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THE LANDINGS CABARRUS	4968 MILESTONE AVE KANNAPOLIS, NC 28081

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D 000	Initial Comments The Adult Care Licensure Section an initial survey via desk review on 07/09/20-07/23/20, with an exit conference via telephone on 07/23/20.	D 000		
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 interviews and record reviews, the facility failed to provide supervision for 1 of 3 residents sampled (Resident #1) with multiple falls resulting in physical injuries. The findings are: Review of the facility's Fall policy dated 08/01/15 revealed: -The policy of the facility was for residents to be monitored and identify the risk for falls. -For any fall, the resident was to be placed on "hot box/alert charting" for 72 hours for follow-up and monitoring. -Staff were to complete "72 Hour follow-up and monitoring to investigate possible circumstances and contributing to the fall, and document vital signs and observations for 72 hours after the fall. -The Falls policy did not include any information related to the supervision of residents with falls. Review of Resident #1's current FL-2 dated	D 270		

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05/07/20 revealed:
-Diagnoses included dementia, fibromyalgia, hypertension, and tachycardia.
-The resident was constantly disoriented and semi-ambulatory.

Review of Resident #1's Resident Register revealed she was admitted to the facility 05/13/20.

Review of Resident #1's care plan dated 05/14/20 revealed:
-Documentation which indicated the resident was ambulatory with the use of a rolling walker and wheelchair, was independent with transfers and required supervision with ambulation.
-The care plan section entitled, Risk Management Provisions - Safety Measures To Implement included "secure assisting living area due to wandering".

Review of a second care plan for Resident #1 dated 06/13/20 revealed:
-Documentation which indicated the resident was non-ambulatory with the use of a wheelchair, required extensive assistance with transfers and for ambulation.
-The care plan section entitled, Risk Management Provisions - Safety Measures To Implement included secure assisting living area due to wandering", redirecting with verbal and physical aggression towards staff, reeducate resident on safety, not getting out of chair without[sic]"

Review of Resident #1's progress notes and Incident/Accident reports revealed:
-On 05/15/20 at 9:05pm, the resident was found "on her bottom sitting in front of chair". The resident was redirected several times to wait and get help standing when needing to get up

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because she was unsteady on her feet. Staff found resident "crawling on the floor out of the lounge area", no injuries sustained. There was documentation the resident was sitting with staff and would continue to be monitored.
-On 06/02/20 at 8:04pm, after attempts from the staff to prompt resident not to stand without any assistance, resident attempted to stand and fell on her buttocks, no injuries sustained. Staff document that 15-minute checks were conducted when resident was found.
-On 06/03/20 at 8:00pm, the resident was found face down on the ground in the living area by staff. No injuries were sustained. There was a note written by the Administrator on the bottom of the incident report "Resident has a history of placing herself on the floor per family and notes from the previous facility".
-On 06/05/20 at 10:15pm, the resident "shut the door", when staff went to check on the resident, she was found on her knees attempting to get into her wheelchair, there were no documented injuries. The resident was found alone, there was documentation, that the resident stated, "she did not fall".
-On 06/06/20 at 10:00pm, the resident was found "on her knees in front of wheelchair and lounge chair, then laid back on her back". There was documentation that the resident stated that she did not fall. There were no documented injuries.
-On 06/08/20 at 6:56pm, staff documented redirecting resident to "not keep leaning over and adjusted resident", the resident fell out of a stationary chair and hit left side of her forehead on the floor. There was a "goose egg size knot above her left eye that stretches just above nose, reddish and purple discoloration". The resident was transported to the emergency department "due to history of subdural hematoma" which was diagnosed in December 2019.

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D 270	Continued From page 3 -On 06/16/20 at 9:00am, the resident was found on the floor in a sitting position, the resident was sitting in between the legs of the wheelchair, the resident was alone. There were no documented injuries. -On 06/16/20 at 6:25pm, the resident was found "laying on back with legs straight out between the wall and bed". The resident was documented as being alone. There were no documented injuries. -On 06/17/20 at 6:00am, when staff walked in to check on the resident "she was on the floor next to her bed in a seated position". The resident was alone and there were no documented injuries. -On 06/17/20 at 12:43pm there was documentation, the Responsible Party (RP) was notified via telephone that the resident was a very high safety risk due to numerous falls and combativeness with staff. The Administrator recommended to have a 24-hour sitter by 06/19/20 in order to remain in the facility, if not the facility would issue 30 days discharge because of the resident's safety. -On 06/17/20 at 8:15pm, there was documentation the resident was found "on the floor in bedroom by staff sitting with a pillow". "The resident stated she wanted to get on the floor". The resident was alone and there were no documented injuries. -On 06/26/20 at 9:00pm, there was documentation, the resident was "found on the floor" when staff came to check on the resident. "the resident tried to stand up by herself, the resident was found alert with feet in between the legs of the wheelchair". There was documentation, the resident had a contusion to the forehead and skin tear on her right elbow. Review of Resident #1's progress notes and Accident/Injury reports since admission revealed: -Resident #1 experienced 11 unwitnessed falls	D 270		

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from 05/15/20-06/26/20.
-The physician was notified of all the falls and staff implemented documented 15-minute checks and continuous redirection in effort to decrease falls.
-The resident was found alone when each of the 11 falls occurred.
-Nine falls occurred during 2nd shift, one occurred during 1st shift, and one occurred during 3rd shift.
-Documented fall injuries included a facial contusion, forehead contusion and a skin tear.
-There was documentation that staff completed 15-minute checks on all residents.

Review of the facility's "15-minute Check Log" revealed:
-There was a log that listed the last names of the residents who resided in the secured assisted living unit of the facility.
-There were times listed in 15-minute increments with the initials of the personal care aide (PCA) and the medication aide (MA)/supervisors' signature or each shift.
-The 15-minute check logs included Resident #1 and indicated 15-minute checks were completed, there were initials and signatures of staff for 06/15/20-06/30/20.

Review of the Emergency Department Visit Report revealed:
-On 06/08/20, Resident #1 was admitted to the emergency department at 10:48pm and was discharged at 06/09/20 at 4:07am due to a fall. "patient fell trying to stand up, hematoma noted to left forehead, noted increased swelling within last hour per caregiver".
-On 06/26/20 Resident #1 was admitted to the emergency department at 9:59pm and discharged at 11:10pm due to a fall. The chief

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complaint was documented as "advanced dementia patient nonverbal since fall on 06/08/20, fell tonight transferring from wheelchair to use a walker, fell forward hitting head on tile floor" The resident sustained a hematoma to right forehead and skin tear to right lower forearm.

Review of receipt of service provided by the sitter company for Resident #1 revealed:
-Sitter services for Resident #1 began on 06/18/20.
-Resident #1 received 24/7 companion services.
-The resident did not receive coverage on 06/26/20 from 3:00pm-11:00pm.

Telephone interview with Resident #1's Responsible Party (RP) on 07/13/20 at 1:47pm revealed:
-Resident #1 had multiple falls since admitted to the facility.
-Resident #1 was unsteady on her feet due to the medication she was prescribed.
-She informed the facility of her family member's condition including the side effects to her medications upon admission.
-After the resident continued to fall, she was told to "fix it or else".
-She was told to hire a sitter to sit with the resident because she could not be left alone.

Telephone interview with a second shift personal care aide (PCA) on 07/16/20 at 2:27pm revealed:
-She worked on both the assisted living and secured assisted living unit of the facility.
-When she worked on the secure assisted living unit during second shift it was hard to watch all the residents.
-The secure assisted living had only one staff person working and there were 6 residents in the unit.

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D 270	Continued From page 6 -Several residents on the secure unit were combative and "it is hard to watch all of them". -Resident #1 had a sitter assigned but there was not a sitter always available. -She would try to keep all residents in the common area, however it was hard to watch them because residents also had personal care tasks. -She was responsible for completing 15-minute checks, however "it is hard". Telephone interview with another second shift PCA on 07/16/20 at 11:00am revealed: -She worked on both the assisted living and the secure assisted living unit of the facility. -Staff were supposed to complete 15-minute checks on all residents and document on a 15-minute log for all residents. -She did not always initial the 15-minute checks and had been called into the facility to document her initials on the forms on 07/16/20. -It was "not feasible" to complete the 15-minute checks during her shift. -There was one PCA on both sides of the facility and one medication aide (MA) available. -At times, it had been "a mess" trying to watch the residents and provide necessary care. -The PCA on the other side and MA was not always available to come to the secured unit to assist when needed due to providing care duties for the other residents. -Resident #1 had a sitter but the sitter was not present at each shift. -Resident #1 fell on 06/26/20 when a sitter was not available. -Staff were not able to provide continuous supervision to Resident #1 and a fall occurred. -There was not additional staff to sit with Resident #1 when a sitter was not available.	D 270		

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Telephone interview with a third second shift PCA on 07/16/20 at 2:37pm revealed:
-During her shift it was "hard" to keep an eye on residents every 15 minutes.
-Resident #1 was a fall risk and required staff to frequently watch her.
-"I cannot keep an eye on everybody when I am alone".
-She told the Administrator that she needed extra help in order to keep eyes on all of the residents, "this is contributing to the falls".
-"I do everything in my power to watch the resident but I am only one person".

Telephone interview with a fourth second shift PCA on 07/16/20 at 2:38pm revealed:
-There was one staff person on the secured assisted living unit with 6 residents.
-The PCA complained to the Administrator about needing more staff to assist residents in the unit and was told there was one staff person to 8 residents.
-The staff was responsible for completing showers on second shift, it took 25 minutes to complete one shower.
-When one staff was completing showers, the other residents were left in the common area by themselves, "we can't see or hear them when we are caring for another resident, so they are falling".
-The staff from the assisted living unit of the facility was not always available to provide assistance to the PCA that was assigned to the secured unit.

Telephone interview with a second shirt MA/Supervisor on 07/22/20 at 12:14pm revealed:
-She had worked when Resident #1 had a fall.
-She had been instructed by the Director of Resident Care (DRC) and Administrator to "lay

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eyes on her" and continue to complete 15-minute checks.
-"The only thing we can do is make sure she is in a safe area".
- All staff addressed with management the need of two staff on the secured unit to have enough coverage to provide the frequent checks.
-Resident #1 had to be constantly redirected because she attempted to stand independently.
-There was no way for staff to provide supervision for one resident continuously and provide care for other residents.
-There was no additional staff available to provide continuous supervision for Resident #1 when a sitter was not present.

Telephone interview with the DRC on 07/17/20 at 1:30pm revealed:
-Resident #1 had frequent falls and was supposed to be monitored "as often as possible".
-Staff were responsible for completing 15 -minute checks for all residents.
-The facility Resident #1 came from notified staff that Resident #1 had a tendency of getting on the floor.
-Resident #1 had to be re-directed and staff needed "to pay closer attention to her".
-She expected staff to take Resident #1 along with them when completing tasks and "not to turn their back".
-Staff never complained about not being able to complete 15-minute checks.
-Staff should have been able to provide care for all the residents with the staff provided.
-The family was contacted on 06/17/20 requesting to obtain a sitter due to numerous falls.

Telephone interview with the supervising physician for Resident #2's primary care provider

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D 270	Continued From page 9 (PCP) on 07/17/20 at 4:03pm revealed: -She was the supervising physician for Resident #1's PCP. -The PCP was notified of all falls Resident #1 had at the facility. -The PCP was aware that Resident #1 had frequent falls and ordered a fall mat, physical therapy, a hospital bed, scoop mattress to help prevent falls. -She could not say how much care was needed for Resident #1, however she would expect staff to provide supervision to the resident to meet her needs and do what was necessary to try to prevent falls. Review of Resident #1's physician visit note dated 06/15/20 revealed Resident #1 needed physical therapy services, she was considered homebound status and required 24-hour supervision and would be unable to leave the facility unassisted. Telephone interview with the Administrator on 07/21/20 at 2:20pm revealed: -She knew Resident #1 had frequent falls and required supervision to maintain safety. -Staff were responsible for completing 15-minute checks on each resident in the facility. -She spoke with Resident #1's RP on 06/17/20 that the resident needed a 24-hour sitter to maintain safety. -There were enough staff present in the facility to provide the supervision and care needed for the residents. -Staff never expressed any concerns about there not being enough staff available to provide the required supervision for residents. -She had not scheduled additional staff to provide the required supervision for Resident #1 on 06/26/20 because the sitter agency did not	D 270		

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D 270	Continued From page 10 always notify in time that coverage would not be available. _____ The facility failed to ensure Resident #1, who required 24-hour supervision was adequately supervised which resulted in 10 falls from 05/15/20-06/17/20 and a fall on 06/26/20 which resulted in the resident sustaining a hematoma to the right forehead and skin tear to right lower forearm. This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/22/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute healthcare needs for 1 of 3 sampled residents (Resident #3) related to a fractured finger.	D 273		

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D 273	Continued From page 11 The findings are: Review of Resident #3's current FL2 dated 03/02/20 revealed diagnoses included Parkinson's disease, Meniere's disease, and depression. Review of Resident #3's accident/injury report dated 05/09/20 revealed: -Resident #3 had an unwitnessed fall and was found lying on the floor in front of his wheelchair at 8:33pm. -Resident #3 had one injury documented; a skin tear to his right wrist. -The accident/injury report was completed by a medication aide (MA); reviewed and signed by the Administrator. Review of a fax to Resident #3's Primary Care Provider (PCP) dated 05/09/20 revealed the PCP was notified via fax at 9:16pm that Resident #3 had a "fall and skin tear to right hand." Review of Resident #3's charting notes revealed: -There was documentation on 05/10/20 at 8:51pm by a MA, staff noticed Resident #3's left hand was swollen. -There was documentation on 05/10/20 at 9:12pm by a MA, Resident #3's left hand was swollen, and the MA had "elevated that hand every time that it could be." -There was documentation on 05/11/20 at 2:29pm by a MA, Resident #3's left hand was swollen this morning. -There was documentation on 05/12/20 at 9:06pm by a personal care aide (PCA), Resident #3 had complaints about his hand being swollen. -There was documentation on 05/15/20 at 10:18am by the Director of Resident Care (DRC), Resident #3 had complaints of pain in his 5th digit	D 273		

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on his left hand with mild edema. PRN (as needed) Tylenol was administered (a medication used to treat mild pain), his PCP was contacted, and she gave orders to apply cold compresses for the edema.
-There was documentation on 05/19/20 at 2:29pm, Resident #3 was administered PRN Tylenol due to complaints of pain and an ice pack was applied to his left hand due to it being swollen.

Review of Resident #3's charting notes dated 05/19/20 revealed there was documentation at 10:32am by the DRC, Resident #3 had a telehealth visit with his PCP for complaints of pain in his 5th digit on his left hand. The PCP recommended to continue using cold compresses for a week and if "worsens or no improvement x-ray to be ordered."

Review of Resident #3's PCP encounter note dated 05/19/20 and electronically signed by the PCP revealed there were no medication changes made, no lab orders, and no diagnostic orders.

Review of Resident #3's charting notes dated 05/22/20 revealed there was documentation at 9:34am, a message was sent to Resident #3's PCP regarding his continued complaints of pain in his left index finger and it was still swollen and had a bruise on it even though staff had applied ice packs to his hand twice a day.

Review of Resident #3's physician's orders dated 05/22/20 revealed:
-There was an order to discontinue as needed Tylenol and start Tylenol Extra Strength 500mg two tablets three times daily.
-There was an order to start capsaicin 0.025% topical cream to apply to the left 5th finger twice

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13 daily as needed for pain. Review of Resident #3's charting notes dated 05/26/20 revealed there was documentation at 2:26pm, Resident #3 complained of hand pain, "cream" was applied, and Tylenol was administered. Review of Resident #3's charting notes dated 05/27/20 revealed: -There was documentation at 12:21pm by the DRC, she sent a "Smartpage" message to Resident #3's PCP reporting "resident developed swelling and pain on left hand 5th digit approax. [sic] a week and half ago. Onset resident denied injury. Cold compress applied per provider order at onset. Swelling still present. The recent order for Tylenol and analgesic cream administered in addition to cold compress (3 days). Swelling and pain continues. Resident is refusing Tylenol now, but pain continues. Please advise." -There was documentation at 12:44pm, the PCP ordered an x-ray of Resident #3's left hand and fingers and ordered indomethacin (an anti-inflammatory medication used to treat pain) 1 capsule four times daily for 5 days. -There was documentation at 10:05pm, Resident #3 had a mobile x-ray performed at 6:30pm with findings including an acute fracture of the 5th proximal phalanx on his left hand. Review of Resident #3's physician's orders dated 05/27/20 revealed: -There was an order to start indomethacin 25mg four times daily for five days and then discontinue. -There was an order for an x-ray of Resident #3's left hand. Review of Resident #3's charting notes dated	D 273		

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D 273	Continued From page 14 05/28/20 revealed there was documentation at 10:45am, Resident #3's PCP ordered to discontinue his "gout medication" and to place a splint on the resident's finger. Review of Resident #3's physician's orders dated 05/28/20 revealed: -There was an order for Home Health (HH) to manage Resident #3's fracture of the left hand, 5th digit and place a hard splint to the 5th digit left hand for four weeks. -There was an order to discontinue indomethacin. Review of Resident #3's charting notes dated 05/29/20 revealed: -There was documentation at 4:55pm, the DRC was contacted by the HH agency stating they would not be able to place Resident #3's splint. The DRC attempted to schedule an appointment for Resident #3 to go to an Orthopedic urgent care, but they were only doing virtual visits due to COVID-19. Resident #3's PCP ordered to tape the 4th and 5th digit together until an Orthopedic appointment could be scheduled. -There was documentation at 8:26pm, an appointment was made for Resident #3 to see an Orthopedist on 06/01/20 at 2:00pm. Review of Resident #3's physician's orders dated 05/30/20 revealed: -There was a referral to Orthopedics for further evaluation and splinting of the 5th digit on the left hand. -There was an order to stabilize the 5th digit of the left hand to the adjacent finger with Coban until Resident #3 could be evaluated by Orthopedics. Review of Resident #3's charting notes dated 06/01/20 revealed:	D 273		

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D 273	Continued From page 15 -There was documentation at 10:04am, Resident #3's family was unable to take him to his scheduled Orthopedic appointment, and the family was going to reschedule his appointment for the following day (06/02/20) so facility transportation could be utilized. -There was documentation at 11:05am, Resident #3's Orthopedic appointment had been rescheduled for 06/02/20 at 9:15am. Review of Resident #3's charting notes dated 06/02/20 revealed there was documentation at 4:57pm, Resident #3's Orthopedist had ordered to buddy tape the small finger to the next finger with Coban for three weeks and then discontinue. Review of Resident #3's Orthopedic visit note dated 06/02/20 revealed: -Resident #3's present pain level was 5 out of 10 on a 10-point scale. -The facility had obtained an x-ray due to swelling and discomfort in Resident #3's finger that showed a nondisplaced fracture through the proximal phalanx of the left small finger. -The Orthopedist Physician's Assistant (PA) recommended continued conservative treatment with buddy taping of the ring and small finger using Coban wrap for 3-4 weeks since it would be the least obtrusive to Resident #3 and the easiest for the facility to apply consistently. Telephone interview with a second shift MA on 07/16/20 at 10:51am revealed: -Resident #3 sustained a fractured finger after a fall. -She was working the day Resident #3 had an unwitnessed fall (05/09/20). -She checked Resident #3 when he fell, and she did not notice any injuries. -"Days later," Resident #3's finger began to swell.	D 273		

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-She immediately reported the swelling to the DRC, as was the procedure.
-She thought she had also notified Resident #3's PCP via "Smartpage," and this would be documented in Resident #3's charting notes.

Telephone interview with a first shift MA on 07/16/20 at 1:24pm revealed:
-Resident #3 sustained a fractured finger after a fall on second shift.
-Two days after his fall, she noticed Resident #3's finger was swollen, and he complained of pain in the finger.
-She immediately reported Resident #3's complaints to the DRC, as was the procedure.
-She did not report the pain and swelling to Resident #3's PCP because this was the DRC's responsibility.
-The first intervention ordered by the PCP was to apply cold compresses to Resident #3's finger.

Telephone interview with a second shift PCA on 07/16/20 at 2:38pm revealed:
-The day after Resident #3's unwitnessed fall, he complained of pain in his finger on his left hand, and the PCA observed swelling in the same area.
-He reported Resident #3's pain and swelling to the MA on duty that shift, as was the procedure.
-He thought the MA had documented the pain and swelling in Resident #3's charting notes and notified the DRC.

Telephone interview with the DRC on 07/17/20 at 1:30pm revealed:
-She was responsible for notifying the PCP of any acute healthcare needs of the residents.
-Any notifications to the PCP would be documented in the residents' charting notes.
-She thought she had notified Resident #3's PCP earlier than 5 days after staff reported swelling in

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D 273	Continued From page 17 his finger, and she would attempt to find documentation of this. Telephone interview with Resident #3's PCP on 07/17/20 at 4:08pm revealed: -Her office was first notified of Resident #3's pain and swelling of his finger on 05/22/20. -She expected to be notified of Resident #3's pain and swelling on the same day it was discovered by facility staff (05/10/20) so she could determine what treatment would be appropriate, including whether he needed to be sent to the hospital. -The delay in notifying her, caused a delay in treating Resident #3's pain and a delay in ordering an x-ray. -Resident #3's pain and discomfort were prolonged due to the facility not notifying her office in a timely manner. Telephone interview with the Administrator on 07/20/20 at 11:16am revealed: -Resident #3's pain and swelling in his finger should have been immediately reported to his PCP through their "Smartpage" system by the MA or DRC. -The response from the PCP should be documented in Resident #3's charting notes. -She was told by the DRC she notified Resident #3's PCP prior to the documented charting note dated 05/15/20. -She would send a copy of the "Smartpage" thread to verify earlier notification. Review of the "Smartpage" thread provided by the Administrator revealed documentation dated 05/27/20 of the PCP being notified "Resident developed swelling and pain on left hand 5th digit approax. [sic] a week and half ago. Onset resident denied injury. Cold compresses applied per provider order at onset. Swelling still present.	D 273		

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Then recent order for Tylenol and analgesic cream administered in addition to cold compress (3 days). Swelling and pain continues. Resident is refusing Tylenol now, but pain continues. Please advise."

Telephone interview with Resident #3's Orthopedic PA on 07/21/20 at 3:53pm revealed:
-He saw Resident #3 during an office visit on 06/02/20 for a non-displaced fracture of the finger.
-He ordered to buddy tape Resident #3's fractured finger to his adjacent finger to stabilize it.
-The delay in communicating Resident #3's pain and swelling in his finger caused a delay in discovering his finger was fractured and a delay in the treatment.
-This delay in treatment caused Resident #3 undue discomfort and put him at risk for further injuring the finger while it was not stabilized.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

The facility failed to notify Resident #3's healthcare provider, for at least five days, of his swollen and painful finger which delayed treatment of a fracture resulting in pain and discomfort for an extended period and placed Resident #3 at risk for further injuring his finger prior to it being stabilized. Failure to ensure referral and follow-up to meet the acute healthcare needs was detrimental to the health of the resident and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/21/20 for

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D 273	Continued From page 19 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2020.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure physician's orders were implemented for 1 of 3 sampled residents (Resident #3) related to an order for geri-sleeves. The findings are: Review of Resident #3's current FL2 dated 03/02/20 revealed diagnoses included	D 276		

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D 276	Continued From page 20 Parkinson's disease, Meniere's disease, and depression. Review of Resident #3's emergency room discharge summary dated 03/07/20 revealed Resident #3 had sustained a skin tear to his upper extremity during a fall. Review of Resident #3's charting notes revealed: -There was documentation on 03/08/20, Resident #3 had a skin tear on his right wrist. -There was documentation on 03/24/20, Resident #3's arm was bandaged again due to bleeding; he hit it and made it bleed again x2. -There was documentation on 03/24/20, Resident #3's Primary Care Physician (PCP) made a referral for home health for skin care evaluation and treatment. -There was documentation on 03/25/20, Resident #3's arm was rewrapped over the skin tear. -There was documentation on 03/26/20, Resident #3's skin tear on his arm was cleaned and re-bandaged. -There was documentation on 03/27/20, Resident #3's left arm was rewrapped. -There was documentation on 03/29/20, Resident #3's bandage was changed on his left arm. -There was documentation on 03/31/20, Resident #3 complained of pain in his left arm and PRN (as needed) Tylenol (a medication used to treat mild pain) was administered. -There was documentation on 04/02/20, Resident #3 complained of pain in his left arm and PRN Tylenol was administered. -There was documentation on 04/03/20, Resident #3's RP (responsible party) was notified about a skin tear that was found on his left arm near the elbow bend. Review of Resident #3's accident/injury report	D 276		

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dated 04/03/20 at 4:35pm revealed Resident #3 was found to have a skin tear on his left upper arm near the bend of his elbow.

Review of Resident #3's charting notes dated 04/05/20 revealed there was documentation Resident #3's "PRNs" were not effective, and he was still complaining of left arm skin tear pain and agitation was still there.

Review of Resident #3's physician's order dated 04/07/20 revealed an order for geri-sleeves due to skin tears (geri-sleeves are worn over the arms and hands to protect from skin tears).

Review of Resident #3's physician's order dated 04/15/20 revealed "geri-sleeves on hold until delivered to community."

Review of Resident #3's charting notes revealed:
-There was documentation on 04/18/20, Resident #3 complained of hand pain on the left side where he had two skin tears.
-There was documentation on 04/23/20, Resident #3 complained of left-hand pain and PRN Tylenol was administered.
-There was documentation on 04/29/20, Resident #3 complained of left-hand pain and "PRN" was administered.

Review of Resident #3's accident/injury report dated 05/02/20 at 5:30pm revealed blood was observed on the floor and prior to that observation, Resident #3 was observed being agitated and shaking his arms on the arm of his wheelchair. He sustained a skin tear on his left arm.

Review of Resident #3's charting notes revealed:
-There was documentation on 05/02/20, Resident

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#3 sustained a skin tear before dinner.
-There was documentation on 05/07/20, Resident #3 had the skin tear on his left arm rewrapped and first aid ointment applied.
-There was documentation on 05/08/20, Resident #3 complained of left-hand pain and a "PRN" would be given at 9:00pm.
-There was documentation on 05/09/20, Resident #3's family member was contacted regarding a skin tear he sustained to his right hand.

Review of Resident #3's accident/injury reports revealed:
-On 05/09/20 at 8:33pm Resident #3 had an unwitnessed fall and sustained a skin tear on his right hand.
-On 05/16/20 at 10:28pm, Resident #3 was trying to pull himself up on the toilet and sustained a skin tear to his right thumb.

Review of Resident #3's physician's order dated 06/15/20 revealed "please obtain geri-sleeves."

Review of Resident #3's March 1, 2020-July 9, 2020 electronic medication administration records (eMAR) revealed:
-Resident #3 was administered PRN Tylenol for "skin tears" on 03/27/20, 04/04/20, 04/05/20, 04/25/20, and 05/02/20.
-Resident #3 was administered PRN Tylenol for "left arm pain" on 03/25/20, 03/31/20, 04/02/20, and 05/13/20.
-Resident #3 was administered PRN Tylenol for "right hand pain" on 05/14/20.

Observation of Resident #3 conducted via video conference on 07/20/20 at 12:10pm revealed Resident #3 was wearing geri-sleeves that covered both arms and hands.

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Telephone interview with Resident #3's Power of Attorney (POA) on 07/15/20 at 2:34pm revealed:
-She knew Resident #3 had an order for geri-sleeves due to skin tears.
-Resident #3 was to receive geri-sleeves from the medical equipment company this Friday (07/17/20).
-It had taken a long time for Resident #3 to get his geri-sleeves due to "staff changes" at the facility and "something happening," but she was not sure exactly why it had taken so long.

Telephone interview with a second shift medication aide (MA) on 07/16/20 at 10:51am revealed:
-Resident #3 had "several" skin tears since his admission to the facility.
-The most recent skin tear she observed on Resident #3 was 2-3 weeks ago.
-Resident #3 did not have geri-sleeves, but she thought the Director of Resident Care (DRC) was "on top of it."

Telephone interview with a first shift MA on 07/16/20 at 1:24pm revealed:
-Resident #3 had "multiple" skin tears since his admission to the facility.
-Resident #3 had sustained skin tears from falls and from hitting the side of his sink with his arms.
-Resident #3 did not have geri-sleeves.

Telephone interview with a second shift personal care aide (PCA) on 07/16/20 at 2:08pm revealed:
-Resident #3 had "a lot" of skin tears.
-Resident #3 had Parkinson's disease and when he became inpatient, he would flail his arms against his wheelchair and it would cause skin tears.
-The most recent skin tear he observed on Resident #3 was last Friday (07/10/20) on his

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right arm.
-Resident #3 did not have geri-sleeves, but they had been ordered by the DRC.

Telephone interview with the Clinical Supervisor at Resident #3's Home Health (HH) agency on 07/17/20 at 9:07am revealed:
-Resident #3's start of care (SOC) date for physical therapy (PT) services was 04/08/20.
-Resident #3's SOC date for speech therapy (ST) services was 04/10/20.
-Resident #3's SOC date for occupational therapy (OT) services was 05/27/20.
-OT was discontinued by the HH agency on 07/14/20 due to the facility not having the equipment needed to instruct Resident #3 and facility staff on its use, including the geri-sleeves.
-The HH agency received a fax from the facility on 07/01/20 with an order for geri-sleeves, dated 04/07/20, for Resident #3.
-Typically, facilities obtained physician's orders for medical equipment and sent the orders directly to a medical equipment company.
-Once the facility received the medical equipment, the HH staff would begin working with the resident and the facility staff on its use.
-It was ultimately the facility's responsibility to ensure proper follow-up with the medical equipment company, but the HH agency would assist them, at times, upon request.
-The HH agency had attempted to assist the facility and follow-up with Resident #3's medical equipment company via phone, regarding his geri-sleeves, but were unable to get a response.

Telephone interview with the DRC on 07/17/20 at 1:30pm revealed:
-She had worked at the facility since the second week in May 2020.
-She was responsible for ensuring new orders

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were implemented.
-She was not aware of the order dated 04/07/20 for Resident #3's geri-sleeves.
-Once Resident #3 began seeing OT (05/27/20), she had a discussion with the OT about Resident #3's "thin skin," and the OT had recommended geri-sleeves.
-She thought the OT was going to reach out to the PCP to get an order for the geri-sleeves.
-She "went back and forth" with the OT for about 2 weeks before deciding to obtain the order from the PCP herself.
-She obtained the geri-sleeve order dated 06/15/20 and sent it to the medical equipment company.
-The medical equipment company informed her the family would need to contact them regarding payment before they could place the order.
-Communication with the family took an additional couple of days.
-Getting equipment from a medical equipment company usually took about one week.
-Resident #3 had received his geri-sleeves yesterday (07/16/20).

Telephone interview with Resident #3's PCP on 07/17/20 at 4:08pm revealed:
-When she ordered medical equipment for a resident, she expected the facility to get it "ASAP" and at most within one week.
-If the facility could not get the medical equipment within this timeframe, she expected to be notified so she could encourage facility staff to follow-up, or she could clarify the order if necessary.
-The original order was written on 04/07/20 for Resident #3 to have geri-sleeves due to skin tears.
-Her office was notified on 04/15/20 the facility had not yet received the geri-sleeves so an order was written they could place the geri-sleeves on

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hold until received by the community.
-No further communication was provided by the facility regarding Resident #3 not having his geri-sleeves.
-Geri-sleeves would reduce the severity of Resident #3's skin tears and would decrease the amount of time required for them to heal.
-With more severe skin tears, Resident #3 was at risk of the skin tears becoming infected.

Telephone interview with Resident #3's OT on 07/20/20 at 9:54am revealed:
-Resident #3's SOC date with OT was 05/27/20.
-She recalled some confusion regarding Resident #3's geri-sleeves; with the HH agency thinking the facility was ordering the geri-sleeves from the medical equipment company, and the facility thinking the HH agency was ordering them.
-Resident #3 had a skin tear on his left arm while receiving OT services.
-She recommended the geri-sleeves to prevent skin tears.
-She also recommended a power wheelchair to help calm Resident #3's spastic movement of his arms, against the arms of his current wheelchair, because that was causing skin tears.
-Resident #3's OT services were discontinued on 07/14/20 because the facility had not yet received the recommended equipment she needed to educate staff on their use, including the geri-sleeves.

Telephone interview with the Administrator on 07/20/20 at 11:16am revealed:
-It was the DRC's responsibility to ensure medical equipment was obtained for the residents.
-She expected a physician's order for medical equipment to immediately be faxed to the medical equipment company by the DRC.
-She thought there was a hold up "due to

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COVID-19" and the medical equipment company having the inability to fill the original order, dated 04/07/20, for Resident #3's geri-sleeves.
-The second order obtained on 06/15/20 was originally sent to Resident #3's HH agency, but the HH agency never got the geri-sleeves.
-The DRC eventually ordered the geri-sleeves from a different medical equipment company.
-Resident #3's geri-sleeves were delivered to the facility sometime last week.

Telephone interview with a representative at a medial equipment company (identified by the Administrator as the first medical equipment company Resident #3's geri-sleeves were ordered) on 07/20/20 at 10:35am revealed they had never received an order for geri-sleeves for Resident #3.

Telephone interview with a representative at a second medical equipment company on 07/20/20 at 10:48am revealed:
-She was contacted by the DRC on or about 07/13/20 regarding ordering geri-sleeves for Resident #3.
-She informed the DRC, no physician's order was required for Resident #3's geri-sleeves due to them not being covered by his health insurance.
-She informed the DRC, Resident #3's family would need to contact her regarding payment for the geri-sleeves prior to her placing the order.
-Resident #3's family member contacted her on 07/15/20 to verify payment for the geri-sleeves.
-She placed the order the same day and Resident #3's geri-sleeves were delivered to the facility two days later on 07/17/20.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

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D 276	Continued From page 28 The facility failed to implement physician's orders for geri-sleeves for Resident #3, who had frequent skin tears that caused the resident pain, resulting in subsequent skin tears with delayed healing, putting him at risk for infection. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/21/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2020.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to contact the physician to clarify	D 344		

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medication orders for 1 of 3 sampled residents (Resident #2) related to physician's orders for Tylenol.

The findings are:

Review of Resident #2's current FL2 dated 02/27/20 revealed:
-Diagnoses included presence of right artificial hip joint, cerebral infarction, anxiety disorder, bipolar disorder, and major depressive disorder.
-There was an order for Tylenol 8-hour arthritis pain tab 650mg one tablet every 6 hours (medication used to treat pain, fever, and aches).
-There was an order to give Tylenol 8-hour 650mg one tablet as needed.

Review of Resident #2's signed "FL2 Medication Clarification Form" dated 03/03/20 revealed:
-There was an order for Tylenol 8-hour arthritis pain tab 650mg one tablet every 6 hours.
-There was an order to give Tylenol 8-hour 650mg one tablet as needed twice daily.

Review of Resident #2's medication list dated 03/09/20 revealed:
-There was an order for Tylenol 8-hour arthritis pain tab 650mg one tablet every 6 hours at 6:00am, 12:00pm, 6:00pm, and 12:00am.
-There was an order for Tylenol 8-hour 650mg one tablet twice daily as needed.
-The medication list was signed by a provider.

Review of for Resident #2's physician's order dated 03/09/20 revealed:
-There was an order to discontinue Tylenol 650mg twice daily as needed for pain, change time of every 6-hour Tylenol to 8:00am, 12:00pm, 4:00pm, and 8:00pm.

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Review of Resident #2's hand written physician's order dated 03/09/20 revealed:
-There was a signed physician's order dated 03/09/20 for Tylenol 650mg twice daily as needed for pain, discontinue Tylenol 650mg every 6 hours.

Further review of Resident #2's record revealed there was no contact with the PCP for clarification of the Tylenol order.

Review of Resident #2's May 2020 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Tylenol 8-hour 650mg to be administered twice daily as needed.
-Tylenol was documented as administered 7 times from 05/01/20-05/31/20.
-There was no entry for Tylenol 650mg every 6 hours.

Review of Resident #2's June 2020 eMAR revealed:
-There was a computer-generated entry for Tylenol 8-hour 650mg to be administered twice daily as needed.
-Tylenol was documented as administered 9 times from 06/01/20-06/30/20.
-There was no entry for Tylenol 650mg every 6 hours.

Review of Resident #2's signed physician's progress note dated 07/07/20 revealed:
-There was a list of medications currently prescribed for Resident #2.
-There was an order for Tylenol 8-hour arthritis pain tab 650mg one tablet every 6 hours.
-There was an order to give Tylenol 8-hour 650mg one tablet as needed twice daily.

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-The progress note was electronically signed by the primary care provider (PCP).

Review of Resident #2's July 2020 eMAR revealed:
-There was a computer-generated entry for Tylenol 8-hour 650mg to be administered twice daily as needed.
-Tylenol was documented as administered 2 times from 07/01/20-07/09/20.
-There was no entry for Tylenol 650mg every 6 hours.

Based on interviews and record review Resident #2 was not interviewable.

Telephone interview with a pharmacist from the contracted pharmacy for Resident #2 on 07/15/20 at 11:35am revealed:
-The pharmacy received orders from the facility and entered them on the eMAR.
-The pharmacy received a Tylenol order on 03/09/20 for Tylenol 650mg to be administered every 6 hours changing the time to 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The pharmacy had since discontinued the Tylenol orders and removed them from the eMAR because there was some confusion with the orders received for the Tylenol.
-The facility would need to send a current order for Tylenol to make it an active order.

Telephone interview with the supervising physician for Resident #2's PCP on 07/17/20 at 4:03pm revealed:
-She was the supervising physician for Resident #2's PCP.
-She and the PCP discussed the medical treatment for Resident #2.
-She reviewed Resident #2's record and the

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current order was for Tylenol 650mg every 6 hours at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The Tylenol 650mg to be administered twice daily as needed was discontinued on 03/09/20 to avoid conflict with the scheduled Tylenol.
-She could not determine if the facility reached out to the PCP to clarify which order was valid since there were 3 orders signed on the same day.

Telephone interview with a medication aide (MA) on 07/15/20 at 6:04pm revealed the Director of Resident Care (DRC) was responsible for processing all medication orders for the residents, including clarification of orders.

Telephon interview with the DRC on 07/17/20 at 1:30pm revealed:
-She became the DRC the second week of May 2020.
-She was not the DRC when the Tylenol orders came from the PCP.
-She had not gone through all of the resident records to check to determine if the most recent orders matched the eMAR.
-She was responsible for contacting a resident's physician to clarify medication orders.
-She did not know there were seperate orders written on the same day for Tylenol for Resident #2.

Telephone interview with the Administrator on 07/21/20 at 2:20pm revealed:
-The DRC was responsible for processing orders when received from the physician.
-The DRC would be responsible for contacting the PCP if medication clarification was needed.
-She knew Resident #2 had 3 different orders written on 03/09/20 for Tylenol 650mg.
-She expected staff to follow the handwritten

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D 344	Continued From page 33 order written on 03/09/20 as she thought it was the last order written by the physician.	D 344		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 367		

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facility failed to ensure the electronic Medication Administration Record (eMAR) was accurate for 1 of 3 sampled residents (Resident #3), related to an anti-inflammatory medication.

The findings are:

Review of Resident #3's current FL2 dated 03/02/20 revealed:
-Diagnoses included Parkinson's disease, Meniere's disease, and depression.
-There was an order for indomethacin 50mg PRN (as needed). (Indomethacin is an anti-inflammatory medication used to treat pain).

Review of Resident #3's signed FL2 Medication Clarification form dated 03/03/20 revealed an order for indomethacin 50mg capsule every eight hours PRN.

Review of Resident #3's signed physician's order dated 05/28/20 revealed an order to discontinue indomethacin.

Review of Resident #3's March, April, and May 2020 eMAR revealed there was no entry for indomethacin.

Telephone interview with the Director of Resident Care (DRC) on 07/17/20 at 1:30pm revealed:
-She began working at the facility the second week of May.
-She was responsible for faxing new orders to the pharmacy.
-The pharmacy would enter the new orders onto the resident's eMAR and she had to approve the orders so they would populate on the eMAR for the medication aides (MA) to see.
-She did not work at the facility when Resident #3 was admitted, and the former DRC would have

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D 367	Continued From page 35 been responsible for faxing orders to the pharmacy. Telephone interview with Resident #3's Primary Care Provider (PCP) on 07/17/20 at 4:08pm revealed: -Resident #3 was ordered indomethacin for gout. -Resident #3 had an order for indomethacin 50mg every eight hours PRN from 03/03/20-05/28/20. -Facility staff requested the indomethacin be discontinued on 05/28/20 so she gave the order to discontinue it. -She was not sure why the facility had requested it to be discontinued. -Resident #3 should have had indomethacin on his eMAR and available for administration from 03/03/20-05/28/20. -Not having indomethacin on his eMAR and available for administration put Resident #3 at risk of having inadequate pain control during a gout flare-up. Telephone interview with the Administrator on 07/20/20 at 11:16am revealed: -She, the MAs, and the DRC were responsible for faxing new orders to the pharmacy. -The pharmacy entered the orders onto the eMAR, and either she or the DRC had to approve them. -She did not know why indomethacin was not on Resident #3's March, April, or May 2020 eMARs. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/20/20 at 2:53pm revealed: -The facility faxed orders to the pharmacy and the pharmacy entered the orders onto the eMAR. -In order for the medication to populate on the eMAR for MAs to see, someone at the facility had	D 367		

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D 367	Continued From page 36 to approve the order. -The pharmacy received Resident #3's FL2 Medication Clarification form dated 03/03/20 and "profiled" the order for indomethacin 50mg capsule every eight hours PRN. -If someone at the facility had approved the order, it would have populated on the eMAR. -PRN medications were dispensed to the facility upon request. -The first time indomethacin was dispensed for Resident #3 was on 05/21/20 with 30 tablets dispensed. A second telephone interview with the Administrator on 07/21/20 at 2:20pm revealed: -The DRC was responsible for ensuring the accuracy of the eMARs. -The DRC was responsible for auditing the residents' records once monthly by comparing physician's orders to the entries on the eMAR. -In the absence of the DRC, it was her responsibility to audit the eMARs and ensure their accuracy. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 37 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to supervision and healthcare implementation. The findings are: 1. Based on interviews and record reviews, the facility failed to provide supervision for 1 of 3 residents sampled (Resident #1) with multiple falls resulting in physical injuries. [Refer to Tag D270, 10A NCAC 13F .0901(b) Supervision (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure physician's orders were implemented for 1 of 3 sampled residents (Resident #3). [Refer to Tag D276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents were free neglect as related to health care referral and follow-up. The findings are: Based on interviews and record reviews, the	D914		

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D914	Continued From page 38 facility failed to ensure referral and follow-up to meet the acute healthcare needs for 1 of 3 sampled residents (Resident #3) related to a fractured finger. Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D914		