometimes he fell out of bed onto the floor, and staff left him on the floor all night.

Interview with a first shift medication aide (MA) on 12/06/19 at 10:21am revealed:
-Resident #12 had fallen at least ten times in within the past month.
-The resident's health had declined fast.

Interview with a first shift personal care aide (PCA) on 12/04/19 at 9:46am revealed:
-Two weeks ago, Resident #12 complained he could not move his lower limbs and pain when his legs and feet were touched.
-Last month emergency medical services (EMS) were called at least twice because Resident #12 had symptoms of a stroke with weakness and he was unable to move his limbs.

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-The resident had been to the hospital at least two times within the past month with the same stroke like symptoms.
-Resident #12 had fallen at least ten times within the past two weeks due to being unstable and unable to sit up in the chair.
-She was not sure if the Primary Care Provider (PCP) had been notified because the facility's policy was for her to notify the MA, then the MA notified Supervisor and the Administrator. The Supervisor and Administrator notified the PCP.
-She had come to work many days on the first shift and found Resident #12 lying on the floor.
-The third shift staff left the resident on the floor.

Interview with a second first shift personal care aide (PCA) on 12/12/19 at 9:38am revealed:
-Resident #12 had significantly declined in health in the past four months.
-No one could understand why some days Resident #12 can barely move, he is lethargic and can't get out of bed.
-Resident #12 usually complained about the pain in his legs and feet.
-At one point everyone thought Resident #12 had a stroke because he could barely move his legs and he cried out stating "it hurts" when she attempted to move his legs.
-The resident did not like getting out of bed.
-Resident #12 had declined so much that did not eat much food anymore.
-Yesterday (12/11/19), Resident #12 never got out of the bed.
-The resident missed breakfast, but she was able to get the resident up for lunch and he ate two bites and nothing else.
-The resident did not eat any food for dinner and declined to get out of the bed.

Interview with a third first shift medication aide

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D 273	Continued From page 132 (MA) on 12/12/19 at 11:37am revealed: -Resident #12 had frequent falls and was usually found on the floor. -A third shift PCA left the resident on the floor or in the bed really sick. -She often found the resident slumped over in the chair. -The Administrator and the Supervisor were aware the resident was frequently found on the floor because she reported it to them both. -Also, both of them had witnessed the resident on the floor. -She was not sure if the PCP was notified because that was the responsibility ofthe Administrator and the Supervisor. -No one told her that she should notify the PCP regarding the resident's falls or decline in health until last week. -Resident #12 had slowed down and no longer was able to get himself out of bed. -Within the past month Resident #12 had fallen more than six times that she had witnessed and was totally dependent upon staff for ambulation and transfers. -She documented each time she had seen the resident on the floor, and she documentedthe resident's condition. -The book with her documentation was previously at the nurses' desk but had disappeared after the surveyors entered the facility. Interview with Resident #12's PCP on 12/12/19 at 4:30pm revealed: -The resident was weak especially in his legs. -The resident had been sent out to the hospital several times with stroke like symptoms. -She was not surprised the resident had falls due to the weakness in his legs. -She was in the facility twice a month to see residents, and recently she changed her schedule	D 273		

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to being in the facility every week.
-No one at the facility had informed Resident #12 had repeated falls.
-She wanted to be informed when the resident had falls.
-The falls were an example of why it was important for Resident #12 to have tests completed.
-The tests would help to determine the proper treatment to provide Resident #12.
-She expected facility staff to notify her regarding how frequently the resident is falling.

Interview with the Administrator on 12/12/19 at 10:09am revealed:
-She did not know Resident #12 had a fall every day.
-She had seen the resident on the floor on his hands and knees, but to her Resident #12 did not appear that he had fallen on the floor.
-She thought the resident was on the floor on his hands and knees trying to stand up.
-She knew the resident had declined in his ability to walk and stand but had not put any interventions in place because she did not know the resident had falls every day.

2. Review of Resident #3's current FL2 dated 06/28/19 revealed diagnoses include closed head injury, stroke, muscle weakness, and chronic pain.

Review of Resident #3's Care Plan dated 05/03/19 revealed:
-Resident #3 was totally dependent upon facility staff for toileting, ambulation, bathing, dressing, grooming, and transferring.
-The resident was totally dependent upon facility staff for "pressure ulcer prevention."

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D 273	Continued From page 134 Review of Resident #3's Primary Care Provider's (PCP) orders revealed: -There was an order dated 01/28/19 stating the resident needed frequent changes and positioning. -There was an order dated 05/13/19 that referred the resident to a home care agency to evaluate and treat a sacral wound. Review of a PCP order for Resident #3 dated 05/13/19 revealed a referral for home care agency to evaluate and treat sacral wound. Review of home care agency notes dated 05/15/19 revealed: -Resident #3 had a stage 1 pressure ulcer of sacral region. -Resident #3 required moderate to maximum assistance with moving and complete lifting without sliding against sheets. -The home care agency was waiting for orders from Resident #3's PCP in order to plan home care treatment. Observation of Resident #3's wound on 12/06/19 at 8:35am revealed: -Resident #3 was sitting in a motorized wheelchair. -There was a strong odor of urine coming from the resident and the resident's bed. -The resident's bed was observed soiled and wet. -The bed had a strong urine odor. -The resident's pants were observed soaked wet in the front. -Two personal care aides (PCAs) lifted Resident #3 up to a standing position. -When the resident stood up the seat of his chair was wet. -The back of Resident #3's pants was soiled and wet.	D 273		

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-One PCA pulled down the resident's pants and incontinent brief.
-The resident had a two-inch diameter wound near the lower bottom of his right buttock.
-The inner part of the wound had a pea-sized area that was white at the top of the wound.

Interview with Resident #3 on 12/03/19 at 10:39am revealed:
-He had a sore on his bottom, and it was stinging and burning.
-The sore had been there for some time, close to one year.
-It healed up and then came back when he stayed soiled for a long period of time.
-Earlier in the year he had staff take a picture of the wound and it was a little bigger than a quarter.
-He wanted some type of cream for the wound to ease the stringing and burning.
-It was hard to get staff to get him up and put him on the commode to urinate.
-If he had to urinate, staff told him to go in his incontinent brief.
-The PCAs put him on two incontinent briefs and told him to go (urinate) in the brief.

Interview with a first shift PCA on 12/06/19 at 8:45am revealed:
-The wound had been on the resident's bottom for two to three months.
-She did not tell anyone about the wound because the resident did not complain.
-The protocol was PCAs notified the MA, the MA notified the Supervisor and Administrator.
-The Supervisor and or the Administrator were responsible for notifying the resident's PCP.
-Resident #3 told her that the wound bothered him, and she told the MA or Supervisor, but she was unable to recall exactly who she had told about the wound.

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Interview with the facility's Licensed Health Professional Support (LHPS) nurse on 12/06/19 at 9:30am revealed:
-She started working as a contract nurse for the facility in the fall of 2019.
-She did not know as the LHPS nurse exactly what she had to look at for each resident.
-She verbally asked staff about each resident 's healthcare need.
-In October 2019, one staff informed her that Resident #3 had a wound on his sacrum.
-She did not see the wound because the resident and a different staff verbally told her the wound was healed.
-She did not ask to check to see if the wound was healed.
-Once when visiting the facility (November 2019, unable to recall the exact date), she noticed the resident was "soaked" with urine and the whole front of the resident's pants was wet. She informed staff the resident needed incontinent care.

Interview with another first shift PCA on 12/12/19 at 9:55am revealed:
-She was aware that Resident #3 had a wound on his bottom.
-The wound would heal and then come back again.
-The wound was back because the resident was kept soiled.
-She had notified the MA about the resident's wound because that was the facility's policy.
-The MA should have notified the Supervisor and the Administrator so they could notify the PCP.

Interview with a first shift medication aide (MA) on 12/12/19 at 11:25am revealed:
-Two months ago, a PCA had reported to her that

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D 273	Continued From page 137 Resident #3 had a bump or scar on his bottom, and he was soaked with urine. -This had been reported to the Administrator, but nothing was done. Interview with Resident #3's Primary Care Provider (PCP) on 12/06/19 at 12:30pm revealed: -On 05/13/19 she referred Resident #3 to home health due to a wound on the resident's right buttock. -She did not know home health was not caring for the wound as she ordered. -She did not know the wound had gotten worse. -The facility staff should have notified her the resident's wound was not being treated by home health. -She expected the facility staff to inform her that the wound had gotten worse. -She will look at the wound today and order something accordingly. Interview with the Administrator on 12/12/19 at 9:13am revealed: -She was not aware Resident #3 had a wound on his bottom. -If staff were looking at the resident's bottom and knew about the wound, they should have made the MA aware. -The MA should go and look at the wound. -The MA should call the resident's PCP to make the PCP aware. -With any skin concern staff should be alert and report any skin breakdown to her or the Supervisor. Attempted interview with the home care agency on 12/06/19 at 4:32pm, 12/10/19 at 9:21am and 9:31am were unsuccessful. 3. Review of Resident #5's current FL2 dated	D 273		

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10/04/19 revealed:
-Diagnoses included fracture of left ankle, bipolar, gastroesophageal reflux disease (GERD), and anemia.
-Resident #5 was constantly disoriented.
-The resident had inappropriate behavior, wandered and was verbally abusive at times.

Review of Resident #5's Care Plan dated 08/23/19 revealed:
-Resident #5 required extensive assistance with bathing, dressing and grooming.
-Resident #5 required limited assistance with eating, toileting, ambulation, and transfers.

Observation of Resident #5's lower extremities on 12/05/19 at 8:53am revealed:
-The resident had on socks that were anklets.
-The personal care aide (PCA) removed the socks.
-Resident #5 had two plus pitting edema when touched by the PCA.
-Resident #5's feet were white with grayish patches of dry skin.
-There were loose flakes like a chalky substance that fell to the floor from both the resident's feet.
-The resident's toenails on the first three toes were black and thick.

Interview with Resident #5 on 12/05/19 at 8:53am revealed:
-His feet were swollen, and they hurt when he walked.
-His feet had been swollen for over one month.
-He had not seen the Primary Care Provider (PCP) for almost a month.
-He did not know if the PCP was aware his feet were swollen.
-He believed the facility staff knew his feet were swollen because they could see his feet.

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D 273	Continued From page 139 Interview with Resident #5's Guardian on 12/05/19 at 11:56am revealed: -She was not aware the resident's feet were swollen. -She wished someone from the facility had called to tell her the resident's feet were swollen, and he was unable to wear the shoes. -She expected the facility staff to contact the PCP regarding the resident's swollen feet. Interview with the Supervisor on 12/05/19 at 10:19am revealed: -When Resident #5 came to the facility one of his ankles was swollen because he previously had surgery on the ankle. -She did not know the resident's legs and ankles were currently swollen. -She knew the resident was subject to swelling due to the previous surgery. -She expected the staff to inform her when the resident had a change in health status like swollen legs. Interview with the facility's Licensed Health Professional Support (LHPS) nurse on 12/06/19 at 9:30am revealed: -She last saw Resident #5 on 10/28/19 and the resident had slight edema. -She did not report the slight edema to anyone. Interview with a first shift medication aide (MA) on 12/06/19 at 10:18am revealed: -The Administrator knew Resident #12 had swollen legs and feet. -The Administrator told her the resident just did not want to wear his shoes. -The Administrator was responsible for notifying the resident's PCP.	D 273		

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Interview with another MA on 12/12/19 at 11:37am revealed:
-No one told her that Resident #5 had swollen feet and legs.
-The PCA that was responsible for showers was supposed to report their assessment of the resident.
-The PCA should report if something was wrong.

Interview with a first shift PCA on 12/12/19 at 10:15am revealed:
-Resident #5 had complained about his shoes being too small because his feet were swelling.
-The resident's feet had been that way for almost two months.
-She believed the MA had notified the resident's PCP and the Administrator.
-The Administrator was aware that Resident #5's feet were swollen, and he was unable to wear his shoes.
-It was the Administrator and the Supervisor's responsibility to notify Resident #5's Guardian.
-They also were responsible for notifying the resident's PCP regarding the resident's swollen feet.

Interview with Resident #5's PCP on 12/05/19 at 10:46am revealed:
-Previously, she was in the facility twice a month, recently she increased her visits to weekly.
-Last week, she was in the facility, but Resident #5 was not put on her list to be seen.
-She was not aware the resident still had swollen lower extremities (legs, ankles and feet).
-Last month, she identified the resident had swollen lower extremities and she ordered furosemide for five days.
-If the resident still had swollen lower extremities, she expected facility staff to contact her.
-Her concern was the facility did not use lotion on

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the residents.

Interview with the Administrator on 12/05/19 at 9:00am revealed:
-She was not aware the resident's feet were swollen.
-The PCA assisting the resident should inform the MA if the resident had swollen feet.
-The MA should contact the resident's PCP regarding his swollen feet.

4. Review of Resident #18's current FL2 dated 05/19/19 revealed:
-Diagnoses included dementia, acute encephalopathy and schizoaffective disorder .
-Resident #18 was disoriented intermittently.
-Resident #18 was semi-ambulatory, with functional limitations of hearing and sight.
-There was documentation Resident #18 required personal care assistance with bathing, dressing, feeding and verbal communication.

Review of Resident #18's Care Plan dated 01/22/19 revealed:
-Resident #18 required limited assistance with eating, toileting, ambulation, dressing and transferring.
-Resident #18 required extensive assistance with bathing and grooming.
-Resident #18 had disruptive inappropriate behaviors.
-Resident #18 had a history of mental illness and was currently being seen by mental health.

Observation of Resident #18's on 12/10/19 from 10:00am to 6:30pm at various times revealed:
-At 10:45am Resident #18 was in the snack room with the vending machines.
-The resident was yelling loud as if he was in an argument with someone.

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D 273	Continued From page 142 -The resident was hitting the tables with his hands and pushing the chairs with his hand. -The resident did not respond when called by name but continued to fuss and yell (words could not be understood). -No staff were observed near Resident #18 or in view of the resident to provide redirection. -At 1:05pm Resident #18 was observed wheeling himself through the main hallway of the facility. -There were other residents sitting in the hallway. -Resident #18 did not touch any residents but he appeared to be angry. -He yelled and fussed at everyone as he wheeled himself past the residents. -No staff attempted to redirect or communicate with Resident #18. -At 3:35pm Resident #18 was observed in the snack room with the vending machines. -No staff were observed in view of the resident. -Resident #18, was fussing and yelling out loud. -The resident was beating hard on the tables; he used one hand to pick up and attempted to throw chairs around the room. -Resident #18 wheeled his wheelchair over the vending machines and beat hard on the vending machines. -Resident #18 wheeled himself to the wall outlet where the wall-mounted television was set-up. -The resident started to jerk and pull the cord attached to the wall-mounted television. -Resident #18 unplugged the television cord from the outlet and again started to pull the cord. -Facility staff removed Resident #18 from the room. -At 5:10pm Resident #18 was agitated, angry and fussing at everyone in the hallway. Interviews with three residents sitting in the main hallway on 12/10/19 at 5:12pm revealed: -Resident #18 was always agitated.	D 273		

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D 273	Continued From page 143 -He hit and beat the walls and pushed chairs. -Resident #18 never attempted to hit or push residents. -Resident #18 yelled, fussed and even cursed at residents, but that did not bother them. -They were annoyed with Resident #18 yelling and cursing, but they were not afraid of the resident. -No staff attempted to assist Resident #18 when he was yelling and hitting walls; they just let him do what he wanted to do. Interview with a personal care aide (PCA) on 12/10/19 at 5:20pm revealed: -Although, Resident #18 showers werescheduled for first shift she tried to give him a shower on the second shift. -Resident #18 did not cooperate when she tried to shave him. -When she attempted to shower Resident #18, he usually refused the shower, became combative and fought a lot. -She attempted three to four times to get Resident #18 to take a shower, then she left him alone. -She gave the resident a bed-bath if he allowed her. -Resident #18's agitation today was his normal level of agitation. -When Resident #18 was agitated he hit walls, and tables and threw chairs. -Dealing with Resident #18's agitation and combativeness were a daily issue. -She had heard the medication aide (MA) say as needed medications did not work for Resident #18. -She did not know if the resident's PCP was notified. Interview with a second PCA on 12/12/19 at	D 273		

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10:01am revealed:
-She had to do everything for Resident #18.
-Sometimes Resident #18 became combative and would fight staff.
-When he became combative "we just put him in the room and left him alone until he calmed down."
-She did not tell the MA every time this happened.
-She did not know if the resident's PCP or mental health were notified.

Interview with the mental health provider (MHP) on 12/06/19 at 3:37pm revealed:
-If Resident #18 was agitated he expected facility staff to administer the as needed medication .
-If the medication did not work, he expected facility staff to contact him.
-During his visit to the facility on 12/03/19 he was verbally informed Resident #18 had increased agitation.
-During that visit he also noticed the facility did not utilize as needed medications and they did not call regarding Resident #18's increased agitation.
-The agency had a 24-hour hotline, and he could be paged within that 24-hour period.

Interview with the Administrator on 12/12/19 at 9:49am revealed:
-The MA that worked the second shift on 12/09/19, contacted Resident #18's mental health provider on 12/09/19, but did not contact the provider on 12/10/19.
-Her expectations were that staff contacted Resident #18's mental health provider to let the provider know when the resident was having behaviors.
-Staff should let her know if they are having difficulty with anything especially if a resident is being combative.

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-Prior to 12/09/19, no staff had reached out to her or let know they were having difficulties with Resident #18.
-She had been verbalizing to staff to use Resident #18's as needed medications when he was combative.
-Also, she told staff if the as needed medication was not effective, then they were to communicate with the resident's PCP.
-She did not document when she told staff to contact Resident #18's mental health provider regarding the resident's behaviors.
-She did not tell staff to document when Resident #18 had behaviors or when they notified the PCP.

5. Review of Resident #1's FL2 dated 10/04/19 revealed
-Diagnoses included Cerebral Palsy, seizure disorder, hypothyroidism, and arthritis.
-The skin condition was checked as normal.
-Resident #1 required assistance with bathing and dressing.
a. Review of the signed physicians order dated 11/08/19 revealed:
-There was an order for fluconazole 100mg daily for 9 days for yeast dermatitis.
-The fluconazole 100mg daily ended on 11/11/19.
-There was an order for nyamycin powder 100,000u/gm apply to affected area once daily as needed for redness.

Review of Resident #1's Care Plan dated 01/22/19 revealed:
-Resident #1 was able to groom herself.
-Resident #1 required limited assistance with getting dressed.
-Resident #1 required extensive assistance for toileting and bathing.

Review of Resident #1's progress notes revealed

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there was no documentation informing the primary care provider (PCP) of the red, inflamed rash with blisters underneath the resident's breast.

Observation of Resident #1 on 12/03/19 at 10:42am revealed:
-The skin under her left breast when lifted was bright red and inflamed with red blistered areas.
-There was a trace of yellowish powder residue in the front and to the far side of her left breast.
-The skin under her right breast when lifted had a very foul odor and was bright red and inflamed.
-There was sticky, yellowish, clumpy powder under her right breast.
-There was no cloth under her right or left breast.

Observation of Resident 1's medication on hand on 12/06/19 at 9:28 am revealed:
-There was 1 half full bottle of nyamycin powder 100,000u/gm available for use.
-The nyamyc powder was dispensed on 09/26/19 and had instructions to apply to affected areas daily as needed for redness.

Interview with Resident #1 on 12/03/19 at 10:43am revealed:
She did not know how long she had been red underneath her breast.
-Sometimes staff applied power under her breast but not every day.
-Sometimes staff placed a cloth under her breasts.
-The areas under her breast burned and was painful.

Interview with a personal care aide (PCA) on 12/06/19 at 8:50 am revealed:
-She did not know how long Resident #1 had the "rash" under her breasts.

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D 273	Continued From page 147 -She tried to keep a soft cloth under the residents breasts. -The MAs were aware of the rash underneath Resident #1's breasts. -She did not know when the primary care provider (PCP) had last seen the rash, if at all. Interview with the PCP on 12/06/19 at 11:16 am revealed: -She did not know Resident #1 currently had a rash under her breasts; it had not been reported to her and the resident was not placed on her list to be seen. -She last treated Resident #1's rash in November 2019 but she thought it had cleared up. -She had tried to teach staff how to properly care for resident #1 as she needed to be patted dry under her breast after her bath and each time she was washed and had requested a soft cloth of some sort be placed underneath Resident #1's breasts to prevent skin from touching skin. -She did not believe Resident #1 received adequate care. -She expected the facility staff to keepher informed when there were changes with a resident. Interview with a MA on 12/12/19 at 3:29 pm revealed: -Resident #1 had problems with a rash off and on for a while, especially when she refused to bathe. -Resident #1 was treated for a rash in November 2019. -She had not informed the PCP of Resident #1 having the rash under her breast again or of Resident #1 refusing a cloth under her breast sometimes. Interview with a second MA on 12/12/19 at 4:45 pm revealed:	D 273		

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-Resident #1 had a rash under her breasts for a few weeks.
-Staff tried to keep cloths under Resident #1's breasts, but she removed them.
-She had not informed the PCP of Resident #1 having the rash under her breast.

Interview with the Supervisor on 12/13/19 at 11:09 am revealed:
-She did not help on the floor very often as she was more of an administrative assistant.
-She did not know Resident #1 had a rash under her breasts.
-Usually, if a rash was found, the MAs would inform the PCP.

Interview with the Administrator on 12/12/19 at 6:55pm revealed:
-She did not know how long Resident #1 had a rash under her breasts.
-She was made aware of Resident #1's rash on 10/31/19 when she saw an order to use pillowcases under her breasts to keep her skin from touching.
-She expected the resident's skin to be checked with each bath.
-She expected the MAs to notify the PCP when the rash did not clear up.

b. Review of Resident #1's record revealed:
-An order on 07/26/19 for a gastroenterologist (GI) appointment to be scheduled.
-There was no documentation of a referral for a GI appointment in the residents' record.

Interview with Resident #1 on 12/12/19 at 10:05am revealed:
-She had not been to an appointment with a GI physician.
-She could not recall why she was not taken to

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the appointment.

Interview with the Administrator on 12/12/19 at 11:57am revealed:
-She or the Supervisor were responsible for scheduling appointments.
-Resident #1 "showed off, refused to go to her appointment, took her clothes off and wouldn't go."

Telephone interview with Resident #1's family nurse practitioner (FNP) on 12/12/19 at 9:49am revealed:
-Resident #1's GI appointment was either rescheduled or the facility forgot about the appointment.
-Resident #1's referral was due to severe gastroesophageal reflux.

6. Review of Resident #14's current FL2 dated 05/14/19 revealed diagnoses included Diabetes Mellitus Type II and diabetic neuropathy.

Review of Resident #14's physicians order dated 10/04/19 revealed there was an order to check finger stick blood sugars (FSBS) before meals.

Review of Resident #14's signed physician orders dated 10/31/19 revealed there was an order to check finger stick blood sugars (FSBS) before meals.

Observation of Resident #14's glucometer on 12/04/19 at 9:15am revealed the glucometer would not turn on for the medication aide (MA).

Second observation of Resident #14's glucometer on 12/04/19 at 4:30pm revealed the glucometer turned on but would not read a FSBS test strip.

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D 273	Continued From page 150 Review of Resident #14's November and December 2019 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS before meals scheduled at 7:30am, 11:30am, and 4:30pm. -FSBS were not obtained for 7 of 90 opportunities in November with a documented reason of "missed dose". -FSBS were not obtained for 4 of 12 opportunities in December with a documented reason of "missed dose". -FSBS ranged from 83 to 495 in November 2019. -FSBS ranged from 88 to 296 in December 2019. Review of Resident #14's record revealed there were no physician orders, progress notes, or a referral for the contracted pharmacy or a medical equipment provider to obtain a new glucometer from 10/01/19 to 12/04/19. Interview with Resident #14 on 12/04/19 at 9:18am revealed: -Her blood sugar was checked before meals. -She did not know her glucometer was not working properly. Interview with an MA on 12/04/19 at 9:19am revealed: -Resident #14's glucometer had not worked for three weeks. -She had been using Resident #2's glucometer to check Resident #14's FSBS. -She had informed the contracted facility nurse, the Supervisor, and the Administrator of Resident #14's glucometer not working about 3 weeks ago when it stopped working. Interview with a second MA on 12/04/19 at 9:30am revealed: -Resident #14's glucometer had not been working	D 273		

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properly for three weeks.
-She had been using Resident #2's glucometer to check Resident #14's FSBS.
-She had informed the Supervisor and the Administrator that Resident #14's glucometer was not working properly about 3 weeks ago when it quit working properly.

Interview with the Supervisor on 12/04/19 at 10:02am revealed:
-She did not know Resident #14's glucometer did not work properly.
-If she had been told Resident #14's glucometer did not work she would have ordered her a new one.

Interview with the Administrator on 12/04/19 at 10:35am revealed:
-She did not know that Resident #14's glucometer did not work properly.
-She had not tried to get a replacement glucometer for Resident #14.
-She expected the MAs to report to her when glucometers were broken.

Interview with Resident #14's primary care provider on 12/04/19 at 4:05pm revealed:
-She did not know Resident #14's glucometer had not been working properly.
-She would have written an order to obtain a new glucometer if she had known.

7. Review of Resident #9's FL2 dated 06/28/19 revealed:
-Diagnoses included dementia, hypertension, anemia, schizoaffective disorder, major depression, and chronic fungal and atopic dermatitis.
-Resident #9 required assistance with bathing and dressing herself.

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D 273	Continued From page 152 -Resident #9's skin condition was listed as chronic and fungal atopic dermatitis. -There was an order for nystatin 100,000u/gm apply to affected areas BID under bilateral breast and abdominal folds. Review of the signed physicians order dated 11/08/19 revealed there was an order for nystatin 100,000u/gm apply to affected areas BID under bilateral breast and abdominal folds. Review of Resident #9's progress notes revealed there were no documentation informing the primary care provider (PCP) of the red, inflamed rash underneath the resident's abdominal folds between 11/01/19 to 12/11/19. Observation of Resident #9 on 12/11/19 at 9:05am revealed: -The skin in her left abdominal/groin fold was red and inflamed with blister like bumps and extended from the most medial aspect of the abdominal fold to the most lateral aspect of the abdominal fold. -There was a scant amount of tacky yellowish powder in the crease of her left abdominal fold. -The skin in her right abdominal/groin skin fold as red and inflamed with blister like bumps with one open irregular shaped, ½ inch in diameter, area to the most lateral aspect of her right abdominal skin fold; the area extended to the most medial aspect of her right abdominal skin fold. -There was a scant amount of tacky, yellowish powder in the abdominal skin fold. Interview with a medication aide (MA) on 12/12/19 at 3:29 pm revealed: -Resident #9's rash never went away. -The PCP was aware of the continual problem with Resident #9's rash.	D 273		

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D 273	Continued From page 153 Interview with a second MA on 12/12/19 at 4:45 pm revealed: -Resident #9 kept a rash off and on. -Resident #9 had an order for nystatin powder that was used. -She thought the PCP knew Resident #9 had a rash, so she did not report it. Interview with the Supervisor on 12/13/19 at 11:09 am revealed: -She did not help on the floor very often as she was more of an administrative assistant. -Resident #9 had dealt with a rash off an on a long time. -The PCP had increased the frequency of her nystatin powder (did not say when). -Usually, if a rash was found, the MAs would inform the PCP. Interview with the Administrator on 12/12/19 at 6:55pm revealed: -She knew Resident #9 had a rash off and on for a while. -The MA applied Resident #9's nystatin powder as ordered. -She expected the MAs to ensure skin was intact and apply medications to the rash as ordered. -She expected the MAs to notify the PCP when the rash did not clear up. Interview with Resident #9's PCP on 12/12/19 at 4:50 pm revealed -She did not know that Resident #9 currently had a rash. -Resident #9 was treated for a rash in early November 2019. -Resident #9 did not have an ongoing issue with a rash. -She expected the facility staff to keep her	D 273		

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D 273	Continued From page 154 informed when there were changes with a resident. Based on observation, interview, and record review, it was determined Resident #9 was not interviewable. ______ The facility failed to assure referral and follow up for the acute health care needs of 7 of 11 sampled residents including a resident ordered a MRI and serve conduction study for muscle weakness that resulted in frequent falls (#12), a resident with a pressure ulcer ulcer that caused burning and stinging when sitting (#3), a resident with swelling in his lower extremities resulting pain when walking (#5), a resident with aggressive/agitated behaviors that yelled at other residents, beat on the walls and threw chairs (#18) a resident whose glucometer was not working properly which led to staff sharing glucometers (#14), two residents who had a rash that burned and caused pain (#1 and # 9), and two residents with missed gastroenterologist appointments (#1 and #9). This facility's failure placed the residents at substantial risk of neglect and physical harm and constitutes a Type A2 Violation. ______ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/06/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 12, 2020.	D 273		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service	D 285		

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10A NCAC 13F .0904 Nutrition And Food Service
(a) Food Procurement and Safety in Adult Care Homes:
(4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to assure there was at least a three-day supply of perishable food and a five-day supply of non-perishable food on hand in the facility, based on the menus.

The findings are:

Interview with the Administrator on 12/03/19 at 9:45am revealed the facility census was 31 residents.

1. Review of the breakfast menu for regular diets dated 12/04/19 revealed the meal consisted 1/2 cup (4 ounces) of juice vitamin C fortified, breakfast meat, muffin, milk (8 ounces), and water.

Observation food storage areas including the pantry, refrigerator and freezer compared to the regular menu on 12/03/19 at 10:42am revealed:
The facility had 1 each unopened full container (60 ounces) of orange juice and one open container (20 ounces) of orange juice on hand at the facility.
-Per the facility menu, ½ cup (4 ounces) of fruit vitamin C fortified should be served at the breakfast meal daily.
-A total of 31 residents residing in the facility requiring 124 ounces of fruit vitamin C juice for one breakfast meal.

Provider's Plan of Correction (D 285):

IT IS THE ADMINSTRATOR'S RESPONSIBILITY TO ORDER GROCERIES WEEKLY. IT IS OUR POLICY (COPY ATTACHED) THAT AT LEAST ONE WEEK'S SUPPLY IS TO BE IN THE HOME AT ALL TIMES. WEEKLY FOOD BUDGET FOR A HOME WITH 31 RESIDENTS WAS $950.00 TO $1,100.00 WEEKLY, WHICH IS APPROPRIATE BASED ON THE NUMBER OF RESIDENTS.

AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN PLACED IN APPROPRIATE LEVELS OF CARE AND THE HOME HAS BEEN CLOSED.

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-There was a shortage of 44 ounces of juice.
-There was not have enough fruit vitamin C juice for a three- or five-day supply.
-There were no muffins in the facility.

Refer to interview with the cook on 12/03/19 at 1:07pm

Refer to interview with the Administrator on 12/04/19 at 1:10pm

2. Review of the dinner menu for regular diets dated 12/03/19 revealed the meal consistedof chicken fried rice, broccoli, dessert, white or wheat roll, milk and water.

Observation food storage areas including the pantry, refrigerator and freezer compared to the regular menu on 12/03/19 at 10:42am revealed:
The facility had 3 gallons (384 ounces) of milk on hand.
-Per the facility menu, milk should be served at breakfast and dinner.
-For a census of 31 residents, a total of 496 ounces of milk was required to serve milk at the breakfast and dinner meals on 12/03/19.
-There was a shortage of 112 ounces of milk for one day.

Refer to interview with the cook on 12/03/19 at 1:07pm

Refer to interview with the Administrator on 12/04/19 at 1:10pm

3. Review of the lunch menu for regular diets dated 12/03/19 revealed the meal was chef's choice entrée, starchy vegetable, seasonal fresh fruit, cook's choice bread, beverage/water.

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Observation food storage areas including the pantry, refrigerator and freezer compared to the regular menu on 12/03/19 at 10:42am revealed:
-There was canned fruit in the facility, but no fresh fruit was available.

Refer to interview with the cook on 12/03/19 at 1:07pm

Refer to interview with the Administrator on 12/04/19 at 1:10pm

4. Review of the lunch menu for regular diets dated 12/04/19 revealed the meal was to consist of meatloaf, mashed potatoes, green beans, wheat or white roll, and beverage/water.

Observation food storage areas including the pantry, refrigerator and freezer compared to the regular menu on 12/03/19 at 10:42am revealed:
-There were 2 packages of 8 hamburger buns and 1 pack 8 of hot dog buns.
-There was no ground beef in the facility.
-There were no instant mashed potatoes and there were no whole potatoes.
-There were no white or wheat rolls.

Refer to interview with the cook on 12/03/19 at 1:07pm

Refer to interview with the Administrator on 12/04/19 at 1:10pm

______

Interview with the cook on 12/03/19 at 1:07pm revealed:
-The food truck delivered on Thursday each week.
-She did not order the food.
-The Administrator ordered all food for the facility.
-She cooked the food that she had available.

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D 285	Continued From page 158 Interview with the Administrator on 12/04/19 at 1;10pm revealed: -The food truck delivered every Thursday. -She felt the facility had enough food until the truck arrived. -She did not realize that she needed to have enough to supply the menu for the three to five days.	D 285		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the dishwasher was in a safe and operating condition for the residents. The findings are: Observation of the dishwasher in use on 12/04/19 at 4:04pm revealed: -There were dishes waiting to be washed in the dishwasher. -The first cycle maximum temperature reached was 92 degrees Fahrenheit (F). -The second cycle maximum temperature reached was 98 degrees F. -The third cycle maximum temperature reached was 100 degrees F. -The fourth cycle maximum temperature reached was 102 degrees F.	D 286	THE DISHWASHER REFERENCED HERE IS LEASED FROM, AND SERVIED BY AUTO-CHLOR ON A MONTHLY BASIS. IT IS THEIR RESPONSIBILITY TO ENSURE THE MACHINE IS MAINTAINED TO MEET THE STANDARDS REQUIRED BY THE HEALTH DEPARTMENT. IT IS THE COOK'S RESPONSIBILITY (SEE ATTACHED JOB DESCRIPTION) TO "ASSURE SANITATION STANDARDS" WERE BEING MET AND THE RESPONSIBILITY OF THE ADMINSTRATOR TO SEE THAT ALTERNATE MEANS OF SANITIZING, WERE BEING MET THROUGH USING THE 3 COMPARTMENT SINK METHOD..	

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-The instructions on the machine advised a minimum water temperature of 125 degrees F.
-The three compartment sink was not being used.

Interview with a second shift Dietary Aide on 12/04/19 at 4:04pm revealed:
-The machine had to be ran 3 or 4 times to get hot.
-She did not know the machine was not reaching the proper temperature.
-The machine was serviced once a month.

Telephone interview with the food service equipment technician on 12/05/19 at 9:17am revealed:
-The facility dishwasher had been serviced every 28 days and was last serviced on 11/22/19 with no problems noted.
-"The dishwasher was a low temperature machine."
-The water temperature in the machine was the water temperature of the hot water going into the machine.
-The water temperature in the machine must be 120 degrees F - 125 degrees F to sanitize the dishes.
-He did not know the water temperature was below 120 degrees F - 125 degrees F.

Interview with the Health Inspector on 12/05/19 at 4:39pm revealed:
-The dishwasher temperature was 110 degrees F during the final rinse cycle.
-Facility staff were to use the 3 compartment sink to hand wash and sanitize the dishes until the machine was repaired.

Interview with a first shift Dietary Aide on 12/06/19 at 9:07am revealed she had been told today by another dietary aide to hand wash and sanitize

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D 286	Continued From page 160 the dishes in the three compartment sink until the dishwasher was repaired. Interview with the Administrator on 12/06/19 at 9:21am revealed she did not know the dishwasher temperature was not getting hot enough until she met with the Health Inspector on 12/05/19.	D 286		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were provided with a non-disposable place setting including a a non-disposable bowl for breakfast cereal, fruit and desserts. The findings are: Interview with the Administrator on 12/03/19 at 9:45am revealed 31 residents currently resided in the facility. Observation of the lunch meal service on	D 287	STAFF WERE ABLE TO ORDER FOOD SUPPLIES AS NEEDED THRU PEFORMANCE FOOD SERVICE. ADMINISTRATOR WAS TO CONDUCT MONTHLY INVENTORY COUNTS AND ADJUST LEVELS AS NEEDED, TO MEET GUIDELINES IDENTIFIED ON ATTACHED INVENTORY CONTROL SHEET.	

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12/03/19 from 12:15pm to 1:30pm revealed:
-There was one dining room with multiple tables with 4 to 5 residents sitting at one table.
-There were 31 residents present for the meal.
-The meal consisted of chicken with white gravy, sweet peas, carrots, a hamburger bun, tea, water and peaches.
-The meal excluding the peaches was served in non-disposal service ware.
-The peaches were served in disposable bowls.

Observation of kitchen service ware section on 12/03/19 at 1:06pm revealed:
-There non-disposable service ware was stored on a wire rack in the kitchen.
-One the third rack down there were eleven bowls.
-There were four 12-ounce bowls, and eleven 20 ounce bowls.

Observation of the breakfast meal on 12/05/19 from 8:15am to 8:50am revealed:
-There were 26 residents present for the meal.
-The meal consisted of eggs, toast, and dry cereal.
-Eleven residents received cereal in non-disposable plastic bowls.
-Five residents got cereal that was pre-packed in plastic disposable bowls.
-Ten residents got disposable bowls.

Interview with the cook on 12/03/19 at 1:07pm revealed:
-She had worked at the facility for one month.
-Since she started working at the facility, she had always served desserts in disposable bowls.
-Sometimes when she served cereal for breakfast, she did not have enough bowls, so she used disposable bowls.
-She usually had at least 25 hard plastic bowls

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but was unable to find enough bowls for all the residents.
-The residents' took the bowls from thedining room.
-The Administrator was aware the facility did not have hard plastic bowls because she purchased the disposable bowls.
-She thought the Administrator had ordered more bowls.

Interview with a personal care aide (PCA) on 12/04/19 at 12:03pm revealed:
-Three weeks ago, she told the Administrator the kitchen was low on hard plastic bowls,
-In the morning for breakfast, they rotated giving resident's non-disposal bowls and disposable bowls.
-For example, if five residents got disposable bowls this morning, then tomorrow shemade sure they got non-disposable bowls.
-Some mornings, residents got cereal thatcame packaged in a plastic disposable bowl.

Interviews with a resident in the dining room during the lunch meal service on 12/03/19 from 12:15pm to 12:55pm revealed:
-Desserts and fruit were always served in disposable bowls.
-Cereal was served almost every morning in plastic disposable bowls and disposable bowels.

Interviews with a resident in the dining room during the lunch meal service on 12/03/19 from 12:15pm to 12:55pm revealed:
-Some people got hard plastic bowls, but not everyone.
-It had been a long time since all residents got hard plastic bowls.

Interview with the Administrator on 12/04/19 at

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D 287	Continued From page 163 1:10pm revealed: -Had staff told her they needed bowls she would have ordered more bowls. -She believed the disposable bowls were already at the facility. -The residents' took bowls from the dining room which caused the kitchen to not have enough bowls.	D 287		
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program (c) The activity director, as required in Rule .0404 of this Subchapter, shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities which shall be easily readable with large print, posted in a prominent location by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, religious, aging and developmentally disabled-associated agencies, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and	D 316		

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(6) assure there are adequate supplies, supervision and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to assure residents were offered activities designed to promote the residents' active involvement.

The findings are:

Observation of on 12/03/19 at 9:55am revealed:
-There was an activities calendar dated November 2019 hanging on the wall in the main hallway.
-There were 6 activities scheduled daily Monday through Friday, 4 activities scheduled on Saturdays, and 3 to 4 activities scheduled on Sundays in the month of November.
-There was no December 2019 calendar posted.
-There were start times for the activities, but no stop times.

Observation on 12/04/19 between 3:00pm and 5:00pm revealed there were 5 to 10 residents participating in a craft project being led by a personal care aide (PCA).

Observation on 12/06/19 between 3:00pm and 5:00pm revealed there was a local high school group in the facility singing to residents.

There were no other activities observed between 12/03/19 and 12/12/19.

Interview with a first shift medication aide (MA) on

POLICIES WERE IN PLACE (SEE ATTACHED) TO PROVIDE ACTIVITIES FOR THE RESIDENTS AND THIS WAS THE RESPONSIBILITY OF THE ADMINISTRATOR TO ENSURE THESE WERE CARRIED OUT.

AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN MOVED TO APPROPRIATE LEVELS OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S.

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12/12/19 at 9:50am revealed:
-There was an activity director hired to do activities, but she had only seen him twice.
-The residents had been asking for the activity director to do activities.
-If a staff member had time, they would lead an activity.
-She saw the activities calendar for November 2019, but there was not an activities calendar posted prior to or after November 2019.

Interview with a second first shift MA on 12/12/19 at 11:46am revealed:
-The activity director was hired about one month ago.
-Previously there had not been an activity director and no calendar of scheduled activities.
-She had only seen a calendar for November 2019 and had only seen maybe one activity carried out with residents in November 2019.
-When she had down time, she tried to paint residents' nails or put a movie in for residents to watch.
-Residents had complained to her about not having activities and she had talked to the Administrator regarding residents' concerns with not having activities.

Interview with the Supervisor on 12/12/19 at 12:48pm revealed:
-There was an activity director, but he was not doing activities with the residents.
-There should be at least one activity daily if not more.

Interview with 3 residents on 12/12/19 at 6:00pm revealed:
-There were no activities at the facility.
-Once a month, a group came to the facility from a church.

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-Occasionally they showed movies and the library truck came to the facility once a month.
-There were not 14 hours of activities offered at the facility on a weekly basis.

Interview with the Administrator on 12/12/19at 6:20pm revealed:
-There was an activity director when she first came to the facility who worked from January 2019 through May 2019.
-She hired an activity director in October 2019, but she did not think she had one anymore.
-"I think he quit."
-The activity director was responsible for creating the monthly activities calendar.
-The company had decided to offer 24 hours of activities weekly rather than 14.
-The activity director may have completed 6-8 activities in November 2019 and some of those activities were completed on the weekends.

Interview with the Activity Director on 12/13/19 at 2:18pm revealed:
-He was hired as an activity director a month and a half ago, but he also passed medication a few times.
-He had completed an activity director course.
-He was hired to work 24 hours a week.
-He did not have the necessary supplies to complete activities with residents.
-Supplies were not provided by the facility and he had to purchase them with his own money.
-The Administrator should have put up a calendar for December 2019.
-He purchased the application to create the calendar for November 2019 and he was not going to do it again.
-The last time he was in the facility was 11/27/19.

Interview with a resident on 12/03/19 at 7:50am

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D 316	Continued From page 167 revealed: -Activities were very rare at the facility. -Sometimes someone came and took two to three residents to church on Sunday. -In October 2019, a male put up an activity calendar. -The male did not work at the facility. -She came to the facility in April 2019 and had never been on an outing. -She would like to go on an outing and do something, she was not sure exactly what, but it would be nice to go out. Interview with a resident on 12/03/19 at 10:39am revealed: -Activities "what's that?" -No activities were conducted at the facility. -They (residents') just sat around all day watching television and sometimes smoking because there was nothing to do. Interview with a resident on 12/05/19 at 9:03am revealed: -No activities were offered at the facility. -The only activities were sitting and looking out the window. -There was nothing going on at the facility, so she tried to get out daily and go somewhere. -She liked doing things and being active. -There was no nothing to do at the facility. -No one had asked her if she liked to a specific activity.	D 316		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other	D 319		

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month. Residents interested in being involved in the community more frequently shall be encouraged to do so.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to assure each resident had the opportunity to participate in at least one outing every other month.

The findings are:

Observation on 12/03/19 at 9:55am revealed:
-There was an activities calendar dated November 2019 hanging on the wall in the main hallway of the facility.
-There were 6 activities scheduled daily Monday through Friday, 4 activities scheduled on Saturdays, and 3 to 4 activities scheduled on Sundays in the month of November.
-There was no December 2019 calendar posted.
-There was a "store outing" scheduled for 12/8/19 at 3:00pm and on 12/22/19 at 3:00pm.

Observations at various times from 12/03/19 through 12/12/19 revealed there were no outings being conducted for residents.

Interview with a resident on 12/03/19 at 7:50am revealed:
-Activities were very rare at the facility.
-Sometimes someone came and took two to three residents to church on Sunday.
-She came to the facility in April 2019 and had never been on an outing.
-She would like to go on an outing and do something, she was not sure exactly what, but it

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would be nice to go out.

Interview with a first shift medication aide (MA) on 12/12/19 at 9:50am revealed:
-There was an activity director hired to do activities, but she had only seen him twice.
-If a staff member had time, they would lead an activity.
-The residents went on a shopping outing once since the activity director started.
-There had not been any previous outings that she knew of.

Interview with a second first shift MA on 12/12/19 at 11:46am revealed:
-She had only seen a calendar for November 2019 and had only seen maybe one activity carried out with residents.
-She had not seen any resident outings.

Interview with the Supervisor on 12/12/19 at 12:48pm revealed:
-There was an activity director, but he was not doing activities with the residents.
-She did not know when the last resident outing was.
-"They sometimes have an outing when staff can leave the floor."

Interview with 3 residents on 12/12/19 at 6:00pm revealed:
-There were no outings scheduled for residents.
-The residents had never been on an outing initiated by the facility.
-They would like to go on outings if they were offered by the facility.

Interview with the Administrator on 12/12/19 at 6:20pm revealed:
-There was an activity director when she first

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D 319	Continued From page 170 came to the facility who worked from January 2019 through May 2019. -She hired an activity director in October 2019, but she did not think she had one anymore. -"I think he quit." -The activity director was responsible for creating the monthly activities calendar. -The activity director took some residents shopping in November 2019. -There had been no other outings offered to residents. Interview with the activity director on 12/13/19 at 2:18pm revealed: -He was hired as an activity director a month and a half ago, but he also passed medication a few times. -Supplies were not provided by the facility and he had to purchase them with his own money. -The last time he was in the facility was 11/27/19. -He took residents on 3 to 4 outings since he started working at the facility, but they were not all listed on the calendar.	D 319		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.	D 328		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 328	Continued From page 171	D 328		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to immediately notify the local county Department of Social Services (DSS) for incidents involving 1 of 1 sampled residents (Resident #5), regarding a resident who eloped (#5).

The findings are:

1. Review of Resident #5's current FL2 dated 10/04/19 revealed:
-Diagnoses included fracture of left ankle, bipolar, gastroesophageal reflux disease (GERD), and anemia.
-Resident #5 was constantly disoriented.
-There was documentation the resident had inappropriate behavior, wandered and was verbally abusive at times.

Review of a report from the local police department dated 10/01/19 revealed:
-The Resident #5 was found by the police officers standing on dark street.
-The location where the resident was found was almost two blocks from the facility.
-It was 3:13am and the resident appeared disoriented.
-The resident told the police officers that he was having chest pains and pains in his left arm, but facility staff would not call medical assistance for him to go to the hospital.
-The resident was transported back to the facility.
-The staff at the facility did not know the resident had left the building.
-The door was observed being held open by a door stop, which caused the alarm to be deactivated, which was how Resident #5 left the building.
-No staff at the facility could advise when

Provider's Plan of Correction (D 328):

ANY EPISODE REGARDING A WANDERING RESIDENT ARE FIRST , TO BE RECORDED IN THE MED TECH SHIFT REPORT. THE ADMINISTRATOR'S JOB DESCRIPTION STATES SHE IS TO FILL OUT ACCIDENT/INCIDENT REPORT. (COPY ATTACHED) THESE ARE TO BE SENT TO DAVIE COUNTY D.S.S. IMMEDIATLEY AND ALL RESPONSIBLE PERSONS NOTFIED.

AS OF 2/7/2020 ALL RESIDENTS HAVE BEEN MOVED TO APPROPRIATE LEVELS OF CARE AND THE HOME HAS BEEN CLOSED.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 328	Continued From page 172 Resident #5 left the facility. Interview with the Supervisor on 12/04/19 at 10:42am revealed: -She worked part-time at the facility and mostly did paper work in the office. -She previously worked at other facility's and was aware that and incident/accident report should be completed for a resident that eloped. -The facility did not do incident/accident reports. Interview with the local county Adult Home Specialist on 12/05/19 at 1:00pm revealed: -The facility did not send her accident/incident reports. -She previously had a conversation with the Administrator regarding her not getting incident reports. Interview with the Administrator on 12/06/19 at 3:32pm revealed: -When a resident was sent out to the hospital staff were to do an accident/incident report. -A month or more ago, she had instructed staff to start doing accident/incident reports. -She was unable to find any accident/incident reports.	D 328		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION	D 338	ALL STAFF ARE PROVIDED A COPY OF THE RESIDENTS BILL OF RIGHTS UPON HIRE. VIOLATION OF THESE RIGHTS ARE CAUSE FOR IMMEDIATE TERMINATION, ADMINISTRATOR SHOULD HAVE FILED A REPORT AND TERMINATED STAFF MEMBER IMMEDIATELY. AS OF 2/7.2020, ALL RESIDENTS HAVE BEEN MOVED TO APPROPRIATE LEVELS OF CARE AND THE HOME HAS BEEN CLOSED.	

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THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

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D 338	Continued From page 173	D 338		

Based on record review and interviews the facility failed to assure 1 of 17 sampled residents (Resident #19) were free of abuse and neglect resulting in a resident (#19) being physically assaulted by a medication aide (Staff M).

The findings are:

Review of Resident #19's current FL2 dated 10/22/19 revealed:
-Diagnoses included vascular dementia without behaviors, chronic diastolic congestive heart failure, depression/anxiety, hearing loss, heart disease, diabetes mellitus and neuropathy.
-Resident #19 was intermittently disoriented.

Review of Resident #19's Care Plan dated 11/08/19 revealed:
-Resident #19 required supervision with eating, toileting, ambulation, bathing, dressing, grooming and transferring.
-There was no documentation regarding the resident's mental health status or the agency to contact.

Review of a police report dated 11/13/19 revealed:
-There was an altercation at the facility between a staff (Staff M, medication aide (MA)) and a resident (#19).
-Staff M admitted she was"punching"Resident #19 in the face so the resident would stop assaulting her.
-The report noted the resident had blood on her lip.

Interview with Resident #19 on 12/05/19 at 9:03am revealed:
-She lived at the facility since the end of October 2019.

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NAME OF PROVIDER OR SUPPLIER: THE HERITAGE OF CEDAR ROCK

STREET ADDRESS, CITY, STATE, ZIP CODE: 191 CRESTVIEW DRIVE, MOCKSVILLE, NC 27028

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-A couple of weeks after she moved into the facility, she had an incident with Staff M.
-One night it was cold and Staff M came into her room.
-When Staff M came into the room she left the door open.
-She asked Staff M to close the room door because she was cold.
-Staff M said, "Wait a minute."
-Staff M proceeded to give her roommate some medication and did not close the door.
-Staff M and her started yelling at each other.
-Staff M and her struggled back and forth.
-She pushed Staff M because she was in her face.
-Staff M pushed her back, she did not recall her lip bleeding, the police coming to the facility or the Administrator talking with her regarding the incident.

Interview with Resident #19's roommate on 12/05/19 at 5:05pm revealed:
-One day Staff M came to her room to give her medications.
-Resident #19 had complained about the door being open.
-Resident #19 had asked the MA (Staff M) to close the door.
-Staff M left the door open.
-Resident #19 got upset and got in Staff M's face.
-There was a struggle but she could not see very well.

Interview with Resident #19's mental health provider (MHP) on 12/06/19 at 3:37pm revealed:
-He last visited Resident #19 on 11/05/19.
-He recommended the facility provide social interactions to help with mood/anxiety cognition.
-He was not aware that Resident #19 had an altercation with Staff M at the facility.

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D 338	Continued From page 175 -He did not have any reports of Resident #19 in altercations. -The agency had a 24-hour hotline, and he could be paged any time of day if there were problems with Resident #19. Interview with Staff M on 12/06/19 at 10:20am revealed: -On 11/13/19 she went into Resident #19's room to give 12:00pm medication to Resident #19's roommate. -She left the door open because that was what she usually did when she administered medications. -Resident #19 said close the door and she replied "in a minute." -Resident #19 pushed her using her body, and then started hitting, biting and scratching her. -On 11/13/19, the hallway was cool, and Resident #19 wanted the door to be kept closed. -She tried to protect herself by pushing Resident #19 off her, so she pushed the resident, but she did not hit Resident #19. -She called the Administrator and was told to call the police. -She did not call Resident #19's mental health provider. Interview with the Administrator on 12/05/19 at 9:31am revealed: -She was aware of an incident between Resident #19 and Staff M on the second shift because Staff M had informed her of the incident. -She told Staff M to call the police and make a report. -She talked with Staff M, but did not interview the resident because it was her understanding the resident started the incident. ______________ The facility failed to protect the rights of 1 of 1	D 338		

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D 338	Continued From page 176 sampled residents (#19) from abuse and neglect regarding a resident (#19) being pushed and hit by a staff (Staff M). The facility's failure to the rights of resident was detrimental to the residents health safety and welfare and constitutes a Type B violation. __________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/12/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to administer medications as ordered by a licensed practicing practitioner for 6 of 6 sampled residents (#1, #2, #3, #4, #5 and #12) related to a topical antiseptic (#3), an anti-coagulant and a narcotic pain reliever (#4), a rapid acting insulin (#2, #3 and #12), a diuretic (#5), and a gastric acid reducer	D 358	FACILITY POLICIES (SEE ATTACHED) ONLY ALLOW CERTIFIED MED TECHS TO ADMINISTER MEDICATIONS & TREATMENTS, ACCORDING TO ORDERS BY DOCTORS. IT IS THE RESPONSIBILITY OF THE RCC AND THE ADMINISTRATOR TO ASSURE THAT ALL MEDS ARE BEING GIVEN PROPERLY. QUARTERLY, PHARMACIST WAS COMING IN TO DO MED REVIEWS. AFTER SURVEY, OWNER HAD PHARMACY NURSE COME IN TO DO DIABETIC TRAINING FOR MED TECHS (SEE ATTACHED). A NURSE ALSO CAME IN ON 1/16/20 & 1/17/20, TO PROVIDE TRAINING ON WOUND CARE AND MORE MEDICATION TRAINING FOR STAFF. ON 2/7/2020, ALL RESIDENTS WERE MOVED TO APPROPRIATE LEVELS OF CARE AND HOME WAS CLOSED WITH THE ASSITANCE OF DAVIE COUNTY D.S.S.	

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(#1).

The findings are:

1. Review of Resident #4's current FL2 dated 10/02/19 revealed:
-Diagnoses included primary malignant neuroendocrine tumor of ileum, hyponatremia, chronic diastolic congestive heart failure, protein calorie malnutrition, and mass of small intestine.
-There was an order for enoxaparin (lovenox) injection 30mg subcutaneously twice a day for 30 days to reduce the risk of blood clotting.

a. Review of a previous hospital discharge summary dated 09/25/19 revealed an order for lovenox injections (used to treat blood clots) twice a day for 30 days.

Review of a physician's order dated 10/04/19 revealed resident was able to self-administer lovenox every 12 hours and a Home Health Nurse (HHN) was to instruct.

Review of a physician's order dated 10/15/19 revealed continue lovenox injections until completed and then discontinue.

Review of a subsequent physician's order dated 10/18/19 revealed discontinue lovenox injections.

Review of an emergency medical services (EMS) report dated 09/27/19 revealed:
-EMS was called for Resident #4 on 09/27/19.
-The chief complaint was transport for lovenox injection.
-EMS assessed Resident #4 and transported her to a hospital emergency room for anticoagulant therapy.

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Review of Resident #4's electronic Treatment Administration Record (eTAR) for September 2019 revealed:
-There was an entry for lovenox 30mg/0.3 ml syringe inject 0.3ml (30mg) subcutaneously every 12 hours for 30 days at 9:00am and 9:00pm.
-There was no documentation lovenox was administered to Resident #4 from 09/25/19 through 09/30/19.
-There was documentation Resident #4 was in the hospital on 09/30/19 at 9:00pm.

Review of Resident #4's eTAR for October 2019 revealed:
-There were 3 entries for lovenox 30mg/0.3 ml syringe inject 0.3ml (30mg) subcutaneously every 12 hours for 30 days at 9:00am and 9:00pm.
-There was no documentation lovenox was administered for 7 of 35 opportunities from 10/01/19 through 10/18/19.
-There was no documentation lovenox was administered on 10/03/19 at 9:00am with the reason documented as: Home Health (HH) will administer.
-There was no documentation lovenox was administered on 10/04/19 at 9:00am with the reason documented as: not administered by staff.
-There was no documentation lovenox was administered on 10/04/19 at 9:00pm with the reason documented as: nurse/MD.
-There was no documentation lovenox was administered on 10/07/19 at 9:00am with the reason documented as: self-administered.
-There was documentation Resident #4 was in the hospital on 10/07/19 at 9:00pm through 10/09/19 at 9:00am.
-There was no documentation lovenox was administered on 10/09/19 at 9:00pm or 10/10/19 at 9:00am with no reason documented.

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Observation of Resident #4's medications on hand on 12/05/19 at 2:41pm revealed there was no lovenox in the medication cart.

Interview with Resident #4 on 12/03/19 at 10:56am revealed:
-She was admitted to the facility on 09/25/19 from the hospital.
-She remembered going back to the hospital not long after she was admitted to the facility because she could not catch her breath and she had not been getting her lovenox injections.
-She was told by staff they could not give her lovenox injections.
-When staff did get the lovenox injections in the facilty, they were kept on the medication cart, but she self-administered the injection.

Interview with medication aide (MA) on 12/12/19 at 9:50am revealed:
-She did not know why lovenox injections were not available in the facility for Resident #4.
-Resident #4 was transported to the hospital by EMS for her lovenox injection and came back to the facility on 09/27/19.
-She ordered Resident #4's lovenox from the pharmacy on 09/28/19 during a visit from Resident #4's HHN.
-She did not know why lovenox was not ordered when Resident #4 was admitted from the hospital or when the HHN was in the facility on 09/27/19.

Interview with the Director of Operations at Resident #4's home health agency on 12/12/19 at 11:23am revealed:
-Resident #4's start of care was 09/27/19.
-A home health nurse visited Resident #4 on 09/27/19 to provide education to Resident #4 on the administration of the lovenox injection.
-The home health nurse found there were no

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lovenox injections in the facility.
-The home health nurse contacted Resident #4's previous primary care provider (PCP) for clarification and explained the need for lovenox to be started, but it was not available in the facility.
-Resident #4 was sent out to the hospital by the facility for a lovenox injection.
-The home health nurse visited Resident #4 on 09/28/19 to provide education regarding the lovenox injections.
-Resident #4 was discharged from home health nursing services on 10/11/19 due to a hospitalization on 10/07/19.

Interview with the Supervisor on 12/12/19 at 12:48pm revealed:
-She knew Resident #4 had physician's orders for lovenox injections twice daily.
-"The hospital was supposed to discontinue the lovenox injections but they did not."
-She had told the hospital staff Resident #4 could not be admitted to the facility with lovenox injections because they were not able to administer them.
-The hospital staff was supposed to reach out to the (HH) agency.
-She thought the (HH) agency was responsible for obtaining the lovenox injections since they would be the ones who administered them.
-"It did not matter if the lovenox injections were in the facility or not because we could not administer them."
-She thought Resident #4 was taken to the hospital by EMS on 09/27/19 due to difficulty breathing, she did not know the EMS report documented she was transported to the hospital for lovenox injections.
-She had talked to the PCP about the Resident #4 having an order for lovenox injections, but she did not remember when.

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-There was no documentation of contact with Resident #4's PCP regarding her being admitted to the facility with lovenox injections and the injections not being administered for 3 days.

Interview with Resident #4's previous PCP on 12/2/19 at 3:47pm revealed:
-She did not know Resident #4 had been admitted to the facility with an order for lovenox injections.
-She received a call from a HHN who told her Resident #4 did not have any lovenox injections in the facility.
-She contacted a hospital discharge staff and asked why Resident #4 was admitted to the facility with the lovenox injections.
-The hospital discharge staff told her the only reason Resident #4 was discharged to the facility was because facility staff had assured her they would have HH in place upon Resident #4's discharge from the hospital and HH would be able to administer the lovenox.
-She expected the facility to contact a HH provider and HH should have been in place to ensure a nurse was available to administer lovenox injections as ordered for Resident #4.

b. Review of Resident #4's current FL2 dated 10/02/19 revealed an order for oxycodone 10mg ½ tablet every 8 hours as needed.

Review of a physician's order dated 10/15/19 revealed oxycodone 10mg 1 tablet every 4 hours scheduled and 1 tablet every hour as needed for pain.

Review of Resident #4's electronic Medication Administration Record (eMAR) for October 2019 revealed:
-There was an entry for oxycodone 10mg tablets

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½ tablet every 8 hours up to 7 days as needed for severe pain.
-There were two entries for oxycodone 10mg tablets ½ tablet every 8 hours as needed for severe pain.
-There were two entries for oxycodone 10mg tablets 1 tablet every 1 hour as needed for pain/shortness of breath.
-There was an entry for oxycodone 5mg tablets 1 tablet four times a day as needed for pain and was discontinued on 10/10/19.
-There was an entry for oxycodone 10mg tablet 1 tablet every 4 hours for pain at 2:00am, 6:00am, 10:00am, 2:00pm, 4:00pm, and 10:00pm.
-There was a second entry for oxycodone 10mg tablet 1 tablet every 4 hours for pain at 2:00am, 6:00am, 10:00am, 2:00pm, 4:00pm, and 10:00pm.
-Oxycodone was documented as not administered for 27 of 96 opportunities from 10/16/19 through 10/31/19.
-Oxycodone was documented as not administered 14 times at 2:00am; there was documentation Resident #4 refused oxycodone on 10/28/19 at 2:00am; there was documentation Resident #4 was sleeping on 10/29/19 at 2:00am.
-Oxycodone was documented as not administered 7 times at 6:00am.
-Oxycodone was documented as not administered 1 time at 10:00am.
-Oxycodone was documented as not administered 2 times at 2:00pm; there was documentation oxycodone was already administered at 12:42pm on 10/17/19.
-Oxycodone was documented as not administered 3 times at 6:00pm.

Review of Resident #4's eMAR for November 2019 revealed:
-There were two entries for oxycodone 10mg

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tablets 1 tablet every 1 hour as needed for pain/shortness of breath.
-There was an entry for oxycodone 10mg tablet 1 tablet every 4 hours for pain at 2:00am, 6:00am, 10:00am, 2:00pm, 4:00pm, and 10:00pm.
-Oxycodone was documented as not administered for 16 of 180 opportunities from 11/01/19 through 11/30/19.
-Oxycodone was documented as not administered 8 times at 2:00am there was documentation Resident #4 was asleep on 11/21/19 at 2:00am; there was documentation Resident #4 was sleeping soundly 11/11/22/19 at 2:00am.
-Oxycodone was documented as not administered 5 times at 6:00am.
-Oxycodone was documented as not administered 1 time at 10:00am.
-Oxycodone was documented as not administered 1 time at 6:00pm.
-Oxycodone was documented as not administered 1 time at 10:00pm.

Observation of Resident #4's medications on hand on 12/05/19 at 2:41pm revealed:
-Oxycodone was available on the medication cart.
-The label on the bubble pack of oxycodone revealed oxycodone was dispensed on 11/30/19 with a quantity of 100 tablets.
-There were 90 tablets of oxycodone dispensed in the bubble pack in the medication cart and 73 tablets were remaining.

Interview with Resident #4 on 12/03/19 at 10:56am revealed:
-She had physician's orders for oxycodone every 4 hours and as needed for pain.
-She had gone "long stretches" without her pain medication on numerous occasions and had gone as long as 10 hours.

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D 358	Continued From page 184 -The times she had to go without her pain medication, she experienced severe pain. -She sometimes went until her pain was unbearable to ask for pain medication because she did not want to get a cold response from staff. -She had been told by staff her pain medication was in medication totes and staff had not gotten around to putting medication on the medication cart from the totes yet. -Many times there were no medication aides (MA) working to administer medication on third shift. Interview with hospice nurse from Resident #4's primary care provider's office on 12/03/19 at 11:10am revealed: -Resident #4 had told her there were times when there was no staff in the facility at night and she was not able to get her oxycodone. -Resident #4 had physician's orders for oxycodone every 4 hours around the clock and every hour as needed for pain. Interview with a third shift MA on 12/05/19 at 8:12am revealed: -She administered medication to Resident #4 during her shift. -She did not know why there was no documentation Resident #4 did not receive her medication multiple times on third shift. -Resident #4 was sometimes asleep during her 2:00am administration time. -She thought she had documented on the eMAR when Resident #4 was not administered her medication and the reason. -If the eMAR was not initialed then the medication was not given. Interview with the facility contracted pharmacy on 12/11/19 at 12:51pm revealed:	D 358		

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D 358	Continued From page 185 -There was an order dated 10/02/19 for oxycodone 10mg tablets ½ tablet every 8 hours as needed and was dispensed on 10/09/19 with a quantity of 30 ½ tablets. -There was an order dated 10/18/19 for oxycodone 10mg tablets 1 tablet every 4 hours and 1 tablet every 1 hour as needed and was dispensed on 10/18/19 with a quantity 240 tablets. -There was an order dated 11/29/19 for oxycodone 1 tablet every 4 hours and 1 tablet every 1 hour as needed and was dispenses on 11/30/19 with a quantity of 100 tablets. Interview with a first shift MA on 12/12/19 at 9:50am revealed: -Resident #4 had physician's orders for oxycodone every 4 hours and every hour as needed. -She administered oxycodone to Resident #4 during her shift and did not remember any time when she did not administer oxycodone. -If a medication was not marked on the eMAR with an initial, then the medication was not administered to the resident. Interview with the Administrator on 12/12/19 at 6:20pm revealed: -She did not know there were multiple missed doses of oxycodone for Resident #4 in the months of October and November 2019. -The eMAR audits were completed once a month by MAs. -The last eMAR audit was completed in November 2019 and staff did not inform her of any missed doses of medication for Resident #4. -She expected medication to be administered as prescribed by the physician and if there was a medication error, the MAs should have contacted the physician.	D 358		

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Interview with the Hospice Nurse from Resident #4's PCP's office on 12/12/19 at 11:03am revealed missed doses of oxycodone could cause increased pain levels and increased anxiety.
2. Review of Resident #12's current FL2 dated 10/21/19 revealed:
-Diagnoses included diabetes mellitus, psychotic disorder, and deep vein thrombosis.
-There was an order for humalog inject 14 units subcutaneously (a rapid-acting insulin used to lower elevated blood sugar levels) if fingerstick blood sugar (FSBS) are greater than 250. Give additional 14 units if FSBS are greater than 400 at 6:30am and 4:00pm.

Review of a hospital discharge summary report dated 09/05/19 revealed:
-Resident #12 was treated for hypoglycemia in diabetes and altered mental status.
-It was recommended to follow-up with the Primary Care Provider (PCP) to discuss insulin regimen.

Review of Resident #12's September 2019 electronic Medication Administration Records (eMARs) revealed:
-There was an entry for humalog sliding scale subcutaneously for FSBS greater than 250 scheduled twice daily at 6:30am and 4:00pm.
-There was documentation humalog was administered 6 times from 09/01/19 through 09/30/19 when the resident's FSBS were less than 250 as follows:
-On 09/03/19 at 6:30am FSBS 140, received "246" units.
-On 09/04/19 at 4:00pm FSBS 142, received 14 units.
-On 09/12/19 at 4:00pm FSBS 178, received 14 units.

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D 358	Continued From page 187 -On 09/26/19 at 4:00pm FSBS 383, received 28 units (more than the required 14 units). -On 09/30/19 at 6:30am FSBS 157, received 14 units. -On 09/30/19 at 4:00pm FSBS 199, received 14 units. Review of Resident #12's October 2019 eMARs revealed: -There was an entry for humalog sliding scale subcutaneously for FSBS greater than 250 scheduled twice daily at 6:30am and 4:00pm. -There was documentation humalog was administered 14 times from 10/01/19 through 10/31/19 when the resident's FSBS were less than 250 as follows: -On 10/02/19 at 6:30am FSBS 221, received 14 units. -On 10/04/19 at 4:00pm FSBS 144, received 14 units. -On 10/10/19 at 4:00pm FSBS 202, received 14 units. -On 10/14/19 at 6:30am FSBS 143, received 14 units. -On 10/14/19 at 4:00pm FSBS 185, received 14 units. -On 10/15/19 at 6:30am FSBS 56, received 14 units. -On 10/16/19 at 6:30am FSBS 132, received 14 units. -On 10/15/19 at 4:00pm FSBS 145, received 14 units. -On 10/17/19 at 4:00pm FSBS 143, received 14 units. -On 10/18/19 at 4:00pm FSBS 233, received 14 units. -On 10/21/19 at 4:00pm FSBS 181, received 14 units. -On 10/25/19 at 4:00pm FSBS 167, received 14 units.	D 358		

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D 358	Continued From page 188 -On 10/29/19 at 4:00pm FSBS 195, received 14 units. -On 10/30/19 at 4:00pm FSBS 165, received 14 units. Review of Resident #12's November 2019 eMARs revealed: -There was an entry for humalog sliding scale subcutaneously for FSBS greater than 250 scheduled twice daily at 6:30am and 4:00pm. -There was documentation humalog was administered 8 times from 11/01/19 through 11/30/19 when the resident's FSBS were less than 250 as follows: -On 11/02/19 at 4:00pm FSBS 160, received 14 units. -On 11/03/19 at 4:00pm FSBS 166, received 14 units. -On 11/04/19 at 6:30am FSBS 144, received 14 units. -On 11/05/19 at 6:30am FSBS 152, received 14 units. -On 11/11/19 at 6:30am FSBS 188, received 14 units. -On 11/14/19 at 6:30am FSBS 173, received 14 units. -On 11/15/19 at 6:30am FSBS 129, received 14 units. -On 11/28/19 at 4:00pm FSBS 128, received 14 units. Review of Resident #12's December 2019 eMARs revealed: -There was an entry for humalog scheduled twice daily at 6:30am and 4:00pm. -There was documentation humalog was administered 3 times from 12/01/19 through 12/12/19 when the resident's FSBS were less than 250 as follows: -On 12/02/19 at 4:00pm FSBS 110, received 14	D 358		

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units.
-On 12/03/19 at 4:00pm FSBS 110, received 14 units.
-On 12/09/19 at 4:00pm FSBS 219, received 14 units.

Review of a local Emergency Medical Services (EMS) report dated 07/17/19 revealed:
-Staff informed EMS that Resident #12 was "not acting like his normal self."
-Resident #12 stated he didn't feel like his normal self, he felt weak.
-Resident #12 was assessed as being weak and transported to the hospital.

Review of a local EMS report dated 11/19/19 revealed:
-Resident #12's chief complain was altered mental status.
-The resident was transported to the hospital.

Review of Resident #12's record revealed there were no discharge or return hospital visit notes related to the visits on 07/17/19 and 11/19/19.

Observation of Resident #12 on 12/04/19 at 11:04am revealed:
-The resident was sitting in a wheelchair.
-The resident's front was facing the bed.
-The resident was leaned forward with his head lying on the bed.
-When the resident talked, he used his hands to hold his head up.
-The resident appeared to tired and lethargic.

Interview with Resident #12 on 12/04/19 at 11:06am revealed:
-He was a diabetic and received medication to help control his diabetes.
-He did not know the specific medications

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ordered to control his diabetes.
-The medication aide (MA) checked his blood sugars daily.
-The MA did not share the FSBS results.
-He did received insulin injections but did not know the units of insulin administered.
-Some days he felt weak but did not know if it was related to his blood sugar being low.

Interview with the second shift medication aide (MA) on 12/11/19 at 5:45pm revealed:
-She read the order for Resident #12's humalog and she thought the order required humalog 14 units each time she checked the resident's blood sugar, and if the blood sugar was greater than 250 give an additional 14 units.
-She did administer 14 units of humalog to Resident #12 when his blood sugar was less than 250.
-On 09/26/19 at 4:00pm she administered 28 units of insulin to Resident #12 because she thought if the FSBS was greater than 250 she had to give twice the amount of insulin.
-She felt the order needed to be clarified because it was difficult for her to understand.
-She had not contacted the Primary Care Provider (PCP) to get the order clarified.
-She thought the Supervisor had contacted the PCP to clarify the order.

Telephone interview with a third shift medication aide (MA) on 12/12/19 at 4:50pm revealed:
-She was aware Resident #12's humalog was ordered when the resident's blood sugar was greater than 250.
-She did not recall administering humalog when the resident's blood sugar was less than 250.
-If she administered the medication when it was not needed that was an error.

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Interview with a pharmacist at the contracted pharmacy on 12/12/19 at 3:36pm revealed:
-When he did quarterly drug reviews he looked at the blood sugars from a "vital sign" report that he printed from the eMAR system.
-He mainly checked the blood sugars to ensure they were being done.
-He did not look at the eMARs.
-He mainly focused on as needed medications that were being used a lot.
-He also focused on refusals.
-He made recommendations based on what he observed from the vitals sign report, as needed medications and refusals.
-He did not know that staff administered Humalog to Resident #12 when the resident's blood sugars were not within range for the medication.

Interview with Resident #12's PCP on 12/12/19 at 4:30pm revealed:
-She had previously talked with the Supervisor about Resident #12's humalog because she had identified the medication was being administered when the resident's blood sugars were less than 250.
-The Supervisor blamed the problem on the MAs and said it would be taken care of.
-She felt some things, like insulin administration needed not wait when it comes to caring for the residents.
-Resident #12 had been to the hospital several times weakness and altered mental status.
-The resident getting the incorrect units of humalog could also contribute to some of the weakness and lethargic episodes the resident was experiencing.

Interview with the Administrator on 12/12/19 at 10:09am revealed:
-The pharmacist was supposed to check the

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eMARs and medication on hand at the facility to ensure the medications were administered as ordered.
-She was not aware the medication aide was administering humalog insulin when Resident #12's blood sugars was not within range for the insulin.

Second interview with the Administrator on 12/12/19 at 6:15pm revealed:
-In November 2019, she had identified that MAs were administering insulin incorrectly for Resident #12's blood sugars that were less than 250.
-She had an in-service with the MAs the first week in November to tell them not to administer insulin for residents with orders for insulin when blood sugars were less than 250.
-She had contacted the PCP to review Resident #12's humalog order because the resident's blood sugars were often less than 250.
-She did not have any documentation to show her communication with Resident #12's PCP.
-She did not have documentation regarding a response from Resident #12's PCP.

3. Review of Resident #3's current FL2 dated 06/28/19 revealed:
-Diagnoses include closed head injury, stroke, muscle weakness, and chronic pain.
-There was no order for betadine solution.

Review of Resident #3's December 2019 electronic medication administration record (eMAR) revealed:
-There was an entry on the eMAR for betadine solution (used to treat skin infections) use twice daily for wound at 7:00am and 7:00pm.
-There was documentation the medication was started on 12/08/19.
-There was documentation staff applied betadine

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solution on 12/08/19 at 7:00pm, 12/09/19 at 7:00am and 7:00pm and 12/10/19 at 7:00am.

Observation of Resident #3's wound on 12/06/19 at 8:35am revealed:
-The resident had a two-inch diameter wound near the lower bottom of his right buttock.
-The inner part of the wound had a pea-sized area that was white at the top of the wound.

Observation of Resident #3's medications on hand at the facility on 12/10/19 at 10:12am revealed:
-The medication aide was unable to find betadine solution on the medication cart.
-The Supervisor later found the medication in the medication storage area.

Interview with Resident #3's Primary Care Provider (PCP) on 12/05/19 at 4:50pm revealed:
-Today (12/05/19), she assessed Resident #3's wound and it was a stage II.
-She sent an order for betadine for Resident #3's wound on 12/05/19.
-The medication should be in the facility later today, or at the latest early tomorrow morning.
-She was going to make frequent checks on the resident's wound.

Interview with the medication aide (MA) on 12/10/19 at 10:15am revealed:
-She was unable to find betadine solution on the medication cart.
-This morning she did not use the betadine solution on Resident #3's wound.
-She used nystatin (used to treat fungal infections) cream on Resident #3's wound.
-The nystatin cream did not belong to any resident at the facility; it was in a box stored underneath the counter at the nurses' station.

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-She did not have an order to use the nystatin cream.
-She did not realize that she needed an order to use the cream on Resident #3's wound.
-In addition, another resident told her that she gave Resident #3 her cream to use on his wound.
-The resident told the MA she gave her cream to the PCA to put on Resident #3's wound.
-She signed the eMAR for the betadine solution but she did not use the Betadine solution on Resident #3's wound.

Interview with Resident #3 on 12/10/19 at 8:10am revealed:
-Prior to today, no one put anything on his wound.
-This morning he borrowed cream for his wound from another resident.
-He told the PCA to put the cream on the wound that was on his right buttock.
-The cream that he borrowed helped his wound and eased the burning and stinging.

Interview with a resident on 12/10/19 at 10:15am revealed:
-Resident #3 had complained to her for several days that his "bottom" was burning and itching.
-Today, Resident #3 borrowed her cream to help with the burning and itching.
-She had the cream for several months and used it for skin irritation.
-She figured the cream would help Resident #3's burning and itching.
-She gave the cream to the PCA and the PCA put the cream on Resident #3.

Observation of of the resident's cream that was used on Resident #3's wound on 12/10/19 at 10:20am revealed:
-The cream was clotrimazole (used to treat fungus infection).

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-The pharmacy printed label showed the medication was filled and dispensed on 07/11/19.

4. Review of Resident #5's current FL2 dated 10/04/19 revealed:
-Diagnoses included fracture of left ankle, bipolar, gastroesophageal reflux disease (GERD), and anemia.
-Resident #5 was constantly disoriented.
-There was documentation the resident had inappropriate behavior, wandered and was verbally abusive at times.

Review of a physician's order dated 11/15/19 in Resident #5's record reveled an order for furosemide 20mg daily for five days.

Review of Resident #5's November 2019 electronic Medication Administrator Record (eMAR) revealed:
-There was an entry for furosemide 20mg (diuretic used for fluid retention) one table every day for five days.
-There was documentation furosemide 20mg was administered at 9:00am from 11/16/19 through 11/20/19.
-On 11/21/19 staff documented "Exp" on the eMAR.

Observation of Resident #5's medications on hand at the facility on 12/05/19 at 11:28am revealed:
-A bubble-packed container of furosemide 20mg was available for administration.
-There were two tables of furosemide left in the bubble-packed container.

Review of the pharmacy printed label revealed the medication was filled and dispensed on 11/15/19 for a quantity of five tablets.

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Interview with the medication aide (MA) thatwas on duty revealed:
-"Exp" on the eMAR meant the order for furosemide had expired, meaning all the medication was administered as ordered.
-She did not know why Resident #5's furosemide was not administered.
-She observed the eMAR was signed off, but she had no reason why the medication was not administered.

Observation of Resident #5's lower extremities on 12/05/19 at 8:53am revealed:
-The resident had on socks that were anklets.
-The personal care aide (PCA) removed the socks.
-Resident #5 had two plus pitting edema when touched by the PCA.
-Resident #5's feet were white with grayish patches of dry skin.
-There were loose flakes like a chalky substance that fell to the floor from both the resident's feet.
-The resident's toenails on the first three toes were black and thick.

Interview on 12/05/19 at 8:53am with Resident #5 revealed:
-His feet were swollen and they hurt badly.
-His feet had been swollen for over one month and they hurt when he walked.
-The facility staff administered medications to him, but he did not know the medications administered.

Interview with Resident #5's PCP on 12/05/19 at 10:46am revealed:
-Last month, she identified the resident had swollen lower extremities and she ordered furosemide for five days.

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D 358	Continued From page 197 -She expected facility staff to administered the medication as ordered. -If there was a problem administering the medications she expected staff to notify her . Interview with the Administrator on 12/05/19 at 9:00am revealed: -She the MAs were to administer medications as ordered. -She did not know Resident #5's furosemide was administered as ordered. -The facility did not have a system to checking the medication cart to ensure medications were administered. 5. Review of Resident #2's current FL2 dated 01/23/19 revealed: -Diagnoses included Diabetes Mellitus Type II and polyneuropathy (damage of the nerves causing weakness, numbness, and a burning pain) of the legs. -There was an order to check fingerstick blood sugars (FSBS's) 2 times a day before breakfast and supper. -There was an order Novolog Insulin (Novolog is a rapid-acting insulin used to lower elevated blood sugar levels) 100U/ML inject 12 units subcutaneously if FSBS > 250. Hold if FSBS under 100. Review of Resident #2's signed physician orders dated 11/08/19 revealed: -There was an order to check finger stick blood sugar (FSBS) 2 times a day before breakfast and dinner. -There was an order for Novolog Insulin 100U/ML inject 12 units subcutaneously for FSBS over 250. Give an additional 8 units for FSBS over 400. Hold if FSBS under 100.	D 358		

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Review of Resident #2's September 2019 electronic Medication Administration record (eMAR) revealed:
-There was an entry to check finger stick blood sugar (FSBS) 2 times a day before breakfast and dinner scheduled for 6:30am and 5:00pm.
-FSBS were not checked at 6:30am on 09/04/19, 09/08/19, 09/09/19, 09/10/19, 09/11/19, 09/12/19, 09/14/19, 09/16/19, 09/17/19, 09/19/19, 09/22/19, 09/24/19, 09/25/19, and 09/26/19 with a reason of "missed dose" documented. It was unknown if Resident #2 needed Novolog insulin at those times.
-There was an entry for Novolog Insulin 100U/ML inject 12 units subcutaneously for FSBS over 250. Give an additional 8 units for FSBS over 400. Hold if FSBS under 100.
-There was documentation Novolog was administered incorrectly 6 times from 09/01/19 through 09/30/19 as follows:
-On 09/04/19 at 5:00pm, FSBS 40, received 12 units when should not have received insulin.
-On 09/11/19 at 5:00pm, FSBS 468, received 12 units when should have received 20 units.
-On 09/14/19 at 5:00pm, FSBS 559, received 12 units when should have received 20 units.
-On 09/16/19 at 5:00pm, FSBS 420, received 12 units when should have received 20 units.
-On 09/18/19 at 6:30am, FSBS 309, received 10 units when should have received 12 units.
-On 09/30/19 at 5:00pm, FSBS 167, received 12 units when should not have received insulin.

Review of Resident #2's October 2019 eMARs revealed:
-There was an entry to check finger stick blood sugar (FSBS) 2 times a day before breakfast and dinner scheduled for 6:30am and 5:00pm.
-FSBS were not checked at 5:00pm on 10/04/19, 6:30am and 5:00pm on 10/06/19, 6:30am on

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10/14/19, 6:30am on 10/24/19, 6:30am on 10/28/19, and 6:30am on 10/29/19 with a reason of "missed dose" documented. It was unknown if Resident #2 needed Novolog insulin at those times.
-There was an entry for Novolog Insulin 100U/ML inject 12 units subcutaneously for FSBS over 250. Give an additional 8 units for FSBS over 400. Hold if FSBS under 100.
-There was documentation Novolog was administered incorrectly 6 times from 10/01/19 through 10/31/19 as follows:
-On 10/11/19 at 5:00pm, FSBS 427, received 12 units when should have received 20 units.
-On 10/18/19 at 5:00pm, FSBS 487, received 14 units when should have received 20 units.
-On 10/20/19 at 6:30am, FSBS 285, received 0 units when should have received 12 units.
-On 10/21/19 at 5:00pm, FSBS 402, received 12 units when should have received 20 units.
-On 10/25/19 at 5:00pm, FSBS 332, received 20 units when should have received 12 units.
-On 10/26/19 at 5:00pm, FSBS 358, received 8 units when should have received 12 units.

Review of Resident #2's November 2019 eMARs revealed:
-There was an entry to check finger stick blood sugar (FSBS) 2 times a day before breakfast and dinner scheduled for 6:30am and 5:00pm.
-FSBS were not checked at 6:30am on 11/06/19, 11/07/19, 11/10/19, 11/12/19, 11/13/19, 11/18/19, 11/20/19, 11/21/19, 11/25/19, 11/26/19,11/27/19 and 11/30/19 with a reason of "missed dose" documented. It was unknown if Resident #2 needed Novolog insulin at those times.
-There was an entry for Novolog Insulin 100U/ML inject 12 units subcutaneously for FSBS over 250. Give an additional 8 units for FSBS over 400. Hold if FSBS under 100.

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-There was documentation Novolog was administered incorrectly 7 times from 10/01/19 through 10/31/19 as follows:
-On 11/02/19 at 5:00pm, FSBS 249, received 12 units when should not have received insulin.
-On 11/03/19 at 6:30am, FSBS 169, received 12 units when should not have received insulin.
-On 11/06/19 at 5:00pm, FSBS 434, received 12 units when should have received 20 units.
-On 11/11/19 at 6:30am, FSBS 201, received 12 units when should not have received insulin.
-On 11/20/19 at 5:00pm, FSBS 415, received 18 units when should have received 20 units.
-On 11/26/19 at 5:00pm, FSBS 290, received 20 units when should have received 12 units.
-On 11/28/19 at 5:00pm, FSBS 212, received 12 units when should not have received insulin.

Review of Resident #2's December 2019 eMARs revealed:
-There was an entry to check finger stick blood sugar (FSBS) 2 times a day before breakfast and dinner scheduled for 6:30am and 5:00pm.
-FSBS were not checked at 6:30am on 12/01/19, 5:00pm on 12/04/19, 6:30am and 5:00pm on 12/05/19, 5:00pm on 12/06/19, and 6:30am on 12/09/19 with a reason of "missed dose" documented. It was unknown if Resident #2 needed Novolog insulin at those times.
-There was an entry for Novolog Insulin 100U/ML inject 12 units subcutaneously for FSBS over 250. Give an additional 8 units for FSBS over 400. Hold if FSBS under 100.

Interview with a medication aide (MA) on 12/11/19 at 6:05 pm revealed:
-She could not have administered 12 units of Novolog insulin for a FSBS of 40 on 09/04/19.
-She believed the Novolog insulin 12 units was a standing order and not a sliding scale so she

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would administer the insulin if the FSBS was not less than 100.
-She must have read the order incorrectly.
-The Administrator talked with each of the MAs regarding reading insulin orders correctly and administering the correct dose sometime in November 2019.

Interview with a MA on 12/12/19 at 4:45pm revealed:
-Some FSBS were not completed at 6:30am because there was no MA on duty.
-The Administrator was aware that sometimes she could not stay until 7:00am when she worked night shift.
-She thought the first shift MA would do the FSBS when they were not completed by night shift MAs at 6:30am.
-She did not know she had administered incorrect dosages of insulin to Resident #2.
-She did not audit the eMARS and did not know if anyone reviewed them.

Interview with Resident #2's primary care physician's (PCP) nurse practitioner on 12/12/19 at 4:55 pm revealed:
-She did not know Resident #2 had received incorrect dosages of insulin as she did not review the eMARs.
-To much or to little insulin leads to hypoglycemia and hyperglycemia and poorly controls the resident's diabetes.

Interview with the Supervisor on 12/13/19 at 11:09am revealed:
-At times there were no MAs on duty to pass medications or complete FSBS checks.
-The MAs had to stop and assist with personal care which sometimes caused the MAs to get behind on the medication pass.

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-The Administrator knew that medications had been missed.

Interview with the Administrator on 12/13/19 at 1:55pm revealed:
-She knew there were some medications that had been missed.
-She knew there had been an issue with administering incorrect dosages of insulin, so she held a brief in-service for the MA's sometime in November 2019.
-Sometimes there was not an MA on duty at 6:30am for various reasons one of which was staffing issues.
-First shift should administer medications not passed at 6:30am.
-She was responsible for auditing eMARs but had not done them lately as she had depended on the pharmacy reviews to let her know if there was a problem.
-She expected medications to be administered as ordered and in a timely manner to the right resident.

Based on observation, interview, and record review, it was determined Resident #2 was not interviewable.

6. Review of Resident #1's FL2 dated 10/04/19 revealed:
- Diagnoses included cerebral palsy, seizures, hypothyroidism, arthritis, gastroesophageal reflux disorder, and hypomagnesemia.
-There was an order for omeprazole (used to treat gastroesophageal reflux) 20mg 2 times a day at 6:30 am and 4:30 pm.

Review of Resident #1's September 2019 electronic Medication Administration record (eMAR) revealed:

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D 358	Continued From page 203 -There was an entry for omeprazole 20mg 1 capsule 2 times daily scheduled for administration at 6:30am and 4:30pm daily. -Omeprazole 20mg was not documented as administered on 09/10/19 at 6:30am, 09/11/19 at 6:30am, 09/12/19 at 6:30am, 09/16/19 at 6:30am and 4:30pm, 09/17/19 at 6:30am, 09/18/19 at 6:30am, 09/24/19 at 6:30am and 4:30pm, 09/25/19 at 6:30am, 09/26/19 at 6:30am, 09/27/19 at 4:30pm, and 09/28/19 at 6:30am with a documented reason of missed dose. Review of Resident #1's October 2019 eMAR revealed: -There was an entry for omeprazole 20mg 1 capsule 2 times daily scheduled for administration at 6:30am and 4:30pm daily. -Omeprazole 20mg was not documented as administered on 10/02/19 at 4:30pm, 10/03/19 at 6:30am and 4:30pm, 10/04/19 at 4:30pm, 10/06/19 at 6:30am, 10/07/19 at 6:30am, 10/09/19 at 6:30am, 10/10/19 at 6:30am and 4:30pm, 10/11/19 at 4:30pm, 10/19/19 at 6:30am, 10/24/19 at 6:30am, 10/25/19 at 6:30am, and 10/29/19 at 6:30am with a documented reason of missed dose; and on 10/08/19 at 4:30pm, with a documented reason of refused medication. Review of Resident #1's November 2019 eMAR revealed: -There was an entry for omeprazole 20mg 1 capsule 2 times daily scheduled for administration at 6:30am and 4:30pm daily. -Omeprazole 20mg was not documented as administered on 11/06/19 at 6:30am, 11/07/19 at 6:30am, 11/13/19 at 6:30am, 11/18/19 at 6:30am, 11/20/19 at 6:30am, 11/21/19 at 6:30am, 11/29/19 at 4:30pm, and 11/30/19 at 6:30am with a documented reason of missed dose.	D 358		

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Review of Resident #1's December 2019 eMAR revealed:
-There was an entry for omeprazole 20mg 1 capsule 2 times daily scheduled for administration at 6:30am and 4:30pm daily.
-Omeprazole 20mg was not documented as administered on 12/01/19 at 6:30am with a documented reason of missed dose.

Observation of Resident #1's medications on hand on 12/05/19 at 4:10pm revealed:
-There was 1 partially filled blister packs of omeprazole 20mg capsules with instructions to take 1 capsule (20mg) 2 times a day at 6:30am and 4:30pm.
-The omeprazole had a dispense date of 05/03/19.
-The omeprazole had 40 of 60 capsules remaining.

Interview with Resident #1 on 12/1/19 at 9:23am revealed:
-She did not know what medicine she took.
-The staff brought her medication to her.
-Sometimes she had chest pain and had to go to the hospital but it was not her heart.

Interview with a medication aide (MA) on 12/06/19 at 5:45pm revealed:
-She did not recall not administering omeprazole to Resident #1 that was scheduled for 6:30 am.
-Sometimes there was no MA on duty at 6:30am and sometimes Resident #1 would refuse her medications.
-She documented on the eMAR when a resident refused their medications.

Interview with third shift MA on 12/12/19 at 4:45pm revealed:
-She primarily worked third shift.

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D 358	Continued From page 205 -She did not recall not administering omeprazole to Resident #1 that was scheduled for 6:30 am. -Sometimes there was no MA on duty at 6:30am. -Sometimes she was not able to work until 7:00am but the Administrator k new she would not be able to work the full shift. -She thought that if a medication was missed at 6:30 am then the next MA on duty would administer the medication. Interview with a second MA on 12/12/19 at 12:10pm revealed: -Third shift was responsible for administering medications scheduled for 6:30am. -She did not recall what might have happened to cause Resident #1 not to receive her omeprazole at 6:30am. -She did not know if the Nurse Practitioner (NP) knew that multiple doses of omeprazole for Resident #1 had not been administered. -Just because a medication had a missed dose did not mean it was due to not having an MA on duty; sometimes the third shift MA just did not administer the medications at 6:30am. -She did not review the eMARs as thecomputer would only let her go back a few days. -She did not know who was responsible for auditing the eMARs to ensure the residents received medications as ordered. Interview with Resident #1's primary care physician's (PCP) nurse practitioner on 12/12/19 at 4:50 pm revealed: -She did not know Resident #1 had not been receiving her omeprazole as ordered. -Resident #1 had reflux and had to go tothe hospital a few months ago due to chest pain caused by the reflux. -Resident #1 continued to have problems with reflux and could experience increased episodes	D 358		

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D 358	Continued From page 206 of chest pain due to not receiving her medication as ordered. -She expected medications to be administer as ordered. Interview with the Administrator on 12/13/19 at 1:55pm revealed: -She knew some medications had not been given at times but could not recall whom had not received their medication. -Sometimes there was not an MA on duty at 6:30am for various reasons one of which was staffing issues. -First shift should administer medications not passed at 6:30am. -She was responsible for auditing eMARs but had not done them lately as she had depended on the pharmacy reviews to let her know if there was a problem. -She expected medications to be administered as ordered and in a timely manner to the right resident. __________ The facility failed to administer medications as ordered to 6 of 6 sampled residents resulting in a resident not administered Lovenox for 3 days which resulted in the resident having to be transported to the hospital for a Lovenox injection and placed the resident at risk for blood clotting (#4); a resident not administered a narcotic pain medication resulting in the resident experiencing severe pain for extended amounts of time (#4); two residents administered incorrect dosages of insulin placing the residents at risk for hypoglycemia and hyperglycemia (#2 and #12); a resident not administered a topical antiseptic to a wound for 3 days placing the resident at risk for further skin breakdown and infection (#3); a resident not administered a diuretic placing the resident at risk for continued swelling in his feet	D 358	THERE WERE NUMEROUS POLICIES AND PROCEDURES CONCERNING MEDICATION MANAGEMENT AND FOLLOW-UP WITH DOCTORS. ADMINISTRATOR, BY HER OWN ADMISSION IN INTERVIEW WITH STATE, ACKNOLEDGED SUCH. COPIE OF PROCEDURES ATTACHED. HOME WAS CLOSED ON 2/7/20 AND WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S., ALL RESIDENTS WERE RELOCATED TO APPROPRIATE LEVELS OF CARE.	

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D 358	Continued From page 207 (#5); and a resident with multiple missed doses of a gastric acid reducer placing the resident at risk for having chest pain and increased acid reflux (#1). This failure placed residents at 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 12/04/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 12, 2020.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents . This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered in accordance with infection control measures for 1 of 8 sampled medication aides (Staff M) not using appropriate infection control measures when medications were dropped on the floor. The findings are:	D 371	FACILITY POLICY STATES THAT ALL STAFF ARE TO RECEIVE OSHA TRAINING UPON HIRE. AFTER SURVEY, STAFF RECEIVED ANOTHER OSHA INFECTION CONTROL TRAINING CLASS PROVIDED BY EXPRESS CARE PHARMACY. (SEE ATTACHED) AS OF 2/7/2020, ALL RESIDENTS HAVE BEEM MOVED TO AN APPROPRIATE LEVEL OF CARE WITH ASSISTANCE FROM DAVIE COUNTY D.S.S. AND THE HOME IS NOW CLOSED.	

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Observation on 12/05/19 at 10:35am revealed:
-There was a small, white, round tablet on the floor in a resident's room by his wheelchair.
-A medication aide (MA), Staff M, on first shift was informed that the resident had a tablet on the floor in his room by his wheelchair.
-Staff M went into the resident's room, picked up the white tablet off the floor and proceeded to give the tablet to the resident and watched the resident until he swallowed the tablet.

Observation on 12/05/19 at 11:08am revealed:
-Staff M went into another resident's room and dropped a tablet on the floor.
-Staff M picked the tablet off the floor and attempted to give the tablet to the other resident.
-Staff M was prompted by surveyor to dispose of the tablet according to facility policy and get another tablet to give to the other resident.
-Staff M gave the resident another tablet.

Interview with Staff M on 12/05/19 at 10:35am revealed she did not know the tablets on the floor needed to be disposed of.

Interview with Resident #12 on 12/06/19 at 4:27pm revealed MAs had administered medications to him before that were dropped on the floor.

Interview with a second shift MA on 12/06/19 at 4:44pm revealed if a tablet was dropped on the floor, it was documented as wasted and then "thrown away or flushed."

Interview with the Supervisor on 12/06/19 at 4:37pm revealed:
-Facility policy for a dropped tablet was for the MA to pick the tablet up and dispose of it.
-She did not know MAs were giving dropped

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D 371	Continued From page 209 medications to the residents. Telephone interview with a representative from the facility's contracted pharmacy on 12/10/19 at 10:34am revealed: -If medications were dropped, staff "punched another pill." -The MA should document and the pharmacy should be contacted. Interview with the Administrator on 12/06/19 at 4:51pm revealed: -Facility policy for a dropped medication was to waste the medication. -The dropped tablet was thrown away in a sharps container or flushed. Telephone interview with Resident #12's Primary Care Physician on 12/10/19 at 11:07am revealed: -The facility should have a process in place for medications that were dropped. -She would not expect medications that were dropped to be administered to the residents.	D 371		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION	D 392		

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D 392	Continued From page 210 Based on observations, interviews, and record reviews, the facility failed to assure records of the administration of controlled substances were maintained, accurate and reconciled for 5 of 8 sampled residents (Residents #4, #5, #15, #17 and #18) who were prescribed Oxycodone (#4 and #17), lyrica (#4), zolpidem tartrate (#4), hydrocodone (#15), and lorazepam (#5 and #18). The findings are: Review of the facility's Medication Administration Policy for Controlled Drugs revealed: -Individual controlled drug records shall be maintained for each resident; one medication per record with the following information: name of resident, name of medication, dosage administered, date of administration, initial and ending count. -All controlled drugs shall be counted each shift by two persons (not from the same shift, one from the preceding shift and one from the incoming shift). -Documentation of the count shall be maintained on individual controlled drug sheets, on the active medication administration record, signed by two persons. -If all drugs were not accounted for, the Resident care Director, Executive Director and vendor pharmacy must be notified. -Return of controlled substances from the community to vendor pharmacy required documentation of such drugs on the Return to Pharmacy Form and placed in a sealed tote for return to the vendor via the delivery driver. The vendor pharmacy would confirm the returned medications and return the confirmed receipt to the community.	D 392	POLICIES (SEE ATTACHED) WERE IN PLACE TO PROPERLY ADMINISTER CONTROLLED SUBSTANCES. ANY INCONSISTENCIES WERE TO BE REPORTED TO ADMINISTRATOR OR RCC IMMEDIATELY. AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN MOVED TO AN APPROPRIATE LEVEL OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME IS NOW CLOSED.	

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D 392	Continued From page 211 1. Review of Resident #17's FL2 dated 07/29/19 revealed: -Diagnoses included scoliosis, restrictive lung disease, chronic pain, and fibromyalgia. -Admission date was 07/29/19. -There was an order for oxycodone (a narcotic used to treat moderate to severe pain) 20mg one tablet every 6 hours as needed for pain. Review of Resident #17's physician's orders revealed: -There was a copy of a prescription dated 07/26/19 for oxycodone 20mg take 1 tablet every 6 hours as needed for pain with a dispensed quantity of 120 tablets. -There was a second copy of a prescription dated 09/25/19 for oxycodone 20mg take 1 tablet every 6 hours as needed for pain with a dispensed quantity of 120 tablets. -There was a third copy of a prescription dated 10/25/19 for oxycodone 20mg take 1 tablet every 6 hours as needed for pain with a dispensed quantity of 120 tablets. Review of Resident #17's progress notes revealed: -On 07/29/19, Resident #17 was admitted and had 110 oxycodone 20mg tablets with her. -A Controlled Substance Count Sheet (CSCS) was created for Resident #17's oxycodone. -On 08/05/19, two oxycodone 20mg tablets were wasted with a witness at 1:59 pm. -On 08/05/19 at 1:59 pm, the CSCS for oxycodone 20mg did not match the quantity on hand; there were 5 tablets not accounted for and the Supervisor informed the Administrator. -On 08/09/19, it was noted that the Administrator went behind staff and found that the medication was "on point" so the count was left. -On 08/09/19, the second page for the CSCS	D 392		

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D 392	Continued From page 212 sheets started on 08/08/19 at 1:30pm with a count of 90 and 7 tablets were left out of the count. -On 08/18/19, the CSCS for oxycodone 20mg for Resident #17 count was noted to be off by 3 tablets. -On 08/18/19, it was noted that the Supervisor and the Administrator were informed of the oxycodone 20mg count being off by 3 tablets. Review of Resident #17's CSCS for oxycodone compared to the July 2019 electronic Medication Administration Record (eMAR) revealed: -There was not an entry for oxycodone 20mg 1 tablet every 6 hours as needed on the eMAR. -There were 5 oxycodone 20mg tablets documented as administered in the medication notes on the eMAR. -There was no CSCS available for review for documentation of oxycodone signed out for 07/29/19 through 07/31/19. (Resident #17 was admitted on 07/29/19 with 110 oxycodone 20mg tablets). -Based on review of the July 2019 eMAR and documentation of oxycodone available for Resident #17, there were 105 tablets of oxycodone unaccounted for. Review of Resident #17's CSCS for oxycodone compared to the August 2019 eMAR revealed: -There was an entry for oxycodone 20mg 1 tablet every 6 hours as needed on the eMAR. -Oxycodone 20 mg was documented as administered 77 times from 08/01/19 through 08/27/19. There was no CSCS available for review for documentation of administration for 08/01/19 through 08/27/19. (Resident #17 was admitted with 110 oxycodone 20mg tablets). -From 07/29/19 through 08/27/19 a total of 28	D 392		

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oxycodone 20mg tablets were unaccounted for.
-Oxycodone 20mg (120 tablets) were dispensed on 08/26/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 08/27/19 to 08/31/19.
-There were 20 tablets signed out as compared to the eMAR from 08/27/19 through 08/31/19 and 19 tablets were documented as administered on the eMAR.
-The CSCS count started at 120 tablets on 08/27/19 and ended at 100 tablets on 08/31/19 for a total of 1 tablet not accounted for.

Review of Resident #17's CSCS for oxycodone 20 mg compared to the September 2019eMAR revealed:
-There was an entry for oxycodone 20mg 1 tablet every 6 hours as needed on the eMAR.
-Oxycodone 20mg (120 tablets) were dispensed on 08/26/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 09/01/19 to 09/27/19 with 93 tablets signed out as compared to the eMAR from 09/01/19 through 09/27/19 102 tablets were documented as administered on the eMAR.
-The CSCS count started at 100 tablets and ended at 0 tablets on 09/27/19 at 12:20am for a total of 7 tablets not accounted for.
-Oxycodone 20mg (120 tablets) were dispensed on 09/27/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 09/28/19 to 09/30/19 with 11 tablets signed out as compared to the eMAR from 09/28/19 through 09/30/19 at 6:36am and 11 tablets were documented as administered on the eMAR.
-The CSCS count started at 120 and ended at 88 on 09/30/19 for a total of 21 tablets not accounted for.

Review of Resident #17's CSCS for oxycodone

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D 392	Continued From page 214 compared to the October 2019 eMAR revealed: -There was an entry for oxycodone 20mg 1 tablet every 6 hours as needed on the eMAR. -Oxycodone 20mg (120 tablets) were dispensed on 09/27/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 10/01/19 to 10/25/19 at 12:00am with 88 tablets signed out as compared to the eMAR from 10/01/19 through 10/25/19 at 12:00am and 89 tablets were documented as administered on the eMAR. -The CSCS count started at 88 and ended at 0 on 09/27/19 at 12:20am for a total of 1 tablet not accounted for. -There was a CSCS with a handwritten label with Resident #17's name, drug name and strength, and instructions for use. There was no prescription number on it. It did not have a beginning count on it. The first time signed out was 10/25/19 at 12:00 pm beside number 17 and counted down to 0. -Oxycodone 20mg was documented on the handwritten label CSCS from 10/25/19 to 10/29/19 at 6:00pm with 17 tablets signed out as compared to the eMAR from 10/25/19 through 10/29/19 at 6:00pm and 13 tablets were documented as administered. -Oxycodone 20mg (120 tablets) were dispensed on 10/28/19 and documented on the CSCS for administration 1 tablet every 6 hours from 10/30/19 to 10/31/19 with 9 tablets signed out as compared to the eMAR from 10/30/19 through 10/31/19 and 8 tablets were documented as administered on the eMAR. -The CSCS count started at 120 and ended at 111 on 10/31/19 for a total of 1 tablet not accounted for. Review of Resident #17's CSCS for oxycodone compared to the November 2019 eMAR revealed:	D 392		

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D 392	Continued From page 215 -There was an entry for oxycodone 20mg 1 tablet every 6 hours on the eMAR. -Oxycodone 20mg (120 tablets) were dispensed on 10/28/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 11/01/19 to 11/27/19 at 6:00pm with 107 tablets signed out (1 documented as dropped and another was documented as wasted but not signed out by anyone) as compared to the eMAR from 11/01/19 through 11/27/19 at 6:00pm and 103 tablets were documented as administered on the eMAR. -The CSCS count started at 111 tablets and ended at 0 tablets on 11/27/19 at 6:00pm for a total of 8 tablets not accounted for. -Oxycodone 20mg (120 tablets) were dispensed on 10/28/19 and documented on the CSCS for administration 1 tablet every 6 hours from 11/28/19 to 11/30/19 with 12 tablets signed out as compared to the eMAR from 11/28/19 through 11/30/19 and 11 tablets were documented as administered on the eMAR. -The CSCS count started at 120 and ended at 107 on 11/30/19 for a total of 1 tablet not accounted for. Review of Resident #17's CSCS for oxycodone 20 mg compared to the December 2019 eMAR revealed: -There was an entry for oxycodone 20mg 1 tablet every 6 hours on the eMAR. -Oxycodone 20mg (120 tablets) were dispensed on 10/28/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 12/01/19 to 12/06/19 at 12:00pm with 22 tablets signed out as compared to the eMAR from 12/01/19 through 12/06/19 at 12:00pm and 23 tablets were documented as administered on the eMAR. -The CSCS count started at 107 and ended at 85	D 392		

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D 392	Continued From page 216 on 12/06/19 at 12:00pm for a total of 1 tablet not accounted for. Observation of Resident #17's medications on hand on 12/06/19 at 1:30pm revealed there were 85 oxycodone 20mg available for administration. Interview with a MA on 12/03/19 at 4:40pm revealed: -Resident #17's oxycodone 20mg were initially in a bottle instead of a blister pack. -When Resident #17 was admitted, she brought 110 tablets of oxycodone 20mg to the facility with her. -A CSCS was created for Resident #17's 110 oxycodone 20mg. Interview with a PCA on 12/04/19 at 7:25am revealed she had counted controlled substances with a MA a few times, including Resident #17's oxycodone, because there was not another MA in the building. Interview with the Administrator on 12/06/19 at 5:25pm revealed: -She had been told Resident #17's oxycodone count was off. -The count for Resident #17's oxycodone was questioned in October and November 2019, but when she looked at the CSCS there had been a staff error. -She did not recall Resident #17 missing oxycodone in in July or August 2019 after Resident #17 was admitted. -She could not find the CSCS for July and August 2019 for Resident #17. -She would double check her notes for any oxycodone that might had been reported as missing. -She knew any suspected diversion was required	D 392		

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to be reported to DSS, the police, and the vendor pharmacy.
-She had no proof of any diversion of oxycodone.

Interview with a MA on 12/06/19 at 5:45 pm revealed:
-She knew Resident #17 had an order and was administered oxycodone 20mg for her pain since she had been admitted in July 2019.
-She remembered signing out on the CSCS the oxycodone 20mg for Resident #17.
-Some MAs placed a circle around the number on the CSCS indicating that was the actual number for there count.
-She had left notes for other MAs to sign for Resident #17's oxycodone when the CSCS had been left blank.
-The Administrator knew Resident #17's oxycodone count was off because staff had told her.
-The Administrator had instructed the MAs to notify her if a controlled count was off.
-The MAs had been documenting the beginning and ending count of controlled substances in the shift report notebook.
-At shift change, the off going MAand the oncoming MA were supposed to count all controlled substances together.
-There had been a few times in which she had to count by herself due to no oncoming MA when her shift was over.
-When she counted by herself, she reviewed the controlled substance label and the medication label and then counted the tablets 2 times.

Telephone interview with a pharmacy representative on 12/12/19 at 9:50am revealed:
-The pharmacy dispensed Resident #17's oxycodone 20mg to the facility on 08/26/19 with a dispense quantity of 120 tablets.

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D 392	Continued From page 218 -The pharmacy dispensed Resident #17's oxycodone 20mg to the facility on 09/27/19 with a dispense quantity of 120 tablets. -The pharmacy dispensed Resident #17's oxycodone 20mg to the facility on 10/28/19 with a dispense quantity of 120 tablets. -The pharmacy dispensed Resident #17's oxycodone 20mg to the facility on 11/27/19 with a dispense quantity of 120 tablets. -The pharmacy sent a CSCS to the facility with each dispensed date for the oxycodone 20mg. -The procedure for returning narcotics for destruction to the pharmacy was as follows: -After the narcotics were discontinued or the resident had been discharged the facility was responsible for returning narcotics to the pharmacy. The facility staff were to fill out a return form with documentation of how many tablets were to be sent back and include a signature. The pharmacy courier would pick up the narcotics nightly at the facility. -There were no returned oxycodone 20mg for Resident #17. -The pharmacy representative was not aware of any discrepancies with Resident #17's oxycodone. Interview with a MA on 12/12/19 at 12:10pm revealed: -There had been times when she came to work and there were no MAs on duty, so she had to count controlled drugs by herself. -She did not want to lose her MA certification so she would have a PCA count with her as a witness only as a last resort. -The Administrator was aware of the PCA being utilized when counting controlled medications. -The Administrator told us the PCA was "in training" to be a MA.	D 392		

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D 392	Continued From page 219 Interview with Resident #17 on 12/12/19 at 1:00pm revealed: -She knew that she had at least 10 oxycodone missing after she was admitted to the facility and then a few in October 2019 were missing because she ran short. -The Administrator had investigated the missing oxycodone. -The MA that was suspected of taking her oxycodone was still employed at the facility. -Sometimes the MA would not show up for work on night shift and she had to go without her pain medication. -She had some difficulty getting her oxycodone especially on night shift when no MA would not show up for work. -Her physician scheduled her oxycodone around the clock so she would not have to wait extended periods for her pain medication. Interview with a MA on 12/12/19 at 4:45pm revealed: -The Administrator had told her that some oxycodone were missing for Resident #17 about 2 months ago. -She did not know how the situation was investigated. -When the oxycodone went missing, they had to start documenting beginning and end counts in the shift report book in addition to using the CSCS. Interview with Resident #17's facility Nurse Practitioner on 12/12/19 at 4:50pm revealed: -She did not know Resident #17 was missing some oxycodone. -Resident #17 had been prescribed oxycodone 20mg by another medical provider. -She never reviewed Resident #17's eMAR for how many times she had used the oxycodone	D 392		

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D 392	Continued From page 220 20mg. Interview with the Supervisor on 12/13/19 at 11:09am revealed: -She knew Resident #17 had an order and was administered oxycodone 20mg for her pain since she was admitted in July 2019. -She remembered signing out on the CSCS for oxycodone 20mg for Resident #17. -The CSCS required a signature each time a controlled substance was signed out. -Resident #17 had 110 oxycodone 20mg when she was admitted on 07/29/19. -The MAs were not doing what they were supposed to do (filing the CSCSs) so the CSCS logs for July and August 2019 could not be found. -The Administrator knew Resident #17 was missing some oxycodone 20mg because she had told her in August 2019. -After the first time Resident #17's oxycodone went missing, the Administrator put in place for each MA to document the beginning and end count on a sheet of paper and had the resident to sign stating she received her medication. -Also, the beginning and end counts of controlled substances were to be documented in the shift report notebook. -The first time some of Resident #17's oxycodone went missing, the investigation was narrowed down to 3 MAs, then one of the 3 quit. -She asked the Administrator to notify the police of the missing oxycodone in August 2019. -The second time Resident #17's oxycodone went missing, the same 2 MAs were suspected, but the police were not notified. -No staff were drug tested as a result of the missing oxycodone. -Sometimes the MAs would have to count by themselves as there was no other MA in the building.	D 392		

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-When the off-going MAs counted by themselves and then left the building the keys were placed in an unidentified area so that the oncoming MA knew where they were at.
-She knew sometimes the MAs would utilize a PCA to count controlled substances when no other MA was in the building.
-The Administrator knew PCAs were being utilized sometimes as a witness to the controlled substance count.

Interview with a MA on 12/13/19 at 1:34 pm revealed:
-He trained with another MA for 2 days on the cart.
-The oxycodone was missing before he worked on the cart.
-He told the Supervisor and the Administrator Resident #17's oxycodone count was off just by looking at the CSCS.
-Nothing was put in place to prevent the oxycodone from being unaccounted for.

Interview with the Administrator on 12/12/19 at 6:55pm revealed:
-There was a span of time during September and October 2019 when there was no MA in the building and residents may have not gotten their pain medication as soon as they requested it.
-There had been a few shifts during November 2019 when there was no MA on duty, especially on third shift.
-The facility no longer had any on call staff for the facility that could come in and give medications as needed.
-The MAs had to count the controlled substances by themselves at times due to the oncoming MA running late.
-When the next MA arrived, they would also count the controlled substances.

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D 392	Continued From page 222 Interview with the Administrator on 12/13/19 at 1:55pm revealed: -Resident #17 had 110 oxycodone when she was admitted to the facility. -She knew Resident #17 had an order and was administered oxycodone 20mg for her pain since she was admitted in July 2019. -She remembered signing out on the CSCS for oxycodone 20mg for Resident #17. -The CSCS required a signature each time a controlled substance was signed out. -She knew Resident #17 had some oxycodone unaccounted for. -She had looked at Resident #17's CSCS and compared it to the oxycodone on hand. -She thought that initially 5 oxycodone went missing. -She interviewed staff and residents and found that some of the oxycodone had been wasted. -After her investigation, the information led her to 2 individuals who were MAs. -She did not drug test either of the suspected staff or report the missing oxycodone to the police (when asked why she did not respond). -After the second incident when 1 or 2 went missing, she put a new system in place requiring the resident to sign stating she had gotten her medications. -She did not drug test the suspected staff or notify the police after the second incident when Resident #17's oxycodone went missing (when asked why she did not respond). -She "could not answer why she did not report the missing oxycodone to the police". -She informed the representative for the local Department of Social Services face to face when she came in to monitor the facility. 2. Review of Resident #15's FL2 dated 04/18/19	D 392		

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D 392	Continued From page 223 revealed: -Diagnoses included dementia, insomnia, hypothyroidism -Admission date was 09/14/06. Review of Resident #15's record revealed: -There was a copy of a prescription dated 07/12/19 for hydrocodone/acetaminophen 5/325mg take one-half(1/2) tablet 4 times a day as needed for pain, and one-half tablet 4 times a day with a dispensed quantity of 150 whole tablets. Review of Resident #15's controlled substance count sheet (CSCS) for the prescription dated 07/12/19 for hydrocodone/acetaminophen 5/325mg take one-half(1/2) tablet 4 times a day as needed for pain, and one-half tablet 4 times a day with a dispensed quantity of 150 whole tablets on one line of the form revealed: -There were 4 CSCS tracking sheets generated for hydrocodone/acetaminophen 5/325mg with three sheets for 90 one-half tablets (equaling 135 whole tablets) and one CSCS tracking sheet for 30 one-half tablets (equaling 15 whole tablets) for a total of 150 whole tablets totaling 300 one-half tablets. -There was documentation hydrocodone/acetaminophen dispensed on 07/12/19 for 300 of one-half tablets was signed out for 42 one-half tablets from 07/13/19 to 08/09/19. Telephone interview with a representative forthe contracted pharmacy on 12/13/19 at 2:12pm revealed: -The pharmacy received a physician's order dated 07/12/19 from Resident #15's primary care provider's Nurse Practitioner (NP) for hydrocodone 5/325mg (a narcotic pain reliever	D 392		

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used to treat moderate pain) take one-half(1/2) tablet 4 times a day as needed for pain, and one-half tablet 4 times a day for pain with a dispensed quantity of 150 whole tablets equal to 300 half tablets.
-The pharmacy received a subsequent physician's order dated 08/09/19 from Resident #15's primary care provider's NP for hydrocodone 5/325mg take one tablet every 4 hours as needed for pain, and one tablet 4 times a day for pain with a dispensed quantity of 150 tablets.
-The pharmacy discontinued the order for one-half tablet every 4 hours as needed and one-half tablet 4 times a day.
-The pharmacy routinely sent controlled substance count sheets (CSCS) with each controlled medication sent to the facility.
-The CSCS were to be used by the facility to track administration and/or return of the medication.

Review of the facility's pharmacy return credits revealed:
-There was a pharmacy form completed for "prescription returned to pharmacy" on 8/10/19 for 258 one-half tablets of hydrocodone/acetaminophen 5/325mg as follows: 48 of one-half tablets on one line of the form; 90 of one-half tablets on one line of the form; 90 of one-half tablets on one line of the form; and 30 of one-half tablets on one line of the form.
-There was a signature for the staff completing the form but no "pharmacy signature'.

Telephone interview with a pharmacist at the contracted pharmacy on 12/12/19 at 12:14pm revealed:
-The facility staff should have documentation of administration by signing out or return of controlled medications on the CSCS that was sent to the facility with the medications when

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delivered.
-The facility should complete a "prescription returned to pharmacy" form, retain a copy, and send two copies of the multiple copy form in the sealed medication return tote to the pharmacy with the delivery driver on the next delivery.
-The form had a place for the pharmacy to sign and return to the pharmacy once the returns had been processed for disposition of the controlled substance (medication).
-The facility should keep the signed return sheet along with a copy of the CSCS for tracking administration and/or disposition of medications.

Interview with the Administrator on 12/12/19 at 1:10pm revealed:
-She did not have any medications returned to the pharmacy.
-Staff should use the CSCS to document administration of medications and place in the residents' record when the CSCS were completed.

Confidential interview with a staff member revealed:
-The keys to the medication cart were not always handed off from one medication aide (MA) to another MA.
-Sometimes the MA left before the next MA came into the facility and the keys were hidden for the next MA.
-The staff had not reported to the Administrator regarding the keys being left unattended.

Telephone interview with the facility's contracted primary care physician's Nurse Practitioner (NP) on 12/12/19 at 4:45pm revealed:
-The NP was not aware of Resident #15 missing any medications for pain.
-The NP had changed Resident #15's pain

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medication a couple of times but always wrote new orders for the pain medication.
-The resident had not reported being out of medication or missing any medication doses when she saw the resident during routine visits.

-Interview with a medication aide on 12/12/19 at 5:40pm revealed:
-She completed a "prescription returned to pharmacy" form for all controlled substances she sent back to the contracted pharmacy.
-The controlled substances were placed in atote going back to the pharmacy, sealed with a return seal, and picked up by the delivery driver.
-The facility signed for totes received but they did not have the driver sign for returns sent back to the pharmacy.

Interview with the Administrator on 12/12/19 at 6:30pm revealed:
-When she did pharmacy returns, the pharmacy returns were written on a return sheet and the medication and the forms were placed in the sealed tote for the pharmacy delivery driver to pick up.
-She did not keep a copy of the returns.
-She did not know if the pharmacy sent a return document for receipt of the returned controlled substances or if staff tracked the disposition of controls.

Interview with the pharmacist at the contracted pharmacy on 12/12/19 at 12:14pm revealed:
-He was not able to locate any papers to document receipt of the return for 258 of one-half tablets of hydrocodone/acetaminophen 5/325mg since 08/10/19 for Resident #15.
-The pharmacist had checked the processed CSCS returned sheets, the "prescription returned to pharmacy" form for all controlled substances

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returned around 08/11/19, checked with the pharmacy staff working in the controlled substance return area and even looked for documentation of destruction of the medication by the contracted destruction company used by the contracted pharmacy and was unable to locate documentation for disposition of the medication.
-He could not find any record the pharmacy received the returned "prescription returned to pharmacy" form for Resident #15.

Telephone interview with the MA who prepared the return sheet for Resident #15's hydrocodone/acetaminophen 5/325mg on 12/13/19 at 12:40pm revealed:
-She routinely worked Friday, Saturday, and Sundays at the facility.
-When she prepared controlled substances for return to the contracted pharmacy, she completed the "prescription returned to pharmacy", made a copy, placed the form in a pharmacy tote, sealed the tote with pharmacy zip ties, and placed the returns in the locked medication room.
-She had prepared the return or Resident #15's hydrocodone/acetaminophen 5/325mg 258 one-half tablets on 08/10/19 and sealed the tote because the residents' medication changed to one tablet per dose instead of one-half tablet on 08/09/19.
-She routinely was not working when the returns were picked up on Monday.
-She did not know if the facility had received a credit or documentation for returning the medication.

Telephone interview with the a staff at the contracted pharmacy who processes returned controlled substances for the facility on 12/13/19 at 1:16pm revealed:

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-There was no documentation for receipt of the returned 258 one-half tablets of hydrocodone/acetaminophen 5/325mg for Resident #15.
-The staff would continue to look in returns for the medication.

Telephone interview with the Administrator on 12/13/19 at 1:27pm revealed:
-She could not locate documentation for the return of Resident #15's hydrocodone/acetaminophen 5/325mg 258 one-half tablets written up on 08/10/19.
-No staff had reported to her that medications processed for return had been missing.
-She had not been tracking the credit or return of the processed "prescription returned to pharmacy" for controlled substances previously but would start now.

Based on observation, interviews, and record reviews it was determined Resident #15 was not interviewable.

Based on review of documentation on the CSCS, dispensing records from the contracted pharmacy and record of no return of hydrocodone/acetaminophen 5/325mg for Resident #15, medications on hand for administration, and medications awaiting return to the contracted pharmacy for Resident #15, there were 258 doses of one-half tablet of 300 doses of one-half tablets dispensed on 07/12/19 not accounted for.

3. Review of Resident #4's current FL2 dated 10/02/19 revealed:
-Diagnoses included primary malignant neuroendocrine tumor of ileum, hyponatremia, chronic diastolic congestive heart failure, protein

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calorie malnutrition, and mass of small intestine.
-There was a physician's order for oxycodone 10 mg tablets ½ tablet every 8 hours as needed for pain.

a. Review of a hospital discharge summary dated 09/25/19 revealed an order for oxycodone 5mg every 8 hours as needed.

Review of Resident #4's physician's orders dated 10/15/19 revealed oxycodone 10mg every 4 hours scheduled and 1 tablet every 1 hour as needed.

Review of Resident #4's electronic Medication Administration Record (eMAR) for September 2019 revealed:
-There was an entry for oxycodone 10mg ½ tablet every 8 hours up to 7 days as needed for severe pain.
-There was a second entry for oxycodone 10mg ½ tablet every 8 hours up to 7 days as needed for severe pain.
-There was documentation of 4 oxycodone 10mg ½ tablets administered from 09/25/19 through 09/30/19.

Review of Resident #4's controlled substance count sheet (CSCS) revealed there was documentation 4 oxycodone 10mg ½ tablet were signed out from 09/25/19 through 09/30/19.

Review of Resident #4's eMAR for October 2019 revealed:
-There was an entry for oxycodone 10mg 1 tablet every 4 hours for pain.
-There was a second entry for oxycodone 10mg 1 tablet every 4 hours for pain.
-There were 3 entries for oxycodone 10mg ½ tablet every 8 hours as needed for severe pain.

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D 392	Continued From page 230 -There were 2 entries for oxycodone 10mg 1 tablet every 1 hours as needed for pain/shortness of breath. -There was a third entry for oxycodone 5mg 1 tablet 4 times a day as needed for severe pain. -There was documentation 70 oxycodone 10mg tablets were administered from 10/01/19 through 10/31/19. -There was documentation 16 oxycodone 10mg ½ tablets were administered from 10/01/19 through 10/14/19. -There was documentation 11 oxycodone 10mg tablets as needed were administered from 10/15/19 through 10/31/19. -There was documentation 1 oxycodone 5 mg tablet was administered from 10/01/19 through 10/31/19. -There was a total of 17 oxycodone 10mg ½ tablets documented as administered from 10/01/19 through 10/31/19. -There was a total of 81 oxycodone 10mg tablets documented as administered from 10/01/19 through 10/31/19. Review of Resident #4's CSCS revealed: -There were 60 one-half tablets of oxycodone 10mg received by the facility on 10/09/19. -There was a total of 73 oxycodone 10mg ½ tablets documented as signed out from 10/01/19 through 10/20/19. -There were 23 oxycodone 10mg ½ tablets returned to the pharmacy on 10/20/19. -There were 240 oxycodone 10mg tablets received by the facility on 10/19/19. -There was a total of 56 oxycodone 10mg tablets documented as signed out from 10/01/19 through 10/31/19. -There was a total of 25 tablets documented as administered on the eMAR, but not signed out on the CSCS.	D 392		

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Review of Resident #4's eMAR for November 2019 revealed:
-There was a total an entry for oxycodone 10mg 1 tablet every 4 hours for pain.
-There was a second entry for oxycodone 10mg 1 tablet every 1 hour as needed for severe pain.
-There was documentation 190 tablets of oxycodone 10mg were administered from 11/01/19 to 11/30/19.

Review of Resident 4's CSCS revealed:
-There were 100 tablets of oxycodone 10mg dispensed to the facility on 11/30/19.
-There was a total of 179 oxycodone 10mg tablets documented as signed out from 11/01/19 through 11/30/19.
-There was a total of 11 tablets documented as administered on the eMAR, but not signed out on the CSCS.

Review of Resident #4's eMAR for December 2019 revealed:
-There was an entry for oxycodone 10mg 1 tablet every 4 hours for pain.
-There was a second entry for oxycodone 10mg 1 tablet every 1 hour as needed for severe pain.
-There was documentation 29 tablets of oxycodone 10mg were administered from 12/01/19 through 12/05/19 at 2:00pm.

Review of Resident #4's CSCS revealed:
-There were a total of 27 oxycodone 10mg tablets documented as signed out from 12/01/19 at 10:00am through 12/05/19 at 2:00pm.
-There were a total of 2 tablets documented as administered on the eMAR, but not signed out on the CSCS.

Observation of Resident #4's oxycodone on hand

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D 392	Continued From page 232 on 12/05/19 at 2:41pm revealed: -There was a bubble-packed container of oxycodone 10mg tablets 1 tablet every 4 hours for pain and 1 tablet every 1 hours as needed for pain/shortness of breath. -There were 90 tablets in a bubble pack, but there were a total of 100 tablets (2 bubble packs: 90 tablets in one bubble pack and 10 tablets in the other bubble pack) dispensed by the pharmacy on 11/30/19. -The first bubble pack of 10 oxycodone tablets had already been administered to Resident #4. -There were 73 tablets of 90 tablets of oxycodone remaining in the second bubble pack. According to review of the October, November and December 2019 eMARS, dispensing records and medications on hand, there were 38 oxycodone tablets unaccounted for. Interview with Resident #4 on 12/03/19 at 10:56am revealed: -She had physician's orders for oxycodone every 4 hours and as needed for pain. -She had gone "long stretches" without her pain medication on numerous occasions and had gone as long as 10 hours. -The times she had to go without her pain medication, she experienced severe pain. -She sometimes went until her pain was unbearable to ask for pain medication because she did not want to get a cold response from staff. -She had been told by staff her pain medication was in medication totes and staff had not gotten around to putting medication on the medication cart from the totes yet. -Many times there were no medication aides (MA) working to administer medication on third shift.	D 392		

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Interview with a third shift medication aide (MA) on 12/05/19 at 8:12am revealed:
-She administered medication to Resident #4 including controlled substances.
-When she administered controlled substances, she popped the pill and then she would document that the pill was signed out on the CSCS.
-She did not know if anyone reviewed the CSCS for accuracy.
-There were two omissions of oxycodone on the CSCS that occurred during her shift on 10/21/19.
-Resident #4's physician's order for oxycodone changed from ½ tablets to whole tablet, but she did not remember when.
-She thought she purposefully skipped signing out two ½ tablet on 10/21/19 because she was using the ½ tablets to make a whole tablet to administer to Resident #4.
-She did not realize the ½ tablets of oxycodone were returned to the pharmacy on 10/20/19.

Interview with the Supervisor on 12/05/19 at 4:37pm revealed:
-The pharmacy reviewed the CSCS once a quarter.
-There was no facility staff who reviewed the CSCS for accuracy on a regular basis.
-She had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she informed the Administrator.
-There was a shift to shift notebook where MAs noted how many controlled substance tablets they started with and how many tablets they administered.
-She did not know what happened to the shift to shift notebook, but it was at the MAs work station at the beginning of the week.

Interview with a representative from the

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contracted pharmacy on 12/11/19 at 12:51pm revealed:
-There was a physician's order for oxycodone 10mg ½ tablet every 8 hours as needed which was dispensed to the facility on 10/09/19 with a quantity of 30 tablets.
-There was a physician's order dated 10/15/19 for oxycodone 10mg 1 tablet every 4 hours and 1 tablet every 1 hours as needed and was dispensed to the facility on 10/18/19 with a quantity of 240 tablets.
-On 11/29/19, 100 tablets of oxycodone 10mg 1 tablet every 4 hours and 1 tablet every one hour as needed was dispensed to the facility.
-On 10/22/19, 23 tablets of oxycodone 10mg ½ tablets were keyed into the system as being returned to the pharmacy.

Interview with a first and second shift MA on 12/12/19 at 9:50am revealed:
-She found the controlled substance count off for Resident #4's oxycodone "many times" when she started her shift.
-She notified a Supervisor and the Administrator when she found the controlled medication count did not match the number of controlled medication on the medication cart.
-There was a shift to shift notebook at the MA's work station where MAs recorded the beginning and ending count of controlled medications for Resident #4, but she had not seen the notebook since 12/03/19 (survey entrance date).
-When she administered controlled medication, she documented the administration on the CSCS.
-When she saw missing sign outs of controlled medications from the CSCS or if a sign out was not signed, she went through the eMAR to see who was working and wrote the names of the MAs on a sheet of paper and gave it to the Administrator.

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Interview with a first shift MA on 12/12/19 at 11:46am revealed:
-She had talked to the Administrator about missing controlled medications.
-The supervisor tried to get the Administrator to contact law enforcement to report the missing controlled medications, but the Administrator did not.

Interview with the Supervisor on 12/12/19 at 12:48pm revealed:
-She had informed the Administrator about missing controlled medications, but nothing was done.
-Law enforcement should have been called, the suspected MA(s) should have been drug tested and suspended until an investigation was completed.

Interview with the Administrator on 12/12/19 at 6:20pm revealed she knew there had been issues with residents' controlled medications, but she did not know there was an issue with Resident #4's controlled medications.

b. Review of Resident #4's current FL2 dated 10/02/19 revealed an order for pregabalin (lyrica) 25mg 1 tablet twice daily (a schedule III controlled substance used to treat pain with low potential for abuse).

Review of Resident #4's electronic Medication Administration Record (eMAR) for October 2019 revealed:
-There was an entry for lyrica 25mg 1 capsule twice a day for pain.
-There was a second entry for lyrica 25mg 1 capsule twice a day for pain.
-There was an entry for pregabalin 25mg 1

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capsule twice a day for pain
-There was a second entry for pregabalin 25mg 1 capsule twice a day for pain.
-There was documentation 52 pregabalin (lyrica) capsules were administered from 10/03/19 through 10/31/19.

Review of Resident #4's controlled substance count sheet (CSCS) revealed:
-There was documentation 48 pregabalin (lyrica) were signed out from 10/03/19 through 10/31/19.
-There was a total of 4 pregabalin (lyrica) documented as administered on the eMAR, but not signed out on the CSCS.

Review of Resident #4's eMAR for November 2019 revealed:
-There was an entry for lyrica 25mg 1 capsule twice a day for pain.
-There was documentation 59 lyrica capsules were administered from 11/01/19 through 11/30/19

Review of Resident #4's CSCS reveled:
-There was documentation 58 lyrica capsules were signed out from 11/01/19 through 11/30/19.
-There was a total of 1 lyrica capsule documented as administered on the eMAR, but not signed out on the CSCS.

Review of Resident #4's eMAR for December 2019 revealed:
-There was an entry for lyrica 25mg 1 capsule twice a day for pain.
-There was documentation 7 lyrica capsules were administered from 12/01/19 through 12/31/19.

Review of Resident #4's CSCS revealed there was documentation 7 lyrica capsules were signed out from 12/01/19 through 12/04/19.

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Observation of Resident #4's lyrica on hand on 12/05/19 at 2:41pm revealed:
-There was a bubble-packed container of lyrica 25mg 1 capsule twice a day for pain.
-There were 56 capsules dispensed by the pharmacy on 10/18/19 with 5 capsules remaining.
-There was a second bubble-packed container of lyrica 25mg 1 capsule twice a day for pain.
-There were 60 capsules in the second bubble pack dispensed by the pharmacy on 11/08/19.

According to review of the October, November and December 2019 eMARS, dispensing records and medications on hand, there 5 lyrica tablets unaccounted for.

Interview with Resident #4 on 12/03/19 at 10:56am revealed:
-She was on several pain medications.
-She had gone "long stretches" without her pain medication on numerous occasions and had gone as long as 10 hours.
-The times she had to go without her pain medication, she experienced severe pain.
-She sometimes went until her pain was unbearable to ask for pain medication because she did not want to get a cold response from staff.
-She had been told by staff her pain medication was in medication totes and staff had not gotten around to putting medication on the medication cart from the totes yet.

Interview with a third shift medication aide (MA) on 12/05/19 at 8:12am revealed:
-She administered medication to Resident #4 including controlled substances.
-When she administered controlled substances, she popped the pill and then she would write that

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the pill was administered on the CSCS.
-She did not know if anyone reviewed the CSCS for accuracy.

Interview with the Supervisor on 12/05/19 at 4:37pm revealed:
-The pharmacy reviewed the controlled substance logs once a quarter.
-There was no facility staff who reviewed the controlled substance logs for accuracy on a regular basis.
-She had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she informed the Administrator.
-There was a shift to shift notebook where MAs noted how many controlled pills they started with and how many pills they administered.
-She did not know what happened to the "shift to shift" notebook, but it was at the MAs work station at the beginning of the week.

Interview with a representative from the facility contracted pharmacy on 12/11/19 at 12:51pm revealed:
-There was an active order for Lyrica 25mg 1 capsule twice daily for Resident #4 and was dispensed by the pharmacy on 10/02/19 with a quantity of 10 capsules, on 10/18/19 with a quantity of 56 capsules, on 11/18/19 with a quantity of 60 capsules, and on 12/02/19 with a quantity of 62 capsules.
-There had been no lyrica returned to the pharmacy.

Interview with a first and second shift MA on 12/12/19 at 9:50am revealed:
-She found the count off for Resident #4's controlled medications many times when she started her shift.

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-She notified the Supervisor and the Administrator when she found the controlled medication count did not match the controlled medication on the medication cart.
-There was a shift to shift notebook at the MA's work station where MAs recorded the beginning and ending count of controlled medications for Resident #4, but she had not seen the notebook since 12/03/19 (survey entrance date).
-When she administered controlled medication, she documented the administration on the CSCS.
-When she saw missing deductions from the CSCS or if a deduction was not signed, she went through the eMAR to see who was working and wrote the names of the MAs on a sheet of paper and gave it to the Administrator.

Interview with a first shift MA on 12/12/19 at 11:46am revealed:
-She had talked to the Administrator about missing controlled medications.
-The Supervisor tried to get the Administrator to contact law enforcement to report the missing controlled medications, but the Administrator did not.

Interview with the Supervisor on 12/12/19 at 12:48pm revealed:
-She had informed the Administrator about missing controlled medications, but nothing was done.
-Law enforcement should have been called, the suspected MA(s) should have been drug tested and suspended until an investigation was completed.

Interview with the Administrator on 12/12/19 at 6:20pm revealed she knew there had been issues with residents' controlled medications, but she did not know there was an issue with Resident #4's

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controlled medications.

c. Review of Resident #4's physician's orders revealed an order dated 10/15/19 for Zolpidem Tartrate (Ambien) 5mg 1 tablet at bedtime for insomnia (a schedule IV controlled substance which can be abused and can lead to dependence), may repeat in 1 hour if not effective.

Review of Resident #4's electronic Medication Administration Record (eMAR) for October2019 revealed:
-There was an entry for zolpidem tartrate 5mg 1 tablet at bedtime for insomnia.
-There was a second entry for zolpidem tartrate 5mg 1 tablet at bedtime for insomnia.
-There was documentation 15 tablets of zolpidem tartrate were administered from 10/16/19 through 10/31/19.

Review of Resident #4's controlled substance count sheet (CSCS) revealed:
-There was documentation 13 tablets of zolpidem tartrate signed out from 10/03/19 through 10/31/19.
-There was a total of 2 tablets of zolpidem tartrate documented as administered on the eMAR, but not signed out on the CSCS.

Review of Resident #4's eMAR for November 2019 revealed:
-There was an entry for zolpidem tartrate 5mg 1 tablet at bedtime for insomnia.
-There was documentation 28 tablets of zolpidem tartrate were administered from 11/01/19through 11/30/19.

Review of Resident #4's CSCS revealed:
-There was documentation 25 tablets of zolpidem

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tartrate were signed out from 11/01/19 through 11/30/19.
-There was no documentation zolpidem tartrate was signed out on the CSCS from 11/15/19 through 11/22/19, but there was documentation on the eMAR zolpidem tartrate was administered 11/15/19 through 11/20/19.
-There was a total of 3 tablets of zolpidem tartrate administered on the eMAR , but not signed out on the CSCS.

Review of Resident #4's eMAR for December 2019 revealed:
-There was an entry for zolpidem tartrate 5mg 1 tablet at bedtime for insomnia.
-There was documentation 3 tablets of zolpidem tartrate 5mg were administered from 12/01/19 through 12/03/19.

Review of Resident #4's CSCS revealed documentation 3 tablets of zolpidem tartrate were signed out from 12/01/19 through 12/03/19.

Observation of Resident #4's zolpidem tartrate on hand at the facility on 12/05/19 at 2:41pm revealed:
-There was a bubble-packed container of zolpidem tartrate 5mg 1 tablet at bedtime for insomnia with a quantity of 15 tablets and there were 15 tablets remaining.
-There was a bubble-packed container of zolpidem tartrate 5mg 1 tablet 1 tablet in additional to scheduled dose in 1 hour if first dose is ineffective for insomnia with a quantity of 15 tablets and there were 3 tablets remaining.

According to review of the October, November and December 2019 eMARS, dispensing records and medications on hand, there 5 zolpidem tartrate tablets unaccounted for.

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Interview with a third shift medication aide (MA) on 12/05/19 at 8:12am revealed:
-She administered medication to Resident #4 including controlled substances.
-When she administered controlled substances, she popped the pill and then she would write that the pill was administered on the CSCS.
-She did not know if anyone reviewed the CSCS for accuracy.

Interview with the Supervisor on 12/05/19 at 4:37pm revealed:
-The pharmacy reviewed the controlled substance logs once a quarter.
-There was no facility staff who reviewed the controlled substance logs for accuracy on a regular basis.
-She had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she informed the Administrator.
-There was a shift to shift notebook where MAs noted how many controlled pills they started with and how many pills they administered.
-She did not know what happened to the shift to shift notebook, but it was at the MAs work station at the beginning of the week.

Interview with a representative from the facility contracted pharmacy on 12/11/19 at 12:51pm revealed:
-There was an active order for Resident #4 for Zolpidem Tartrate 5mg 1 tablet at bedtime, may repeat 1 dose if medication was not effective in 1 hour.
-Zolpidem Tartrate 5mg was dispensed by the pharmacy on 10/18/19 with a quantity of 30 tabs and on 11/22/19 with a quantity of 30 tablets.
-There had been no tablets returned to the

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pharmacy.

Interview with a first and second shift MA on 12/12/19 at 9:50am revealed:
-She found the count off for Resident #4's controlled medications many times when she started her shift.
-She notified the Supervisor and the Administrator when she found the controlled medication count did not match the controlled medication on the medication cart.
-There was a shift to shift notebook at the MA's work station where MAs recorded the beginning and ending count of controlled medications for Resident #4, but she had not seen the notebook since 12/03/19 (survey entrance date)..
-When she administered controlled medication, she documented the administration on the CSCS.
-When she saw missing deductions from the CSCS or if a deduction was not signed, she went through the eMAR to see who was working and wrote the names of the MAs on a sheet of paper and gave it to the Administrator.

Interview with a first shift MA on 12/12/19 at 11:46am revealed:
-She had talked to the Administrator about missing controlled medications.
-The supervisor tried to get the Administrator to contact law enforcement to report the missing controlled medications, but the Administrator did not.

Interview with the Supervisor on 12/12/19 at 12:48pm revealed:
-She had informed the Administrator about missing controlled medications, but nothing was done.
-Law enforcement should have been called, the suspected MA(s) should have been drug tested

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and suspended until an investigation was completed.

Interview with the Administrator on 12/12/19 at 6:20pm revealed she knew there had been issues with residents' controlled medications, but she did not know there was an issue with Resident #4's controlled medications.

4. Review of Resident #18's current FL2 dated 05/19/19 revealed:
-Diagnoses included dementia, acute encephalopathy, and schizoaffective disorder.
-There was a medication order for lorazepam 1mg every eight hours as needed for anxiety/agitation (used to treat anxiety disorder).

Review of physician's orders in Resident #18's record revealed:
-There was an order dated 07/01/19 that changed lorazepam from 1mg to 0.5mg twice daily as needed for anxiety/agitation.
-There was an order dated 12/10/19 that changed lorazepam from 0.5mg to 1mg every eight hours as needed for anxiety/agitation.

Review of Resident #18's September 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg twice a day as needed for anxiety/agitation.
-There was documentation lorazepam 0.5mg was administered 8 times from 09/01/19 through 09/30/19.

Review of Resident #18's September 2019 Controlled Substance Count Sheet(CSCS) revealed:
-There was documentation Resident #18 had 36 tablets of 0.5mg lorazepam.

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D 392	Continued From page 245 -There was documentation lorazepam 0.5mg was administered 9 times from 09/01/19 through 09/30/19. -There was documentation Resident #18 had 27 lorazepam 0.5mg tablets remaining. Review of Resident #18's September 2019 eMAR revealed: -There was no entry for lorazepam 1mg as needed for anxiety/agitation. -There was no documentation lorazepam 1mg was not documented on the eMAR. Review of Resident #18's September 2019 CSCS revealed: -There was documentation Resident #18 had 37 tablets of 1mg lorazepam. -There was documentation lorazepam 1mg was signed out 7 times on 09/07/19 at 2:00pm, 09/10/19 at 9:00am, 09/11/19 at 10:05am, 09/12/19 at 8:58am, 09/16/19 at 10:15am, 09/28/19 at 8:49am, and 09/29/19 at 8:30am. -There was documentation 23 tablets of lorazepam 1mg were remaining. Review of Resident #18's October 2019 eMAR revealed: -There was an entry for lorazepam 0.5mg twice a day as needed for anxiety/agitation. -There was documentation lorazepam 0.5mg was administered 10 times from 10/01/19 through 10/31/19. Review of Resident #18's October 2019 CSCS revealed: -There was documentation lorazepam 0.5mg was signed out 7 times from 10/01/19 through 10/31/19. -There was documentation Resident #18 had 20 lorazepam 0.5mg tablets remaining.	D 392		

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Review of Resident #18's October 2019 eMAR revealed:
-There was no entry for lorazepam 1mg as needed for anxiety/agitation.
-There was no documentation Lorazepam 1mg was administered.

Review of Resident #18's October 2019 CSCS revealed:
-There was documentation lorazepam 1mg was signed out 11 times on 10/08/19 at 1:40pm, 10/11/19 at 9:30pm, 10/12/19 at 8:55pm, 10/18/19 at 9:15am, 10/19/19 at 9:00am, 10/19/19 at 7:00pm, 10/20/19 at 8:00am, 10/22/19 at 9:00am, 10/24/19 (no time specified), 10/27/19 at 4:12pm and 10/27/19 (no time specified).
-There was documentation 11 tablets of lorazepam 1mg was remaining.

Review of Resident #18's November 2019 eMAR revealed:
-There was an entry for lorazepam 0.5mg twice a day as needed for anxiety/agitation.
-There was documentation lorazepam 0.5mg was administered 6 times from 11/01/19 through 11/30/19.

Review of Resident #18's November 2019 CSCS revealed:
-There was documentation lorazepam 0.5mg was signed out 1 time from 11/01/19 through 11/30/19.
-There was documentation Resident #18 had 19 lorazepam 0.5mg tablets remaining.

Review of Resident #18's November 2019 eMAR revealed:
-There was no entry for lorazepam 1mg as needed for anxiety/agitation.

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-There was no documentation Lorazepam 1mg was administered.

Review of Resident #18's November 2019 CSCS revealed:
-There was documentation lorazepam 1mg was signed out 7 times on 11/01/19 at 6:39pm, 11/02/19 at 9:00am, 11/02/19 at 8:46pm, 11/18/19 at 7:54pm, 11/16/19 at 11:23pm, 11/23/19 at 11:22am and 11/24/19 at 11:21am.
-There was documentation 4 tablets of lorazepam 1mg was remaining.

Review of Resident #18's December 2019 eMAR revealed:
-There was an entry for lorazepam 0.5mg twice a day as needed for anxiety/agitation.
-There was documentation lorazepam 0.5mg was administered 1 time from 12/01/19 through 12/12/19.

Review of Resident #18's December 2019 CSCS revealed:
-There was documentation lorazepam 0.5mg was signed out 2 times from 12/01/19 through 12/12/19.
-There was documentation Resident #18 had 17 lorazepam 0.5mg tablets remaining.

Review of Resident #18's December 2019 eMAR revealed:
-There was no entry for lorazepam 1mg as needed for anxiety/agitation.
-There was no documentation Lorazepam 1mg was administered on the eMAR.

Review of Resident #18's CSCS revealed lorazepam 1mg was not signed out from 12/01/19 through 12/12/19.

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Observation of Resident #18's lorazepam on hand at the facility on 12/12/19 at 11:50am revealed:
-There was one bubble-packed container of lorazepam 1mg tablets.
-The were no lorazepam tablets missing from the container.
-There were 75 tables of 1mg lorazepam in the container.
-There was documentation the medication was filled on 12/10/19.
-There was no other lorazepam in the medication cart for Resident #18.

According to review of the September, October, November and December 2019 eMARs, CSCS, dispensing records and medications on hand, there were 12 tablets of the 1mg lorazepam tablets unaccounted for, and there were 33 tablets of the 05mg lorazepam tablets unaccounted for.

Interview with Resident #18's mental health provider (MHP) on 12/06/19 at 3:37pm revealed:
-During his visit to the facility on 12/03/19 he was verbally informed Resident #18 had increased agitation.
-Review of Resident #18 eMARs he identified the facility staff did not utilize as needed lorazepam for the increased anxiety/agitation.
-The facility did not call him regarding Resident #18's increased agitation.
-The staff requested that he write another order for the as needed lorazepam.
-He informed facility staff that the medication had recently been filled and based on their documentation there should be medication left.
-He requested to view the lorazepam on the medication cart.
-He identified there was a card of lorazepam

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0.5mg with tablets left.
-There was also a card of lorazepam 1mg with tablets left.
-He informed that facility staff that he would not write an order because there was medications available.
-He also informed facility staff that lorazepam 1mg was discontinued in June 2019 and there was no current order to administer the medication.
-He suggested the medication be sent back to the pharmacy.

Second interview with Resident #18's MHP on 12/11/19 at 3:13pm revealed:
-On 12/09/19 he received a call from a staff at the facility.
-The complaint was Resident #18 had behavior problems.
-He asked had she tried to give the lorazepam 0.5mg.
-The staff the resident was out of the 0.5mg lorazepam.
-He changed the lorazepam from 05mg twice daily as needed to 1mg every eight hours as needed.

Interview with a pharmacist at the contracted pharmacy on 12/12/19 at 3:36pm revealed:
-Resident #18's 1mg as needed lorazepam was initially filled and dispensed on 06/27/19 for a quantity of thirty whole tablets.
-Resident #18's 0.5mg as needed lorazepam was last filled and dispensed on 07/01/19 for a quantity of sixty tablets.
-The pharmacy received an order dated 12/10/19 for lorazepam 1mg as needed every eight hours for anxiety.
-The lorazepam 1mg tablet was filled and 75 tablets were dispensed on 12/10/19.

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Interview with a pharmacy representative in the records department at the contracted pharmacy on 12/13/19 at 2:36pm revealed a search of their records showed no lorazepam for Resident #18 had been returned to the pharmacy.

Interview with the Administrator on 12/11/19 at 11:13am revealed:
-She sent Resident #18's unused lorazepam 0.5mg tablets and 1mg tablets back to the pharmacy on the morning of 12/10/19.
-The she did not document the number of lorazepam (0.5mg and 1mg) tablets she sent back to the pharmacy.
-She had never documented medications that she returned to the pharmacy.

Based on record review, observations, interviews it was determined that Resident #18 was not interviewable.

5. Review of Resident #5's current FL2 dated 10/04/19 revealed:
-Diagnoses included fracture of left ankle, bipolar, gastroesophageal reflux disease (GERD), and anemia.
-There was no physician's order for lorazepam 0.5mg as needed for agitation/anxiety.

Review of the physician's order dated 08/26/19 in Resident #5's record revealed an order for lorazepam 0.5mg 1 tablet every 8 hours as needed for agitation/anxiety.

Review of Resident #5's August 2019 electronic Medication Administration Record (MAR) revealed:
-There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety/agitation.

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-There was documentation lorazepam 0.5mg was administered 5 times from 08/01/19 through 08/31/19.

Review of Resident #5's August 2019 Controlled Substance Count Sheet (CSCS) revealed:
-There was documentation lorazepam 0.5mg was signed out 7 times from 12/01/19 through 12/12/19.
-There was documentation on 08/28/19 at 8:00pm and 08/31/19 at 8:11pm that was not documented on the eMAR.
-There was documentation Resident #5 had 83 lorazepam 0.5mg tablets remaining.

Review of Resident #5's September 2019 electronic Medication Administration Record (MAR) revealed:
-There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety/agitation.
-There was documentation lorazepam 0.5mg was administered 8 times from 09/01/19 through 09/30/19.

Review of Resident #5's September 2019 CSCS revealed:
-There was documentation lorazepam 0.5mg was signed out 12 times from 09/01/19 through 09/30/19.
-There was documentation lorazepam 0.5mg was signed out on 09/02/19 at 8:38pm, 09/06/19 at 8:44pm, 09/07/19 at 7:35pm, 09/08/19 at 9:30am, 09/09/19 at 8:00pm, 09/13/19 at 8:58am, 09/14/19 at 9:00am, 09/27/19 at 8:00pm, and 09/27/19 at 8:00pm but not documented on the eMAR.
-There was documentation Resident #5 had 71 lorazepam 0.5mg tablets remaining.

Review of Resident #5's October 2019 eMAR

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revealed:
-There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety/agitation.
-There was documentation lorazepam 0.5mg was administered 0 times from 10/01/19 through 10/31/19.

Review of Resident #5's October 2019 CSCS revealed:
-There was documentation lorazepam 0.5mg was signed out 3 times from 10/01/19 through 10/31/19.
-There was documentation on 10/11/19 at 10:00pm, 10/12/19 at 4:30pm and 10/29/19 at 9:00pm that were not documented on the eMAR.
-There was documentation Resident #5 had 69 lorazepam 0.5mg tablets left.

Review of Resident #5's November 2019 eMAR revealed:
-There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety/agitation.
-There was documentation lorazepam 0.5mg was administered 2 times from 11/01/19 through 11/30/19.

Review of Resident #5's November 2019 CSCS revealed:
-There was documentation lorazepam 0.5mg was signed out 2 times from 11/01/19 through 11/30/19.
-There was documentation Resident #5 had 66 lorazepam 0.5mg tablets left.

Review of Resident #5's December 2019 eMAR revealed:
-There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety/agitation.
-There was no documentation that showed lorazepam 0.5mg was administered from

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12/01/19 through 12/11/19.

Review of Resident #5's December 2019 CSCS record revealed:
-There was documentation the resident currently had 63 tablets of lorazepam .05mg tablets with no documented who or why the medication was signed out.

Observation of Resident #5's medications on hand at the facility on 12/06/19 at 11:58am revealed:
-Resident #5 had lorazepam 0.5mg as needed for anxiety on hand at the facility.
-There was documentation 63 tablets were left in the bubble-packed container.
-There was documentation the medication was filled on 08/26/19 for a quantity of 90 tablets.

According to review of the August, September, October, November and December 2019 eMARs, CSCS, dispensing records and medications on hand, there were 3 tablets of the 05mg lorazepam tablets unaccounted for.

Interview with Resident #5 on 12/05/19 at 8:53am revealed:
-His medications were administered by facility staff.
-He did not know the type of medications ordered him.
-He did not know if he was ordered a medication for agitation and anxiety.

Interview with the pharmacist at the contracted pharmacy on 12/10/19 at 12:30pm revealed:
-On 08/2619 the pharmacy dispensed a 90-day supply of lorazepam 0.5mg for Resident #5.
-They had not dispensed the medication since August 2019.

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D 392	Continued From page 254 Interview with the Administrator on 12/11/19 at 11:13am revealed: -The MAs should be counting off the controlled drugs. -A month or more ago she realized the controlled drugs were incorrect. -She informed staff to remember to document when they administered Resident #5's lorazepam. -Currently, she did not have a system of checking behind the MAs to ensure the controlled drug count was correct. The facility failed to assure 5 of 8 residents had a readily retrievable record of controlledsubstances by documenting the disposition of Resident #17's oxycodone with 324 tablets unaccounted for, Resident #15's hydrocodone/acetaminophen 5/325mg with 42 tablets unaccounted for, Resident #4's oxycodone, 38 tablets unaccounted for, lyrica, 5 tablets unaccounted for, zolpidem tartrate, 5 tablets unaccounted for, Resident #18 lorazepam 1mg, 12 tablets unaccounted for, lorazepam 0.5mg 33 tablets unaccounted for and Resident #5 lorazepam 0.5mg 3 tablets unaccounted for. The failure of the facility to locate the Controlled Substance Count Sheets or documentation that controlled drugs were returned to the pharmacy was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/06/19 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D 392	THERE WERE SEVERAL WRITTEN POLOCIES IN PLACE (SEE ATTACHED) THAT ADMINISTRATOR OR RCC WERE NOT FOLLOWING. ADMINSTRATOR STATES IT WAS HER RESPONSIBILITY TO DO SO. RCC IS ALSO RESPONSIBLE. HOME WAS CLOSED ON 2/7/2020 WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND RESIDENTS WERE RELOCATED TO APPROPRIATE LEVELS OF CARE	

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D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to report suspected drug diversion of controlled substances to the pharmacy, local law enforcement, and the Health Care Personnel Registry for 1 of 5 sampled residents (#17) who was prescribed Oxycodone. The findings are: Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances. Based on observations, interviews, and record reviews, the facility failed to report suspected drug diversions of controlled substances to the pharmacy, local law enforcement, and the Health Care Personnel Registry for 1 of 5 sampled residents (#17) who were prescribed Oxycodone. The findings are: Review of Resident #17's FL2 dated 07/29/19 revealed diagnoses included scoliosis, restrictive lung disease, chronic pain, and fibromyalgia.	D 399	OWNER'S HAD NEVER BEEN MADE AWARE OF ANY DRUG DIVERSIONS. THE ADMINISTRATOR HAD STATE GUIDELINES (SEE ATTACHED) ON HOW TO REPORT ANY ISSUE. THE ADMINISTRATOR FAILED TO DO SO. AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN PLACED IN AN APPROPRIATE LEVEL OF CARE WITH ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME IS NOW CLOSED. ALL REMAINING MEDICATIONS HAVE BEEN RETURNED TO EXPRESS CARE PHARMACY.	

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-Admission date was 07/29/19.
-There was an order for oxycodone (a narcotic used to treat moderate to severe pain) 20mg one tablet every 6 hours as needed for pain.

Review of Resident #17's physician's orders dated 11/08/19 revealed there was an order oxycodone 20mg one tablet every 6 hours.
Observation of Resident #1's medications on hand on 12/06/19 at 1:30pm revealed there were 85 oxycodone 20mg available for administration.

Review of Resident #17's record revealed:
-Resident #17 110 oxycodone 20mg upon admission.
-There were no controlled substance count sheets (CSCS's) available for the 110 oxycodone 20mg tablets Resident #17 had upon admission.
-Between 08/27/19 and 12/06/19 Resident #17 had 41 oxycodone 20mg unaccounted for on the CSCS's.

Interview with the Administrator on 12/06/19 at 5:25pm revealed:
-She had been told Resident #17's oxycodone count was off.
-The count for Resident #17's oxycodone was questioned in October and November 2019, but when she looked at the CSCS there had been a staff error.
-She could not find the CSCS for July and August 2019 for Resident #17.
-She knew any suspected diversion was required to be reported to Department of Social Services (DSS), the police, and the vendor pharmacy.
-She had no proof of any diversion of oxycodone.

Interview with a MA on 12/06/19 at 5:45 pm revealed:
-She knew Resident #17 had an order and was

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administered oxycodone 20mg for her pain since she had been admitted in July 2019.
-She had left notes for other MAs to sign for Resident #17's oxycodone when the CSCS had been left blank.
-The Administrator knew Resident #17's oxycodone count was off because staff had told her.
-The Administrator had instructed the MAs to notify her when a controlled count was off.
-The MAs had been documenting the beginning and ending count of controlled substances in the shift report notebook.
-At shift change, the off going MAand the oncoming MA were supposed to count all controlled substances together.
-There had been a few times in which she had to count by herself due to no oncoming MA when her shift was over.
-When she counted by herself, she reviewed the controlled substance label and the medication label and then counted the tablets 2 times.

Interview with a MA on 12/12/19 at 12:10pm revealed:
-There had been times when she came to work and there were no MAs on duty, so she had to count controlled drugs by herself.
-She did not want to lose her MA certification so she would have a PCA count with her as a witness only as a last resort.

Interview with Resident #17 on 12/12/19 at 1:00pm revealed:
-She knew that she had at least 10 oxycodone missing after she was admitted to the facility and then a few in October 2019 were missing because she ran short.
-The Administrator had investigated the missing oxycodone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: ___ B. WING ___	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 399	Continued From page 258 -The MA that was suspected of taking her oxycodone was still employed at the facility. Interview with a MA on 12/12/19 at 4:45pm revealed: -The Administrator had told her that some oxycodone were missing for Resident #17 about 2 months ago. -She did not know how the situation was investigated. -When the oxycodone went missing, the MAs had to start documenting beginning and end counts in the shift report book. Interview with the Supervisor on 12/13/19 at 11:09am revealed: -She knew Resident #17 had an order and was administered oxycodone 20mg for her pain since she was admitted in July 2019. -The CSCS required a signature each time a controlled substance was signed out. -Resident #17 had 110 oxycodone 20mg when she was admitted on 07/29/19. -The MAs were not doing what they were supposed to do (filing the CSCSs) so the CSCS logs for July and August 2019 could not be found. -The Administrator knew Resident #17 was missing some oxycodone 20mg because staff had told her. -After the first time Resident #17's oxycodone went missing, the Administrator put in place for each MA to document the beginning and end count on a sheet of paper and had the resident to sign stating she received her medication. -Also, the beginning and end counts of controlled substances were to be documented in the shift report notebook. -The first time some of Resident #17's oxycodone went missing, the investigation was narrowed down to 3 MAs, then one of the 3 quit.	D 399		

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D 399	Continued From page 259 -She asked the Administrator to notify the police of the missing oxycodone in August 2019. -The second time Resident #17's oxycodone went missing, the same 2 MAs were suspected, but the police were not notified. -No staff were drug tested as a result of the missing oxycodone. -Sometimes the MAs would have to count by themselves as there was no other MA in the building. -When the off-going MAs counted by themselves and then left the building the keys were placed in an unidentified area so that the oncoming MA knew where they were at. Interview with a MA on 12/13/19 at 1:34 pm revealed: -He trained with another MA for 2 days on the cart. -The oxycodone was missing before he worked on the cart. -He told the Supervisor and the Administrator Resident #17's oxycodone count was off just by looking at the CSCS. -Nothing was put in place to prevent the oxycodone from being unaccounted for. Interview with the Administrator on 12/12/19 at 6:55pm revealed: -The MAs had to count the controlled substances by themselves at times due to the oncoming MA running late. -When the next MA arrived, they would also count the controlled substances. Interview with the Administrator on 12/13/19 at 1:55pm revealed: -Resident #17 had 110 oxycodone when she was admitted to the facility. -The CSCS required a signature each time a	D 399		

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D 399	Continued From page 260 controlled substance was signed out. -She knew Resident #17 had some oxycodone unaccounted for. -She had looked at Resident #17's CSCS and compared it to the oxycodone on hand. -She thought that initially 5 oxycodone went missing. -She interviewed staff and residents and found that some of the oxycodone had been wasted. -After her investigation, the information led her to 2 individuals who were MAs. -She did not drug test either of the suspected staff or report the missing oxycodone to the police. -After the second incident when 1 or 2 went missing, she put a new system in place requiring the resident to sign stating she had gotten her medications. -She did not drug test the suspected staff or notify the police after the second incident when Resident #17's oxycodone went missing. -She "could not answer why she did not report the missing oxycodone to the police". -She informed the representative for the local Department of Social Services face to face when she came in to monitor the facility.	D 399		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

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D 438	Continued From page 261 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to report allegations of physical abuse of a resident (Resident #19) by a medication aide (Staff F), to the Health Care Personnel Registry (HCPR). The findings are: Review of Resident #19's current FL2 dated 10/22/19 revealed: -Diagnoses included vascular dementia without behaviors, chronic diastolic congestive heart failure, depression/anxiety, hearing loss, heart disease, diabetes mellitus and neuropathy. -Resident #19 was intermittently disoriented. Review of Resident #19's Care Plan dated 11/08/19 revealed there was no documentation regarding the resident's mental health status or the agency to contact. Review of a police report dated 11/13/19 revealed: -There was an altercation at the facility between a staff and a resident. -Staff F, medication aide (MA) admitted "punching" Resident #19 in the face so the resident would stop assaulting her. -The report noted the resident had blood on her lip. Interview with Resident #19 on 12/05/19 at 9:03am revealed: -She lived at the facility since the end of October 2019. -A couple of weeks after she moved into the	D 438	OWNER'S WERE NEVER MADE AWARE OF ANY RESIDENT ABUSE, FACILITY POLICY STATES THAT RESIDENT ABUSE OF ANY KIND IS CAUSE FOR IMMEDIATE TERMINATION. ADMINISTRATOR FAILED TO FOLLOW POLICY AND FAILED TO FOLLOW STATE GUIDELINES FOR REPORTING STAFF TO HCPR. ON 2/7/2020, ALL RESIDENTS HAVE BEEN PLACED IN AN APPROPRIATE LEVEL OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME HAS BEEN CLOSED.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 438	Continued From page 262 facility, she had an incident with Staff F. -One night it was cold and Staff F came into her room. -When Staff F came into the room she left the door open. -She asked Staff F to close the room door, because she was cold. -Staff F said, "Wait a minute." -Staff F proceeded to give her roommate some medication and did not close the door. -Staff F and her started yelling at each other. -Staff F and her struggled back and forth. -She pushed the MA because she was in her face. -Staff F pushed her back. -She did not recall her lip bleeding. -She did not recall the police coming to the facility. -She did not recall the Administrator talking with her regarding the incident. Interview with Resident #19's roommate on 12/05/19 at 5:05pm revealed: -One day Staff F came to her room to give her medications. -Prior to Staff F coming into the room another staff had come into the room. -Resident #19 had complained about the door being open. -Resident #19 had asked Staff F to close the door. -Staff F left the door open. -Resident #19 got upset and got in Staff F's face. -There was a struggle but she could not see very well. Interview with the Administrator on 12/05/19 at 9:31am revealed: -She was aware of an incident between Resident #19 and Staff F on the second shift.	D 438		

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D 438	Continued From page 263	D 438		

-She did not interview the resident because it was her understanding the resident started the incident.
-She did not contact the HCPR regarding the incident because she did not know that she was supposed report the incident.

Interview with Staff F on 12/06/19 at 10:20am revealed:
-On 11/13/19 she went into Resident #19's room to give 12:00pm medication to Resident #19's roommate.
-She left the door open.
-Resident #19 pushed her body on the her and started hitting, biting and scratching her.
-Prior to her coming into the room another staff member had come in the room and left the door open.
-On 11/13/19, the hallway was cool, and Resident #19 wanted the door to be kept closed.
-She tried to protect herself by pushing Resident #19 off her, so she pushed the resident, but she did not hit Resident #19.
-She did not call Resident #19's mental health provider.

____

The facility failed to investigate and report allegations of alleged physical abuse of Resident #19 by Staff F on 11/13/19 to the HCPR resulting in Staff F continuing to work and Resident #19 was unprotected from further physical harm. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/19 for this violation.

CORRECTION DATE FOR THE TYPE B

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D 438	Continued From page 264 VIOLATION SHALL NOT EXCEED, JANUARY 27, 2020	D 438		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to immediately notify the local county Department of Social Services (DSS) for incidents involving 1 of 1 sampled residents (Residents #19) who received injuries from staff. The findings are: Review of Resident #19's current FL2 dated 10/22/19 revealed: -Diagnoses included vascular dementia without behaviors, chronic diastolic congestive heart failure, depression/anxiety, hearing loss, heart disease, diabetes mellitus and neuropathy. Review of a police report dated 11/13/19 revealed: -There was an altercation at the facility between a staff member and a resident. -The staff admitted she "punching" Resident #19 in the face so the resident could stop assaulting	D 453	THERE ARE FACILITY POLICIES IN PLACE THAT REQUIRE ADMINISTRATOR TO REPORT ACCIDENTS/INCIDENTS TO DAVIE COUNTY D.S.S. ADMINISTRATOR FAILED TO FOLLOW THESE POLICIES. AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN PLACED IN AN APPROPRIATE LEVEL OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME HAS BEEN CLOSED.	

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D 453	Continued From page 265 her. -The report noted the resident had blood on her lip. Interview with the local county Adult Home Specialist on 12/05/19 at 1:00pm revealed: -The facility did not send her accident/incident reports. -A few months ago, she had a conversation with the Administrator regarding her not getting incident reports. Interview with the Supervisor on 12/04/19 at 10:42am revealed: -She worked part-time at the facility and mostly did paper work in the office. -She previously worked at other facility's and was aware that accident/incident reports needed to be completed. -The facility did not do incident/accident reports. Interview with the Administrator on 12/06/19 at 3:32pm revealed: -When a resident was sent out staff were to do an incident report. -She had instructed staff to start doing incident reports. -She was unable to find incident reports.	D 453		
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:	D914		

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D914	Continued From page 266	D914		

Based on observations, record reviews and interviews, the facility failed to assure all residents were free from abuse and neglect related to personal care and other staffing, criminal background checks, training on the care of diabetic resident, training on cardio-pulmonary resuscitation, staffing of personal care aide supervisor, ACH infection prevention requirements, ACH medication aide; training and competency, examination and screening, health care, personal care and supervision, Residents' Rights, and implementation.

The findings are:

1. Based on record reviews, observations and interviews the facility failed to contact the health care and mental health providers and specialist health care providers for 7 of 11 sampled residents (Residents #1, #3, #5, #9, #12, #14, and #18) regarding a resident with a pressure ulcer (#3), a resident with extreme muscle weakness resulting in falls who missed a nerve conduction study and two MRI appointments (#12), a resident with swollen lower extremities that caused pain when walking (#5), a resident with aggressive/agitated behaviors that yelled at other residents, beat on the walls and threw chairs (#18), two residents with rashes which made the residents uncomfortable (#1 and #9) and a glucometer which did not work properly (#14). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].

2. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered by a licensed practicing practitioner for 6 of 6 sampled residents (#1, #2, #3, #4, #5 and #12) related to a topical antiseptic (#3), an anti-coagulant and a narcotic pain

Provider's Plan of Correction:

THE POLICIES AND PROCEDURES TO ASSURE THAT THESE ITEMS WERE BEING ADHERED TO, WERE IN PLACE AT ALL TIMES IN THE HOME. THE ADMINISTRATOR AND RCC, FAILED TO FOLLOW THESE POLICIES.

AS OF 2/7/2020, ALL RESIDNETS HAVE BEEN PLACED IN AN APPROPRIATE LEVEL OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME IS NOW CLOSED.

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D914	Continued From page 267	D914		

reliever (#4), a rapid acting insulin (#2, #3 and #12), a diuretic (#5), and a gastric acid reducer (#1). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

3. Based on interviews and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for ACH infection prevention requirements, medication administration, controlled substances, supervision, physical environment, personal care, housekeeping and furnishings, criminal background check, health care personnel registry check, nutrition and food services, residents' rights, health care personnel registry, incident and accident reports, activities, tuberculosis test, health care, ACH medication aides; training and competency requirements, test for tuberculosis, training on cardio-pulmonary resuscitation, examination and screening for controlled substances, personal care and other staffing, competency validation for licensed health professional support tasks, personal care training and competency, management of resident funds, training on care of diabetic residents, staffing of personal care aide supervisors, and implementation. [Refer to Tag 980 G.S. 131D-25 Implementation (Type A2 Violation)].

4. Based on interviews, record reviews, and observations, the facility failed to assure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled residents (Resident #5) who was constantly disorientated and had wandering behaviors and eloped from the facility without staff's knowledge. [Refer to Tag D067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)].

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D914	Continued From page 268 5. Based on record reviews and interviews, the facility failed to assure 9 of 12 sampled staff (Staff A, B, C, E, F, G, I, J, and K) were tested for Tuberculosis (TB) disease upon hire. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for Tuberculosis (Type B Violation)]. 6. Based on observations, interviews and record reviews, the facility failed to assure 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K) had a criminal background check completed prior to hire. [Refer to Tag D139 10A NCAC 13F .0407(a)(7) Criminal Background Check (Type B Violation)]. 7. Based on record reviews and interviews, the facility failed to assure 4 of 11 sampled staff (Staff C, D, I, and J) who provided personal care to residents had documentation of successful completion of an 80 hour personal care training and competency evaluation program. [Refer to Tag D150 10A NCAC 13F .0501 Personal Care Training (Type B Violation)]. 8. Based on observations, record reviews and interviews, the facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic resident prior to the administration of insulin. [Refer to Tag D164 10A NCAC 13F .0505 Training on Care of Diabetic Residents (Type B Violation)]. 9. Based on observations, record reviews and interviews, the facility failed to assure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 27 of69	D914		

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D914	Continued From page 269 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to Tag D167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)]. 10. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing at the facility for 8 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to Tag D188 10ANCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation)]. 11. Based on interviews and record review, the facility failed to assure first and second shifts were staffed with a minimum of 20 hours including 16 hours of personal care staff and 8 hours of supervision with up to 4 hours counted toward personal care hours, and third shift was staffed with 16 hours of personal care aide and 8 supervisor hours when there was not a supervisor within 500 feet of the facility for 5 of 69 sampled shifts when there was a census of 31 residents in an unsprinkled facility. [Refer to Tag D214 10A NCAC 13F .0605(c) Staffing of Personal Care Aide Supervisor (Type B Violation)]. 12. Based on observations, interviews and record reviews, the facility failed to assure personal care was provided to 8 of 11 sampled residents (#1, #5, #7, #8, #11, #12, #18, and #20) including foot care to three residents (#5, #12, and #18,); residents having to wait for incontinence care (#7, #8, and #20), and residents with a yeast rash (#1 and #11). [Refer to Tag D269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)].	D914		

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D914	Continued From page 270	D914		

13. Based on record reviews, observation and interviews the facility failed to provide supervision to meet the needs of 2 of 5 sampled residents (Residents #5 and #12) who had muscle weakness causing him to repeatedly fall (#12) and a resident who eloped without staff's knowledge (#5). [Refer to Tag D270 10A NCAC 13F .0902(b) Personal Care and Supervision (Type B Violation)].

14. Based on record review and interviews the facility failed to assure 1 of 17 sampled residents (Resident #19) were free of abuse and neglect resulting a resident (#19) being physically assaulted by a medication aide (Staff M). [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].

15. Based on observations, interviews, and record reviews, the facility failed to assure records of the administration of controlled substances were maintained, accurate and reconciled for 5 of 8 sampled residents (Residents #4, #5, #15, #17 and #18) who were prescribed Oxycodone (#4 and #17), lyrica (#4), zolpidem tartrate (#4), hydrocodone (#15), and lorazepam (#5 and #18). [Refer to Tag D392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].

16. Based on record reviews and interviews, the facility failed to report allegations of physical abuse of a resident (Resident #19) by a medication aide (Staff F), to the Health Care Personnel Registry (HCPR). [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].

17. Based on observation, record reviews, and interviews, the facility failed to implement a

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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 2 of 3 sampled residents (Residents #2, and #14) with diabetes, resulting in sharing glucometers between residents. [Refer to Tag D932 G.S. 131D-4.4 ACH Infection Prevention Requirements (Type B Violation)].

18. Based on record reviews and interviews, the facility failed to assure 7 of 7 medication aides (MAs) sampled (Staff C, E, F, I, J, and K) andthe Administrator had completed the state approved mandatory annual infection control training. [Refer to Tag D934 G.S. 131D-4.5B(a) ACH Infection Prevention Requirements (Type B Violation)].

19. Based on observations, interviews and record reviews, the facility failed to assure 6 of 7 sampled staff (Staff C, E, F, I, J, and K) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration courses (Staff C, E, F, I, J, and K), completed the Medication Administration Skills Validation (Staff C, E, F, and K), and passed the state written medication aide exam (Staff E) prior to administering medications. [Refer to Tag D935 G.S. 131D-4.B(b) ACH Medication Aide Training and Competency (Type B Violation)].

20. Based on interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was completed for 8 of 12 sampled staff (Staff B, C, E, F, I, J, K) and the Administrator prior to hire. [Refer to Tag D992 G.S. 131D-45(a) Examination and Screening for

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D916	G.S. 131D-21(6) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 6. To have his or her personal and medical records kept confidential and not disclosed without the written consent of the individual or guardian, which consent shall specify to whom the disclosure may be made, except as required by applicable state or federal statute or regulation or by third party contract. It is not the intent of this section to prohibit access to medical records by the treating physician except when the individual objects in writing. Records may also be disclosed with the written consent of the individual to agencies, institutions or individuals which are providing emergency medical services to the individual. Disclosure of information shall be limited to that which is necessary to meet the emergency. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain residents' personal information in a confidential manner. The findings are: Review of Resident #15's current FL2 revealed: -Diagnoses included dementia. -There was documentation Resident #15 was intermittently disoriented. Review of an information packet regarding Personal Health Information (PHI) provided to residents upon admission revealed the facility was required by law to maintain the privacy of the	D916	COMPANY POLICY STRICTLY PROHIBITS THE SHARING OF ANY/ALL RESIDENT/EMPLOYEE INFORMATION OUSTIDE OF THE BUSINESS OFFICE. ALL RESIDENT MEDICAL INFORMATION NORMALLY STAYS IN A LOCKED ROOM AT THE MED ROOM, IN A PRIVATE NOTEBOOK. AS OF 2/7/2020, THE HOME IS CLOSED AND ALL RESIDENT FILES ARE LOCKED IN TWO FILE CABINTES IN THE BUSINESS OFFICE. THE FACILITY OWNER IS THE ONLY PERSON WITH A KEY TO THIS OFFICE AND THE FILE CABINETS.	

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resident's PHI.

Observation of Resident #15's room at various times on 12/03/19 between 9:45am and 5:45pm revealed:
-Resident #15's room door remained opened throughout the day.
-There were 8 stacks of paper on Resident #15's bed.
-There were 4 stacks of paper on Resident #15's dresser.

Observation Resident #15's room at various times on 12/04/19 between 8:00am and 5:30pm revealed:
-Resident #15's room door remained opened throughout the day.
-There were 8 stacks of paper on Resident #15's bed.
-There were 4 stacks of paper on Resident #15's dresser.

Review of the stacks of paper in Resident #15's room on 12/04/19 at 5:18pm revealed there was information on multiple sheets of paper which included other residents' names, dates of birth, social security numbers, Medicaid identification numbers, diagnoses, bank account information, and medications.

Interview with Resident #15 on 12/04/19 at 5:20pm revealed:
-Resident #15 stated, "They gave me this to work on."
-He did not know where the documents came from or what the documents were.
-He did not know how long the documents had been in his room.
-Resident #15 appeared confused.

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Interview with medication aide (MA) on 12/04/19 at 5:23pm revealed:
-Resident #15 had documents in his room spread across his bed since she was hired 3 months ago.
-If papers were laying on the MA station desk at night, Resident #15 would pick them up and take them to his room to mark on.
-"He's not picking up anything other than blank paper."
-There was no other residents' personal information on the documents in Resident #15's room that she knew of.

Interview with a personal care aide (PCA) on 12/04/19 at 5:27pm revealed:
-She saw the documents in Resident #15's room, but she had never looked at them.
-Resident #15 had documents in his room on his bed since she was hired 4 to 5 months ago.
-She just thought they were blank papers.

Interview with a second PCA on 12/04/19 at 5:31pm revealed:
-She had seen the documents in Resident #15's room, but she had never looked at any of them.
-"I thought they were his."

Observation of Resident #15's room on 12/04/19 at 5:32pm revealed the Administrator had gathered the stacks of documents from Resident #15's bed and dresser into her arms and she was headed out of Resident #15's room.

Interview with the Administrator on 12/04/19 at 5:32pm revealed:
-She and the MAs were responsible for keeping residents' personal information in a secured place.
-She did not know where Resident #15 got the

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documents from that were in his room.
-The room where resident records were stored was usually locked.
-She removed other resident documents from Resident #15's room about a month ago.
-She had seen the stacks of documents on Resident #15's bed on 12/04/19 and on 12/03/19, but she did not look to see what was on the documents.
-"Some of it is old."

Observation of Resident #15's room on 12/04/19 at 5:45pm revealed:
-There was another stack of documents which contained other residents' personal information on Resident #15's bed.
-The Administrator removed the documents from Resident #15's room.

Observation of Resident #15 on 12/05/19 at 8:55am revealed:
-Resident #15 was standing in his room by his night stand holding a stack of documents which contained other residents' personal information.
-Resident #15 placed the stack of documents in the bottom drawer of his nightstand and there were additional documents in the bottom drawer.
-Resident #15 stated, "I'm going to keep these."
-The Administrator removed the documents from Resident #15's room.

Observation of Resident #15 on 12/06/19 at 9:42am revealed Resident #15 was standing in his room with a stack of documents which contained other residents' personal information.

Interview with Resident #15 on 12/06/19 at 9:43am revealed:
-He had to "finish his work."
-He had gotten the stack of documents from a

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D916	Continued From page 276 box in his closet. -"They took the rest of them." Observation of Resident #15's room on 12/06/19 at 9:44am revealed: -There was a box in Resident #15's closet which contained an old, empty resident record binder. -There were file folders and other items in the bottom of the box. -It could not be determined by observation if there were additional resident documents in the box. Interview with the Administrator on 12/06/19 at 9:50am revealed: -She thought she had removed all the documents from Resident #15's room which contained other residents' personal information on 12/05/19. -Resident #15's room was at the end of the hall prior to her becoming Administrator. -The room where Resident #15 currently resided was once used as a storage room. -She thought boxes which contained residents' personal information may not have been removed from Resident #15's room before he moved to the room.	D916		
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	D932		

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D932	Continued From page 277 control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.	D932		

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D932	Continued From page 278 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record reviews, and interviews, 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 2 of 3 sampled residents (Residents #2, and #14) with diabetes, resulting in sharing glucometers between residents. The Findings are: 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 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 and did not give any cleaning/disinfection instructions. Observation of a finger stick blood sugar (FSBS) check for a resident on 12/04/19 at 9:14 am revealed: -The medication aide (MA) retrieved a glucometer from the medication cart that was labeled with	D932	THE HOME HAD WRITTEN POLICIES IN PLACE REGARDING ACH INFECTION PREVENTION. THE FACILITY ADMINISTRATOR FALIED TO ASSURE THESE POLICIES WERE BEING FOLLOWED PROPERLY AND THE APPROPRIATE TRAINING DONE. A NURSE FROM EXPRESS CARE PHARMACY CAME IN TO REFRESH TRAINING WITH STAFF REGARDING SUCH. AS OF 2/7/2020. ALL RESIDENTS HAVE BEEN PLACE IN AN APPROPRIATE LEVEL OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME IS CLOSED.	

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Resident #14's name.
-She then returned Resident #14's glucometer and picked up a glucometer labeled with Resident #2's name.
-She carried the glucometer labeled with Resident #2's name to Resident #14's room.
-She put on a pair of gloves, opened the pouch and turned on the glucometer labeled with Resident #2's name.
-Next, she cleaned Resident # 14's finger with alcohol and proceeded to prick her finger with a disposable lancet.
-She picked up the glucometer labeled with Resident #2's name and began to move toward Resident #14's finger.
-At 9:17 am, the procedure was stopped by the surveyor prior to applying blood to the wrong glucometer.
-There was not any disinfection wipe available.
-The MA placed the glucometer back in the labeled pouch and returned it to the medication cart.

Observation of medication cart A on 12/04/19 at 9:34am revealed:
-There were five glucometer cases labeled with residents' names with glucometers inside the cases.
-There were 3 glucometers of Brand A and 2 glucometers of Brand B.

Observation of medication cart B on 12/04/19 at 10:15am revealed:
-There were five glucometer cases labeled with residents' names with glucometers inside the cases.
-There were 3 glucometers Brand A and 2 glucometers Brand C.

There were 9 residents in the building with orders

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for FSBS checks and disposable lancets were available for use.

1. Review of Resident #14's current FL2 dated 05/14/19 revealed diagnoses included Diabetes Mellitus Type II and diabetic neuropathy.

Review of Resident #14's physicians order dated 10/04/19 revealed there was an order to check finger stick blood sugar (FSBS) before meals.

Review of Resident #14's signed physician orders dated 10/31/19 revealed there was an order to check finger stick blood sugar (FSBS) before meals.

Review of Resident #14's November and December 2019 electronic medication administration record (eMAR) revealed there was an entry to check FSBS before meals scheduled at 7:30am, 11:30am, and 4:30pm.

Review of Resident #14's Brand A glucometer's history on 12/04/19 at 4:30pm revealed:
-The date and time were not set correctly but some values matched the eMAR.
- FSBS values were inconsistent compared to values documented on Resident #14's November and December 2019 eMAR.
-FSBS values documented on Resident #14's November 2019 eMAR were not recorded in Resident #14's glucometer history with examples of inconsistencies as follows:
-There were 8 FSBS readings that were documented on the eMAR that were not in Resident #14's glucometer history.
-On 11/25/19, FSBS value of 188 at 7:30am and FSBS value of 231 at 11:30am were documented on the eMAR, but not in Resident #14's glucometer history.

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D932	Continued From page 281 -On 11/26/19, FSBS value of 123 at 7:30am and FSBS value of 130 at 11:30am were documented on the eMAR, but not in Resident #14's glucometer history. -On 11/27/19, FSBS value of 117 at 7:30am, FSBS value of 254 at 11:30am, and FSBS value of 158 at 4:30pm were documented on the MAR, but not in Resident #14's glucometer history -On 11/29/19, FSBS value of 169 at 11:30am was documented on the eMAR, but not in Resident #14's glucometer history. -The FSBS values documented on the eMAR for 11/25/19 at 7:30am, 11/26 at 7:30am and 11:30am, and 11/27/19 at 7:30 am matched FSBS values in the glucometer for Resident #2. -There were FSBS values on the November 2019 eMAR that could not be matched up to Resident #14 or Resident #2's glucometer. -FSBS values documented on Resident #14's December 2019 eMAR were not recorded in Resident #14's glucometer history with examples of inconsistencies as follows: -There were 4 FSBS readings that were documented on the eMAR that were not in Resident #14's glucometer history. -On 12/02/19, FSBS value of 296 at 11:30am and FSBS value of 238 at 4:30pm were documented on the eMAR, but not in Resident #14's glucometer history. -On 12/03/19, FSBS value of 88 at 7:30 am and FSBS value of 127 at 11:30am were documented on the eMAR, but not in Resident #14's glucometer history. -The FSBS values documented on the eMAR for 12/02/19 at 11:30am and 12/03/19 at 7:30am and 11:30 am matched FSBS values in the glucometer for Resident #2. -There were FSBS values on the December 2019 eMAR that could not be matched up to Resident #14 or Resident #2's glucometer.	D932		

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Interview with Resident #14 on 12/04/19 at 9:18am revealed:
-Her blood sugar was checked before meals.
-She thought each resident had their own glucometer.
-She thought the medication aide (MA) used her glucometer when her FSBS was checked.
-She never looked at the glucometer to see whose name was on it.

Interview with an MA on 12/04/19 at 9:19am revealed:
-She took Resident #2's glucometer into Resident #14's room to check her FSBS at 9:14am this morning.
-There were no disinfecting wipes available to clean the glucometers after each use.
-Resident #14's glucometer had not worked for three weeks.
-She used Resident #2's glucometer to check Resident #14's FSBS before meals when she worked.
-She had observed other MA's use other Resident's glucometer to check Resident #14's FSBS.
-She had informed the contracted facility nurse, the Supervisor, and the Administrator of Resident #14's glucometer not working.
-The Supervisor and the Administrator had told her to use one of the other residents' glucometer to check Resident #14's FSBS.

Interview with a second MA on 12/04/19 at 9:30am revealed:
-Resident #14's glucometer had not been working properly for three weeks.
-There were no disinfecting wipes available to clean the glucometers after each use.
-She used Resident #2's glucometer when she

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THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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had to check Resident #14's FSBS.
-She had informed the Supervisor and the Administrator that Resident #14's glucometer was not working properly.
-The Administrator and the Supervisor had instructed her to use another residents' glucometer to check Resident #14's FSBS.

Interview with the Supervisor on 12/04/19 at 10:02am revealed:
-She did not know Resident #14's glucometer did not work properly.
-If she had been told Resident #14's glucometer did not work she would have ordered her a new one.
-She had passed medications and checked residents FSBS's, but it had been awhile.

Interview with the Administrator on 12/04/19 at 10:35am revealed:
-She did not know that Resident #14's glucometer did not work properly.
-She had not tried to get a replacement glucometer for Resident #14.

Refer to interview with the Administrator on 12/04/19 at 10:35am.

Refer to interview with the primary care provider (PCP) on 12/04/19 at 4:05pm.

2. Review of Resident #2's current FL2 dated 01/23/19 revealed:
-Diagnoses included Diabetes Mellitus Type II and polyneuropathy of legs.
-There was an order to check fingerstick blood sugars (FSBS's) 2 times a day before breakfast and supper.

Review of Resident #2's signed physician orders

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dated 11/08/19 revealed there was an order to check finger stick blood sugar (FSBS) 2 times a day before breakfast and dinner.

Review of Resident #2's November and December 2019 electronic medication administration record (eMAR) revealed there was an entry to check FSBS before meals scheduled at 6:30am and 5:00pm.

Review of Resident #2's Brand A glucometer's history on 12/04/19 at 4:50pm revealed:
- FSBS values were inconsistent compared to values documented on Resident #2's November and December 2019 eMAR.
-FSBS values documented on Resident #2's November 2019 eMAR were not recorded in Resident #2's glucometer history with examples of inconsistencies as follows:
-There were 4 FSBS readings that were documented on the eMAR that were not in Resident #2's glucometer history.
-On 11/24/19, FSBS value of 198 at 6:30am and FSBS value of 250 at 5:00pm were documented on the eMAR, but not in Resident #2's glucometer history.
-On 11/26/19, FSBS value of 290 at 5:00pm was documented on the eMAR, but not in Resident #2's glucometer history.
-On 11/27/19, FSBS value of 255 at 5:00pm was documented on the eMAR, but not in Resident #2's glucometer history.
-There were FSBS values on the November 2019 eMAR that could not be matched up to Resident #2's glucometer.
-FSBS values documented on Resident #2's December 2019 eMAR were not recorded in Resident #2's glucometer history with examples of inconsistencies as follows:
-There were 2 FSBS values that were

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documented on the eMAR that were not in Resident #2's glucometer history.
-On 12/02/19, FSBS value of 258 at 6:30am was documented on the eMAR, but not in Resident #2's glucometer history.
-On 12/03/19, FSBS value of 251 at 6:30am was documented on the eMAR, but not in Resident #2's glucometer history.
-There were FSBS values on the December 2019 eMAR that could not be matched up to Resident #2's glucometer.

Interview with Resident #2 on 12/12/19 at 12:27am revealed:
-Staff did her FSBS checks of the mornings.
-She could not remember if they checked her FSBS 2 times a day.
-She did not know anything about her glucometer and did not ask to see her name on it.

Interview with an MA on 12/04/19 at 9:19am revealed:
-She took Resident #2's glucometer into Resident #14's room to check her FSBS at 9:14am this morning.
-There were no disinfecting wipes available to clean the glucometers after each use.
-She used Resident #2's glucometer to check Resident #14's FSBS before meals when she worked.
-The Supervisor and the Administrator had told her to use one of the other residents' glucometer to check Resident #14's FSBS.

Interview with a second MA on 12/04/19 at 9:30am revealed:
-She used Resident #2's glucometer when she had to check Resident #14's FSBS.
-There were no disinfecting wipes available to clean the glucometers after each use.

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-She had informed the Supervisor and the Administrator that Resident #14's glucometer was not working properly.
-The Administrator and the Supervisor had instructed her to use another residents' glucometer to check Resident #14's FSBS.

Refer to interview with the Administrator on 12/04/19 at 10:35am.

Refer to interview with the primary care provider (PCP) on 12/04/19 at 4:05pm.

Interview with the Administrator on 12/04/19at 10:35am revealed:
-There were no residents who had ordersfor FSBS testing with a diagnosis of bloodborne illness.
-She expected each resident to have their own glucometer.
-She expected the MA's to report to her when glucometers were broken.

Interview with the PCP on 12/04/19 at 4:05pm revealed:
-She did not know the MA's had been sharing glucometers.
-Each resident were supposed to have their own glucometer.
-Their could be cross contamination from resident to resident especially if they was a resident with any bloodborne pathogens.

The facility failed to implement infection control procedures consistent with CDC guidelines placing residents receiving finger stick blood sugar checks with glucometers at risk due to possible exposure to bloodborne pathogen diseases for Residents #14 and #2. This failure was detrimental to the health safety and welfare

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D932	Continued From page 287 of the residents and constitutes a Type B Violation. ____________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/04/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2019.	D932	STATE APPROVED OSHA TRAINING WAS COMPLETED WITH MED TECH STAFF BY EXPRESS CARE PHARMACY.	
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5	D934		

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

Based on record reviews and interviews, the facility failed to assure 7 of 7 medication aides (MAs) sampled (Staff C, E, F, I, J, and K) and the Administrator had completed the state approved mandatory annual infection control training.

The findings are:

1. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C was hired on 08/27/18.
-Staff C passed the written medication aide exam on 11/20/17.
-There was documentation Staff C had completed an online computer training of the state approved annual infection control training dated 09/06/19.
-There was no documentation for subsequent completion of the state approved infection control training with skills requiring return demonstration.

Interview with Staff C on 12/12/19 at 4:20pm revealed:
-She was rehired in January 2019.
-She had worked at the facility off and on since 2010.
-She completed the state approved mandatory infection control training online on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required returned demonstration.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

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Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

2. Review of Staff E's, medication aide (MA), personnel record revealed:
-Staff E was hired on 06/27/19.
-Staff E had not taken and passed the written medication aide exam as of 12/10/19.
-There was documentation Staff E had completed an online computer training of the state approved mandatory annual infection control training dated 07/03/19.
-There was no documentation for subsequent completion of the state approved mandatory infection control training.

Interview with Staff E on 12/12/19 at 10:37am revealed:
-She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19.
-She worked as a MA and administered medications to residents.
-She completed the state approved mandatory infection control training online on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required returned demonstration.

Interview with a resident on 12/12/19 at 4:00pm revealed Staff E was a MA at the facility and administered medications to the resident.

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D934	Continued From page 290 [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. 3. Review of Staff F's, medication aide (MA), personnel record revealed: -Staff F was hired on 08/16/19. -Staff F passed the written medication aide exam on 03/24/10. -There was no documentation Staff F had completed training of the state approved mandatory annual infection control training. Interview with Staff F on 12/11/19 at 5:00pm revealed: -She worked as a MA at the facility since 08/16/19. -She administered medications to residents at the facility. -She completed the state approved mandatory infection control training online on the computer. -She did not know the state approved mandatory infection control training could not be completed as an online computer training. -She did not know there was a skills validation section that required returned demonstration. Interview with a resident on 12/12/19 at 4:00pm revealed Staff F was a MA at the facility and administered medications to the resident. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B	D934		

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Violation).]

Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

4. Review of Staff I's, medication aide (MA), personnel record revealed:
-Staff I was hired on 03/13/19.
-Staff I passed the written medication aide exam on 06/12/02.
-There was no documentation Staff I had completed training of the state approved mandatory annual infection control training.

Interview with Staff I on 12/11/19 at 4:38pm revealed:
-She was hired as the Activity's Director and she then transitioned to a medication aide (MA) in March 2019.
-She completed state approved mandatory infection control training online on the computer.
-She did not know state approved mandatory infection control training could not be completed as an online computer training.

Observation of Staff I on 12/12/19 from 8:00am to 12:00pm revealed Staff I administered medications to residents at the facility.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

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Refer to interview with the Administrator on 12/12/19 at 5:25pm.

5. Review of Staff J's, medication aide (MA), personnel record revealed:
-Staff J was hired on 03/13/19.
-Staff J passed the written medication aide exam on 03/26/14.
-There was documentation Staff J had completed an online computer training of the state approved mandatory annual infection control training dated 03/05/19.
-There was no documentation for subsequent completion of the state approved mandatory infection control training.

Interview with a resident on 12/12/19 at 4:00pm revealed Staff J was a MA at the facility and administered medications to the resident.

Telephone interview with Staff J on 12/12/19 at 4:38pm revealed:
-She was hired as a MA in February 2019.
-She completed the state approved mandatory infection control training online on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required returned demonstration.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

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Refer to interview with the Administrator on 12/12/19 at 5:25pm.

6. Review of Staff K's, medication aide (MA), personnel record revealed:
-Staff K did not have a hire date in her record
-Staff K passed the written medication aide exam on 08/28/13.
-There was no documentation Staff K had completed the state approved mandatory annual infection control training.
-There was no documentation for subsequent completion of the state approved mandatory infection control training.

Telephone interview with Staff K on 12/12/19 at 4:38pm revealed:
-She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a medication aide (MA).
-She completed the state approved mandatory infection control training online on the computer.
-She did not know there was a skills validation section that required returned demonstration.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

7. Review of the Administrator's personnel record revealed:
-The Administrator was hired on 11/01/18.
-The Administrator passed the written medication

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aide exam on 01/10/19.
-There was documentation the Administrator had completed an online computer training of the state approved mandatory annual infection control training dated 03/05/19.
-There was no documentation for subsequent completion of the state approved mandatory infection control training.

Interview with the Administrator on 12/12/19at 5:35pm revealed:
-She was hired as the Administrator in November 2018 and started working at the facility in January 2019.
-She completed the state approved mandatory infection control training online on the computer on 03/05/19.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am revealed:
-He was responsible for providing infection control training for the MAs at the facility.
-He was hired by the contracted pharmacy one year ago.
-He was told by a member at the contracted pharmacy, when he was hired, that the contracted pharmacy had approval by the State for the annual infection control to be taken on the

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computer along with other trainings required.
-He did not know the state approved mandatory annual infection control training had skills evaluations that had to be validated by a return demonstration therefore could not be approved as an online computer training with out documentaiton of return demonstration.
-He would arrange for a corporate nurse or contracted nurse to come to the facility to do competency validations for the infection control training and complete training certifications.

Interview with the Administrator on 12/12/19at 5:25 revealed:
-The facility contracted pharmacy taught thestate approved mandatory infection control training on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required return demonstration.

The facility failed to assure the state approved mandatory annual infection control training for 7 of 7 sampled medication aides (Staff C, E, F, I, J, and K) and the Administrator was completed resulting in staff sharing of glucometers between 2 residents exposing the residents to possible blood borne pathogen diseases. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.

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D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.	D935		

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D935	Continued From page 297 b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 6 of 7 sampled staff (Staff C, E, F, I, J, and K) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration courses (Staff C, E, F, I, J, and K), completed the Medication Administration Skills Validation (Staff C, E, F, and K), and passed the state written medication aide exam (Staff E) prior to administering medications. The findings are: 1. Review of Staff C's, medication aide (MA) personnel record revealed: -Staff C was hired on 08/27/18. -There was no documentation of employment verification confirming Staff C worked as a MA within the past 24 months. -There was no documentation Staff C completed the 5, 10 or 15-hour medication administration training. -There was no documentation Staff C completed the Medication Administration Skills Validation checklist. -Staff C passed the written MA exam on 11/20/17.	D935		

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Review of a residents' electronic Medication Administration Record (eMAR) revealed Staff C documented administration of medications 15 days in October 2019, 14 days in November 2019, and 2 days in December 2019.

Telephone interview with Staff C on 12/12/19 at 4:20pm revealed:
-She worked off and on at the facility since 2010 and she recently came back to work at the facility in January 2019.
-There was no verification for employement as a medication aide within the last 24 months available for review.
-She administered residents' medications including oral medications, eye drops, creams, and insulin, and she obtained residents' finger stick blood sugars.
-She did not know which 5, 10, or 15-hour medication administration training she completed or when she completed the course.
-She was "checked off on the medication cart" by a Registered Nurse (RN) (date unknown).

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She did not know Staff C had not completed the 5, 10, or 15-hour medication administration training.
-She did not know Staff C had not completed a Medication Administration Skills Validation checklist.
-She had not audited Staff C's personnel record for Staff C's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH

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D935	Continued From page 299 Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 2. Review of Staff E's, medication aide (MA) personnel record revealed: -Staff E was hired on 06/27/19. -There was no documentation of employment verification confirming Staff E worked as a MA within the past 24 months. -There was no documentation Staff E completed the 5, 10 or 15-hour medication administration training. -There was no documentation Staff E completed the Medication Administration Skills Validation checklist. -There was no documentation Staff E passed the state written MA exam. Review of a residents' eMAR revealed Staff E documented administration of medications 12 days in October 2019, and 4 days in November 2019. Interview with Staff E on 12/12/19 at 10:37am revealed: -She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19. -She had been a MA since 2004, but she was not employed as a MA consecutively over thepast 24 months. -She administered residents' medications including oral medications, eye drops, and insulin, and she obtained residents' finger stick blood	D935		

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sugars.
-She was never asked to provide her MA paperwork to the facility.
-She did not complete the 5, 10, or 15-hour medication administration training.
-She did not know she needed the 5-hour course in order to pass medications to the residents.
-She was "checked off by a nurse" in November 2019.
-She did not know why the Medication Clinical Skills Validation checklist was not in her personnel record.
-She was scheduled to take the state written MA exam in January 2020.
-She did not know she needed to take the written MA exam within 60 days of completing the Medication Clinical Skills Validation checklist; the Administrator told her she had 90 days until she had to take the written MA exam.
-The Administrator told her she "could [administer] medications because [she] was checked off on [medications]".

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She thought Staff E had 90 days from completion of the Medication Clinical Skills Validation checklist to schedule and take the written MA test.
-She was unable to locate the Medication Clinical Skills Validation checklist completed for Staff E.
-She did not know Staff E did not complete the 5, 10, or 15-hour medication administration training.

Telephone interview with the LHPS nurse on 12/12/19 at 8:40pm revealed she had not completed a Medication Administration Skills Validation checklist for Staff E.

[Refer to Tag D358 10A NCAC 13F .1004(a)

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D935	Continued From page 301 Medication Administration (Type B Violation)]. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 3. Review of Staff F's, medication aide (MA) personnel record revealed: -Staff F was hired on 08/16/19. -There was no documentation of employment verification confirming Staff F worked as a MA within the past 24 months. -There was no documentation Staff F completed either the 5, or 10 hour, or the 15-hour medication administration training. -There was no documentation Staff F completed the Medication Administration Skills Validation checklist. -Staff F passed the written MA exam on 03/24/10. Review of a residents' eMAR revealed Staff F documented administration of medications 10 days in October 2019, 8 days in November 2019, and 4 days in December 2019. Interview with Staff F on 12/11/19 at 5:00pm revealed: -Staff F was hired as a MA on 08/16/19. -She administered medications to residents including oral medications, eye drops, creams, and insulin, and she obtained residents' finger stick blood sugars. -She had not completed the Medication Administration Skills Validation checklist yet.	D935		

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-She did not know she needed to complete the 5-hour training prior to administering medications to residents at the facility.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She did not know Staff F had not completed the 5, 10, or 15-hour medication administration training.
-She had not audited Staff F's personnel record for Staff F's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.

4. Review of Staff I's, medication aide (MA) personnel record revealed:
-Staff I was hired on 03/13/19.
-There was no documentation of employment verification confirming Staff I worked as a MA within the past 24 months.
-There was no documentation Staff I completed the 5, 10 or 15-hour medication administration training.
-Staff I completed the Medication Administration Skills Validation checklist on 03/04/19.
-Staff I passed the written MA exam on 06/12/02.

Review of a residents' eMAR revealed Staff I documented administration of medications 2 days

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in October 2019 and 3 days in November 2019.

Observation of Staff I on 12/11/19 from 8:00am to 12:00pm revealed Staff I was administering medications to residents.

Interview with Staff I on 12/11/19 at 4:38pm revealed:
-She was hired as the Activity's Director and she then transitioned to a MA in March 2019.
-She had completed the 15-hour medication administration training (date unknown).
-She did not know why the 15-hour medication administration training was not in her personnel record.
-She had been a nursing assistant for 30 years and she previously worked as a MA; she did not provide information regarding if she worked as a MA in the past 24 months.
-She did not provide employment verification to the facility because she did not have it and she completed the MA training.
-She started administering medications to residents in March 2019.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She knew Staff I had previously worked as a MA.
-She did not know Staff I did not have documentation of the 5, 10, or 15-hour medication administration training.
-She did not know why documentation of Staff I's 5, 10, or 15-hour medication administration training was not in her personnel record.
-She had not audited Staff I's personnel record for Staff I's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

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[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)].

Refer to the interview with the Administrator on 12/12/19 at 5:25pm.

Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.

5. Review of Staff J's, medication aide(MA) personnel record revealed:
-Staff J was hired on 03/13/19.
-There was no documentation of employment verification confirming Staff J worked as aMA within the past 24 months.
-There was no documentation Staff J completed the 5, 10 hours, or 15-hour medication administration training.
-Staff J completed the Medication Administration Skills Validation checklist on 03/04/19.
-Staff J passed the written MA exam on 03/26/14.

Review of a residents' eMAR revealed Staff J documented administration of medications 10 days in October 2019, 10 days in November 2019, and 1 day in December 2019.

Telephone interview with Staff J on 12/12/19 at 4:38pm revealed:
-She was hired as a MA in February 2019.
-Staff J administered medications to residents including oral medications, nebulizer's, eye drops, and insulin.
-She did not know if she completed the 5, 10 or 15-hour medication administration training.
-She did not know she needed the 5-hour training before she administered medications toresidents at the facility.

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Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She did not know Staff J had not completed the 5, 10, or 15-hour medication administration training.
-She had not audited Staff J's personnel record for Staff J's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.

6. Review of Staff K's, medication aide (MA) personnel record revealed:
-Staff K did not have a documented hire date.
-There was no documentation of employment verification documenting Staff K worked as a MA within the past 24 months.
-There was no documentation Staff K completed the 5, 10 or 15-hour medication administration training.
-There was no documentation Staff K completed the Medication Administration Skills Validation checklist.
-Staff K passed the written MA exam on 08/28/13.

Review of a residents' eMAR revealed Staff K documented administration of medications 3 days in November 2019.

Telephone interview with Staff K on 12/12/19 at

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4:38pm revealed:
-She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a MA.
-She administered oral medications to residents at the facility.
-She worked 3rd shift and she did not obtain residents' finger stick blood sugars and she did not administer insulin because blood sugar checks and insulin were not scheduled at the times she worked.
-She had completed the 5-hour MA training, but did not provide documentation to the facility because she was not asked for the documentation.
-She had not completed the Medication Administration Skills Validation checklist because she was waiting on a nurse to complete the checklist with return demonstration.
-She worked as a MA for over 10 years and never had a break in her employment.
-She did not provide employment verification to the facility because she was never asked for the documentation.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She did not have documentation of Staff K's 5-hour medication administration training.
-She did not know why documentation of Staff K's 5-hour medication administration training was not in her personnel record.
-She had not requested documentation of Staff K's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B

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Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.

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Interview with the Administrator on 12/12/19 at 5:25pm revealed:
-She was responsible for personnel records and ensuring they were complete and up to date.
-She was responsible for ensuring the 5, 10, or 15-hour training was completed by staff.
-She did not know the 5-hour training was required before MAs administered medications to residents.
-The obligation for staffing duties interfered with her administrative duties and interfered with her responsibility of ensuring MAs had the required training prior to administering medication.
-The Licensed Health Personnel Support (LHPS) nurse conducted trainings including Medication Administration Skills Validation checklist.

Telephone interview with the LHPS nurse on 12/12/19 at 8:30pm revealed:
-She had been the LHPS nurse at the facility for 3 months.
-She had not conducted any MA trainings at the facility.
-The Administrator did not request for her to complete any Medication Clinical Skills Validation checklists.

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The facility failed to assure the 5, 10, or 15-hour medication aide training with no previous employment verification as a medication aide within the last 24 months were completed for 6 of 7 sampled medication aides (Staff C, E, F, I, J,

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D935	Continued From page 308 and K), the Medication Administration Skills Validation were completed for 4 of 7 staff (Staff C, E, F, and K), and the state approved MA exam was passed within 60 days of the Medication Administration Skills Validation completion for 1 of 7 sampled staff (Staff E) prior to the staff administering medications to the residents, which resulted in an increased the risk for medication errors and exposing the residents to possible blood borne pathogen diseases from staff sharing glucometers between residents. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. ________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D935		
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 A2 VIOLATION Based on interviews and record reviews, the Administrator failed to assure the management,	D980		

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operations, and policies of the facility were implemented and rules were maintained for ACH infection prevention requirements, medication administration, controlled substances, supervision, physical environment, personal care, housekeeping and furnishings, criminal background check, health care personnel registry check, nutrition and food services, residents' rights, health care personnel registry, incident and accident reports, activities, tuberculosis test, health care, ACH medication aides; training and competency requirements, test for tuberculosis, training on cardio-pulmonary resuscitation, examination and screening for controlled substances, personal care and other staffing, competency validation for licensed health professional support tasks, personal care training and competency, management of resident funds, training on care of diabetic residents, staffing of personal care aide supervisors, and implementation.

The findings are:

Interview with a first shift medication aide (MA) on 12/12/19 at 11:37am revealed she reported resident issues to the Administrator and the Supervisor.

Interview with the Supervisor on 12/12/19 at 12:48pm revealed:
-She reported issues with residents and staff to the Administrator.
-The Administrator was responsible for the operations of the facility.

Interview with the Administrator on 12/12/19 at 5:25pm revealed:
-She had been the Administrator since January 2019.

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-The facility's Resident Care Coordinator (RCC) left in late April 2019.
-The RCC had been responsible for hiring staff, assuring staff qualifications were completed , including criminal backgrounds checks, Health Care Personnel Registry checks, Tuberculosis testings completed, and scheduling staff.
-The facility had experienced a large number of staff turnover.
-The Administrator had assumed the RCC duties as well as staffing for medication administration since the RCC left in April 2019.
-"Her obligations for staffing duties interfered with her administrative duties."
-The personnel records were being transitioned to electronic records, and some of the staffing documents were not available for review.

Interview with the Administrator on 12/13/19 at 12:53pm revealed:
-She was at the facility at least 5 days a week and at least 10 hours a day.
-She was responsible for the total operations of the facility including adherence to rules and regulations.
-Her duties included hiring new staff, scheduling staff to work, marketing and admissions, business office functions, and passing medications when she could not get a medication aide to work.
-It was difficult for her to fulfill her responsibilities as Administrator because she was responsible for more than Administrator tasks.

1. Based on record reviews, observations and interviews the facility failed to contact the health care and mental health providers and specialist health care providers for 7 of 11 sampled residents (Residents #1, #3, #5, #9, #12, #14, and #18) regarding a resident with a pressure

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D980	Continued From page 311 ulcer (#3), a resident with extreme muscle weakness resulting in falls who missed a nerve conduction study and two MRI appointments (#12), a resident with swollen lower extremities that caused pain when walking (#5), a resident with aggressive/agitated behaviors that yelled at other residents, beat on the walls and threw chairs (#18), two residents with rashes which made the residents uncomfortable (#1 and #9) and a glucometer which did not work properly (#14). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered by a licensed practicing practitioner for 6 of 6 sampled residents (#1, #2, #3, #4, #5 and #12) related to a topical antiseptic (#3), an anti-coagulant and a narcotic pain reliever (#4), a rapid acting insulin (#2, #3 and #12), a diuretic (#5), and a gastric acid reducer (#1). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on interviews, record reviews, and observations, the facility failed to assure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled residents (Resident #5) who was constantly disorientated and had wandering behaviors and eloped from the facility without staff's knowledge. [Refer to Tag D067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 4. Based on record reviews and interviews, the facility failed to assure 9 of 12 sampled staff (Staff A, B, C, E, F, G, I, J, and K) were tested for Tuberculosis (TB) disease upon hire. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for	D980		

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Tuberculosis (Type B Violation)].

5. Based on observations, interviews and record reviews, the facility failed to assure 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K) had a criminal background check completed prior to hire. [Refer to Tag D139 10A NCAC 13F .0407(a)(7) Criminal Background Check (Type B Violation)].

6. Based on record reviews and interviews, the facility failed to assure 4 of 11 sampled staff (Staff C, D, I, and J) who provided personal care to residents had documentation of successful completion of an 80 hour personal care training and competency evaluation program. [Refer to Tag D150 10A NCAC 13F .0501 Personal Care Training (Type B Violation)].

7. Based on observations, record reviews and interviews, the facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic resident prior to the administration of insulin. [Refer to Tag D164 10A NCAC 13F .0505 Training on Care of Diabetic Residents (Type B Violation)].

8. Based on observations, record reviews and interviews, the facility failed to assure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 27 of69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to Tag D167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].

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D980	Continued From page 313 9. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing at the facility for 8 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to Tag D188 10ANCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation)]. 10. Based on interviews and record review, the facility failed to assure first and second shifts were staffed with a minimum of 20 hours including 16 hours of personal care staff and 8 hours of supervision with up to 4 hours counted toward personal care hours, and third shift was staffed with 16 hours of personal care aide and 8 supervisor hours when there was not a supervisor within 500 feet of the facility for 5 of 69 sampled shifts when there was a census of 31 residents in an unsprinkled facility. [Refer to Tag D214 10A NCAC 13F .0605(c) Staffing of Personal Care Aide Supervisor (Type B Violation)]. 11. Based on observations, interviews and record reviews, the facility failed to assure personal care was provided to 8 of 11 sampled residents (#1, #5, #7, #8, #11, #12, #18, and #20) including foot care to three residents (#5, #12, and #18,); residents having to wait for incontinence care (#7, #8, and #20), and residents with a yeast rash (#1 and #11). [Refer to Tag D269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)]. 12. Based on record reviews, observation and interviews the facility failed to provide supervision to meet the needs of 2 of 5 sampled residents (Residents #5 and #12) who had muscle weakness causing him to repeatedly fall (#12) and a resident who eloped without staff's	D980		

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knowledge (#5). [Refer to Tag D270 10A NCAC 13F .0902(b) Personal Care and Supervision (Type B Violation)].

13. Based on record review and interviews the facility failed to assure 1 of 17 sampled residents (Resident #19) were free of abuse and neglect resulting a resident (#19) being physically assaulted by a medication aide (Staff M). [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].

14. Based on observations, interviews, and record reviews, the facility failed to assure records of the administration of controlled substances were maintained, accurate and reconciled for 5 of 8 sampled residents (Residents #4, #5, #15, #17 and #18) who were prescribed Oxycodone (#4 and #17), lyrica (#4), zolpidem tartrate (#4), hydrocodone (#15), and lorazepam (#5 and #18). [Refer to Tag D392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].

15. Based on record reviews and interviews, the facility failed to report allegations of physical abuse of a resident (Resident #19) by a medication aide (Staff F), to the Health Care Personnel Registry (HCPR). [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].

16. Based on observation, record reviews, and interviews, 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 2 of 3 sampled residents (Residents #2, and#14) with diabetes, resulting in sharing glucometers

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D980	Continued From page 315 between residents. [Refer to Tag D932 G.S. 131D-4.4 ACH Infection Prevention Requirements (Type B Violation)]. 17. Based on record reviews and interviews, the facility failed to assure 7 of 7 medication aides (MAs) sampled (Staff C, E, F, I, J, and K) andthe Administrator had completed the state approved mandatory annual infection control training. [Refer to Tag D934 G.S. 131D-4.5B(a) ACH Infection Prevention Requirements (Type B Violation)]. 18. Based on observations, interviews and record reviews, the facility failed to assure 6 of 7 sampled staff (Staff C, E, F, I, J, and K) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration courses (Staff C, E, F, I, J, and K), completed the Medication Administration Skills Validation (Staff C, E, F, and K), and passed the state written medication aide exam (Staff E) prior to administering medications. [Refer to Tag D935 G.S. 131D-4.B(b) ACH Medication Aide Training and Competency (Type B Violation)]. 19. Based on interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was completed for 8 of 12 sampled staff (Staff B, C, E, F, I, J, K) and the Administrator prior to hire. [Refer to Tag D992 G.S. 131D-45(a) Examination and Screening for Controlled Substances (Type B Violation)]. ______ The Administrator neglected to ensure responsibility for the overall operation, administration, management and supervision of the facility resulting in all exit doors not alarmed	D980		

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while a resident who was constantly disoriented eloped from the facility without staff's knowledge; a resident experiencing burning and stinging from a stage II pressure ulcer; a resident having frequent falls due to muscle weakness; aresident in pain and discomfort due to swollen legs, ankles and feet; a resident exhibiting aggressive psychotic behaviors towards other residents; residents having rashes due to lack of personal care that burned and caused pain; a resident with a missed gastroenterologist appointment; a resident who had physcian's orders for medical procedures which were not implemented; a resident being pushed and hit by a staff (Staff M); a resident admitted to the facility and not administered lovenox injection for 3 days; a resident whose glucometer was not working properly which led to staff sharing glucometers ; medications not being available and not administered as ordered; inaccurate accounting for the administration of controlled substances; 5 of 69 sampled shifts where there was no medication aide (MA) supervior on the premises and no staff available to administer medications to residents; 6 MAs who had not completed the MA requirements prior to administering medications and 8 of 69 sampled shifts where staff was short of aide hours and not present at all times to meet the needs of residents. This neglect resulted in substantial risk of physical harm and neglect and constitutes a Type A2 Violation.

The facility provided a plan of protection in accordance with G.S. 131 D-34 on 12/12/19.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 12, 2019.

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D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.	D992		

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D992	Continued From page 318 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was completed for 8 of 12 sampled staff (Staff B, C, E, F, I, J, K) and the Administrator prior to hire. The findings are: 1. Review of Staff B's, personal care aide (PCA) personnel record revealed: -Staff B was hired in August 2019. -There was no documentation Staff B completed the examination and screen for the presence of controlled substance. -There was no consent for a drug screening and examination. Interview with Staff B on 12/11/19 at 4:29pm revealed: -She was hired as a PCA at the end of July 2019. -She provided personal care to residents including bathing, toileting, and feeding. -She did not complete an examination and screening for controlled substances. -She did not know she was required to complete a controlled substance examination and screening prior to hire. -The Administrator was responsible for completing her paperwork when she was hired. Interview with the Administrator on 12/12/19 at 5:40pm revealed: -She was responsible for completing the	D992	POLICIES WERE IN PLACE TO ASSURE PPD TESTING WAS IN PLACE AT THE TIME OF HIRE FOR EMPLOYEES. ALL EMPLOYEES ARE REQUIRED TO HAVE A DRUG TEST COMPLETED PRIOR TO HIRE. WHILE AFTER SURVEY HAD BEEN COMPLETED, THE OWNERS FOUND SOME ADDITIONAL DOCUMENTATION THAT SOME HAD BEEN TESTED, THE OWNER'S CHOSE TO PERFORM DRUG TESTS ON ALL REMAINING STAFF. TWO STAFF MEMBERS THAT FAILED THESE TEST WERE TERMINATED BY THE OWNER'S IMMEDIATELY. AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN PLACE IN AN APPROPRIATE LEVEL OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME HAS BEEN CLOSED.	

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

Based on record reviews and interviews, the facility failed to assure 7 of 7 medication aides (MAs) sampled (Staff C, E, F, I, J, and K) and the Administrator had completed the state approved mandatory annual infection control training.

The findings are:

1. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C was hired on 08/27/18.
-Staff C passed the written medication aide exam on 11/20/17.
-There was documentation Staff C had completed an online computer training of the state approved annual infection control training dated 09/06/19.
-There was no documentation for subsequent completion of the state approved infection control training with skills requiring return demonstration.

Interview with Staff C on 12/12/19 at 4:20pm revealed:
-She was rehired in January 2019.
-She had worked at the facility off and on since 2010.
-She completed the state approved mandatory infection control training online on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required returned demonstration.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

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Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

2. Review of Staff E's, medication aide (MA), personnel record revealed:
-Staff E was hired on 06/27/19.
-Staff E had not taken and passed the written medication aide exam as of 12/10/19.
-There was documentation Staff E had completed an online computer training of the state approved mandatory annual infection control training dated 07/03/19.
-There was no documentation for subsequent completion of the state approved mandatory infection control training.

Interview with Staff E on 12/12/19 at 10:37am revealed:
-She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19.
-She worked as a MA and administered medications to residents.
-She completed the state approved mandatory infection control training online on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required returned demonstration.

Interview with a resident on 12/12/19 at 4:00pm revealed Staff E was a MA at the facility and administered medications to the resident.

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D934	Continued From page 290 [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. 3. Review of Staff F's, medication aide (MA), personnel record revealed: -Staff F was hired on 08/16/19. -Staff F passed the written medication aide exam on 03/24/10. -There was no documentation Staff F had completed training of the state approved mandatory annual infection control training. Interview with Staff F on 12/11/19 at 5:00pm revealed: -She worked as a MA at the facility since 08/16/19. -She administered medications to residents at the facility. -She completed the state approved mandatory infection control training online on the computer. -She did not know the state approved mandatory infection control training could not be completed as an online computer training. -She did not know there was a skills validation section that required returned demonstration. Interview with a resident on 12/12/19 at 4:00pm revealed Staff F was a MA at the facility and administered medications to the resident. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B	D934		

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D934	Continued From page 291 Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. 4. Review of Staff I's, medication aide (MA), personnel record revealed: -Staff I was hired on 03/13/19. -Staff I passed the written medication aide exam on 06/12/02. -There was no documentation Staff I had completed training of the state approved mandatory annual infection control training. Interview with Staff I on 12/11/19 at 4:38pm revealed: -She was hired as the Activity's Director and she then transitioned to a medication aide (MA) in March 2019. -She completed state approved mandatory infection control training online on the computer. -She did not know state approved mandatory infection control training could not be completed as an online computer training. Observation of Staff I on 12/12/19 from 8:00am to 12:00pm revealed Staff I administered medications to residents at the facility. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.	D934		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Refer to interview with the Administrator on 12/12/19 at 5:25pm.

5. Review of Staff J's, medication aide (MA), personnel record revealed:
-Staff J was hired on 03/13/19.
-Staff J passed the written medication aide exam on 03/26/14.
-There was documentation Staff J had completed an online computer training of the state approved mandatory annual infection control training dated 03/05/19.
-There was no documentation for subsequent completion of the state approved mandatory infection control training.

Interview with a resident on 12/12/19 at 4:00pm revealed Staff J was a MA at the facility and administered medications to the resident.

Telephone interview with Staff J on 12/12/19 at 4:38pm revealed:
-She was hired as a MA in February 2019.
-She completed the state approved mandatory infection control training online on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required returned demonstration.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

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D934	Continued From page 293 Refer to interview with the Administrator on 12/12/19 at 5:25pm. 6. Review of Staff K's, medication aide (MA), personnel record revealed: -Staff K did not have a hire date in her record -Staff K passed the written medication aide exam on 08/28/13. -There was no documentation Staff K had completed the state approved mandatory annual infection control training. -There was no documentation for subsequent completion of the state approved mandatory infection control training. Telephone interview with Staff K on 12/12/19 at 4:38pm revealed: -She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a medication aide (MA). -She completed the state approved mandatory infection control training online on the computer. -She did not know there was a skills validation section that required returned demonstration. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. 7. Review of the Administrator's personnel record revealed: -The Administrator was hired on 11/01/18. -The Administrator passed the written medication	D934		

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D934	Continued From page 294 aide exam on 01/10/19. -There was documentation the Administrator had completed an online computer training of the state approved mandatory annual infection control training dated 03/05/19. -There was no documentation for subsequent completion of the state approved mandatory infection control training. Interview with the Administrator on 12/12/19at 5:35pm revealed: -She was hired as the Administrator in November 2018 and started working at the facility in January 2019. -She completed the state approved mandatory infection control training online on the computer on 03/05/19. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. ______ Telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am revealed: -He was responsible for providing infection control training for the MAs at the facility. -He was hired by the contracted pharmacy one year ago. -He was told by a member at the contracted pharmacy, when he was hired, that the contracted pharmacy had approval by the State for the annual infection control to be taken on the	D934		

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D934	Continued From page 295 computer along with other trainings required. -He did not know the state approved mandatory annual infection control training had skills evaluations that had to be validated by a return demonstration therefore could not be approved as an online computer training with out documentaiton of return demonstration. -He would arrange for a corporate nurse or contracted nurse to come to the facility to do competency validations for the infection control training and complete training certifications. Interview with the Administrator on 12/12/19at 5:25 revealed: -The facility contracted pharmacy taught thestate approved mandatory infection control training on the computer. -She did not know the state approved mandatory infection control training could not be completed as an online computer training. -She did not know there was a skills validation section that required return demonstration. ________________ The facility failed to assure the state approved mandatory annual infection control training for 7 of 7 sampled medication aides (Staff C, E, F, I, J, and K) and the Administrator was completed resulting in staff sharing of glucometers between 2 residents exposing the residents to possible blood borne pathogen diseases. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. ________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D934		

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D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.	D935		

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b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

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

Based on observations, interviews and record reviews, the facility failed to assure 6 of 7 sampled staff (Staff C, E, F, I, J, and K) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration courses (Staff C, E, F, I, J, and K), completed the Medication Administration Skills Validation (Staff C, E, F, and K), and passed the state written medication aide exam (Staff E) prior to administering medications.

The findings are:

1. Review of Staff C's, medication aide (MA) personnel record revealed:
-Staff C was hired on 08/27/18.
-There was no documentation of employment verification confirming Staff C worked as a MA within the past 24 months.
-There was no documentation Staff C completed the 5, 10 or 15-hour medication administration training.
-There was no documentation Staff C completed the Medication Administration Skills Validation checklist.
-Staff C passed the written MA exam on 11/20/17.

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Review of a residents' electronic Medication Administration Record (eMAR) revealed Staff C documented administration of medications 15 days in October 2019, 14 days in November 2019, and 2 days in December 2019.

Telephone interview with Staff C on 12/12/19 at 4:20pm revealed:
-She worked off and on at the facility since 2010 and she recently came back to work at the facility in January 2019.
-There was no verification for employement as a medication aide within the last 24 months available for review.
-She administered residents' medications including oral medications, eye drops, creams, and insulin, and she obtained residents' finger stick blood sugars.
-She did not know which 5, 10, or 15-hour medication administration training she completed or when she completed the course.
-She was "checked off on the medication cart" by a Registered Nurse (RN) (date unknown).

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She did not know Staff C had not completed the 5, 10, or 15-hour medication administration training.
-She did not know Staff C had not completed a Medication Administration Skills Validation checklist.
-She had not audited Staff C's personnel record for Staff C's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH

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D935	Continued From page 299 Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 2. Review of Staff E's, medication aide (MA) personnel record revealed: -Staff E was hired on 06/27/19. -There was no documentation of employment verification confirming Staff E worked as a MA within the past 24 months. -There was no documentation Staff E completed the 5, 10 or 15-hour medication administration training. -There was no documentation Staff E completed the Medication Administration Skills Validation checklist. -There was no documentation Staff E passed the state written MA exam. Review of a residents' eMAR revealed Staff E documented administration of medications 12 days in October 2019, and 4 days in November 2019. Interview with Staff E on 12/12/19 at 10:37am revealed: -She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19. -She had been a MA since 2004, but she was not employed as a MA consecutively over thepast 24 months. -She administered residents' medications including oral medications, eye drops, and insulin, and she obtained residents' finger stick blood	D935		

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sugars.
-She was never asked to provide her MA paperwork to the facility.
-She did not complete the 5, 10, or 15-hour medication administration training.
-She did not know she needed the 5-hour course in order to pass medications to the residents.
-She was "checked off by a nurse" in November 2019.
-She did not know why the Medication Clinical Skills Validation checklist was not in her personnel record.
-She was scheduled to take the state written MA exam in January 2020.
-She did not know she needed to take the written MA exam within 60 days of completing the Medication Clinical Skills Validation checklist; the Administrator told her she had 90 days until she had to take the written MA exam.
-The Administrator told her she "could [administer] medications because [she] was checked off on [medications]".

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She thought Staff E had 90 days from completion of the Medication Clinical Skills Validation checklist to schedule and take the written MA test.
-She was unable to locate the Medication Clinical Skills Validation checklist completed for Staff E.
-She did not know Staff E did not complete the 5, 10, or 15-hour medication administration training.

Telephone interview with the LHPS nurse on 12/12/19 at 8:40pm revealed she had not completed a Medication Administration Skills Validation checklist for Staff E.

[Refer to Tag D358 10A NCAC 13F .1004(a)

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Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.

3. Review of Staff F's, medication aide (MA) personnel record revealed:
-Staff F was hired on 08/16/19.
-There was no documentation of employment verification confirming Staff F worked as a MA within the past 24 months.
-There was no documentation Staff F completed either the 5, or 10 hour, or the 15-hour medication administration training.
-There was no documentation Staff F completed the Medication Administration Skills Validation checklist.
-Staff F passed the written MA exam on 03/24/10.

Review of a residents' eMAR revealed Staff F documented administration of medications 10 days in October 2019, 8 days in November 2019, and 4 days in December 2019.

Interview with Staff F on 12/11/19 at 5:00pm revealed:
-Staff F was hired as a MA on 08/16/19.
-She administered medications to residents including oral medications, eye drops, creams, and insulin, and she obtained residents' finger stick blood sugars.
-She had not completed the Medication Administration Skills Validation checklist yet.

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D935	Continued From page 302 -She did not know she needed to complete the 5-hour training prior to administering medications to residents at the facility. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She did not know Staff F had not completed the 5, 10, or 15-hour medication administration training. -She had not audited Staff F's personnel record for Staff F's employment verification. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 4. Review of Staff I's, medication aide (MA) personnel record revealed: -Staff I was hired on 03/13/19. -There was no documentation of employment verification confirming Staff I worked as a MA within the past 24 months. -There was no documentation Staff I completed the 5, 10 or 15-hour medication administration training. -Staff I completed the Medication Administration Skills Validation checklist on 03/04/19. -Staff I passed the written MA exam on 06/12/02. Review of a residents' eMAR revealed Staff I documented administration of medications 2 days	D935		

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in October 2019 and 3 days in November 2019.

Observation of Staff I on 12/11/19 from 8:00am to 12:00pm revealed Staff I was administering medications to residents.

Interview with Staff I on 12/11/19 at 4:38pm revealed:
-She was hired as the Activity's Director and she then transitioned to a MA in March 2019.
-She had completed the 15-hour medication administration training (date unknown).
-She did not know why the 15-hour medication administration training was not in her personnel record.
-She had been a nursing assistant for 30 years and she previously worked as a MA; she did not provide information regarding if she worked as a MA in the past 24 months.
-She did not provide employment verification to the facility because she did not have it and she completed the MA training.
-She started administering medications to residents in March 2019.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She knew Staff I had previously worked as a MA.
-She did not know Staff I did not have documentation of the 5, 10, or 15-hour medication administration training.
-She did not know why documentation of Staff I's 5, 10, or 15-hour medication administration training was not in her personnel record.
-She had not audited Staff I's personnel record for Staff I's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

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D935	Continued From page 304 [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)]. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 5. Review of Staff J's, medication aide (MA) personnel record revealed: -Staff J was hired on 03/13/19. -There was no documentation of employment verification confirming Staff J worked as a MA within the past 24 months. -There was no documentation Staff J completed the 5, 10 hours, or 15-hour medication administration training. -Staff J completed the Medication Administration Skills Validation checklist on 03/04/19. -Staff J passed the written MA exam on 03/26/14. Review of a residents' eMAR revealed Staff J documented administration of medications 10 days in October 2019, 10 days in November 2019, and 1 day in December 2019. Telephone interview with Staff J on 12/12/19 at 4:38pm revealed: -She was hired as a MA in February 2019. -Staff J administered medications to residents including oral medications, nebulizer's, eye drops, and insulin. -She did not know if she completed the 5, 10 or 15-hour medication administration training. -She did not know she needed the 5-hour training before she administered medications to residents at the facility.	D935		

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Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She did not know Staff J had not completed the 5, 10, or 15-hour medication administration training.
-She had not audited Staff J's personnel record for Staff J's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.

6. Review of Staff K's, medication aide (MA) personnel record revealed:
-Staff K did not have a documented hire date.
-There was no documentation of employment verification documenting Staff K worked as a MA within the past 24 months.
-There was no documentation Staff K completed the 5, 10 or 15-hour medication administration training.
-There was no documentation Staff K completed the Medication Administration Skills Validation checklist.
-Staff K passed the written MA exam on 08/28/13.

Review of a residents' eMAR revealed Staff K documented administration of medications 3 days in November 2019.

Telephone interview with Staff K on 12/12/19 at

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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
D935	Continued From page 306	D935		

4:38pm revealed:
-She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a MA.
-She administered oral medications to residents at the facility.
-She worked 3rd shift and she did not obtain residents' finger stick blood sugars and she did not administer insulin because blood sugar checks and insulin were not scheduled at the times she worked.
-She had completed the 5-hour MA training, but did not provide documentation to the facility because she was not asked for the documentation.
-She had not completed the Medication Administration Skills Validation checklist because she was waiting on a nurse to complete the checklist with return demonstration.
-She worked as a MA for over 10 years and never had a break in her employment.
-She did not provide employment verification to the facility because she was never asked for the documentation.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She did not have documentation of Staff K's 5-hour medication administration training.
-She did not know why documentation of Staff K's 5-hour medication administration training was not in her personnel record.
-She had not requested documentation of Staff K's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B

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D935	Continued From page 307 Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. ______________ Interview with the Administrator on 12/12/19 at 5:25pm revealed: -She was responsible for personnel records and ensuring they were complete and up to date. -She was responsible for ensuring the 5, 10, or 15-hour training was completed by staff. -She did not know the 5-hour training was required before MAs administered medications to residents. -The obligation for staffing duties interfered with her administrative duties and interfered with her responsibility of ensuring MAs had the required training prior to administering medication. -The Licensed Health Personnel Support (LHPS) nurse conducted trainings including Medication Administration Skills Validation checklist. Telephone interview with the LHPS nurse on 12/12/19 at 8:30pm revealed: -She had been the LHPS nurse at the facility for 3 months. -She had not conducted any MA trainings at the facility. -The Administrator did not request for her to complete any Medication Clinical Skills Validation checklists. ______________ The facility failed to assure the 5, 10, or 15-hour medication aide training with no previous employment verification as a medication aide within the last 24 months were completed for 6 of 7 sampled medication aides (Staff C, E, F, I, J,	D935		

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D935	Continued From page 308 and K), the Medication Administration Skills Validation were completed for 4 of 7 staff (Staff C, E, F, and K), and the state approved MA exam was passed within 60 days of the Medication Administration Skills Validation completion for 1 of 7 sampled staff (Staff E) prior to the staff administering medications to the residents, which resulted in an increased the risk for medication errors and exposing the residents to possible blood borne pathogen diseases from staff sharing glucometers between residents. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D935		
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 A2 VIOLATION Based on interviews and record reviews, the Administrator failed to assure the management,	D980		

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operations, and policies of the facility were implemented and rules were maintained for ACH infection prevention requirements, medication administration, controlled substances, supervision, physical environment, personal care, housekeeping and furnishings, criminal background check, health care personnel registry check, nutrition and food services, residents' rights, health care personnel registry, incident and accident reports, activities, tuberculosis test, health care, ACH medication aides; training and competency requirements, test for tuberculosis, training on cardio-pulmonary resuscitation, examination and screening for controlled substances, personal care and other staffing, competency validation for licensed health professional support tasks, personal care training and competency, management of resident funds, training on care of diabetic residents, staffing of personal care aide supervisors, and implementation.

The findings are:

Interview with a first shift medication aide (MA) on 12/12/19 at 11:37am revealed she reported resident issues to the Administrator and the Supervisor.

Interview with the Supervisor on 12/12/19 at 12:48pm revealed:
-She reported issues with residents and staff to the Administrator.
-The Administrator was responsible for the operations of the facility.

Interview with the Administrator on 12/12/19 at 5:25pm revealed:
-She had been the Administrator since January 2019.

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D980	Continued From page 310 -The facility's Resident Care Coordinator (RCC) left in late April 2019. -The RCC had been responsible for hiring staff, assuring staff qualifications were completed , including criminal backgrounds checks, Health Care Personnel Registry checks, Tuberculosis testings completed, and scheduling staff. -The facility had experienced a large number of staff turnover. -The Administrator had assumed the RCC duties as well as staffing for medication administration since the RCC left in April 2019. -"Her obligations for staffing duties interfered with her administrative duties." -The personnel records were being transitioned to electronic records, and some of the staffing documents were not available for review. Interview with the Administrator on 12/13/19 at 12:53pm revealed: -She was at the facility at least 5 days a week and at least 10 hours a day. -She was responsible for the total operations of the facility including adherence to rules and regulations. -Her duties included hiring new staff, scheduling staff to work, marketing and admissions, business office functions, and passing medications when she could not get a medication aide to work. -It was difficult for her to fulfill her responsibilities as Administrator because she was responsible for more than Administrator tasks. 1. Based on record reviews, observations and interviews the facility failed to contact the health care and mental health providers and specialist health care providers for 7 of 11 sampled residents (Residents #1, #3, #5, #9, #12, #14, and #18) regarding a resident with a pressure	D980		

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D980	Continued From page 311 ulcer (#3), a resident with extreme muscle weakness resulting in falls who missed a nerve conduction study and two MRI appointments (#12), a resident with swollen lower extremities that caused pain when walking (#5), a resident with aggressive/agitated behaviors that yelled at other residents, beat on the walls and threw chairs (#18), two residents with rashes which made the residents uncomfortable (#1 and #9) and a glucometer which did not work properly (#14). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered by a licensed practicing practitioner for 6 of 6 sampled residents (#1, #2, #3, #4, #5 and #12) related to a topical antiseptic (#3), an anti-coagulant and a narcotic pain reliever (#4), a rapid acting insulin (#2, #3 and #12), a diuretic (#5), and a gastric acid reducer (#1). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on interviews, record reviews, and observations, the facility failed to assure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled residents (Resident #5) who was constantly disorientated and had wandering behaviors and eloped from the facility without staff's knowledge. [Refer to Tag D067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 4. Based on record reviews and interviews, the facility failed to assure 9 of 12 sampled staff (Staff A, B, C, E, F, G, I, J, and K) were tested for Tuberculosis (TB) disease upon hire. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for	D980		

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D980	Continued From page 312 Tuberculosis (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to assure 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K) had a criminal background check completed prior to hire. [Refer to Tag D139 10A NCAC 13F .0407(a)(7) Criminal Background Check (Type B Violation)]. 6. Based on record reviews and interviews, the facility failed to assure 4 of 11 sampled staff (Staff C, D, I, and J) who provided personal care to residents had documentation of successful completion of an 80 hour personal care training and competency evaluation program. [Refer to Tag D150 10A NCAC 13F .0501 Personal Care Training (Type B Violation)]. 7. Based on observations, record reviews and interviews, the facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic resident prior to the administration of insulin. [Refer to Tag D164 10A NCAC 13F .0505 Training on Care of Diabetic Residents (Type B Violation)]. 8. Based on observations, record reviews and interviews, the facility failed to assure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 27 of69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to Tag D167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].	D980		

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9. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing at the facility for 8 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to Tag D188 10ANCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation)].

10. Based on interviews and record review, the facility failed to assure first and second shifts were staffed with a minimum of 20 hours including 16 hours of personal care staff and 8 hours of supervision with up to 4 hours counted toward personal care hours, and third shift was staffed with 16 hours of personal care aide and 8 supervisor hours when there was not a supervisor within 500 feet of the facility for 5 of 69 sampled shifts when there was a census of 31 residents in an unsprinkled facility. [Refer to Tag D214 10A NCAC 13F .0605(c) Staffing of Personal Care Aide Supervisor (Type B Violation)].

11. Based on observations, interviews and record reviews, the facility failed to assure personal care was provided to 8 of 11 sampled residents (#1, #5, #7, #8, #11, #12, #18, and #20) including foot care to three residents (#5, #12, and #18,); residents having to wait for incontinence care (#7, #8, and #20), and residents with a yeast rash (#1 and #11). [Refer to Tag D269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)].

12. Based on record reviews, observation and interviews the facility failed to provide supervision to meet the needs of 2 of 5 sampled residents (Residents #5 and #12) who had muscle weakness causing him to repeatedly fall (#12) and a resident who eloped without staff's

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D980	Continued From page 314 knowledge (#5). [Refer to Tag D270 10A NCAC 13F .0902(b) Personal Care and Supervision (Type B Violation)]. 13. Based on record review and interviews the facility failed to assure 1 of 17 sampled residents (Resident #19) were free of abuse and neglect resulting a resident (#19) being physically assaulted by a medication aide (Staff M). [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 14. Based on observations, interviews, and record reviews, the facility failed to assure records of the administration of controlled substances were maintained, accurate and reconciled for 5 of 8 sampled residents (Residents #4, #5, #15, #17 and #18) who were prescribed Oxycodone (#4 and #17), lyrica (#4), zolpidem tartrate (#4), hydrocodone (#15), and lorazepam (#5 and #18). [Refer to Tag D392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)]. 15. Based on record reviews and interviews, the facility failed to report allegations of physical abuse of a resident (Resident #19) by a medication aide (Staff F), to the Health Care Personnel Registry (HCPR). [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. 16. Based on observation, record reviews, and interviews, 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 2 of 3 sampled residents (Residents #2, and#14) with diabetes, resulting in sharing glucometers	D980		

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between residents. [Refer to Tag D932 G.S. 131D-4.4 ACH Infection Prevention Requirements (Type B Violation)].

17. Based on record reviews and interviews, the facility failed to assure 7 of 7 medication aides (MAs) sampled (Staff C, E, F, I, J, and K) andthe Administrator had completed the state approved mandatory annual infection control training. [Refer to Tag D934 G.S. 131D-4.5B(a) ACH Infection Prevention Requirements (Type B Violation)].

18. Based on observations, interviews and record reviews, the facility failed to assure 6 of 7 sampled staff (Staff C, E, F, I, J, and K) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration courses (Staff C, E, F, I, J, and K), completed the Medication Administration Skills Validation (Staff C, E, F, and K), and passed the state written medication aide exam (Staff E) prior to administering medications. [Refer to Tag D935 G.S. 131D-4.B(b) ACH Medication Aide Training and Competency (Type B Violation)].

19. Based on interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was completed for 8 of 12 sampled staff (Staff B, C, E, F, I, J, K) and the Administrator prior to hire. [Refer to Tag D992 G.S. 131D-45(a) Examination and Screening for Controlled Substances (Type B Violation)].

______

The Administrator neglected to ensure responsibility for the overall operation, administration, management and supervision of the facility resulting in all exit doors not alarmed

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while a resident who was constantly disoriented eloped from the facility without staff's knowledge; a resident experiencing burning and stinging from a stage II pressure ulcer; a resident having frequent falls due to muscle weakness; aresident in pain and discomfort due to swollen legs, ankles and feet; a resident exhibiting aggressive psychotic behaviors towards other residents; residents having rashes due to lack of personal care that burned and caused pain; a resident with a missed gastroenterologist appointment; a resident who had physcian's orders for medical procedures which were not implemented; a resident being pushed and hit by a staff (Staff M); a resident admitted to the facility and not administered lovenox injection for 3 days; a resident whose glucometer was not working properly which led to staff sharing glucometers ; medications not being available and not administered as ordered; inaccurate accounting for the administration of controlled substances; 5 of 69 sampled shifts where there was no medication aide (MA) supervior on the premises and no staff available to administer medications to residents; 6 MAs who had not completed the MA requirements prior to administering medications and 8 of 69 sampled shifts where staff was short of aide hours and not present at all times to meet the needs of residents. This neglect resulted in substantial risk of physical harm and neglect and constitutes a Type A2 Violation.

The facility provided a plan of protection in accordance with G.S. 131 D-34 on 12/12/19.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 12, 2019.

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D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.	D992		

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D992	Continued From page 318 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was completed for 8 of 12 sampled staff (Staff B, C, E, F, I, J, K) and the Administrator prior to hire. The findings are: 1. Review of Staff B's, personal care aide (PCA) personnel record revealed: -Staff B was hired in August 2019. -There was no documentation Staff B completed the examination and screen for the presence of controlled substance. -There was no consent for a drug screening and examination. Interview with Staff B on 12/11/19 at 4:29pm revealed: -She was hired as a PCA at the end of July 2019. -She provided personal care to residents including bathing, toileting, and feeding. -She did not complete an examination and screening for controlled substances. -She did not know she was required to complete a controlled substance examination and screening prior to hire. -The Administrator was responsible for completing her paperwork when she was hired. Interview with the Administrator on 12/12/19 at 5:40pm revealed: -She was responsible for completing the	D992	POLICIES WERE IN PLACE TO ASSURE PPD TESTING WAS IN PLACE AT THE TIME OF HIRE FOR EMPLOYEES. ALL EMPLOYEES ARE REQUIRED TO HAVE A DRUG TEST COMPLETED PRIOR TO HIRE. WHILE AFTER SURVEY HAD BEEN COMPLETED, THE OWNERS FOUND SOME ADDITIONAL DOCUMENTATION THAT SOME HAD BEEN TESTED, THE OWNER'S CHOSE TO PERFORM DRUG TESTS ON ALL REMAINING STAFF. TWO STAFF MEMBERS THAT FAILED THESE TEST WERE TERMINATED BY THE OWNER'S IMMEDIATELY. AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN PLACE IN AN APPROPRIATE LEVEL OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME HAS BEEN CLOSED.	

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

Based on record reviews and interviews, the facility failed to assure 7 of 7 medication aides (MAs) sampled (Staff C, E, F, I, J, and K) and the Administrator had completed the state approved mandatory annual infection control training.

The findings are:

1. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C was hired on 08/27/18.
-Staff C passed the written medication aide exam on 11/20/17.
-There was documentation Staff C had completed an online computer training of the state approved annual infection control training dated 09/06/19.
-There was no documentation for subsequent completion of the state approved infection control training with skills requiring return demonstration.

Interview with Staff C on 12/12/19 at 4:20pm revealed:
-She was rehired in January 2019.
-She had worked at the facility off and on since 2010.
-She completed the state approved mandatory infection control training online on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required returned demonstration.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

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	HAL030007	A. BUILDING: ______ B. WING ______	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

2. Review of Staff E's, medication aide (MA), personnel record revealed:
-Staff E was hired on 06/27/19.
-Staff E had not taken and passed the written medication aide exam as of 12/10/19.
-There was documentation Staff E had completed an online computer training of the state approved mandatory annual infection control training dated 07/03/19.
-There was no documentation for subsequent completion of the state approved mandatory infection control training.

Interview with Staff E on 12/12/19 at 10:37am revealed:
-She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19.
-She worked as a MA and administered medications to residents.
-She completed the state approved mandatory infection control training online on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required returned demonstration.

Interview with a resident on 12/12/19 at 4:00pm revealed Staff E was a MA at the facility and administered medications to the resident.

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[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

3. Review of Staff F's, medication aide (MA), personnel record revealed:
-Staff F was hired on 08/16/19.
-Staff F passed the written medication aide exam on 03/24/10.
-There was no documentation Staff F had completed training of the state approved mandatory annual infection control training.

Interview with Staff F on 12/11/19 at 5:00pm revealed:
-She worked as a MA at the facility since 08/16/19.
-She administered medications to residents at the facility.
-She completed the state approved mandatory infection control training online on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required returned demonstration.

Interview with a resident on 12/12/19 at 4:00pm revealed Staff F was a MA at the facility and administered medications to the resident.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D934	Continued From page 291 Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. 4. Review of Staff I's, medication aide (MA), personnel record revealed: -Staff I was hired on 03/13/19. -Staff I passed the written medication aide exam on 06/12/02. -There was no documentation Staff I had completed training of the state approved mandatory annual infection control training. Interview with Staff I on 12/11/19 at 4:38pm revealed: -She was hired as the Activity's Director and she then transitioned to a medication aide (MA) in March 2019. -She completed state approved mandatory infection control training online on the computer. -She did not know state approved mandatory infection control training could not be completed as an online computer training. Observation of Staff I on 12/12/19 from 8:00am to 12:00pm revealed Staff I administered medications to residents at the facility. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.	D934		

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Refer to interview with the Administrator on 12/12/19 at 5:25pm.

5. Review of Staff J's, medication aide (MA), personnel record revealed:
-Staff J was hired on 03/13/19.
-Staff J passed the written medication aide exam on 03/26/14.
-There was documentation Staff J had completed an online computer training of the state approved mandatory annual infection control training dated 03/05/19.
-There was no documentation for subsequent completion of the state approved mandatory infection control training.

Interview with a resident on 12/12/19 at 4:00pm revealed Staff J was a MA at the facility and administered medications to the resident.

Telephone interview with Staff J on 12/12/19 at 4:38pm revealed:
-She was hired as a MA in February 2019.
-She completed the state approved mandatory infection control training online on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required returned demonstration.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

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D934	Continued From page 293 Refer to interview with the Administrator on 12/12/19 at 5:25pm. 6. Review of Staff K's, medication aide (MA), personnel record revealed: -Staff K did not have a hire date in her record -Staff K passed the written medication aide exam on 08/28/13. -There was no documentation Staff K had completed the state approved mandatory annual infection control training. -There was no documentation for subsequent completion of the state approved mandatory infection control training. Telephone interview with Staff K on 12/12/19 at 4:38pm revealed: -She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a medication aide (MA). -She completed the state approved mandatory infection control training online on the computer. -She did not know there was a skills validation section that required returned demonstration. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. 7. Review of the Administrator's personnel record revealed: -The Administrator was hired on 11/01/18. -The Administrator passed the written medication	D934		

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D934	Continued From page 294 aide exam on 01/10/19. -There was documentation the Administrator had completed an online computer training of the state approved mandatory annual infection control training dated 03/05/19. -There was no documentation for subsequent completion of the state approved mandatory infection control training. Interview with the Administrator on 12/12/19at 5:35pm revealed: -She was hired as the Administrator in November 2018 and started working at the facility in January 2019. -She completed the state approved mandatory infection control training online on the computer on 03/05/19. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am revealed: -He was responsible for providing infection control training for the MAs at the facility. -He was hired by the contracted pharmacy one year ago. -He was told by a member at the contracted pharmacy, when he was hired, that the contracted pharmacy had approval by the State for the annual infection control to be taken on the	D934		

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computer along with other trainings required.
-He did not know the state approved mandatory annual infection control training had skills evaluations that had to be validated by a return demonstration therefore could not be approved as an online computer training with out documentaiton of return demonstration.
-He would arrange for a corporate nurse or contracted nurse to come to the facility to do competency validations for the infection control training and complete training certifications.

Interview with the Administrator on 12/12/19at 5:25 revealed:
-The facility contracted pharmacy taught thestate approved mandatory infection control training on the computer.
-She did not know the state approved mandatory infection control training could not be completed as an online computer training.
-She did not know there was a skills validation section that required return demonstration.

The facility failed to assure the state approved mandatory annual infection control training for 7 of 7 sampled medication aides (Staff C, E, F, I, J, and K) and the Administrator was completed resulting in staff sharing of glucometers between 2 residents exposing the residents to possible blood borne pathogen diseases. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.

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D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.	D935		

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b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

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

Based on observations, interviews and record reviews, the facility failed to assure 6 of 7 sampled staff (Staff C, E, F, I, J, and K) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration courses (Staff C, E, F, I, J, and K), completed the Medication Administration Skills Validation (Staff C, E, F, and K), and passed the state written medication aide exam (Staff E) prior to administering medications.

The findings are:

1. Review of Staff C's, medication aide (MA) personnel record revealed:
-Staff C was hired on 08/27/18.
-There was no documentation of employment verification confirming Staff C worked as a MA within the past 24 months.
-There was no documentation Staff C completed the 5, 10 or 15-hour medication administration training.
-There was no documentation Staff C completed the Medication Administration Skills Validation checklist.
-Staff C passed the written MA exam on 11/20/17.

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Review of a residents' electronic Medication Administration Record (eMAR) revealed Staff C documented administration of medications 15 days in October 2019, 14 days in November 2019, and 2 days in December 2019.

Telephone interview with Staff C on 12/12/19 at 4:20pm revealed:
-She worked off and on at the facility since 2010 and she recently came back to work at the facility in January 2019.
-There was no verification for employement as a medication aide within the last 24 months available for review.
-She administered residents' medications including oral medications, eye drops, creams, and insulin, and she obtained residents' finger stick blood sugars.
-She did not know which 5, 10, or 15-hour medication administration training she completed or when she completed the course.
-She was "checked off on the medication cart" by a Registered Nurse (RN) (date unknown).

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She did not know Staff C had not completed the 5, 10, or 15-hour medication administration training.
-She did not know Staff C had not completed a Medication Administration Skills Validation checklist.
-She had not audited Staff C's personnel record for Staff C's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH

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D935	Continued From page 299 Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 2. Review of Staff E's, medication aide (MA) personnel record revealed: -Staff E was hired on 06/27/19. -There was no documentation of employment verification confirming Staff E worked as a MA within the past 24 months. -There was no documentation Staff E completed the 5, 10 or 15-hour medication administration training. -There was no documentation Staff E completed the Medication Administration Skills Validation checklist. -There was no documentation Staff E passed the state written MA exam. Review of a residents' eMAR revealed Staff E documented administration of medications 12 days in October 2019, and 4 days in November 2019. Interview with Staff E on 12/12/19 at 10:37am revealed: -She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19. -She had been a MA since 2004, but she was not employed as a MA consecutively over thepast 24 months. -She administered residents' medications including oral medications, eye drops, and insulin, and she obtained residents' finger stick blood	D935		

Division of Health Service Regulation

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sugars.
-She was never asked to provide her MA paperwork to the facility.
-She did not complete the 5, 10, or 15-hour medication administration training.
-She did not know she needed the 5-hour course in order to pass medications to the residents.
-She was "checked off by a nurse" in November 2019.
-She did not know why the Medication Clinical Skills Validation checklist was not in her personnel record.
-She was scheduled to take the state written MA exam in January 2020.
-She did not know she needed to take the written MA exam within 60 days of completing the Medication Clinical Skills Validation checklist; the Administrator told her she had 90 days until she had to take the written MA exam.
-The Administrator told her she "could [administer] medications because [she] was checked off on [medications]".

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She thought Staff E had 90 days from completion of the Medication Clinical Skills Validation checklist to schedule and take the written MA test.
-She was unable to locate the Medication Clinical Skills Validation checklist completed for Staff E.
-She did not know Staff E did not complete the 5, 10, or 15-hour medication administration training.

Telephone interview with the LHPS nurse on 12/12/19 at 8:40pm revealed she had not completed a Medication Administration Skills Validation checklist for Staff E.

[Refer to Tag D358 10A NCAC 13F .1004(a)

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D935	Continued From page 301 Medication Administration (Type B Violation)]. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 3. Review of Staff F's, medication aide (MA) personnel record revealed: -Staff F was hired on 08/16/19. -There was no documentation of employment verification confirming Staff F worked as a MA within the past 24 months. -There was no documentation Staff F completed either the 5, or 10 hour, or the 15-hour medication administration training. -There was no documentation Staff F completed the Medication Administration Skills Validation checklist. -Staff F passed the written MA exam on 03/24/10. Review of a residents' eMAR revealed Staff F documented administration of medications 10 days in October 2019, 8 days in November 2019, and 4 days in December 2019. Interview with Staff F on 12/11/19 at 5:00pm revealed: -Staff F was hired as a MA on 08/16/19. -She administered medications to residents including oral medications, eye drops, creams, and insulin, and she obtained residents' finger stick blood sugars. -She had not completed the Medication Administration Skills Validation checklist yet.	D935		

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D935	Continued From page 302 -She did not know she needed to complete the 5-hour training prior to administering medications to residents at the facility. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She did not know Staff F had not completed the 5, 10, or 15-hour medication administration training. -She had not audited Staff F's personnel record for Staff F's employment verification. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 4. Review of Staff I's, medication aide (MA) personnel record revealed: -Staff I was hired on 03/13/19. -There was no documentation of employment verification confirming Staff I worked as a MA within the past 24 months. -There was no documentation Staff I completed the 5, 10 or 15-hour medication administration training. -Staff I completed the Medication Administration Skills Validation checklist on 03/04/19. -Staff I passed the written MA exam on 06/12/02. Review of a residents' eMAR revealed Staff I documented administration of medications 2 days	D935		

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in October 2019 and 3 days in November 2019.

Observation of Staff I on 12/11/19 from 8:00am to 12:00pm revealed Staff I was administering medications to residents.

Interview with Staff I on 12/11/19 at 4:38pm revealed:
-She was hired as the Activity's Director and she then transitioned to a MA in March 2019.
-She had completed the 15-hour medication administration training (date unknown).
-She did not know why the 15-hour medication administration training was not in her personnel record.
-She had been a nursing assistant for 30 years and she previously worked as a MA; she did not provide information regarding if she worked as a MA in the past 24 months.
-She did not provide employment verification to the facility because she did not have it and she completed the MA training.
-She started administering medications to residents in March 2019.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She knew Staff I had previously worked as a MA.
-She did not know Staff I did not have documentation of the 5, 10, or 15-hour medication administration training.
-She did not know why documentation of Staff I's 5, 10, or 15-hour medication administration training was not in her personnel record.
-She had not audited Staff I's personnel record for Staff I's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

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D935	Continued From page 304 [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)]. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 5. Review of Staff J's, medication aide (MA) personnel record revealed: -Staff J was hired on 03/13/19. -There was no documentation of employment verification confirming Staff J worked as a MA within the past 24 months. -There was no documentation Staff J completed the 5, 10 hours, or 15-hour medication administration training. -Staff J completed the Medication Administration Skills Validation checklist on 03/04/19. -Staff J passed the written MA exam on 03/26/14. Review of a residents' eMAR revealed Staff J documented administration of medications 10 days in October 2019, 10 days in November 2019, and 1 day in December 2019. Telephone interview with Staff J on 12/12/19 at 4:38pm revealed: -She was hired as a MA in February 2019. -Staff J administered medications to residents including oral medications, nebulizer's, eye drops, and insulin. -She did not know if she completed the 5, 10 or 15-hour medication administration training. -She did not know she needed the 5-hour training before she administered medications to residents at the facility.	D935		

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Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She did not know Staff J had not completed the 5, 10, or 15-hour medication administration training.
-She had not audited Staff J's personnel record for Staff J's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.

6. Review of Staff K's, medication aide (MA) personnel record revealed:
-Staff K did not have a documented hire date.
-There was no documentation of employment verification documenting Staff K worked as a MA within the past 24 months.
-There was no documentation Staff K completed the 5, 10 or 15-hour medication administration training.
-There was no documentation Staff K completed the Medication Administration Skills Validation checklist.
-Staff K passed the written MA exam on 08/28/13.

Review of a residents' eMAR revealed Staff K documented administration of medications 3 days in November 2019.

Telephone interview with Staff K on 12/12/19 at

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4:38pm revealed:
-She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a MA.
-She administered oral medications to residents at the facility.
-She worked 3rd shift and she did not obtain residents' finger stick blood sugars and she did not administer insulin because blood sugar checks and insulin were not scheduled at the times she worked.
-She had completed the 5-hour MA training, but did not provide documentation to the facility because she was not asked for the documentation.
-She had not completed the Medication Administration Skills Validation checklist because she was waiting on a nurse to complete the checklist with return demonstration.
-She worked as a MA for over 10 years and never had a break in her employment.
-She did not provide employment verification to the facility because she was never asked for the documentation.

Interview with the Administrator on 12/12/19 at 5:35pm revealed:
-She did not have documentation of Staff K's 5-hour medication administration training.
-She did not know why documentation of Staff K's 5-hour medication administration training was not in her personnel record.
-She had not requested documentation of Staff K's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B

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Violation)].

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.

Interview with the Administrator on 12/12/19 at 5:25pm revealed:
-She was responsible for personnel records and ensuring they were complete and up to date.
-She was responsible for ensuring the 5, 10, or 15-hour training was completed by staff.
-She did not know the 5-hour training was required before MAs administered medications to residents.
-The obligation for staffing duties interfered with her administrative duties and interfered with her responsibility of ensuring MAs had the required training prior to administering medication.
-The Licensed Health Personnel Support (LHPS) nurse conducted trainings including Medication Administration Skills Validation checklist.

Telephone interview with the LHPS nurse on 12/12/19 at 8:30pm revealed:
-She had been the LHPS nurse at the facility for 3 months.
-She had not conducted any MA trainings at the facility.
-The Administrator did not request for her to complete any Medication Clinical Skills Validation checklists.

The facility failed to assure the 5, 10, or 15-hour medication aide training with no previous employment verification as a medication aide within the last 24 months were completed for 6 of 7 sampled medication aides (Staff C, E, F, I, J,

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D935	Continued From page 308 and K), the Medication Administration Skills Validation were completed for 4 of 7 staff (Staff C, E, F, and K), and the state approved MA exam was passed within 60 days of the Medication Administration Skills Validation completion for 1 of 7 sampled staff (Staff E) prior to the staff administering medications to the residents, which resulted in an increased the risk for medication errors and exposing the residents to possible blood borne pathogen diseases from staff sharing glucometers between residents. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.	D935		
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 A2 VIOLATION Based on interviews and record reviews, the Administrator failed to assure the management,	D980		

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operations, and policies of the facility were implemented and rules were maintained for ACH infection prevention requirements, medication administration, controlled substances, supervision, physical environment, personal care, housekeeping and furnishings, criminal background check, health care personnel registry check, nutrition and food services, residents' rights, health care personnel registry, incident and accident reports, activities, tuberculosis test, health care, ACH medication aides; training and competency requirements, test for tuberculosis, training on cardio-pulmonary resuscitation, examination and screening for controlled substances, personal care and other staffing, competency validation for licensed health professional support tasks, personal care training and competency, management of resident funds, training on care of diabetic residents, staffing of personal care aide supervisors, and implementation.

The findings are:

Interview with a first shift medication aide (MA) on 12/12/19 at 11:37am revealed she reported resident issues to the Administrator and the Supervisor.

Interview with the Supervisor on 12/12/19 at 12:48pm revealed:
-She reported issues with residents and staff to the Administrator.
-The Administrator was responsible for the operations of the facility.

Interview with the Administrator on 12/12/19 at 5:25pm revealed:
-She had been the Administrator since January 2019.

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-The facility's Resident Care Coordinator (RCC) left in late April 2019.
-The RCC had been responsible for hiring staff, assuring staff qualifications were completed , including criminal backgrounds checks, Health Care Personnel Registry checks, Tuberculosis testings completed, and scheduling staff.
-The facility had experienced a large number of staff turnover.
-The Administrator had assumed the RCC duties as well as staffing for medication administration since the RCC left in April 2019.
-"Her obligations for staffing duties interfered with her administrative duties."
-The personnel records were being transitioned to electronic records, and some of the staffing documents were not available for review.

Interview with the Administrator on 12/13/19 at 12:53pm revealed:
-She was at the facility at least 5 days a week and at least 10 hours a day.
-She was responsible for the total operations of the facility including adherence to rules and regulations.
-Her duties included hiring new staff, scheduling staff to work, marketing and admissions, business office functions, and passing medications when she could not get a medication aide to work.
-It was difficult for her to fulfill her responsibilities as Administrator because she was responsible for more than Administrator tasks.

1. Based on record reviews, observations and interviews the facility failed to contact the health care and mental health providers and specialist health care providers for 7 of 11 sampled residents (Residents #1, #3, #5, #9, #12, #14, and #18) regarding a resident with a pressure

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ulcer (#3), a resident with extreme muscle weakness resulting in falls who missed a nerve conduction study and two MRI appointments (#12), a resident with swollen lower extremities that caused pain when walking (#5), a resident with aggressive/agitated behaviors that yelled at other residents, beat on the walls and threw chairs (#18), two residents with rashes which made the residents uncomfortable (#1 and #9) and a glucometer which did not work properly (#14). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].

2. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered by a licensed practicing practitioner for 6 of 6 sampled residents (#1, #2, #3, #4, #5 and #12) related to a topical antiseptic (#3), an anti-coagulant and a narcotic pain reliever (#4), a rapid acting insulin (#2, #3 and #12), a diuretic (#5), and a gastric acid reducer (#1). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

3. Based on interviews, record reviews, and observations, the facility failed to assure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled residents (Resident #5) who was constantly disorientated and had wandering behaviors and eloped from the facility without staff's knowledge. [Refer to Tag D067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)].

4. Based on record reviews and interviews, the facility failed to assure 9 of 12 sampled staff (Staff A, B, C, E, F, G, I, J, and K) were tested for Tuberculosis (TB) disease upon hire. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for

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D980	Continued From page 312 Tuberculosis (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to assure 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K) had a criminal background check completed prior to hire. [Refer to Tag D139 10A NCAC 13F .0407(a)(7) Criminal Background Check (Type B Violation)]. 6. Based on record reviews and interviews, the facility failed to assure 4 of 11 sampled staff (Staff C, D, I, and J) who provided personal care to residents had documentation of successful completion of an 80 hour personal care training and competency evaluation program. [Refer to Tag D150 10A NCAC 13F .0501 Personal Care Training (Type B Violation)]. 7. Based on observations, record reviews and interviews, the facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic resident prior to the administration of insulin. [Refer to Tag D164 10A NCAC 13F .0505 Training on Care of Diabetic Residents (Type B Violation)]. 8. Based on observations, record reviews and interviews, the facility failed to assure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 27 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to Tag D167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].	D980		

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D980	Continued From page 313 9. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing at the facility for 8 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to Tag D188 10ANCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation)]. 10. Based on interviews and record review, the facility failed to assure first and second shifts were staffed with a minimum of 20 hours including 16 hours of personal care staff and 8 hours of supervision with up to 4 hours counted toward personal care hours, and third shift was staffed with 16 hours of personal care aide and 8 supervisor hours when there was not a supervisor within 500 feet of the facility for 5 of 69 sampled shifts when there was a census of 31 residents in an unsprinkled facility. [Refer to Tag D214 10A NCAC 13F .0605(c) Staffing of Personal Care Aide Supervisor (Type B Violation)]. 11. Based on observations, interviews and record reviews, the facility failed to assure personal care was provided to 8 of 11 sampled residents (#1, #5, #7, #8, #11, #12, #18, and #20) including foot care to three residents (#5, #12, and #18,); residents having to wait for incontinence care (#7, #8, and #20), and residents with a yeast rash (#1 and #11). [Refer to Tag D269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)]. 12. Based on record reviews, observation and interviews the facility failed to provide supervision to meet the needs of 2 of 5 sampled residents (Residents #5 and #12) who had muscle weakness causing him to repeatedly fall (#12) and a resident who eloped without staff's	D980		

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knowledge (#5). [Refer to Tag D270 10A NCAC 13F .0902(b) Personal Care and Supervision (Type B Violation)].

13. Based on record review and interviews the facility failed to assure 1 of 17 sampled residents (Resident #19) were free of abuse and neglect resulting a resident (#19) being physically assaulted by a medication aide (Staff M). [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].

14. Based on observations, interviews, and record reviews, the facility failed to assure records of the administration of controlled substances were maintained, accurate and reconciled for 5 of 8 sampled residents (Residents #4, #5, #15, #17 and #18) who were prescribed Oxycodone (#4 and #17), lyrica (#4), zolpidem tartrate (#4), hydrocodone (#15), and lorazepam (#5 and #18). [Refer to Tag D392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].

15. Based on record reviews and interviews, the facility failed to report allegations of physical abuse of a resident (Resident #19) by a medication aide (Staff F), to the Health Care Personnel Registry (HCPR). [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].

16. Based on observation, record reviews, and interviews, 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 2 of 3 sampled residents (Residents #2, and#14) with diabetes, resulting in sharing glucometers

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between residents. [Refer to Tag D932 G.S. 131D-4.4 ACH Infection Prevention Requirements (Type B Violation)].

17. Based on record reviews and interviews, the facility failed to assure 7 of 7 medication aides (MAs) sampled (Staff C, E, F, I, J, and K) andthe Administrator had completed the state approved mandatory annual infection control training. [Refer to Tag D934 G.S. 131D-4.5B(a) ACH Infection Prevention Requirements (Type B Violation)].

18. Based on observations, interviews and record reviews, the facility failed to assure 6 of 7 sampled staff (Staff C, E, F, I, J, and K) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration courses (Staff C, E, F, I, J, and K), completed the Medication Administration Skills Validation (Staff C, E, F, and K), and passed the state written medication aide exam (Staff E) prior to administering medications. [Refer to Tag D935 G.S. 131D-4.B(b) ACH Medication Aide Training and Competency (Type B Violation)].

19. Based on interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was completed for 8 of 12 sampled staff (Staff B, C, E, F, I, J, K) and the Administrator prior to hire. [Refer to Tag D992 G.S. 131D-45(a) Examination and Screening for Controlled Substances (Type B Violation)].

The Administrator neglected to ensure responsibility for the overall operation, administration, management and supervision of the facility resulting in all exit doors not alarmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: ______ B. WING ______	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 316	D980		

while a resident who was constantly disoriented eloped from the facility without staff's knowledge; a resident experiencing burning and stinging from a stage II pressure ulcer; a resident having frequent falls due to muscle weakness; aresident in pain and discomfort due to swollen legs, ankles and feet; a resident exhibiting aggressive psychotic behaviors towards other residents; residents having rashes due to lack of personal care that burned and caused pain; a resident with a missed gastroenterologist appointment; a resident who had physcian's orders for medical procedures which were not implemented; a resident being pushed and hit by a staff (Staff M); a resident admitted to the facility and not administered lovenox injection for 3 days; a resident whose glucometer was not working properly which led to staff sharing glucometers ; medications not being available and not administered as ordered; inaccurate accounting for the administration of controlled substances; 5 of 69 sampled shifts where there was no medication aide (MA) supervior on the premises and no staff available to administer medications to residents; 6 MAs who had not completed the MA requirements prior to administering medications and 8 of 69 sampled shifts where staff was short of aide hours and not present at all times to meet the needs of residents. This neglect resulted in substantial risk of physical harm and neglect and constitutes a Type A2 Violation.

The facility provided a plan of protection in accordance with G.S. 131 D-34 on 12/12/19.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 12, 2019.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: ______ B. WING ______	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D992	Continued From page 317	D992		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: ______ B. WING ______	12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

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D992	Continued From page 318 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure an examination and screening for the presence of controlled substances was completed for 8 of 12 sampled staff (Staff B, C, E, F, I, J, K) and the Administrator prior to hire. The findings are: 1. Review of Staff B's, personal care aide (PCA) personnel record revealed: -Staff B was hired in August 2019. -There was no documentation Staff B completed the examination and screen for the presence of controlled substance. -There was no consent for a drug screening and examination. Interview with Staff B on 12/11/19 at 4:29pm revealed: -She was hired as a PCA at the end of July 2019. -She provided personal care to residents including bathing, toileting, and feeding. -She did not complete an examination and screening for controlled substances. -She did not know she was required to complete a controlled substance examination and screening prior to hire. -The Administrator was responsible for completing her paperwork when she was hired. Interview with the Administrator on 12/12/19 at 5:40pm revealed: -She was responsible for completing the	D992	POLICIES WERE IN PLACE TO ASSURE PPD TESTING WAS IN PLACE AT THE TIME OF HIRE FOR EMPLOYEES. ALL EMPLOYEES ARE REQUIRED TO HAVE A DRUG TEST COMPLETED PRIOR TO HIRE. WHILE AFTER SURVEY HAD BEEN COMPLETED, THE OWNERS FOUND SOME ADDITIONAL DOCUMENTATION THAT SOME HAD BEEN TESTED, THE OWNER'S CHOSE TO PERFORM DRUG TESTS ON ALL REMAINING STAFF. TWO STAFF MEMBERS THAT FAILED THESE TEST WERE TERMINATED BY THE OWNER'S IMMEDIATELY. AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN PLACE IN AN APPROPRIATE LEVEL OF CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME HAS BEEN CLOSED.	