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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on 03/30/21 - 04/01/21 and 04/05/21 - 04/06/21.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure that hot water temperatures were maintained at 100° to 116° degrees Fahrenheit (F) for 9 fixtures in 3 resident rooms (#404, #406, and #407), the living room, common residents' bath spa, common residents' shower room and nurses' workstation sink on the special care unit (SCU) with temperatures of 117.2°degrees F to 122.1° degrees F. The findings are: Observation of resident room #407 on 03/30/31 at 10:32am revealed: -The hot water temperature at the sink was 117.2°F. Observation of resident room #404 and #406 on 03/30/31 at 10:49am revealed:	D 113		

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D 113	Continued From page 1 -The hot water temperature at the sink was 118.2°F. -The hot water temperature at the tub/shower was 117.4°F Interview with a resident on 03/30/21 at 10:33am revealed: -She had not remembered the sink water temperature being hot. -She mixed cold and hot water together to keep in warm when she used the sink. -She used the shower down the hall but did not think the water was too hot. -She had not complained about the water temperatures being too hot. Interview with a second resident on 03/30/21 at 10:52am revealed: -He had used cold water with the hot water to make it warm. -He had not complained to staff about the water being too hot. -He had not received any burns or skin irritation from the hot water. Based on observations and interviews, it was determined the resident residing in room #404 was not interviewable. Observation of the SUC living room on 03/30/21 at 10:25am revealed the hot water temperature at the sink was 122.1°F. Observation of the common residents' bathing spa on 03/30/21 at 10:43am revealed: -The hot water temperature at the sink was 120.2°F. -The hot water temperature at the tub was 116.9°F.	D 113		

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Observation of the workstation sink on 03/30/21 at 10:59am revealed the hot water temperature was 119.8°F.

Observation of the common shower room on 03/30/21 at 11:03am revealed:
-The hot water temperature at the sink was 117.6°F.
-The hot water temperature at the shower was 119.3°F.

Interview with the housekeeper on 03/30/21 at 10:45am revealed:
-She had not known the water temperatures to be hot.
-The residents had not complained to her about the hot water temperature being hot.

Interview with a personal care aide (PCA) on 03/30/21 at 10:59am revealed:
-She assisted the residents with bathing.
-She had not noticed the hot water temperature being hot.
-Some of the residents had used the sink in the living room.
-She did not know the required water temperatures.
-The residents had not complained about the hot water temperature being too hot.

Interview with a Medication Aide (MA) on 03/30/21 at 4:45pm revealed:
-She had not noticed the hot temperature being too hot.
-Residents had not complained about the hot watering being too hot.

Interview with the Special Care Coordinator (SCC) on 03/30/21 at 11:17am
-Staff nor the residents had complained the hot

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water temperature being too hot.
-He had not noticed the hot water temperature being greater than 116°F.
-He had not noticed any burn areas on the residents.
-The Maintenance Director was responsible for completing hot water temperature checks.

Observation of water thermometers being calibrated on 03/30/21 from 3:58pm-4:08pm revealed:
-The Maintenance Director and two Surveyors' water thermometers were placed in a cup of ice water.
-The Maintenance Director's thermometer temperatures was 30.2°F.
-The first Surveyor's thermometer temperature was 32.8°F.
-The second Surveyor's thermometer temperature was 33.0°F.

Observations of re-check of water temperatures with the Maintenance Director on 03/30/21 from 4:10pm-4:35pm revealed:
-The "Hot Water" sign had been placed on the bathroom mirrors for rooms #404, #406, and #407.
-The "Hot Water" sign had been placed on the wall over the sinks in the living room, the nurses' workstation, common residents' bath spa and shower room.
-The hot water temperature at the sink for residents' rooms #404 and #406 was 104.3°F.
-The hot water temperature for the tub/shower for residents' rooms #404 and #406 was 106.8°F.
-The hot water temperature at the sink in resident room #407 was 106.3°F.
-The hot water temperature at the living room sink was 109°F.
-The hot water temperature at the nurses' station

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D 113	Continued From page 4 sink was 107.7. -The hot water temperature at the bath spa sink was 109°F. -The hot water temperature at the bath spa tub was 106.1°F. -The hot water temperature at the shower room sink was 107.3°F. -The hot water temperature at the shower room shower was 108.6°F. Interview with the Maintenance Director on 03/30/21 at 11:10am revealed: -He completed hot water temperature checks 3-5 times per week for the facility. -He completed hot water temperature checks for the SCU every 2-3 weeks. -He had checked an entire hall at a time. -He was responsible for completing hot water temperature checks. -He posted "hot water" precaution signs in the areas where the hot water temperatures were 117.0°F and higher. Interview with the Administrator on 03/30/31 at 11:26am revealed: -The residents nor staff had complained to about the water temperature being too hot. -There had been an issue with the hot water temperature, but it was fixed. -The Maintenance Director was responsible for managing the water temperatures. -The Maintenance Director was the only staff to monitor the water temperatures. -The Maintenance Director completed hot water temperature checks weekly for the facility. -She would have the Maintenance Director to check the hot water temperature on the SCU weekly.	D 113		

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D 270	Continued From page 5	D 270		
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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#4) who had a history of multiple falls with injuries including facial fractures, hematomas, bruising, intracranial head bleed, and two neck fractures. The findings are: Review of Resident #4's current FL-2 dated 02/16/21 revealed: -Diagnoses included Alzheimer's Disease, epilepsy (unspecified, not intractable, without status epilepticus), anemia, chronic pain due to trauma, and osteoarthritis. -She was constantly disoriented, semi-ambulatory, and passive with activities. -She was incontinent of bladder and bowel, and on a pureed diet. Review of Resident #4's previous FL-2 dated 01/21/20 revealed: -Diagnoses included Alzheimer's disease, osteoarthritis, and anemia. -She was constantly disoriented, ambulatory, and active with activities. -She was incontinent of bladder and bowel, and on a regular diet.	D 270		

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D 270	Continued From page 6 Review of Resident #4's current Special Care Unit (SCU) quarterly care plan dated 02/19/21 revealed: -The resident was afraid and anxious with profound memory loss, contracted muscles, poor swallowing and eating, and limited responsiveness. -The resident required assistance with meals and snacks. -The resident was incontinent and required staff for toileting needs and hygiene. -The resident was ambulatory with a wheelchair requiring staff assistance. -The resident required extensive assistance with bathing, grooming and transferring. -There was no documentation of Resident #4's needs related to fall precautions. Review of Resident #4's previous SCU quarterly care plan dated 10/25/20 revealed: -The resident was very friendly, had no behavior issues, and was encouraged to attend social activities. -The resident was independent with eating and transferring. -The resident required assistance as needed with supervision for toileting, ambulating, bathing, dressing, and grooming. -There was no documentation of any special management needs or physical disabilities. Review of Resident #4's Licensed Health Professional Support (LHPS) evaluation dated 02/24/21 revealed: -The resident required assistance with feeding techniques for swallowing problems. -The resident required assistance with ambulation using assistive devices that required physical assistance, and assistance with transferring.	D 270		

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D 270	Continued From page 7 A reqeust for Resident #4's previous LHPS evaluation was made but it was not provided by the facility prior to exit on 04/06/21. Review of Resident #4's 3rd quarter 2020 LHPS evaluation dated 07/28/21 revealed the resident did not require any other LHPS tasks or assistance. Review of the facility's fall management program revealed: -The falls program was to facilitate a team approach in managing and reducing falls for residents. -Staff received formal training on fall prevention awareness and techniques annually. -Staff were to complete an incident report and contact the primary care provider (PCP) and guardian after every fall. -The Administrator and Resident Care Coordinator (RCC)/Special Care Coordinator (SCC) were to review all incident reports and determine any immediate interventions based on circumstances of falls. -If a resident had two falls in a 4-week period, the facility was to request an order for PT or other treatment/interventions to prevent falls. -The plan did not address increased supervision related to falls, only to monitor the resident's vital signs, injuries, pain, and behavior changes once per shift (every 8 hours) for 72 hours. Observation of Resident #4 on 03/30/21 at 10:23am revealed: -The resident was in her room with the door closed except for a 1-2-inch gap. -The resident's room was located farthest from the nurses' station on the hall near the SCU entrance.	D 270		

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-The resident's room was not visible from the nurses' station.
-The resident was alone in her bed asleep on her left side in a fetal position with a neck brace in place; fall mat was in place at her bedside.

Observation of Resident #4 on 03/30/21 at 4:02pm revealed the resident had a healing abrasion noted to the middle of her forehead and wore a loosely fitting neck collar/brace.

Observation of Resident #4 on 04/01/21 at 12:52pm revealed the resident was awake and alone in her room in a recliner and there was a smell of urine in the room.

Observation or Resident #4 on 04/05/21 from 11:30am to 11:55am revealed:
-The resident was asleep on her left side in her bed with the door open and fall mat present at 11:30am.
-The resident was not observed by staff until 11:55am when she was awakened by staff for lunch.

Interview with a medication aide (MA) on 03/30/21 at 10:50am revealed:
-Resident #4 fell a week and a half ago trying to stand up out of her wheelchair and broke her neck.
-The resident used to walk independently before the falls and was on Hospice after the last fall earlier in that month (March).

Interview with a second MA on 03/30/21 at 4:45pm revealed:
-Resident #4 had a history of falling but she could not remember when.
-The resident used to walk independently and complete tasks such as washing dishes and

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folding clothes prior to her falls, but no longer walked at all.
-The resident was continent prior to falling and was now incontinent.
-The resident recently received a high back wheelchair to make her more comfortable and had been placed on Hospice.

Interview with a personal care aide (PCA) on 04/05/21 at 7:50am revealed:
-She worked the 11:00pm-7:00am shift.
-She was aware of some of Resident #4's falls
-Resident #4 was walking, dressing herself with assistance, and talking more prior to her first fall, not sure of exact date but the first fall was sometime in November or December of 2020.
-When Resident #4 was turned to have her incontinent brief changed or to be dressed, she grabbed on to the PCA.
-Resident #4 acted like she was scared she may fall.
-Resident #4 would try to take her neck brace off at night.
-She would let the MA know she was agitated; she had informed more than one MA.
-Resident #4 was not agitated every night.
-Resident #4 was on hourly monitoring.
-The hourly monitoring was to make sure she was alright and had not fallen.
-She performed hourly monitoring on Resident #4.

Interview with a second PCA on 04/05/21 at 3:44pm revealed:
-Resident #1 used to walk independently without assistive aids prior to her falls in Nov. 2020.
-Resident #4 "went downhill" after the falls and stopped walking after the second fall.
-She thought Resident #4 continued to fall because staff did not frequently check on her.

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-Staff "had a lot to do" and normally checked on her every two hours until today, 04/05/21, when they began to check on Resident #4 every 15 minutes per the SCC instructions.

Review of Resident #4's accident/injury report for Resident #4 dated 11/13/20 revealed:
-Resident #4 fell and had a bump from hitting her head in her room at 10:12am; the fall was witnessed by staff.
-Resident #4 was sent to the emergency department (ED) and admitted to the hospital; she was not administered first aid by the facility.
-Resident #4's physician and responsible party were notified.
-There was no documentation of any plan for increased supervision by staff of Resident #4.

Second interview with the second PCA on 04/06/21 at 9:58am revealed:
-She would know if any resident was a fall risk by looking in the resident's record.
-She would also reference a sheet that hung in resident's closet that outlined if the resident was a DNR, wore glasses, was a fall risk, and the care plan summary.

Observation of Resident #4's room revealed there was no reference sheet in the room or closet that outlined the resident's DNR status, if she wore glasses, if she was a fall risk, or a care plan summary.

Review of Resident #4's ED discharge instructions dated 11/13/20 revealed:
-She was seen status post fall in which she suffered a closed head injury (brain bruising, swelling or tearing, could also cause nerve damage and bleeding around the brain) and a hematoma (bruise caused by pooling of blood

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under the skin) to her forehead.
-Symptoms the resident could experience from this injury included difficulty concentrating and remembering, changes in personality, and difficulty standing or walking.
-The resident was to return to the ED for any new or worsening symptoms or concerns.

Review of Resident #4's fall risk assessment worksheet dated 11/14/20 revealed she was at high risk for falls.

Attempted telephone interview on 04/05/21 at 7:38pm with the PCA who responded to Resident #4 on 11/13/20 was unsuccessful.

Interview with the Special Care Coordinator (SCC) on 04/01/21 at 8:44am revealed:
-Physical Therapy (PT) was ordered for Resident #4 in relation to the 11/13/20 fall.
-Increased supervision of Resident #4 was expected after the 11/13/20 fall.
-There was no documentation of these interventions.

Review of Resident #4's accident/injury report for Resident #4 dated 11/17/20 revealed:
-Resident #4 was found sitting on the floor in her room with an open head injury (open wound to the head) at 8:00am; the fall was not witnessed by staff.
-Resident #4 was sent to the ED, admitted to the hospital, and she was administered first aid by the facility.
-Resident #4's physician and responsible party were notified.
-There was no documentation of any plan for increased supervision by staff of Resident #4.
-There was no request from the facility to obtain a PT order from the PCP per facility fall policy.

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D 270	Continued From page 12 Review of Resident #4's ED, hospital inpatient, and discharge records dated 11/17/20-11/18/20 revealed: -Resident #4 was seen in the ED for an unwitnessed fall in her bathroom, right hip pain, and a 2-inch laceration (a deep cut or tear of the skin) to the back of her head that was closed with five staples. -Resident #4 was consulted by a trauma surgeon who found the resident to have a hematoma and a laceration to the back of her head, a 2-3mm intracranial hemorrhage (bleeding within the skull). -The trauma surgeon ordered a consult for Resident #4 to be seen by a neurosurgeon who recommended overnight hospital admission. -Resident #4 received acute physical therapy (PT) and occupational therapy (OT) while in the hospital and was documented to have a decreased awareness of her need for assistance regarding safety with generalized upper and lower extremity weakness, but able to follow commands and ambulate in her room; she had a discharge plan to include 24-hour assistance and supervision. -Resident #4 was discharged back to the facility on 11/18/20 with a plan for fall and aspiration precautions. Review of Resident #4's fall risk assessment worksheet dated 11/20/20 revealed she as at high risk for falls. Review of Resident #4's physician care note dated 11/24/20 revealed the resident had mild swelling to her lower right eyelid and cheek with scattered bruising, with a steady gait, and gibberish speech w149deith occasionally clear sentences.	D 270		

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D 270	Continued From page 13 Review of Resident #4's primary care provider (PCP) consultation note dated 11/24/20 revealed: -There was an order to monitor the resident for mental status and behavior changes, activity of daily living (ADL) function, and vital signs changes due to her intracranial bleed. -The resident continued to be at risk for further falls, skin breakdown, weight loss, and opportunistic infections. -There were no new orders related to fall prevention. Interview with the SCC on 04/01/21 at 8:44am revealed: -Increased supervision of Resident #4 was expected after the 11/17/20 fall. -There was no documentation of these interventions. Review of Resident #4's accident/injury report for Resident #4 dated 12/19/20 revealed: -Resident #4 was found lying on the floor in her room at 9:45am with a bump on her head and the fall was not witnessed by staff. -Resident #4 was sent to the ED and she was not administered first aid by the facility. -Resident #4's physician and responsible party were notified. -There was no documentation of any plan for increased supervision by staff of Resident #4. Review of Resident #4's ED, in-patient, and discharge hospital records dated 12/19/21-01/01/21 revealed: -Resident #4 was seen in the ED after an unwitnessed fall with a hematoma to the back of her head with moderate to severe cervical stenosis (narrowing of the spinal canal) at C3-6 (neck vertebrae) and limited movement to her	D 270		

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lower extremities.
-There was concern that any additional mild trauma to the cervical spine could cause spinal cord injury; trauma and neurosurgeons were consulted.
-She was placed in an aspen collar (neck brace) with cervical spine precautions.
-Resident #4 was admitted to the hospital in ICU and she underwent surgery with a neurosurgeon for decompression of the spinal cord after being found to have a cervical fracture (neck vertebrae fracture).
-Resident #4 was diagnosed with new seizures during this time and started on Keppra (anti-seizure medication).
-The resident received acute PT/OT after surgery with documentation that she was unable to follow commands, her mobility was below baseline, she was dependent for all care, and would need 24/7 care with intensive rehabilitation upon discharge.
-The resident was documented as severely agitated on 12/28/20 with new seizure activity and a concern she was a risk to her own safety and the safety of others.
-The resident was documented to have increased confusion upon discharge back to the facility.

Review of Resident #4's fall risk assessment worksheet dated 1/4/21 revealed she was at high risk for falls.

Review of Resident #4's PCP consultation note dated 01/05/21 revealed:
-There was an order to monitor the resident for seizure activity.
-There was an order for Norco 5-325mg (a narcotic used to treat pain) ½ tab every 8 hours for pain control.
-There were no new orders related to fall prevention.

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D 270	Continued From page 15 Review of Resident #4's physician order dated 01/04/21 there was an order for a PT/OT evaluation and treatment. Review of Resident #4's record revealed there was no documentation that the order for PT/OT was implemented and completed. Review of Resident #4's PCP consultation note dated 01/12/21 revealed: -There was an order to monitor the resident for seizure activity. -There were no new orders related to fall prevention. Interview with the MA on 04/06/21 at 8:23am who found Resident #4 after her fall on 12/19/21 revealed she did not remember any details related to the fall. Review of Resident #4's accident/injury report for Resident #4 dated 02/03/21 revealed: -Resident #4 was found on the floor in her room at 3:17pm by housekeeping staff and the fall was unwitnessed. -There was no documentation Resident #4 suffered any injury or required first aid from staff. -Resident #4's physician and responsible party were notified. -There was no documentation of any plan for increased supervision by staff of Resident #4. Review of Resident #4's PCP consultation note dated 02/09/21 revealed: -There was an order to monitor the resident for seizure activity, fatigue, and lethargy. -There was an order for Norco 5-325mg every 6 hours for pain control. -There were no new orders related to fall	D 270		

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prevention.

Review of Resident #4's PCP consultation note dated 02/16/21 revealed:
-There was an order to begin PT/OT to increase her muscle mass and overall strength, balance, endurance, stability and safety in transferring and ambulation to reduce the risk of further falls.
-It was expected that the resident would and could demonstrate improved function as a result of the intervention for improved safety and comfort.

Review of Resident #4's record revealed that the order for PT/OT dated 02/16/21 was implemented on 02/23/21.

Review of Resident #4's accident/injury report for Resident #4 dated 02/17/21 revealed:
-Resident #4 was found to be sitting in front of her chair in her room at 4:35pm.
-There was no documentation that Resident #4 suffered any injury or required first aid from staff.
-Resident #4's physician and responsible party were notified.
-There was no documentation of any increased supervision plan by staff of Resident #4 except that the resident would be monitored closely by aids.

Review of Resident #4's fall risk assessment worksheet dated 2/19/21 revealed she was at high risk of falls.

Interview with a personal care aide (PCA) on 04/05/21 at 7:50am revealed:
-She found Resident #4 in front of her chair crying on 02/17/21.
-She notified the medication aide (MA) and they got her off the floor, but she could not remember

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D 270	Continued From page 17 if she was hurt or not. Second interview with the MA on 04/01/21 at 1:29pm revealed: -Prior to Resident #4's falls she would walk around, carry a conversation, and use the bathroom independently. -Resident #4 now required total care, could not walk, did not carry a conversation, and was incontinent. -Staff were expected to monitor Resident #4 every hour, sometimes less than that to prevent falls. -Staff sometimes brought Resident #4 to the television room to keep an eye on her. -On 02/17/21, the staff had walked away from Resident #4 who then fell out of the wheelchair. -There were no interventions implemented to increase supervision on Resident #4 after her falls. Review of Resident #4's PCP consultation note dated 02/23/21 revealed: -The resident was unable to bear weight and remained at risk for falls. -There was an order to anticipate the resident's needs and encourage the resident to be out of bed in a cardiac chair in the common areas to monitor for falls. Review of Resident #4's accident/injury report for Resident #4 dated 02/26/21 revealed: -Resident #4 was sitting on the floor beside her bed at 6:50am. -There was no documentation that Resident #4 suffered any injury or required first aid from staff. -Resident #4's physician and responsible party were notified. -There was no documentation of any plan for increased supervision by staff of Resident #4.	D 270		

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D 270	Continued From page 18 Interview with a third PCA on 04/05/21 at 3:56pm revealed: -After Resident #4's first fall, she became very afraid of falling again. -Resident #4 did not walk anymore and did not try because she was afraid. -Resident #4 required help with all care: bathing, feeding, dressing, and incontinent care. -They tried to keep Resident #4 in common areas to supervise her. -She would walk past Resident #4's room at least twice per hour to check on her. -Resident #4 used to help with cleaning and laundry before falling, but now she cried and moaned all the time, and staff could not tell when she was in pain. Review of Resident #4's PT initial assessment dated 02/26/21 revealed: -The resident was referred due to falls with previous scalp hematoma, cervical fracture with cord compression, and surgical intervention of the cervical spine. -The resident was noted to need fall precautions and to wear the aspen neck collar while out of bed. -The resident's fall risk factors included advanced age, history of falling, cognitive impairment, and several medications that impacted her condition and treatment. -It was documented that the resident was unsteady when standing, had impaired strength in all her lower extremities, and was non-ambulatory (unable to walk) upon examination. -The resident required total dependence with attempts at ambulation and wheelchair mobility. -It was documented that the resident had a significant decline compared to her prior level of function which was independence with	D 270		

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ambulation (walking) and only required supervision with ADLs.
-The resident remained at risk of further decline in function, falls, and decreased mobility.

Review of Resident #4's accident/injury report for Resident #4 dated 03/03/21 revealed:
-Resident #4 was found on the floor in the SCU hallway at 8:30am with an abrasion to her forehead.
-Resident #4 was sent to the ED.
-Resident #4's physician and responsible party were notified.
-There was no documentation of any plan for increased supervision by staff of Resident #4.
-The status of Resident #4 after her ED visit was noted to include a nondisplaced odontoid fracture with type II morphology (a fracture of the C2 neck vertebrae and considered unstable), a closed head injury (traumatic brain injury), and a forehead laceration.

Review of Resident #4's ED discharge instructions dated 03/03/21 revealed:
-Resident #4 was seen in the ED after a fall and diagnosed with a closed nondisplaced odontoid fracture with type II morphology, a closed head injury, and a forehead laceration.
-She received a laceration repair prior to discharge and was instructed to follow up with the neurosurgeon for further evaluation.

Second interview with a MA on 04/01/21 at 1:29pm revealed:
-On 03/03/21 she was working and found Resident #4 on the floor when she fell out of her chair after the PCA walked away.
-After finding Resident #4 on the floor on 03/03/21, she sent her to the ED; the resident fractured her neck and had a "gash" in her

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forehead.
-No interventions were implemented when Resident #4 returned from the ED on 03/03/21 to increase supervision or prevent future falls.
-A few days after the 03/03/21 fall, the resident received a fall mat, but she did not know where it came from.

Review of Resident #4's accident/injury report for Resident #4 dated 03/06/21 revealed:
-Resident #4 was found on the floor mat by her bed at 2:10am and the fall was not witnessed by staff.
-There was no documentation Resident #4 suffered an injury or required first aid from staff.
-Resident #4's physician and responsible party were notified.
-There was no documentation of any plan for increased supervision by staff of Resident #4.

Review of Resident #4's PCP consultation note dated 03/09/21 revealed:
-The resident was a candidate for hospice which would be consulted.
-Due to the odontoid fracture the resident was to remain in the aspen neck collar.
-There was an order to monitor the resident for post-seizure states, fatigue and tremors.
-There was an order to monitor the resident for post-seizure states, fatigue and tremors.
-The resident required increased assistance with all aspects of ADLs and required observation to maintain safety needing fall prevention and high level of care with a plan to seek skilled nursing facility placement.
-No new fall prevention interventions were ordered.

Review of Resident #4's hospice emergency plan identification card dated 03/10/21 revealed that

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D 270	Continued From page 21 Resident #4 was provided with a hospital bed, fall mat and wheelchair. Review of Resident #4's PT discharge summary dated 03/13/21 revealed: -The resident was discharged from PT to be managed by hospice. -The resident continued to need close supervision due to increased high fall risk. Review of Resident #4's accident/injury report for Resident #4 dated 03/12/21 revealed: -Resident #4 was found in the SCU hallway with injuries of lacerations and abrasions to her forehead at 6:06pm and the fall was not witnessed by staff. -Resident #4 was sent to the ED and she was administered first aid by the facility. -Resident #4's physician and responsible party were notified. -Resident #4 was to be monitored 1:1 during shifts. Review of Resident #4's ED and discharge hospital records dated 03/12/21 revealed: -Resident #4 was seen in the ED after a fall from her wheelchair to rule out a subdural hematoma or worsening cervical fracture, and a repair of a head laceration. -Resident #4 was documented to have maintained the odontoid cervical fracture at C3. Third interview with the MA on 04/01/21 at 1:29pm revealed: -On 03/12/21, the staff walked away from Resident #4 to pass meals and did not watch her when she fell. -She had previously told the Resident Care Coordinator (RCC) that the SCU needed more staff.	D 270		

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-She had not told anyone that she felt Resident #4 needed 1:1 supervision and did not know why she had not reported that.

Interview with a second MA on 04/05/21 at 8:23pm revealed:
-Resident #4 seemed to be agitated all day and she notified the SCC of the resident's behavior.
-She never notified Resident #4's PCP about the agitated behavior; she did not know why.
-Resident #4 fell on 03/12/21 when she was sitting in her wheelchair in front of the desk at the nurses' station with staff.
-She turned her back to the resident to go behind the desk to document something.
-The resident fell forward out of her wheelchair and hit her head.
-She applied pressure to the wound and called hospice, EMS, the resident's guardian, and then her manager to notify them that the resident had fallen.
-The resident seemed scared and really needed 1:1 supervision, but they tried to check on her every hour instead.

Review of Resident #4's neurosurgeon progress note dated 03/15/21 revealed:
-Resident #4's visit was a follow-up to her falls, decreased movement of her lower extremities, and her surgery related to decompressive laminectomy and fusion from her cervical stenosis.
-The provider noted that the resident had a fall from her wheelchair on 03/03/21 that resulted in a new type II dens (cervical/neck) fracture.
-The resident presented with another fall out of her wheelchair on 03/12/21 that did not show any new fractures.

A request was made for the facility's documented

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supervision/safety checks for residents but the documentation was not provided prior to exit on 04/06/21.

Interview with the SCC on 03/31/21 at 5:30pm and 04/01/21 at 8:44am revealed:
-Resident #4's first fall occurred in November 2020.
-After falls, the facility should monitor a resident more closely by trying to supervise them 1:1 in common areas, contact the PCP, and request for a fall mat and PT.
-Staff were supposed to provide supervision monitoring every 10-15 minutes on Resident #4 to keep her safe and prevent falls with injuries, which included making sure she was in her bed and staff providing incontinent care.
-The facility did not document supervision monitoring on any residents in the SCU.
-Staff knew to provide increased supervision monitoring for Resident #4 because he told staff to do it and they were to tell each other at change of shift hand-off.
-Resident #4 did not have any bed/chair alarms or call bells as part of her fall prevention plan.
-Resident #4 was admitted to hospice services on 03/10/21 and received a fall mat and hospital bed from Hospice at that time.

Interview with the Administrator on 04/01/21 at 11:30am revealed:
-Resident #4 had a history of frequently falling and recently received a fall mat and reclining wheelchair.
-She told staff to try to provide 1:1 supervision which meant the resident was in her wheelchair and with staff.
-When Resident #4 was asleep, she could be alone in her room.
-Resident #4's physical decline began after her

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first fall; she was able to walk all over the SCU prior.
-Resident #4 fell frequently because she required more supervision and sometimes needed help to the bathroom.
-Increased supervision meant that staff would have to sit outside Resident #4's room, monitor on the resident every hour, make sure her needs were met, take the resident to the bathroom, and remove obstacles from the resident room.
-Resident #4 was not able to call for help and she would not be able to pull a call bell.
-The facility did not document supervision/safety monitoring.
-The facility had recently obtained an FL-2 to get Resident #4 into a skilled nursing facility, but she had not discussed that with the resident's family yet and had therefor not moved forward yet in obtaining skilled nursing for Resident #4.

Review of Resident #4's resident record revealed there was no documentation of Resident #4's new FL-2 or plan for implementation of receiving a higher level of care.

Interview with Resident #4's primary care provider (PCP) on 04/05/21 at 8:57am revealed:
-Resident #4's first fall occurred in November 2020, but it was hard to find staff because they were all out sick with COVID-19; she told staff to keep a closer eye on Resident #4 to prevent falls.
-She saw the resident on December 1st, 2020, because the facility had reported Resident #4 had a rash. The resident instead had a bruise on her right cheek and eye with swollen eyes, not a rash, because she had fallen.
-She was not able to assess Resident #4 after every fall during her weekly visits on Tuesdays because the resident was sometimes at the hospital due to the falls.

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D 270	Continued From page 25 -Because Resident #4 had been in the hospital, she didn't see the resident again until January 5, 2021 for a follow up visit after the resident's surgery to relieve cervical cord compression, and severe central cord stenosis (narrowing of the space for the spinal cord). -Resident #4 was given an order for hospice on March 5, 2021 because she was not eating anymore causing her to be thin with protein mass loss. -She had written an order for the facility to monitor Resident #4's intake. -She ordered blood pressure and pulse monitoring on the resident to see if she had low blood pressure or low pulse that could be causing the resident's falls -She could not say if she had specifically been notified of each fall because the facility should use the after-hours line to notify the provider on call, but instead, the facility wrote it in a book which she would review at her next visit. -She expected the facility to contact her for all falls with injuries and changes in resident condition. -She spoke with the SCC to let him know she wanted the staff to keep the resident out of her room while awake and to be supervised in the common areas. -She expected the staff to provide increased supervision to include safety checks every 2 hours. -There were no other interventions put in place to prevent Resident #4's falls until 03/10/21 when hospice provided a fall mat, hospital bed, and cardiac reclining wheelchair. Attempted telephone interviews with both of Resident #4's guardians on 04/05/21 at 7:55pm and 8:30pm and on 04/06/21 at 9:52am and 9:53am were unsuccessful.	D 270		

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D 270	Continued From page 26 Second interview with the SCC on 04/06/21 at 10:09am revealed: -He would walk the halls of the SCU every 1-2 hours. -He expected staff to monitor the residents in SCU once every hour. -Fall risk assessment sheets were to be done after every fall, but they were not done after every fall for Resident #4 in February and March 2021; he had been working on other things and forgot. -The blank areas on the completed fall risk assessments that were done for Resident #4 should have been addressed because it could have been an area that contributed to the resident's falls. -The purpose of the fall risk assessments was to evaluate if there were any changes the facility could apply to the resident's care to prevent falls, such as new interventions or calling the PCP for further orders. -If this process had been followed, it could have prevented Resident #4 from falling. Interview with the RCC on 04/06/21 at 11:16am revealed: -She was over the clinical operations of the facility when the Administrator was out and was a contact for the SCU when the SCC was out. -She was the previous SCC before the current SCC took the position in October 2020. -Fall risk assessment sheets were to be filled out entirely after every fall and to assess why the fall happened and then presented at the falls meeting. -Staff were to call the PCP after every fall regardless of whether the fall was witnessed or unwitnessed, or whether the resident sustained injury or not. -She would expect staff to notify the SCC or RCC	D 270		

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of agitation so they could follow up with Resident #4's agitation, staff should never assume the PCP was already aware.

Interview with Resident #4's hospice nurse on 04/06/21 at 12:25pm revealed:
-Resident #4 was a high fall risk, had a history of falling, and seemed fearful.
-The resident required maximum assistance with 2-person assistance for transfers and the resident did not ambulate.
-He would expect the resident to receive constant supervision while in common areas and safety checks every 15-minutes when the resident was alone in her room.
-He felt the facility should also implement a bed alarm to help prevent further injury which he would request from the hospice provider at the next meeting, he had not done it yet because he was new.
-Resident #4's facility staff appeared reactive to her falls and supervision of the resident could be improved by individual engagement, smaller groups, more activities, and increase fall supervision to every 15-minutes.

Interview with the Administrator on 04/06/21 at 12:53 revealed:
-Resident #4 was still able to walk after the 11/13/20 and 11/17/20 falls.
-Resident #4 experienced a change in status and stopped walking after the 12/19/20 fall; the fall or the surgery contributed to her change.
-Resident #4 really needed 1:1 supervision, but it had been difficult to find her a bed in a skilled nursing facility and they were unsuccessful.
-Increased supervision for Resident #4 began in November 2020 which included "keeping eyes" on the resident and keeping her at the nurses' station when awake.

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-They did not perform hourly checks and there was no documentation of supervision at the facility.
-Resident #4's PT/OT referral was not carried out in January 2021 due to COVID-19.
-Resident #4 received PT/OT in February 2021.
-Interventions for a fall mat, hospital bed, and high back wheelchair were put in place by Hospice on 03/10/21.
-Without 1:1 supervision, the facility could not have prevented Resident #4's falls.

Second interview with Resident #4's PCP on 04/06/21 at 3:08pm revealed:
-She did not know if the facility had notified her of all of Resident #4's falls, but if she had realized the resident had 10 falls in a 4-month period, she would have ordered more engagement and activities for the resident.
-She was unsure how often the facility provided resdient monitoring, but staff were walking the halls all the time.
-She was not comfortable with Resident #4 at this facility because she really needed a higher level of care after her surgery in December 2020.
-The facility could have provided Resident #4 with a hoyer lift and more specialized care and feeding assistance to keep her safe.

Interview with Resident #4's neurosurgeon on 04/07/21 at 1:37pm revealed:
-He expected Resident #4 to receive full supervision with her status and diagnoses.
-With Resident #4's cervical fractures, further falls put her at more risk of injury such as spinal cord injury, central cord syndrome, and paralysis.
-Further falls causing additional fractures could cause worsening cervical stenosis.
-Cervical stenosis could contribute to falls due to myelopathy, gait instability, and balance

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D 270	Continued From page 29 instability. -He was concerned that the resident continued to fall after surgery and would have expected the facility to contact him for further interventions to prevent falls and a bed alarm to be in place. Based on observations, interviews and record reviews it was determined Resident #4 was not interviewable. _____ The facility failed to provide supervision for Resident #4 which resulted in neglect for the resident sustaining 9 falls between 11/13/20-03/12/21 resulting in multiple head hematomas and lacerations, closed head injuries, intracranial bleeding, multiple cervical fractures, cervical stenosis, and a decrease in the residents ability to function independently. This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation for neglect. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 04/05/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 06, 2021	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 A2 VIOLATION	D 273		

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Based on observations, interviews, and record reviews the facility failed to ensure referral and follow up to meet the acute health care needs of 2 of 5 (#1, #4) sampled residents who missed cardiology appointments and a computerized tomography (CT) scan of the head (#1); and a resident who had episodes of agitation (#4).

The findings are:

1. Review of Resident #1's current FL-2 dated 02/02/21 revealed:
-Diagnoses included atrial fibrillation, hypertension, dementia, and COPD.
-The resident was constantly disoriented and semi ambulatory with a wheelchair.

Review of Resident #1's previous FL-2 dated 05/19/20 revealed:
-Diagnoses included congestive heart failure (CHF), ischemic heart disease, automatic implantable cardiac defibrillator (AICD), hypertension, peripheral vascular disease (PVD), chronic obstructive pulmonary disease (COPD), and dementia.
-The resident was intermittently disoriented and semi ambulatory with the use of a wheelchair.

Review of Resident #1's Resident Register dated 07/30/19 revealed an admission date of 07/30/19.

Review of Resident #1's current care plan dated 03/11/21 revealed:
-The resident was sometimes disoriented, forgetful and needed reminders, and used a wheelchair for mobility.
-The resident required limited staff assistance for grooming and personal hygiene.
-The resident required extensive staff assistance for toileting, ambulation, bathing, dressing, and

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transferring.

Review of Resident #1's previous care plan dated 10/08/21 revealed:
-The resident was sometimes disoriented, forgetful and needed reminders, and used a wheelchair for mobility.
-The resident required limited staff assistance for grooming and personal hygiene, toileting, ambulation, bathing, dressing, and transferring.

a. Review of Resident #1's cardiology visit note dated 03/26/21 revealed:
-The resident " ...came in today after months of trying to get her in for an implantable cardiac device check" (ICD)
-The resident's ICD battery had been depleted.
-There was doubt the ICD would discharge if the resident encountered a life-threatening cardiac rhythm.
-The resident had a history of a cardiac stents, myocardial infarction (death of the heart muscle caused by lack of blood supply), a coronary artery bypass graft, congestive heart failure, and a biventricular AICD.
-The resident would require an ICD generator change.

Review of Resident #1's hospital discharge summary dated 04/17/21 revealed:
-The resident had explantation of a biventricular implantable cardioverter-defibrillator.
-The resident had implantation of a new biventricular implantable cardioverter-defibrillator.

Telephone interview with Resident #1's family member on 03/31/21 at 1:18pm revealed:
-The resident was being treated by a local cardiologist for a cardiac device.
-The resident had recently seen the local

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cardiologist for the cardiac device; he could not remember when.

Telephone interview with a Registered Nurse (RN) from Resident #1's cardiologist office on 04/01/21 at 12:03pm revealed:
-Resident #1 had an AICD implant on 04/17/20 by the cardiac surgeon.
-The resident had a post-operative wound check on 04/22/20.
-The resident was seen on 05/05/20 due to a hematoma.
-The resident was scheduled for a 3 month follow up appointment for an AICD check on 08/07/20.
-The resident's 08/07/20 in office AICD check appointment was canceled; the reason was not documented.
-The resident was scheduled for a 3 month follow up appointment with a general cardiologist on 08/07/20.
-The resident's 08/07/20 cardiologist appointment was canceled; the reason was not documented.
-Residents with cardiac device implants needed a 3 month follow up appointments for device interrogation and with a cardiologist to ensure the device was functioning properly and good cardiac health.
-Resident #1 had a dual chamber defibrillator because her heart was not strong enough to withstand life threatening rhythms.
-As of 04/01/21, Resident #1 had not seen the general cardiologist since 10/05/17.

Interview with the Resident Care Coordinator (RCC) on 04/01/21 at 3:00pm revealed she was not acting RCC in September 2020.

Interview with the Administrator on 04/01/21 at 3:18pm revealed:
-Hospital discharge summaries were returned

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with the resident upon return to the facility.
-It was the responsibility of the RCC to scheduled and reschedule appointments.
-The RCC was responsible for reviewing hospital discharge summaries for referrals and/or orders.
-If the RCC was not present, the Special Care Coordinator (SCC) would be given the hospital discharge summaries to process.
-The hospital discharge summaries would be scanned to the RCC if the RCC and SCC were not in the facility when the hospital discharge summaries were returned with the resident.
-She expected orders from the hospital discharge summaries to be processed within 24 hours of receipt, or the next business day if weekends or holidays.
-She expected all resident appointments to be kept.
-She expected any appointment not kept to have been rescheduled by the RCC and/or SCC.
-There were no out of facility appointments made between November 2020 - January 2021 due to the COVID-19 outbreak.
-Out of facility appointments were to have been made prior to November 2020 and after January 2021.
-Resident #2 should have been taken to her cardiology appointments even though there was the COVID-19 epidemic.
-It was the responsibility of the Administrator to ensure resident appointments were kept and/or rescheduled.
-She would not know resident appointments were not kept and/or not rescheduled if she was not told.
-She had no system in place to ensure resident appointments were kept and/or rescheduled.
-There was no reason why she did not have a system in place to ensure resident appointments were not missed.

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D 273	Continued From page 34 Telephone interview with Resident #1's family member on 04/05/21 revealed: -The resident's AICD battery was low early 2020 and required replacement. -He expected the facility to be certain the resident kept her cardiology appointments because the heart was an important thing. -Cardiology appointments were expected to be a priority. Interview with the Administrator on 04/06/21 at 12:27pm revealed: -She did not know Resident #4 had missed cardiology appointments. -There was no reason or excuse Resident #4 had missed cardiology appointments. Telephone interview with the RN from Resident #1's cardiologist office on 04/06/21 at 2:00pm revealed: -In 2020, Resident #1 had a remote box that was able to transmit readings from the resident's AICD to the office. -On 02/14/20 the facility was called to reschedule Resident #1's missed device check; she did not know the date. -On 02/19/20 the facility was called because there were 2 missed remote device checks. -The caller was placed on hold without anyone from the facility picking up the call. -An appointment card was mailed to the resident's address on file with the cardiologist office. Interview with Resident #4's Primary Care Provider (PCP) on 04/06/21 at 3:15pm revealed: -She expected Resident #4's cardiology appointments to have been kept for the benefit of the resident.	D 273		

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-She expected Resident #4's cardiology appointments to have been rescheduled if they were missed for the benefit of the resident.

Attempted telephone interview with Resident #1's cardiologist on 04/01/21 at 12:03pm was unsuccessful.

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

b. Review of Resident #1's local hospital emergency department (ED) discharge visit note and summary dated 09/17/20 revealed:
-The resident was treated for chest pain with shortness of breath.
-The resident had a biventricular automatic cardioverter/defibrillator, hypertension (HTN), congestive heart failure (CHF), and dementia.
-The resident was to follow-up with her cardiologist on 09/28/20 at 3:00pm.
-The resident was to have an in-office automatic implantable cardiac device (AICD) check on 09/28/21 at 2:00pm.

Review of Resident #1's consultation notes, physician's orders, and the facility's resident progress notes revealed there was no documentation the resident was treated by the general cardiologist.

Telephone interview with a Registered Nurse (RN) from Resident #1's cardiologist office on 04/01/21 at 12:03pm revealed:
-Resident #1 was scheduled for a device check on 09/28/20.
-Resident #1 did not show up for the AICD check on 09/28/20; the reason was not documented.
-Resident #1 was scheduled to see general

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cardiology on 09/28/20.
-Resident #1 did not show for the general cardiology appointment on 09/28/20; the reason was not documented.
-Resident #1 had an in office AICD interrogation on 10/19/20 as a result of the 09/28/20 no show.
-Resident #1's 09/28/20 no show appointment with the cardiologist was not rescheduled.
-Resident #1 had not seen general cardiology since 2017.
-Resident #1 had a dual chamber defibrillator because her heart was not strong enough to withstand life threatening rhythms.

Interview with the Resident Care Coordinator (RCC) on 04/01/21 at 3:00pm revealed she was not acting RCC in September 2020.

Interview with the Administrator on 04/01/21 at 3:18pm revealed:
-Hospital discharge summaries were returned with the resident upon return to the facility.
-It was the responsibility of the RCC to scheduled and reschedule appointments.
-The RCC was responsible for reviewing hospital discharge summaries for referrals and/or orders.
-If the RCC was not present, the Special Care Coordinator (SCC) would be given the hospital discharge summaries to process.
-The hospital discharge summaries would be scanned to the RCC if the RCC and SCC was not in the facility when the hospital discharge summaries were returned with the resident.
-She expected orders from the hospital discharge summaries to be processed within 24 hours of receipt, or the next business day if weekends or holidays.
-She expected all resident appointments to be kept.
-She expected any appointment not kept to have

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been rescheduled by the RCC and/or SCC.
-Resident #2 should have been taken to her 09/28/20 cardiology appointments even thought there was the COVID-19 epidemic.
-It was the responsibility of the Administrator to ensure resident appointments were kept and/or rescheduled.
-She would not know resident appointments were not kept and/or not rescheduled if she was not told.
-She had no system in place to ensure resident appointments were kept and/or rescheduled.
-There was no reason why she did not have a system in place to ensure resident appointments were not missed.

Telephone interview with Resident #1's family member on 04/05/21 revealed:
-He expected the facility to be certain the resident kept her cardiology appointments because the heart was an important thing.
-Cardiology appointments were expected to be a priority.

Interview with the Administrator on 04/06/21 at 12:27pm revealed:
-She did not know Resident #4 had missed cardiology appointments.
-There was no reason or excuse Resident #4 had missed cardiology appointments.

Attempted telephone interview with Resident #1's cardiologist on 04/01/21 at 12:03pm was unsuccessful.

Based on observations, interviews, and record reviews Resident #4 was not interviewable.

c. Review of Resident #1's Primary Care Provider's (PCP) consultation note dated

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D 273	Continued From page 38 03/09/21 revealed: -The resident had ongoing frequent falls. -The resident was at risk for fracture and internal bleeding secondary to Eliquis (a medication used to thin the blood by preventing blood clots from forming) use. -A head CT was pending. Interview with the Resident Care Coordinator (RCC) on 03/31/21 revealed: -Resident #1 was ordered a head CT because of falls. -The CT for Resident #1 required insurance preauthorization. -Resident #1's PCP was obtaining preauthorization from the residents insurance company. Interview with the RCC on 04/01/21 at 9:21am revealed: -Resident #1's head CT was scheduled for 03/18/21 at a local hospital. -The local hospital canceled Resident #1's head CT because insurance preauthorization was needed. -The local hospital was to contact Resident #1's PCP and obtain insurance preauthorization from the insurance company. -Resident #1's head CT had not been rescheduled as of today (04/01/21). -She had not followed up with the local hospital or Resident #1's PCP regarding the status of the preauthorization for the head CT. -She was waiting for the hospital or PCP to contact her once the preauthorization had been obtained to reschedule the head CT. Telephone interview with a medical scheduler at Resident #1's local hospital on 04/01/21 at 11:51am revealed:	D 273		

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-The RCC called on 03/04/21 to schedule a head CT for Resident #1.
-Resident #1's head CT was scheduled for 03/18/21 at 10:30am
-Resident #1 did not show up for the appointment.
-Resident #1's head CT had not been rescheduled.
-There was no documentation regarding needing insurance authorization prior to the CT scan.

Telephone interview with Resident #1's PCP on 04/01/21 at 12:10pm revealed:
-She ordered a head CT for Resident #1 on 03/02/21 because the resident was on Eliquis and had frequent falls.
-She did not know the resident did not have the head CT performed.
-She expected the facility to have called to reschedule the head CT for the resident.
-She did not know anything about the resident's ordered head CT needing a prior authorization from the insurance company.
-There was nothing documented in the resident's electronic record of the PCP's office indicating a prior authorization was required for a head CT.
-She reviewed the residents electronic prior authorization folder and there was nothing documented regarding prior authorization for a head CT.
-The RCC was told when the resident's head CT was ordered, the resident could have a slow intercranial bleed (ICB) from falls because of taking Eliquis which could progress to a cerebral vascular attack [(CVA) a stroke).
-Signs of an ICB were altered mental status, decreased level of consciousness, headache, and nausea.

A second interview with the RCC on 04/01/21 at

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D 273	Continued From page 40 3:00pm revealed: -She did not have documentation that a prior authorization was needed for Resident #1's head CT. -The representative from Resident #1's local hospital called and gave her a phone number for the resident's PCP to call. -She did not have the telephone number the hospital gave her to call for the preauthorization. -She gave the hospital representative Resident #1's PCP's telephone number to call. Interview with the Administrator on 04/01/21 at 3:18pm revealed: -She took a phone call from the hospital when Resident #1's head CT was canceled and was informed a prior authorization was needed. -She wrote the information on a sticky note and gave it to (named) RCC. -The hospital was to call the facility to reschedule the head CT once prior authorization had been obtained. -It was the responsibility of the hospital to inform Resident#1's PCP the head CT was canceled because the PCP was the one who ordered the head CT. -The RCC was responsible to follow up with the hospital or the PCP to ensure insurance authorization for Resident #1's head CT was obtained. -It was the Administrators responsibility to follow up with (named) RCC to ensure the authorization had been obtained and Resident #1's head CT rescheduled. -There was nothing in place to ensure diagnostic tests were rescheduled if canceled. -A system needed to be put in place to ensure diagnostic tests were rescheduled if canceled to be certain residents received the care they needed.	D 273		

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D 273	Continued From page 41 Telephone interview with Resident #1's family member on 04/05/21 revealed: -The resident fell in January 2021 and suffered a head injury. -He thought the resident had a head CT in March 2021 per the RCC. -He expected the head CT to have been performed. -He expected to have been informed if the head CT had not been performed because he wanted to make sure the resident received appropriate care. Second interview with Resident #1's PCP on 04/06/21 at 3:15pm revealed: -The RCC verbally told her sometime between the "middle of March 2021 to today" (04/06/21) a preauthorization for Resident #1's head CT was needed. -She did not expect the facility to have followed up with the status of Resident #4's head CT because the PCP's office was to schedule the CT scan when preauthorization was received from the insurance company. Based on observations, interviews, and record reviews Resident #4 was not interviewable. 2. Review of Resident #4's FL-2 dated 02/16/21 revealed: -Diagnoses included Alzheimer's Disease, epilepsy (unspecified, not intractable, without status epileptics), anemia, chronic pain due to trauma, and osteoarthritis. -She was constantly disoriented, semi-ambulatory, and passive with activities. Review of Resident #4's current Special Care Unit (SCU) quarterly care plan dated 02/19/21	D 273		

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revealed the resident was afraid and anxious with profound memory loss, contracted muscles, poor swallowing and eating, and limited responsiveness.

Review of Resident #4's emergency department (ED) discharge record dated 11/13/20 revealed:
-The resident was seen post fall at the facility in which she suffered a closed head injury (brain bruising, swelling or tearing, could also cause nerve damage and bleeding around the brain).
-Symptoms the resident could experience from this injury included difficulty concentrating and remembering, changes in personality, being anxious without a clear reason, difficulty standing or walking.

Review of Resident #4's primary care provider (PCP) consultation note dated 11/24/20 revealed an order to monitor the resident for sudden behavior or altered mental status changes.

Review of Resident #4's ED, in-patient, and discharge hospital records dated 12/19/20-01/01/21 revealed:
-The resident was admitted to the hospital after a fall that resulted in a cervical fracture (spinal neck fracture) and she underwent surgical intervention to stabilized her neck and decompress cervical stenosis (narrowing of the area the spinal cord is located in the neck).
-The resident was documented as moaning intermittently but becoming quiet once comfortable during physical therapy (PT) on 12/26/20.
-The resident was documented as severely agitated on 12/28/20 with new seizure activity and a concern she was a risk to her own safety and the safety of others.
-The resident was documented to have increased

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confusion upon discharge back to the facility on 01/01/21.

Review of Resident #4's occupational therapy evaluation dated 02/25/21 revealed the staff reported the resident was agitated and cried throughout the day but was unable to verbalize pain.

Review of Resident #4's PT encounter note dated 03/08/21 revealed:
-The resident spent a good amount of time humming and crying.
-No signs or symptoms of pain could be identified, and it was attributed to behavior and anxiety.

Review of Resident #4's PT encounter note dated 03/09/21 revealed that her treatment session had been complicated by the resident's anxiety, crying, and agitation.

Review of Resident #4's PCP consultation note dated 03/16/21 revealed:
-There was an order to continue the medication Seroquel to manage outbursts of agitation or self-harm.
-There was an order for Norco 5-325mg every 6 hours (a narcotic pain medication).
-There was an order to monitor for sedation effects, worsening behaviors, changes to physical function and pain.

Observation of Resident #4 on 03/31/21 at 1:44pm revealed:
-The resident was in her reclining wheelchair at the nurses' station being supervised by a medication aide (MA).
-The resident was crying and asking to "go home".

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D 273	Continued From page 44 Observation of Resident #4 on 04/01/21 at 12:52pm - 1:00pm revealed: -The resident was sitting in a recliner in her room. -The resident was unable to engage in conversation and kept repeating the word "yeah". -The resident was fidgety and unable to follow verbal commands. -The resident was moaning, tearful, and repeated unknown words. Observation of Resident #4 on 04/01/21 at 2:21pm revealed the resident was in the dayroom in her reclining wheelchair moaning and crying. Observation of Resident #4 on 04/05/21 from 12:35pm-12:50pm revealed: -The resident was in her wheelchair at the staff workstation with MA. -The resident was moaning and unable to be understood when she tried to speak. Interview with a personal care aide (PCA) on 04/01/21 at 12:54pm revealed that Resident #4 cried a lot, but she did not know why. Interview with a second PCA on 04/05/21 at 3:44pm revealed: -Resident #4 normally moaned and cried; this behavior began after her first fall in November 2020. -They tried to calm the resident by keeping her in a recliner or wheelchair. Interview with a third PCA on 04/05/21 at 3:56pm revealed: -Resident #4 used to communicate verbally and be a "helper" prior to her falls that began in November 2020. -Resident #4 began crying and moaning after her	D 273		

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falls began.
-Resident #4 could not tell staff if she was hurting.

Interview with a medication aide (MA) on 04/06/21 at 9:58am revealed:
-Resident #4 was frequently agitated.
-She did not report the agitation to the Special Care Coordinator (SCC) because she assumed that he saw and heard the agitation, crying and moaning too and already knew about it.

Interview with a second MA on 04/06/21 at 9:58am revealed:
-The resident was not agitated every day but was agitated most days.
-She did not work on Tuesdays when the PCP came and never reported the agitation to the SCC; there was no reason why.

Interview with a fourth PCA on 04/06/21 at 9:58am revealed:
-Resident #4 was agitated and moaned most days.
-She does not see Resident #4's PCP and "let the boss handle it".

Interview with the Resident Care Coordinator (RCC) on 04/06/21 at 11:16am revealed:
-She oversaw the SCU when the SCC was out and oversaw the facility when the Administrator was out.
-She would expect the resident's increased agitation to be reported to the RCC or SCC so they could follow up with the resident's provider for other interventions or orders.
-Resident #4's increased agitation, crying and moaing was never reported to her and staff should never assume the PCP was aware.

Interview with the Administrator on 04/01/21 at

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D 273	Continued From page 46 11:30am and 04/06/21 at 12:53pm revealed: -Resident #4 was no longer able to ask staff for help or use a call bell, but before her first fall in November 2020, she would come out and ask staff for help. -Resident #4 cried all day and wanted a hug as a baseline but thought the resident's moaning began after her neck surgery in December 2020. -She would expect new or increased moaning to be reported to the RCC or SCC so they could follow up with the PCP to try and adjust interventions. Interview with Resident #4's Hospice nurse on 04/06/21 at 12:25pm revealed: -Resident #4 was fearful and paranoid of medical equipment. -None of the facility staff had reported agitation or concerns of pain prior to yesterday, 04/05/21. -Last week the facility reported that the resident did not seem to be in pain and agitation had never been a concern the facility reported to hospice. -He would expect to be notified of signs and symptoms of agitation or pain as soon as possible, even after hours, to assess interventions and obtain new orders as needed. -He had not noticed signs of pain on his previous visits with Resident #4. Interview with Resident #4's PCP on 04/05/21 at 8:57am revealed: -She was unaware that Resident #4 cried and moaned as current normal daily behavior. -She would have wanted to be made aware of Resident #4's agitated behavior because the resident could be in pain which could have also contributed to the resident's continued falls. The facility failed to ensure appointments were	D 273		

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D 273	Continued From page 47 kept and rescheduled for a resident with an implantable cardiac device for interrogation to assess the battery life for intervention if the resident went into a fatal cardiac arrhythmia which resulted in the resident's battery being depleted which could result in the defibrillator not firing in a fatal cardiac arrhythmia; a 3 month post-operative appointment for a new implantable cardiac defibrillator with a cardiologist to assess the new device to ensure it was working properly; an appointment for a head CT for a resident who was on a blood thinner and had frequent falls which could result in an intercranial bleeding and stroke (#1); and a resident who was diagnosed with dementia, had multiple falls, sustained a traumatic cervical fracture from a fall who had episodes of agitation which could have been because of pain and contributed to the falls (#4). The failure of the facility resulted in substantial risk of serious injury and neglect of the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/05/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 6, 2021.	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	D 276		

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

Based on observations, interviews, and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#4) who had a history of multiple falls with an order for blood pressure, pulse, temperature, and intake monitoring.

The findings are:

Review of Resident #4's FL-2 dated 02/16/21 revealed:
-Diagnoses included Alzheimer's disease, epilepsy (unspecified, not intractable, without status epilepticus), anemia, chronic pain due to trauma, and osteoarthritis.
-She was constantly disoriented, semi-ambulatory, and passive with activities.
-She was incontinent of bladder and bowel, and on a pureed diet.

1. Review of Resident #4's incident and accident reports, and hospital and resident records revealed:
-The resident sustained 9 falls between 11/13/20-03/12/21.
-The resident sustained injuries from these falls which resulted in multiple head hematomas (bruising) and lacerations (deep cuts), closed

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head injuries (brain bruising, swelling, or tears), intracranial bleeding (brain bleeding), multiple cervical fractures (neck vertebrae fractures), cervical stenosis (narrowing of the spinal cord area in the neck), and a decrease in the resident's ability to function independently.
-The resident was admitted to hospice services on 03/10/21.

Review of Resident #4's inpatient and hospital discharge record dated 11/17/20-11/18/20 revealed:
-The resident was hospitalized after a fall due to suffering a cortical hemorrhage (brain bleed) and head laceration (deep cut).
-The resident experienced bradycardia (low heart rate) during the hospital course.
-The resident was to be monitored post-discharge for bradycardia of less than 40 beats per minute.
-If the resident experienced continued bradycardia, she was to follow up with a cardiologist outpatient.

Review of Resident #4's primary care provider (PCP) consultation note dated 11/24/20 revealed:
-The resident suffered an intracranial bleed due to a fall.
-There was a notation to monitor the resident's vital signs.

Review of Resident #4's physician order dated 11/21/20 revealed:
-There was an order to monitor the resident's blood pressure (BP) and pulse once every shift (3 times per day).
-Staff were to notify the PCP if the BP was less than 100/50 or pulse less than 50.

Attempted review of daily vital sign documentation for Resident #4 was unsuccessful

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due to not being provided by the facility prior to exit on 04/06/21.

Interview with a medication aide (MA) on 04/01/21 at 1:29pm revealed:
-The MAs were responsible for obtaining and documenting vital sign information.
-She was not aware of the BP and pulse orders for Resident #4 and vital signs had not been documented on the resident prior to today, 04/01/21.

Interview with the Special Care Coordinator (SCC) on 04/01/21 at 8:44am revealed:
-He was responsible to read PCP notes to process and implement orders into the electronic medication administration record (eMAR) system.
-The order for BP and pulse were to be documented on the eMAR.
-The order for BP and pulse monitoring was never entered into the eMAR where the staff would know to do it because he missed the order.
-He was responsible for doing record audits every quarter but had not done them since fall 2020.
-If he had done the record audits, he would have caught the oversight of missing the BP and pulse orders.

Review of Resident #4's eMAR revealed there was no documentation of her BP or pulse.

Interview with Resident #4's PCP on 04/05/21 at 8:57am revealed:
-The order to monitor the resident's BP and pulse were because she was concerned the resident was experiencing hypotension (low blood pressure) or bradycardia.
-She was not aware that the order had not been implemented.
-Hypotension or bradycardia could have

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contributed to Resident #4's falls.
-She expected the facility to implement all orders for Resident #4.
-Having results of BP and pulse readings on the resident could have helped her to understand why the resident had been falling.

Refer to the interview with the Administrator on 04/01/21 at 11:30am.

2. Review of Resident #4's diet order dated 08/20/20 revealed the resident was on a regular diet with no restrictions.

Review of Resident #4's current diet order dated 02/15/21 revealed the resident was on a pureed diet due to difficulty swallowing.

Review of Resident #4's primary care provider (PCP) consultation note dated 11/24/20 revealed:
-The resident was seen post-fall after suffering an intracranial bleed.
-The resident was at continued risk of falls, skin breakdown, weight loss, and infections.

Review of Resident #4's PCP consultation note dated 02/16/21 revealed:
-The resident was documented as having a diagnosis of mild protein-calorie malnutrition.
-There was an order for Remeron 15mg to stimulate the resident's appetite.

Review of Resident #4's PCP consultation note dated 02/23/21 revealed:
-The resident continued to be at risk for skin breakdown, infections, and weight loss.
-There was an order to monitor the resident's intake by mouth (PO).

Review of Resident #4's PCP consultation note

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dated 03/09/21 revealed:
-The resident remained at risk of aspiration, skin breakdown, and weight loss.

Review of Resident #4's occupational therapy (OT) notes dated 02/25/21-03/17/21 revealed:
-The resident had decreased upper body strength and difficulty with self-feeding.
-Risk factors associated with the resident's assessment included anxiety, falls, muscle atrophy, immobility, compromised general health, dehydration, weight loss and malnutrition.
-The resident required assistance with hand to mouth feeding and extended time for safe swallowing.

Interview with a MA on 04/05/21 at 4:13pm revealed:
-Resident #4 changed, going from independent to dependent, after the fall that injured her neck.
-Resident #4 now required total care and was incontinent, immobile, and unable to feed herself; "she wouldn't eat if we didn't' feed her".

Interview with a MA on 04/01/21 at 1:29pm revealed:
-The MAs or personal care aides (PCA) would help feed Resident #4.
-There was no order that she was aware of to document Resident #4's intake by mouth.

Interview with the Special Care Coordinator (SCC) on 04/01/21 at 8:44am revealed:
-He was responsible to read PCP notes to process and enter orders into the electronic documentation system.
-The medication aide (MA) or the personal care aides (PCA) were responsible to monitor Resident #4's meal intake and document the intake on the activity of daily living (ADL) log.

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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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-He missed the order in Resident #4's PCP notes to monitor intake and did not implement it.
-He was responsible for doing record audits every quarter but had not done them since fall 2020.
-If he had done the record audits, he would have caught the oversight of missing the intake order.

Review of Resident #4's ADL logs on 04/01/21 at 1:29pm revealed that there was no documentation of intake by mouth monitoring for the resident.

Interview with Resident #4's PCP on 04/05/21 at 8:57am revealed:
-She was not aware that the intake by mouth order had not been implemented but was aware the resident had lost weight.
-She would have added nutritional supplements if she knew whether the resident's intake was low.
-Low intake could contribute to weight loss, delayed wound healing and increased risk of infection.

Review of Resident #4's resident record revealed:
-The resident's weight was documented at 114 pounds on 12/21/20.
-The resident's weight was documented at 97 pounds on 03/09/21.
-The resident experienced a 17-pound weight loss in less than 3 months.

Refer to the interview with the Administrator on 04/01/21 at 11:30am.

3. Review of Resident #4's physician order dated 05/05/20 revealed:
-There was an order to monitor the resident's temperature twice per day.
-Staff were to notify the primary care provider (PCP) of a temperature great than 100.1 F.

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D 276	Continued From page 54 Review of Resident #4's PCP consultation note dated 12/01/21 revealed a treatment plan that included monitoring the resident's temperature. Attempted review of daily vital sign documentation for Resident #4 was unsuccessful do to not being provided by the facility prior to exit on 04/06/21. Interview with a medication aide (MA) on 04/01/21 at 1:29pm revealed: -The MAs were responsible for obtaining and documenting vital sign information, including temperatures. -She was not aware of the temperature order for Resident #4 and that data had not been documented prior to today, 04/01/21. Interview with the Special Care Coordinator (SCC) on 04/01/21 at 8:44am revealed: -He was responsible to read PCP notes to process and enter orders into the electronic documentation system. -The order for temperatures were to be documented on the electronic medication administration record (eMAR). -The order for Resident #4's temperature monitoring was never entered into the eMAR where the staff would know to do it because he overlooked the order. -He was responsible for doing record audits every quarter but had not done them since fall 2020. -If he had done the record audits, he would have caught the issue of missing the temperature order. Review of Resident #4's eMAR for January, February, and March 2021 revealed there was no documentation of temperature monitoring twice	D 276		

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D 276	Continued From page 55 per day for the resident as ordered. Interview with Resident #4's PCP on 04/06/21 at 3:08pm revealed: -She expected orders for the resident to be implemented and carried out. -She expected the facility to call her for temperatures outside of ordered parameters. -She would have wanted to have known if Resident #4 had a temperature to rule out issues such as urinary tract infection, pneumonia, pain, bed sores, and infection to decrease her agitation. -Having temperature readings on the resident would have helped her to decrease the resident's agitation and understand why the resident had been falling. Refer to the interview with the Administrator on 04/01/21 at 11:30am. _____ Interview with the Administrator on 04/01/21 at 11:30am revealed: -The SCC was responsible to pull orders from PCP notes and implement them within 24 business hours. -The SCC was expected to audit all records every 6 months and would have expected him to have completed all residents' audits by that time. -Record auditing was a process the facility had in place to ensure residents' orders were accurate. -If record audits had been completed, the missing orders for Resident #4 would have been identified. _____ The facility failed to ensure implementation of blood pressure, pulse, temperature, and recording of daily intake by mouth orders for Resident #4, which resulted in the resident being at increased risk of falling, and had experienced 9	D 276		

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D 276	Continued From page 56 falls; increased risk of weight loss, and had experienced a 17-pound weight loss within a 3-month period; increased risk of delayed wound healing and infection; and experienced a status deterioration within a 4-month period. 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 accordant with G.S. 131D-34 on 04/05/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 21, 2021.	D 276		
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 and interviews, the facility failed to ensure residents received a napkin and non-disposable place setting consisting of at least a knife, fork, and spoon for use during meals.	D 287		

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D 287	Continued From page 57 The findings are: Review of the facility week-at a-glance breakfast menu posted in the kitchen on 03/31/21 revealed scrambled eggs or egg of choice, breakfast ham, and fresh fruit was to be served. Observations of the kitchen for breakfast service on 03/31/21 from 7:53 am - 8:05am revealed: -The plates were prepped by the kitchen manager, and eating utensils placed on the trays by the dietary aide. -Scrambled eggs, sausage patties, chopped sausage patties, grits, oatmeal, and biscuits were being served. -Some plates that were prepared with eggs, whole sausage patties, grits, and a biscuit were given a fork only. -Some plates that were prepared with scrambled eggs, oatmeal, chopped sausage patty, and a biscuit were given a fork and spoon only. -There was no consistency in the silverware provided for the breakfast meal. -There were two plates per tray; the trays were placed on the meal cart by the dietary aide. -There were no napkins placed on the food trays. -The meal cart was transported to the Assisted Living (AL) unit by the dietary aide. Observations of the AL unit during breakfast service on 03/31/21 from 8:05am - 8:25am revealed: -The personal care aides (PCA) distributed the assigned plates to the residents. -The PCAs would take the eating utensils placed on the tray by the resident's assigned plate on the resident's plate when distributing the plates. -The residents did not receive a complete set of eating utensils to include a fork, spoon, and knife and/or butter knife.	D 287		

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D 287	Continued From page 58 -There were no napkins provided to the residents. -There were no napkins on the food cart. Observation of a resident in the AL unit on 03/31/21 at 8:20am revealed: -The resident had a roll of thin toilet paper on his nightstand where he was eating. -The resident wrapped the toilet paper around his hand, tore it off the roll, and wiped his hands. Interview with the first resident in the AL unit on 03/31/21 at 8:20 am revealed: -Napkins were not provided with breakfast, lunch, or dinner since the COVID-19 epidemic. -He would like to use a napkin instead of toilet paper to wipe his hands and mouth. -The toilet paper was thin and would shred easily. -It was disrespectful to have to use toilet paper to wipe his hands and mouth when eating. Observation of a second resident in the AL unit on 03/31/21 at 8:25am revealed: -The resident had a roll of disposable bathroom paper on his nightstand. -He tore a section of the disposable paper from the roll and wiped his hands. Interview with the second resident in the AL on 03/31/21 at 8:25am revealed: -He took the roll of disposable bathroom paper from the bathroom to use it to wipe his hands and mouth when eating. -The facility had not provided napkins to residents with meals since the COVID-19 epidemic. Observation of the Special Care Unit (SCU) dining room on 03/31/21 from 8:01am-8:11am revealed: -There were six residents seated at individual tables that were socially distanced more than six	D 287		

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feet apart.
-There was a beverage pushcart that contained several empty drinking glasses, two pitchers of water with ice, a pitcher of orange juice and a pitcher of milk.
-The beverage cart did not have spoons, knives or napkins on the cart.

Observation of two PCAs entering the SCU dining hall on 03/31/21 at 8:01am revealed:
-The PCAs served the residents their breakfast meal.
-The residents were given a fork to use to eat their meal.
-Residents were served with grits or oatmeal.

Interview with the Special Care Coordinator (SCC) on 03/31/21 at 8:12am revealed residents were to have napkins to be able to wipe their hands and mouth during their meals.

Interview with the Resident Care Coordinator (RCC) on 03/31/21 at 8:30am revealed:
-She did not know residents were not provided napkins with their meals.
-She did not know a resident was using toilet paper to wipe his hands and mouth when eating meals.
-She did not know residents were not provided a spoon or knife with their breakfast this morning on 03/31/21.
-Residents should be served a knife, spoon, and fork with each meal regardless of what was being served because staff did not know each residents' utensil preference with meals.

Interview with the Dietary Manager on 03/31/21 at 8:50am revealed:
-Napkins were available to provide to residents with all their meals.

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D 287	Continued From page 60 -It was the responsibility of the kitchen staff to ensure napkins were provided for the PCAs to provide to the residents with every meal. -Residents were not being provided napkins with their meals when he started in August 2020; he did not know why. -The kitchen staff was not providing residents napkins with their meals when he started, therefore he did not provide the residents with napkins. -Residents were not provided a complete set of eating utensils to consist of a spoon, fork, and knife since he started in August 2020. -He was told by the dietary aides to only serve eating utensils according to the meal's residents were served when he first started. Interview with the Administrator on 03/31/21 at 9:17am revealed: -All residents were supposed to be served a fork, spoon, knife, and napkin with every meal. -It was the responsibility of the dietary aide and Dietary Manager to place a fork, spoon, and knife for each resident on the resident's trays when served meals. -She did not know a resident used toilet paper to wipe his hands and mouth with when eating. -It was the responsibility of the Administrator to ensure kitchen staff were providing residents with a fork, spoon, knife, and napkins. -She would walk the hall during mealtimes to ensure residents were served meals within a timely manner. -She had never noticed residents were not provided a napkin or full set of eating utensils. -She last observed the lunch meal on the AL hall 03/30/21; she did not notice if residents had a full set of eating utensils or napkins. -The kitchen was stocked with enough silverware and napkins to serve the residents.	D 287		

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D 287	Continued From page 61 -She had never noticed a full set of silverware or napkins not being placed on resident trays in the kitchen.	D 287		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure water was served with meals to all residents. The findings are: Review of the week-at-glance menu posted in the kitchen on 03/31/31 revealed: -There was a listing for 100% juice and milk for the breakfast meal. -There was a listing for a beverage of choice for the lunch meal. -There was no water listed on the menu on any day of the week to be served at either of the three meal deliveries. Interview with the Dietary Manager on 03/31/21 at 7:27am revealed all residents in the Assisted Living (AL) unit were being served each meal in their rooms.	D 306		

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D 306	Continued From page 62 Observation of the breakfast beverage cart in the AL unit on 03/31/21 at 7:30am revealed: -On the top of the cart was a 1 gallon container of water that was approximately 40% full, 1 gallon of milk, 1 gallon of cranberry juice, 1 gallon of orange juice, 1 gallon of apple juice, 1 manufacturer container of pre-thickened nectar thick orange juice, 1 manufacturer container of pre-thickened nectar thick water, a bowl of ice, and several hard plastic drinking glasses. -On the bottom of the cart were several empty coffee cups. Observation of 2 personal care aides (PCA) in the AL unit on 03/31/21 at 7:33am revealed: -The PCAs went room to room serving breakfast beverages from the same beverage cart to 8 residents on the 200 hall of the AL unit. -Water was not served by the PCAs to 7 of the 8 residents for breakfast on the 200 hall of the AL unit. -Nectar thickened water was not served to any resident. Observations of the same 2 PCAs in the AL unit on 03/31/21 at 7:45am revealed: -The PCAs went room to room serving breakfast beverages from the same beverage cart to 17 residents on the 100 hall of the AL unit. -Water was not served by the PCAs to 16 of 17 residents for breakfast on the 100 hall of the AL unit. -Nectar thickened water was not served to any resident. Observation of the lunch service in the AL unit dining room on 03/31/21 at 12:10pm revealed: -There was a beverage cart positioned by the entrance to the kitchen through the dining room. -On the top of the cart was a 1-gallon container of	D 306		

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water approximately 25% full, 6 glasses of water, a gallon of tea, two juice containers, and 10 glasses of tea.
-There were 11 total residents seated in the dining room.
-One of the 11 residents were served water with their lunch meal.
-Water was not served to 10 of 11 residents during the lunch meal.

Interview with a resident on the AL unit during the lunch meal on 03/31/21 at 12:20pm revealed:
-She was not offered water with her lunch meal.
-She would not drink water if offered with her lunch meal.

Observation of the Special Care Unit (SCU) dining room on 03/31/21 from 8:01am-8:11am revealed:
-There were six residents seated at individual tables.
-There was a beverage pushcart that contained several empty drinking glasses, two pitchers of water with ice, a pitcher of orange juice and a pitcher of milk.
-Six of 6 residents were not served water.

Observation of the SCU dining room on 03/31/21 at 12:52pm for the lunch meal service revealed:
-There were five residents seated in the dining hall at five separate tables.
-There was a beverage pushcart that contained empty drinking glasses, a pitcher of tea and a pitcher of water with ice.
-The remaining residents were served water.

Interview with a resident on 03/31/21 at 11:43am revealed:
-He was not served water with his meals.
-He thought water was not offered to him

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because he at his meals in his room.
-He filled empty bottles of water and kept in his room because water was not served with meals.

Interview with a resident in the AL unit on 03/31/21 at 12:40pm revealed:
-He was not offered water with his breakfast or lunch meal.
-He would have to ask for water with meals.
-Water would be provided to him if he asked.

Interview with a PCA in the AL unit on 03/31/21 at 7:50am revealed:
-She had never served water to every resident.
-She did not serve water to every resident with all meals because she had never been told to do so.
-She knew which residents liked water because of repetition when passing beverages to the residents with their meals.

Interview with the second PCA in the AL unit on 03/31/21 at 7:52am revealed:
-She had never been told to serve water to residents with every meal.
-She did not know residents were to be served water with every meal.
-She did not serve water to every resident with every meal.
-She had never served water with meals to every resident.

Interview with a PCA on 03/31/21 at 8:12am revealed:
-The PCAs were responsible for serving the residents meals including beverages.
-There was always water on the beverage cart to be served to residents.
-She only gave the residents juice with their meals.
-She served the residents water if they asked for

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D 306	Continued From page 65 a glass of water. Interview with the Dietary Manager on 03/31/21 at 7:25am revealed: -The dietary aide would prepared the beverage cart for the SCU and Assisted Living Unit (AL). -The dietary aide would transport the beverage cart to the SCU and AL for the PCAs to serve beverages. -The beverage cart always had at least one pitcher of water to serve to the residents. A second interview with the Dietary Manager on 03/31/21 at 7:56am revealed: -He did not know water was not being served to every resident with each meal. -All residents were to be served water with every meal by the PCAs. -It was expected the PCAs to automatically serve water to every resident with every meal. -He had never told the PCAs to serve water to every resident with every meal. Interview with the Resident Care Coordinator (RCC) on 03/31/21 at 8:30am revealed: -Some residents did not like water. -Staff were expected to automatically serve water to the residents even if the residents did not like water. -There was a container of water located on the entrance of the 200 hall on the AL unit residents were able to use if they wanted water. Interview with the Administrator on 03/31/21 at 9:17am revealed: -She did not know the residents were not being served water with every meal. -Water was to automatically be served to every resident with every meal. -The PCAs should serve water to every resident	D 306		

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D 306	Continued From page 66 with every meal without asking if the they wanted the water. Interview with a second PCA on 03/31/21 at 1:11pm revealed. -The PCAs were responsible for serving the residents beverages with their meals. -She would only serve residents water if they asked for a glass of water. -She had only served tea to the residents with their meal. -There was water available if the residents wanted to drink water. Interview with the Special Care Coordinator (SCC) on 04/05/21 at 11:53am revealed: -Water was supposed to be served with all meals. -The PCAs served the meals along with beverages to the residents. -The PCAs could had call dietary and asked for water if none was available on the unit. -He expected the residents to be offered water with each meal because it could prevent dehydration and urinary tract infections. -Some of the residents residing on the SCU could not ask for water, so water should have been given to those residents.	D 306		
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: Based on observations, interviews, and record reviews, the facility failed to ensure resident were	D 338		

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treated with respect and dignity providing each resident with tray tables.

The findings are:

a. Observations of the Assisted Living (AL) unit breakfast meal served on 03/31/21 from 7:53am - 8:30am revealed:
-The plates were prepped by the kitchen manager and then placed in a serving cart by the dietary aide from 7:53am - 8:05am.
-The serving cart was pushed to the 200 hall on the Assisted Living (AL) unit by the dietary aide.
-There were 2 PCAs who began passing breakfast plates to the residents on the 200 hall located on the AL side at 8:10am.
-The breakfast plate for the resident in room #104 was placed on the nightstand; there was no tray table.
-The breakfast plate for the first resident in room #106 was placed on an end table across from the bed; there was no tray table.
-The second resident in room #106 was eating with the plate in his lap; there was no tray table.
-One resident in room #105 was eating with his table on a plastic storage bin; there was no tray table.
-One resident in room #107 was eating with his plate in his lap; there was no tray table.
-The first resident in room #111 was eating with his plate in his lap; there was no tray table.
-The plate for the second resident in room #111 was placed in a chair beside a pack of opened adult incontinent briefs.

Interview with a resident in the AL unit on 03/31/21 at 8:20am revealed:
-The facility did not provide tray tables to eat from.
-He would eat his meals from his bed.

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D 338	Continued From page 68 -He would like a tray table to eat from so he would not have to eat his meals from his bed. Interview with a second resident in the AL unit on 03/31/21 at 8:25am revealed: -He had never had a tray table to eat on since being served meals in his room. -He would eat from his nightstand when served meals. -He would like to have a tray table to eat his meals on instead of using his nightstand. Interview with a third resident in the AL unit on 03/31/21 at 9:30am revealed their family member provided a tray table for her to eat meals from instead of having to hold the plate or use the nightstand. Observation of a resident on SCU in their room on 03/31/21 at 8:16am revealed: -The PCA handed the resident his food. -The resident placed his food on his bed. -The resident placed his orange juice on his nightstand. Interview with the resident on the SCU on 03/31/21 at 8:17am revealed: -He did not have a tray table to place his food and beverage on. -He had "gotten use" to eating in his room when residents could not eat in the dining room because of COVID-19. -Staff had not offered him a tray table to place his food on. Interview with the medication aide (MA) on the SCU on 03/31/21 at 8:12am revealed: -The residents did not have tray tables. -Some of the residents ate their meals in their rooms.	D 338		

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D 338	Continued From page 69 -The residents who ate their meals in their rooms "could" use the nightstand to put their food on. Interview with the Resident Care Coordinator (RCC) on 03/31/21 at 8:30am revealed: -The facility did not have tray tables for the residents. -Residents had been eating on their laps, bed, nightstands, or a tray table purchased by the resident or their family since March 2020. Interview with the Dietary Manager on 03/31/21 at 8:50am revealed he had never seen tray tables in resident rooms. Interview with the Administrator on 03/31/21 at 9:17am revealed: -She did not know residents' plates were being placed in chairs in the resident's rooms. -She did not know residents were eating from plastic storage bins in their rooms. -Some residents family members had provided personal tray tables for the residents to use with meals. -Plates for residents who did not have tray tables were placed on the resident's nightstands. -If the resident did not have room on their nightstands for a plate, the PCAs were expected to clean off the nightstands to make room.	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	D 358		

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which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

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

Based on observation interviews, and record reviews, the facility failed to administered medications as ordered and in accordance with the facility's policies for 2 of 3 residents (#7 #8) observed during the medication passes including errors with an inhaler, a calcium supplement not given with meals, and not having eye drops available; and for 2 of 5 residents sampled (#4, #1) for record review including errors with medications for pain and agitation (#4) and for heartburn medication not available for administration (#1).

The findings are:

1.The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the 8:00am/9:00am medication pass on 03/31/21.
a. Review of Resident #7's current FL-2 dated 07/30/20 revealed diagnoses included dementia, anemia, end stage renal disease, and cardiomyopathy.
Review of Resident #7's physician order dated 03/02/21 revealed there was an order for Breo-Ellipta inhaler 1 inhalation by mouth every day, rinse mouth after use. (Breo- Ellipta is used to treat chronic pulmonary disease).

Observation of the 8:00am medication pass on 03/31/21 revealed:
-The medication aide (MA) gave the inhaler to

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Resident #7 and he took two inhalations.
-The MA did not instruct Resident #7 to only take one inhalation.
-Resident #7 did not rinse his mouth after using the inhaler.
-The MA did not instruct Resident #7 to rinse his mouth.
Review of Resident #7's March 2021 electronic medication administration record (e-MAR) revealed:
-There was an entry to administer Breo -Ellipta inhalation administer 1 inhalation by mouth every day, rinse mouth after use.
-The Breo -Ellipta inhaler was scheduled to be administered at 8:00am.

Interview with the MA on 03/31/21 at 11:59am revealed:
-Resident #7 was to "swish and spit after using the inhaler".
-She did not ask Resident #7 to rinse his mouth after he used the inhaler because he did not want to rinse his mouth.
-Resident #7 had told her when she had given him his inhaler before he did not want to rinse his mouth.
-She did not instruct him to not take two inhalations. She did not know why.

Interview with the Resident Care Coordinator (RCC) on 03/31/21 at 12:23pm revealed:
-The MA should read the order before giving the medications.
-The medications should be given as ordered.
-The MA should have instructed Resident #7 on how many inhalations to take and to rinse his mouth.

Interview with the Administrator on 03/31/21 at 12:59pm revealed:

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- She expected all medications to be administered as ordered.
-The order should be read and followed.
-She should have encouraged Resident #7 to rinse his mouth after using the inhaler and to only take 1 inhalation.
-She should have held the inhaler for him.

A second interview with the MA on 03/31/21 at 1:38pm revealed:
-Resident #7 would refuse to rinse his mouth after he used the inhaler.
-She had not notified the primary care physician (PCP) that Resident #7 refused to rinse his mouth after he used his inhaler.
-The MA did not normally notify the PCP, but she could.
- When the RCC was there she usually notified the PCP.
-She should have let the RCC know about Resident #7 refusing to rinse his mouth after using the inhaler, but she had not.

Interview with primary care provider (PCP) on 03/31/21 at 3:31pm revealed:
-She had a concern about Resident #7 taking two inhalations of the inhaler because he would be getting too much.
-She did not think he could administer the inhaler correctly without some help due to his diagnoses of dementia.
-Resident #7 should be instructed to rinse his mouth after using the inhaler because it could cause oral issues over time such as gum problems, cancer, thrush, ulcerations.
-She expected the MA to encourage rinsing after every dose and expected to be contacted if Resident #7 refused medications or rinsing via a form she would have to sign.
-She was at the facility every Tuesday and was

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not aware of Resident #7 refusing to rinse his mouth.

Interview with Resident #7 on 04/01/21 at 12:53pm revealed:
-He liked to hold the inhaler himself.
-He would sometimes take two inhalations because he felt like he needed it.
-He had never reported needing more medication to the MA or the PCP.
-He did not know the inhaler was ordered as 1 inhalation.
-He did not always rinse his mouth after using the inhaler because he would eat breakfast soon after.
-He knew he was suppose to rinse his mouth after the inhaler.

b. Review of Resident #7's current FL-2 dated 07/30/20 revealed diagnoses of dementia, anemia, end stage renal disease, and cardiomyopathy.
Review of Resident #7's physician order dated 03/02/21 revealed an order for Calcium acetate capsule 667mg take 1 capsule three times a day with meals. (Calcium acetate is used as a supplement to control the level of phosphate in the blood for patients on dialysis).
Observation of the 8:00am medication pass on 03/31/21 revealed:
-The medication aide (MA) gave Resident #7 his calcium at 7:29am.
-Resident #7's breakfast had not been delivered.

Review of Resident #7's March 2021 electronic medication administration record (e-MAR) revealed:
-There was an entry to administer Calcium Acetate (phosphate binder) 667 mg take 1 capsule three times a day with meals.

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D 358	Continued From page 74 -Calcium Acetate was scheduled to be given at 7:00am, 12:00pm, and 5:00pm. Observation of Resident #7 on 03/31/21 at 8:10am revealed he was eating his breakfast in his room. Interview with the MA on 03/31/21 at 11:59am revealed: -She was not aware Resident #7 had a medication that was to be served with meals. -She did not read the instructions on the eMAR before giving the calcium. -She should have read the instructions. Interview with the Resident Care Coordinator (RCC) on 03/31/21 at 12:23pm revealed: -Resident #7's calcium was in his multidose pack. -It should be given when he got his meal. -The calcium was a phosphate binder and needed to be given with meals because of his dialysis. -The MA should be checking the order before giving medications because the order may had changed. Interview with the Administrator on 03/31/21 at 12:59pm revealed: -She expected all medications to be administered as ordered. -Each order on the eMAR should be read as the medication was being prepared and should be followed. -She would have expected the MA to wait and give the Calcium Acetate with the meal. Interview with primary care provider on 03/31/21 at 3:31pm revealed: c. Review of Resident #8's current FL-2 dated 02/23/21 revealed diagnoses of depressive	D 358		

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D 358	Continued From page 75 disorder, rhinitis, anxiety disorder, and psychosis. Review of Resident #8's physician order on 02/23/21 revealed there was an order for Restasis 0.05% instill 1 drop into both eyes twice daily. (Restasis is used to treat chronic dry eye). Observation of the 8:00am medication pass on 03/31/21 revealed: -There was no Restasis on the medication cart for Resident #8. -There was no Restasis located in the backup stock for Resident #8. Review of Resident #8's March 2021 electronic medication administration record (e-MAR) revealed: -There was an entry to administer Restasis 0.05% instill 1 drop into both eyes twice daily. -Restasis was scheduled to be given 8:00am and 8:00pm. -Restasis was circled as not given at the 8:ooam dose for 03/31/21. Interview with the MA on 03/31/21 at 7:22 am revealed: -There was no way in the eMAR system to tell if the medication had been reordered. -The medication was to be reordered when there was seven days left of the medication. -She told the Resident Care Coordinator (RCC) today the Restasis needed to be reordered. -She had not let her know prior to today the Restasis needed to be reordered. -She had not filled out a reorder form for the Restasis for Resident #8. Interview with the RCC on 03/31/21 at 8:00am revealed: -There was a form on the end of the shift report that was kept on the medication cart to use to	D 358		

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reorder medications.
-The MA was to turn this form into her or tell her verbally after doing a cart audit what medications needed to be reordered.
-The MA was to let her know when the medication was down to three -five-day supply left.
-When the medication was ordered in the mornings the facility would receive it the same day.
-When the medication was ordered in the afternoon the facility would receive it the next day.
-She had not received a form for reordering Restasis eye drops for Resident #8.
-She was made aware the Restasis needed reordering yesterday.
-She had access to order medications online, so she reordered the Restasis.
-When the medication came in the MA or one of the managers (RCC or Special Care Unit Coordinator (SCC), or the Administrator would sign for the medication and load them into the medication cart.
-Medication cart audits were to be completed weekly and turned into the RCC.
-It was her responsibility to order medications and make sure residents had medications.

Interview with the Administrator on 03/31/21 at 9:57am revealed:
-The RCC had a reordering process for medications.
-When the medication was down to five days left the MA pulled the sticker and put it on a reorder form and faxed to the pharmacy
-There were cart audits completed weekly to try and prevent residents from running out of medications.
-She expected the process to be followed so that residents would not be out of their medications.
-The residents needed their medications if not the

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doctor would not have ordered them.

Telephone interview with Resident#8's PCP on 04/01/21 at 1:29pm revealed:
-She would expect residents to get their medications as ordered.
- Restasis was given to Resident #8 for dry eyes so not getting them my cause her eyes to be drier.

2. Review of Resident #4's current FL-2 dated 02/16/21 revealed:
-Diagnoses included Alzheimer's Disease, epilepsy (unspecified, not intractable, without status epilepticus), anemia, chronic pain due to trauma, and osteoarthritis.
-She was constantly disoriented, semi-ambulatory, and passive with activities.

Review of Resident #4's current Special Care Unit (SCU) quarterly care plan dated 02/19/21 revealed the resident was afraid and anxious with profound memory loss, and limited responsiveness.

Review of Resident #4's previous SCU quarterly care plan dated 10/25/20 revealed the resident was very friendly, had no behavior issues, and was encouraged to attend social activities.

a. Review of Resident #4's emergency department (ED), inpatient, and discharge hospital records dated 12/19/20-01/01/21 revealed:
-The resident was admitted to the hospital after a fall that caused her to have a cervical fracture (neck fracture) and she underwent surgical intervention to stabilized her neck and decompress cervical stenosis (narrowing of the area the spinal cord is located in the neck).

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D 358	Continued From page 78 -The resident was discharged back to the facility on 01/01/21 with an order for Norco 5-325mg (narcotic pain medication), take one tablet every six hours. Review of Resident #4's primary care note (PCP) dated 01/05/21 revealed: -The resident was documented as having chronic pain due to trauma. -There was an order for Norco 5-325mg, take ½ tablet every 8 hours to manage pain. Review of Resident #4's PCP note dated 02/09/21 revealed: -There was an order to discontinue the Norco 5-325mg, ½ tab every 8 hours. -There was an order for Norco 5-325mg, take one tablet every 6 hours to manage pain. Review of Resident #4's occupational therapy evaluation dated 02/25/21 revealed the staff reported the resident cried throughout the day but was unable to verbalize pain. Review of the facility's medication management procedure revealed: -Medication cart audits were to be performed weekly every Wednesday to ensure medications were on hand and available to the resident for administration. -The facility was to ensure all "held per MD order" exceptions had a corresponding physician order. -The facility was to ensure the PCP was notified for all medications that were missed greater than 3 doses. -Omitting medication doses or administered medications to the wrong resident were considered medication errors. Review of Resident #4's physician order dated	D 358		

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D 358	Continued From page 79 02/10/21 revealed: -There was an order for Norco 5-325mg, 1 tablet every 6 hours for chronic pain due to trauma. -The medication was timed to be given at 12:00am, 6:00am, 12:00pm, and 6:00pm. Review of Resident #4's electronic medication administration record (eMAR) for February 2021 revealed: -There was an entry for Norco 5-325mg ½ tablet every 8 hours for chronic pain due to trauma. -The medication was scheduled to be administered at 12:00am, 8:00am, and 4:00pm around the clock. -There was a new entry on 02/10/21 for Norco 5-325mg, 1 tablet every 6 hours for chronic pain due to trauma and the entry for Norco 5-325mg ½ tablet every 8 hours was discontinued. -The medication was documented as "Not Administered: On Hold" for seven doses from 02/06/21 at 12:00pm - 02/08/21 at 8:00am. -There was no entry to hold the medication. -The medication was resumed and administered on 02/08/21 at 4:00pm until an updated order took place on 02/10/21. -Resident #4 missed 7 out of 102 doses of her Norco 5-325mg pain medication in February 2021. Review of Resident #4's record revealed there was no PCP order to hold the Norco in the month of February 2021 or on 02/06/21-02/08/21. Review of Resident #4's eMAR dated March 2021 revealed: -There was an entry for Norco 5-325, 1 tablet every 6 hours for chronic pain due to trauma. -The medication was scheduled to be administered at 12:00am, 6:00am, 12:00pm, and 6:00pm.	D 358		

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-The medication was documented as "Not Administered: On Hold" for 2 doses on 03/13/21 at 12:00pm and 6:00pm.
-The medication was documented as administered for one dose on 03/14/21 at 12:00am that was not calculated to have been on hand per the medication control log.
-The medication was documented as "Not Administered: On Hold" for 11 doses on 03/14/21 at 6:00am - 03/16/21 at 6:00pm.
-The medication was documented administered for 23 doses from 03/17/21 at 12:00am - 03/23/21 at 12:00pm.
-The medication was documented as "Not Administered: On Hold" for 3 doses on 03/23/21 at 6:00pm - 03/24/21 at 6:00am.
-The medication was documented as "Not Administered: On Hold" for 1 dose on 03/31/21 at 6:00pm.
-There was no entry to hold the medication.
-Resident #4 missed 17 out of 124 scheduled doses of her Norco 5-325mg pain medication in March 2020.

Review of Resident #4's record revealed there was no PCP order to hold the Norco for the month of March 2021.

Review of the prescription dispense logs from the facility's contracted pharmacy dated 01/05/21 revealed:
-There were 45 tablets of Norco 5-325mg dispensed for Resident #4 on 01/05/21 at 8:25pm.
-The facility was due to run out of medication for Resident #4 on 02/06/21 per PCP administration orders.

Interview with a pharmacy technicican from the facility's contracted pharmacy on 04/01/21 at

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D 358	Continued From page 81 4:25pm revealed: -The pharmacy received an e-scribed order of Norco 5-325mg for Resident #4 on 02/09/21 at 6:31pm and delivered 120 tablets on 02/10/21 at 3:15pm; the facility was due to run out on 03/11/21. -The pharmacy received an e-scribed order of Norco 5-325mg for Resident #4 on 03/16/21 and delivered 28 tablets to the facility on 03/16/21 at 2:38pm; the facility was due to run out on 03/23/21. -The facility requested a refill Norco 5-325mg for Resident #4 on 03/23/21 and delivered 28 tablets on 03/24/21 at 9:05am; the facility was due to run out on 03/31/21 at 12:00pm. -The pharmacy received an e-scribed order of Norco 5-325mg for Resident #4 on 03/30/21 and delivered 56 tablets on 03/31/21 at 11:15am. -Facility requested refills received by the pharmacy at 12:00pm would have been delivered on the same evening. -New prescriptions received by 5:00pm would have been delivered on the same evening. -If a new a prescription was received after 5:00pm, it would have been delivered the following day. Interview with a medication aide (MA) on 04/01/21 at 1:29pm and on 04/05/21 at 12:35 revealed: -Medications were documented as "Not Administered: On Hold" when the facility ran out of the medication; this documentation was not used for any other reason. -She would let the Special Care Coordinator (SCC) know when a medication needed to be reordered. -It did not take more than 2 days to receive a medication when reordered. -Resident #4's missed doses of Norco 5-325mg	D 358		

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was because there was no medication on hand.
-When Resident #4 received the Norco 5-325mg dose on 03/14/21 that was not calculated to be on hand, the staff had probably borrowed it from another resident.
-Resident #4 experienced pain and she was concerned that the resident was going without pain medication due to the resident being unable to verbalize her pain or ask for medication.

Interview with a second MA on 04/05/21 at 11:38am and 4:13pm revealed:
-MAs were responsible to reorder medications 5-7 days before a resident ran out.
-There was a reorder sheet on the medication cart that was faxed to the pharmacy or given to the SCC at the end of each day to reorder medications for each resident when they had 8 or less doses left.
-Staff would document "Not Administered: On Hold" if a medication had run out for a resident.
-Resident #4's medication ran out because it didn't get ordered in time; she was out of town on those dates.
-Sometimes staff would borrow medications from other residents if they ran out of a medication.
-There was a process with paperwork to document borrowing medications if staff were to do that.

Interview with the SCC on 04/01/21 at 2:24pm and 04/05/21 at 11:58am revealed:
-"Not Administered: On Hold" documentation on eMAR meant that a medication was out of stock and needed to be refilled.
-Resident #4 did not get her medication as ordered on the dates "Not Administered: On Hold" were documented on the resident's eMAR because the MA did not communicate that the medication needed to be reordered.

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-There was no "hold" order on file for Resident #4 to not administer the medication as ordered.
-Resident #4's medication should not have run out prior to reordering the medication.
-The MA was supposed to re-order medications when a resident had 8 doses left and let him know it had been done, but they did not always follow through.
-He did not know why staff did not report medications for Resident #4 needed to be re-ordered prior to her running out of medication.
-The MA or the SCC were supposed to call the PCP when a resident was out of medication.
-If staff borrowed a medication from another resident to administer to Resident #4, they should have filled out a documentation form to verify that and then given it to him.
-There was no documentation that staff borrowed medication from another resident to give to Resident #4 on file.
-Staff were supposed to ask him to borrow medications from other residents - even after hours.
-Resident #4 was probably in pain on the days she went without her medication as ordered.
-He did not notify the PCP that Resident #4 missed more than 3 doses of her medication.

Interview with Resident #4's PCP on 04/05/21 at 8:57am and 04/06/21 at 3:08pm revealed:
-She was not aware that Resident #4 was intermittently going without the Norco 5-325mg medication.
-She expected the facility to call her prior to the medication running out for a refill.
-She expected the resident's medications to be in stock, not run out, and administered as ordered.
-She would want to be notified if the resident missed more than 4 doses of medication.
-Resident #4's agitation and crying could have

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been related to the resident missing the Norco doses because she was probably in pain.
-She would not want the facility to give Resident #4 another resident's Norco because it may not be the same dose.

b. Review of Resident #4's emergency departmetn (ED), in-patient, and discharge hospital records dated 12/19/20-01/01/21 revealed:
-The resident was admitted to the hospital after a fall that caused her to have a cervical fracture (neck fracture) and she underwent surgical intervention to stabilized her neck and decompress cervical stenosis (narrowing of the area the spinal cord is located in the neck).
-The resident was documented to have increased confusion upon discharge.
-The resident was discharged back to the facility on 01/01/21 with Seroquel 50mg by mouth nightly as needed for agitation.

Review of Resident #4's PT encounter note dated 03/08/21 revealed:
-The resident spent a good amount of time humming and crying.
-No signs or symptoms of pain could be identified, and the crying was attributed to behavior and anxiety.

Review of Resident #4's PT encounter note dated 03/09/21 revealed that her treatment session had been complicated by the resident's anxiety, crying, and agitation.

Review of Resident #4's PCP consultation note dated 03/16/21 revealed:
-There was an order to continue the medication Seroquel to manage outbursts of agitation or self-harm.

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D 358	Continued From page 85 -There was an order to monitor for sedation effects for worsening behaviors. Review of Resident #4's physician's order dated 01/01/21 revealed there was an order for Seroquel 50mg, 1 tablet, at bedtime as needed for agitation. Review of the facility's medication management procedure dated 07/2020 revealed: -Medication cart audits were to be performed weekly every Wednesday to ensure medications were on hand and available to the resident for administration. -The facility was to check on medications on hand to ensure the medication was available. Review of Resident #4's electronic medication administration record (eMAR) dated for January 2021 revealed: -There was an entry for Seroquel 50mg, 1 tablet, at bedtime as needed for agitation. -There was one entry documented of the medication being administered on 01/28/21 at 5:03pm for agitation. -There was no documentation of the medication being administered on the eMAR from 01/01/21-01/27/21 or 01/29/21-01/31/21. Review of Resident #4's eMAR dated February 2021 revealed: -There was an entry for Seroquel 50mg, 1 tablet, at bedtime as needed for agitation. -There was no documentation of the medication being administered on the eMAR from 02/01/21-02/28/21. Review of Resident #4's eMAR dated March 2021 revealed: -There was an entry for Seroquel 50mg, 1 tablet,	D 358		

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at bedtime as needed for agitation.
-There was no documentation of the medication being administered on the eMAR from 03/01/21-03/31/21.

Review of Resident #4's progress note dated 03/07/21 at 9:54pm revealed:
-There was documentation by a medication aide (MA) that the resident "was agitated today, she was given a prn (as needed medication) for her anxiety to help her relax."

Interview with the MA on 04/05/21 at 4:13pm revealed:
-She did not document administration of Resident #4's Seroquel on 03/07/21 because she probably did not give the medication due to it not being available at the facility.
-She should have gone back into the computer to edit her note.

Observation of medications on hand for Resident #4 on 04/01/21 at 1:29pm revealed there was no Seroquel 50mg tablets available for administraiton.

Review of Resident #4's medication cart audit documentation dated 03/09/21 revealed there were no Seroquel 50mg tablets on hand.

Review of Resident #4's medication cart audit documentation dated 04/06/21 revealed there were no Seroquel 50mg tablets on hand.

Interview with a medication aide (MA) on 04/05/21 at 12:35pm revealed:
-She performed 2 resident's audit per shift Monday-Thursday.
-She did not know why Resident #4 did not have any Seroquel on hand.

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-She did not normally administer this medication and had not given Resident #4 any Seroquel.
-She would expect all MA to document administration of this medication if they gave it to the resident.
-If the medication was not on the cart, she would assume someone had administered it to the resident.
-She had never completed medication cart audits on Resident #4.
-Medication cart audits should have caught a discrepancy if the medication was missing.

Review of Resident #4's record revealed the MA interviewed above signed the medication cart audits dated 03/09/21 and 04/06/21.

Review of dispensing records from the facility's contracted pharmacy revealed:
-Resident #4 was dispensed 30 tablets of Seroquel 50mg on 02/05/21 to the facility.
-Resident #4 was dispensed 7 tablets of Seroquel 50mg on 03/01/21 to the facility.

Interview with the facility's contracted pharmacy on 04/05/21 at 12:57pm revealed:
-There were 30 Seroquel 50mg tablets dispensed on 01/01/21 to the facility for Resident #4.
-There were 30 Seroquel 50mg tablets dispensed on 02/06/21 to the facility for Resident #4.
-There were 7 Seroquel 50mg tablets dispensed on 03/01/21 to the facility for Resident #4.

Review of Resident #4's pharmacy dispensing records and eMAR revealed the resident should have had 65-66 Seroquel 50mg tablets on hand at the facility.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on

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D 358	Continued From page 88 04/06/21 at 12:15pm revealed she could not find where any Seroquel has been returned to the pharmacy. Interview with the SCC on 04/05/21 at 4:43pm and 04/06/21 at 10:09am revealed: -He reviewed medication cart audits when the staff turned them into him. -The MA reviewed medications on hand during audits and faxed a request to reorder medications if needed. -Medications used PRN (as needed) were kept on the medication cart for residents. -If Resident #4 was administered the Seroquel, it should have been documented on the eMAR. -The staff did not have to give Resident #4 the Seroquel for agitation often; maybe once per week. -He was not aware Seroquel for Resident #4 was missing or not on hand. -He thought maybe staff were giving Resident #4 the Seroquel and not documenting the administration. -They would have kept a 3-month supply of the Seroquel on hand in the medication cart. -He was concerned that Resident #4's Seroquel was missing and did not know where it was. Interview with the Resident Care Coordinator (RCC) on 04/06/21 at 11:16am revealed: -PRN medications should not have been reordered unless they were running low and needed. -The facility would keep up to 2-3 months of PRN medication on hand in the medication cart. -All medications should have been documented on the resident's eMAR after administration so that residents were not overdosed. -She would expect Resident #4's Seroquel to have been on the medication cart unless the staff	D 358		

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were administering the medication without documentation.
-Cart audits were done on every shift in the facility and someone should have caught Resident #4's Seroquel was not available at the facility.
-The SCC should review cart audits to ensure medications were present and reordered as needed.

Interview with the Administrator on 04/06/21 at 12:53pm revealed:
-She did not know where Resident #4's Seroquel was.
-Staff should never administer a medication without documenting it on the resident's eMAR.
-She was concerned that the medication was unavailable to Resident #4 because the resident needed it for her agitation.

Interview with Resident #4's PCP on 04/06/21 at 3:08pm revealed:
-She expected the resident's medications to be on hand and administered as ordered.
-The resident's order for Seroquel was to reduce hallucinations and help the resident sleep which would subsequently reduce the resident's agitation during the day.

3. Review of Resident #1's current FL-2 dated 02/02/21 revealed diagnoses included atrial fibrillation, hypertension, dementia, and COPD.

Review of Resident #1's electronic physician's order dated 02/02/21 revealed there was an order Omeprazole delayed release (DR) 20 milligrams (mg) daily to be administered 30 minutes prior to morning meal.

Review of Resident #1's February 2021 electronic Medication Administration Record

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(eMAR) revealed:
-There was an entry for Omeprazole DR 20mg daily 30 minutes before morning meal.
-There was documentation Omeprazole was held on 02/07/21, 02/11/21 - 02/13/21, and 02/18/21.

Review of Resident #1's physician's orders revealed there was not an order to hold Omeprazole on 02/07/21, 02/11/21 - 02/13/21, and 02/18/21.

Requests for physician's orders to hold Omeprazole on 02/07/21, 02/11/21 - 02/13/21, and 02/18/21 were not provided prior to survey exit on 04/06/21.

Review of Resident #1's medication proof of delivery shipment detail report dated 02/19/21 at revealed 30 tablets of Omeprazole were received by the facility at 11:02pm.

Requests for Resident #1's Omeprazole proof of delivery shipment detail report prior to 02/19/21 was not provided by survey exit on 04/06/21.

Interview with a medication aide (MA) on 04/05/21 at 9:45am revealed:
-Resident #1's Omeprazole was documented in the February 2021 eMAR as held because the medication was "probably" not available in the facility.
-A medication was documented as hold on the eMAR if: there was a physician's order to hold the medication or the medication had run out before being refilled.
-Medications would be reordered by the MA when there were 5 doses remaining, the medication was in the blue section on the prefilled bubble packets, or by the refill by date.
-A label would then be pulled from the prefilled

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bubble packet and placed on the pharmacy reorder sheet; the sheet would be faxed to pharmacy by the MA.
-After faxing, the reorder sheet would be placed in a binder under a blue tab awaiting delivery.
-When the medication was delivered, the delivery receipt would be placed under a red tab in the binder.
-The Resident Care Coordinator (RCC) would review the binder daily to compare the reorder sheets to the delivery sheets.
-The RCC would contact the pharmacy for any medications not delivered
-Medication cart audits were performed by the MAs Monday - Friday on first, second, and third shift; each shift was assigned specific residents to audit for medications.
-The cart audits would address the number of doses remaining, the refill by dates, and the expiration dates.
-Only the prefilled blister packs, eye drops, insulins, inhalants, and narcotics were audited during the medication cart audits.
-The multidose packets were on auto refill with the pharmacy.

Interview with the Resident Care Coordinator (RCC) on 04/06/21 at 1:05pm revealed:
-Hold may have been documented for Resident #1's Omeprazole in the February 2021 eMAR because the MA may not have been able to locate the medication
-Resident #1 could have run out of the Omeprazole in February 2021.
-She did not know the reason Resident #1's Omeprazole was documented as hold for several days in February 2021.
-She would randomly review the medication re-order book 2 times a week to ensure medications ordered had been received from the

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OLIVER HOUSE	4230 WENDELL BOULEVARD WENDELL, NC 27591

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D 358	Continued From page 92	D 358		

pharmacy.
-She would compare the medication reorder sheet completed by the MAs to the medication requisitions to ensure medications had been received from the pharmacy.
-If there was not a medication requisition for the medication(s) reordered, she would call the pharmacy.

Interview with the Administrator on 04/05/21 at 5:15pm revealed:
-Medications were to be reordered by the MAs when there were 5 doses or less remaining.
-The MAs were to pull the medication label from the medication that required reordering and place it on a pharmacy reorder sheet.
-She did not know how to confirm a medication had been received by pharmacy.
-She expected the RCC to follow up with pharmacy by the next day if the reorder sheet was faxed to the pharmacy by second or third shift staff.
-If the pharmacy reorder sheet was faxed by first shift, the RCC was expected to follow up with pharmacy before leaving for the day.
-The MAs were expected to do cart audits on assigned days to catch ensure a resident's medication was always available in the facility.
-It was the responsibility of the RCC to ensure the MAs were doing the cart audits.
-The Administrator had never checked behind the MAs or RCC to ensure cart audits were being performed.

A second interview with the Administrator on 04/06/21 at 12:27pm revealed:
-A physician order was required to hold any medication.
-A medication held without a physician's order meant the facility was waiting for the medication

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D 358	Continued From page 93 to arrive from the pharmacy. Interview with Resident #1's Primary Care Provider (PCP) on 04/26/21 at 3:15pm revealed: -She had not been notified by the facility Resident #1's Omeprazole was held on 02/07/21, 02/11/21 - 02/13/21, and 02/18/21. -The resident was on Eliquis (a medication used to thin the blood by preventing the blood from clotting) which placed the resident at increased risk for a gastrointestinal (GI) bleed. -Omeprazole was prescribed to Resident #1 to treat heart burn and acid indigestion, and aide in decreasing the risk of a GI bleed. -Resident medications should always be available in the facility to ensure doses were not missed. -She expected to have been notified Resident#4's Omeprazole had not been administered if the resident missed more than 4 doses in 1 week. -When asked if she expected Omeprazole to be administrated to Resident #1 as ordered she replied, "Wouldn't you?". Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. _____ The facility failed to administer medications as ordered for 2 of 3 residents observed during the medication pass resulting in a 12% medication error rate with 3 errors out of 25 opportunities including Resident #7 who had a diagnosis of end stage renal disease and had not received Calcium Acetate with meals as ordered; Resident #4, who had sustained a C2 fracture of the neck from multiple falls was not administered scheduled Norco for 7 out of 102 doses in February 2021 and 17 out of 124 scheduled doses of Norco 5-325mg in March 2021 and who had episodes of agitation which could have been	D 358		

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D 358	Continued From page 94 due to pain had only been administered as needed Seroquel 1 time in January 2021 and not documented as administered on the eMAR for February or March 2021. Resident #1's omeprazole was not documented as administered 4 out of 28 opportunities in February 2021 due to the medication not available which could result in gastrointestinal discomfort and bleeding. This was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/31/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 21, 2021.	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 and interview, the facility failed to assure infection control measures were implemented during the morning medication pass on 03/31/21 by 1 of 1 medication aides observed who failed to wash or sanitize her hands prior to preparing and after administering oral medications and eye drops to multiple residents.	D 371		

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D 371	Continued From page 95 The Findings are: Observation of a medication aide (MA) administering medications in the hallway on the assisted living men's hall on 03/31/21 from 7:22am to 7:50am revealed. -There was a bottle of hand sanitizer on top of the medication cart. -The MA was about to prepare medications for a resident. -The MA did not sanitize or wash her hands prior to preparing the medications and she was not wearing gloves. -The MA prepared three oral medicationsan inhaler and a cup of water for the resident. -The MA put the medication cup and cup of water in the resident's hands and the resident took the pills then followed with placing the inhaler in the resident's hand. -The MA went back to the medication cart, documented on the electronic medication administration record (e-MAR), touching the mouse. -The MA then started preparing medication for a second resident. -The MA did not sanitize or wash her hands. -The MA prepared eye drops for the second resident. -The MA put gloves on and administered the resident's eye drops. -The MA removed her gloves and did not sanitize or wash her hands. -The MA prepared a nasal spray. -The MA put on gloves and administered the resident's nasal spray. -The MA removed her gloves. -The MA sanitized her hands. -The MA prepared ten oral medications and a cup of water for the resident.	D 371		

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D 371	Continued From page 96 -The MA put the medication cup and cup of water in the resident's hands and the resident took the pills and the resident handed the water back to the MA. -The MA went back to the medication cart, documented on the e-MAR, touching the computer mouse. -The MA did not sanitize or wash her hands. -The MA then started preparing the next resident's medications. Interview with the MA on 03/31/21 at 11:59am revealed: -She was taught to use hand sanitizer after each resident. -She was to wash her hands with soap and water after the 5th resident. -She was not sure why she did not sanitize her hands after each resident's medication pass. Interview with the Resident Care Coordinator on 03/31/21 at 8:00am revealed: -The MAs have been trained to sanitize after each medication pass. -After 3-5 medication passes the MA should wash her hands or if they get visible soiled before then. Interview with the Administrator on 03/31/21 at 9:57 am revealed: -The MA was to sanitize her hands between each resident. -If her hands got soiled, she was to wash them or wash them after the fifth medication pass. -She expected the MAs to sanitize between residents to prevent spreading germs.	D 371		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage	D 378		

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D 378	Continued From page 97 (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews the facility failed to ensure medications were under locked security related to a mild pain medication and an antihistamin nasal spray.being left unsecured on top of the medication cart; and the medication cart being left unlocked and unattended by the medication aide (MA) staff. The Findings are: Observation of the 200 hall on the AL unit on 03/30/21 at 12:01pm revealed: -The medication cart was on the left side of the 200 hall located outside a resident room. -The keys were in the key slot of the medication cart. -The drawers on the medication cart opened when pulled and closed freely without locking. -The MA was in a resident room. Observation of the morning medication pass on the assisted living unit on 03/31/21 from 7:22am-7:50am revealed: -The MA was in the hallway and was preparing medications for a resident.	D 378		

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D 378	Continued From page 98 -The MA walked into the resident's room after leaving the medication cart unattended, unlocked and the keys in the cart. -There was a bottle of Acetaminophen 325mg (used to treat minor aches and pains) on top of the cart. -There was a resident's Flonase (used to relieve nasal congestion, sneezing, runny nose and itchy eyes) on top of the cart. -The MA had her back to the medication cart. -The MA returned to the medication cart and locked the cart and put the keys in her pocket and returned to the room. -The MA moved the cart across the hall to another resident's room. -The MA prepared the medication for the other resident with the Acetaminophen and Flonase on top. -The MA locked the medication cart. -The MA went into the other resident's room and administered medication while leaving the Acetaminophen and Flonase on top of the medication cart. -The MA returned to the medication cart and prepared medication for the third resident with the Acetaminophen and Flonase on top of the cart. -The MA locked the medication cart. -The MA went into the third resident's room and administered medications without the medication cart being in her view. -The Acetaminophen and Flonase remained on top of the medication cart. Interview with Administrator on 03/30/21 at 12:03pm revealed: -Medication carts were to remain locked when unattended. -She would speak with the MA about leaving the medication cart unattended when unlocked.	D 378		

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D 378	Continued From page 99 Interview with the Administrator on 03/31/21 at 9:57 am revealed: -The medication cart was to remain locked if out of the MA's eyesight. -There should not be any medications on top of the medication cart. -Her expectation was for the MA's to lock the medication cart and put the keys in her pocket when she walked away from it. -There was a resident who wandered the hall and had dementia. A second interview with the Administrator on 03/31/21 at 10:30am revealed: -The MA was in a room with a resident on 03/30/21 when she left the medication cart unattended and unlocked. -The medication cart was in full view of the MA when in the resident room on 03/30/21. -The MA had previously left the medication cart unlocked when it was unattended. -She did not remember when the MA previously left the medication cart unlocked and unattended. Interview with the MA on 03/31/21 at 11:59am revealed: -She forgot and left the medication cart unlocked on 03/30/21. -Sometimes she forgot to lock the medication cart. -She was taught to lock the cart and take the keys with her. -She knew she had the Acetaminophen and Flonase on top of the medication cart. -She was also taught not to leave any medications on top of the cart. -She was nervous when she was administering medications. Interview with the Resident Care Coordinator	D 378		

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D 378	Continued From page 100 (RCC) on 03/31/21 at 12:23 revealed: -The medication cart should never be left unlocked when a MA walks into a resident's room. -There should never be any medication left on top of the medication cart when the MA walked away. -A resident could come along and pick the medication up.	D 378		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure resident received care and services which are adequate, appropriate, and in compliance with relevant federal and State laws, rules, and regulations related to health care and medication administration . The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#4) who had a history of multiple falls that needed blood pressure, pulse, temperature, and daily intake by mouth monitoring. [Refer to Tag 276, 10A NCAC 13F .0902(c) Health Care (Type B Violation)]. 2. Based on observation interviews, and record reviews, the facility failed to administered	D912		

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D912	Continued From page 101 medications as ordered and in accordance with the facility's policies for 2 of 3 residents (#7 #8) observed during the medication passes including errors with an inhaler, a calcium supplement not given with meals, and not having eye drops available; and for 2 of 5 residents sampled (#4, #1) for record review including errors with medications for pain and agitation (#4) and for heartburn medication not available for administration (#1). [Refer to Tag 358, 10A NCAC 13 F .1004(a) Medication Administration (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 observation interviews, and record reviews, the facility failed to enusre residents were of neglect as related to personal care and supervision and health care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#4) who had a history of multiple falls with injuries including facial fractures, hematomas, bruising, intracranial head bleed, and two neck fractures. Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews, and record	D914		

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D914	Continued From page 102 reviews the facility failed to ensure referral and follow up to meet the acute health care needs of 2 of 5 (#1, #4) sampled residents who missed cardiology appointments and a computerized tomography (CT) scan of the head (#1); and a resident who had episodes of agitation (#4). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D914		