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CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 07/14/21 through 07/16/21 and 07/19/21 through 07/20/21.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance for 3 of 7 sampled residents (#1 and #6), residing in the Special Care Unit (SCU) related to a resident who had multiple falls with injuries including a fractured right wrist and skin tears (#1) a resident who had thirteen falls resulting in a bump on the forehead, black eye, bruises, skin tears and multiple injuries of unknown origin (#6), and a resident who wandered throughout the dining room during the lunch meal taking food off other residents' plates and taking the tablecloths off the table (#9). The findings are: Review of the facility's Falls Management and Investigation policy revealed: -All residents were assessed after admission for falls risk, which includes history of falls.	D 270		

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D 270	Continued From page 1 -A Fall Risk Identification and Assessment would be completed. -Fall interventions were documented in the resident's service plan. -The service plan regarding falls was developed within 8 hours of move-in, and updated with the level of care, and significant change in status, post-fall. -The Morse Fall Risk Evaluation Tool was completed when a resident moved-in or upon admission. -If the score on the Tool indicates risk if applicable, it may prompt discussion of a referral to an outside rehabilitation consult. -The Resident Services Director (RSD) was responsible for supervising the process of review, management and monitoring procedures of residents at risk for falls. -The RSD was to manage the process for prediction, minimization, treatment, monitoring, and calculation of the community fall rates. -Fall interventions were reviewed for continued effectiveness. -Falls were investigated, reported and documented, using root cause analysis concepts. -The Executive Director was responsible for instituting/commencing the investigation process. -The RSD would review results and process improvement plans; post fall evaluation, comparison of Morse Fall risk score, analysis data and determination of causal factors if possible, identification of time of day and day of the week that the fall occurred, and review of staff patterns. -Forms used would include: Post-fall observational review guidelines for unlicensed Team members, Post-fall observational review checklist for unlicensed team members, data collection tool, Morse fall risk evaluation tool, fall evaluation intervention tool, post fall investigation	D 270		

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tool, interdisciplinary team falls review and fall tracking tool.
-There was no documentation regarding increased supervision after a fall.

1. Review of Resident #1's current FL2 dated 03/11/21 revealed:
-Diagnoses included dementia, seizure, anxiety, and sensorineural hearing loss.
-He was intermittently disoriented, ambulatory, and recommended level of care was Special Care Unit (SCU).

Review of Resident #1's current care plan dated 03/14/21 revealed:
-He resided in the Special Care Unit (SCU).
-He was independent with eating, toileting, ambulation, dressing, grooming and transferring.
-He required supervision with bathing.

Review of Resident #1's Incident Report dated 03/22/21 revealed:
-On 03/22/21 at 12:40am Resident #1 was observed by the medication aide (MA) sitting on the floor in his bedroom.
-He yelled out "oh don't touch it, it's broken."
-He was sent to the hospital.

Review of Resident #1's Physician's order request dated 03/22/21 revealed:
-On 03/22/21 (no time documented) Resident #1 was observed sitting on the floor in his bedroom.
-His right wrist was swollen, and the resident complained of severe pain.

Review of Resident #1's Resident Service Note dated 03/22/21 revealed:
-Resident #1's right wrist was swelling, and the resident complained of severe pain.
-Resident returned to the facility the same day.

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D 270	Continued From page 3 Review of the facility's "For All Falls" sheet dated 03/22/21 for Resident #1's revealed: -There was documentation Resident #1 was checked at 6:00am, 6:15am, 6:30am, 7:30am, 8:30am, 10:15am, 10:55am, 4:40pm, 8:00pm, 9:21pm, and 10:21pm. -There was no further documentation Resident #1 was checked or monitored for falls. Review of Resident #1's Progress Note from the primary care provider (PCP) dated 03/22/21 revealed the PCP noted that facility staff were to monitor Resident #1 for falls. Review of Resident #1's hospital discharge summary report dated 03/22/21 revealed: -Resident #1 was admitted to the hospital on 03/22/21 at 1:53am. -He had a history of dementia and his chief complaint was pain in his right wrist. -The emergency department physician noted Resident #1 had an unwitnessed fall with an obvious right wrist deformity, bruising and swelling. -He was diagnosed with a fractured right wrist. Review of Resident #1's SCU Profile dated 03/12/21 revealed: -Resident #1's score was "NA (Not Applicable)." -His physical abilities were checked as independent. -The resident was able to provide self-help with dressing grooming, toileting, eating, ambulation and transferring. Review of Resident #1's Resident Service Notes revealed: -On 03/21/21 (time not documented), Resident #1 had a skin tear above his right eyebrow from	D 270		

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D 270	Continued From page 4 hitting his head on the corner of the bookcase in the activity room. -On 03/21/21 (time not documented), Resident #1 hit his head on the table in the activity room and had a skin tear in the middle of his forehead. -On 03/24/21 at 3:20pm, Resident #1 had a fall, no injuries were noted. There was no documentation Resident #1 was monitored according to the facility's policy after the fall. There was no documentation Resident #1 was assessed after the fall according to the facility's policy. -On 03/27/21 at 2:30pm, Resident #1 had a fall, no injuries were noted. There was no documentation Resident #1 was monitored according to the facility's policy after the fall. There was no documentation Resident #1 was assessed after the fall according to the facility's policy. -On 04/03/21 at 9:30pm, Resident #1 observed with a skin tear below the left wrist. There was no documentation how the resident obtained the skin tear. -On 04/08/21 at 10:30pm, Resident #1 was found on the floor in his bedroom on the other side of the room in front of the closet. Resident #1 had a skin tear above the right elbow (arm with the broken wrist). There was no documentation Resident #1 was monitored according to the facility's policy after the fall. There was no documentation Resident #1 was assessed after the fall according to the facility's policy. -On 04/10/21 at 2:35pm, Resident #1 had a fall, observed on the floor, no injuries were noted. There was no documentation Resident #1 was monitored according to the facility's policy after the fall. There was no documentation Resident #1 was assessed after the fall according to the facility's policy.	D 270		

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Review of Resident #1's Progress Note from the Mental Health Provider (MHP) dated 04/07/21 revealed the MHP discussed Resident #1's fall precautions with staff and directed them to monitor the resident for excessive sleepiness and falls.

Review of Resident #1's record revealed there were no fall risk identification/assessments, Morse fall risk evaluation tool, and documentation of the fall investigation available for review from the falls that occurred from 03/22/21 through 04/10/21.

Telephone interview with Resident #1's first Power of Attorney (POA) on 07/16/21 at 10:07am reveled:
-Resident #1 passed away in May 2021.
-Resident #1 had three POAs, and she was the first point of contact for Resident #1.
-Prior to Resident #1's admission to the facility on 03/13/21, he lived at home.
-When Resident #1 lived at home he was a totally independent with walking, ambulation and transferring.
-Resident #1 had Alzheimer's disease and was a little confused.
-On 03/22/21 at 1:00am, she received a telephone call from the MA at the facility.
-The MA said Resident #1 fell and his wrist did not look normal, so she was sending him to the hospital.
-When he returned from the hospital on 03/22/21, staff told her that he was unstable and they would monitor him.
-If facility staff checked on Resident #1, she did not know how frequently they checked on him.
-After the fall on 03/22/21, Resident #1 continued to have falls and receive unexplained injuries.
-The facility appeared to do nothing about the

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falls or that Resident #1 hit his head on the book shelf and on the activity table.
-She thought there were five or six more times she received telephone calls because Resident #1 had falls.
-Usually, it was the MA who called her and the MA would say,"had to call to let you know he missed a chair and ended up on the floor."
-Her question to the MA was "did he have on his glasses?"
-On several occasions when she visited Resident #1 and she noticed he was not wearing his eyeglasses.
-She told facility staff Resident #1 could not see without his eyeglasses and that could possibly contribute to the falls and other injuries.
-After her request Resident #1 still did not have his glasses on when she visited.
-She had talked with the Administrator and the Assistant Director of Resident Care (ADRC) about her concerns, but they never said they were going to monitor Resident #1 to be sure he was safe and secure.

Interview with Resident #1's second POA on 07/16/21 at 9:06am revealed:
-Resident #1 moved into the facility 03/13/21 and left the facility on 04/11/21.
-Prior to moving into the facility Resident #1 did not have falls and walked 2.5 miles per day.
-She had received several telephone calls from the facility regarding Resident #1 falling.
-The facility staff would not initiate any services for Resident #1 to prevent falls unless the family suggested it first.
-When Resident #1 started having falls, the family asked for the PCP to review all the resident's medications to see if the medications were causing the falls.
-The family initiated the request for physical

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therapy after the first fall because Resident #1 broke his right hand, which was his dominant hand.
-The family requested that Resident #1's bed be lowered after the first to help prevent further falls.
-Several times it was asked that staff made sure Resident #1 had his glasses on because he could not see without the glasses and that might be causing the falls.
-The family had left two pair of glasses at the facility for Resident #1.
-One pair of the glasses was lost and other pair was never on the resident even after she requested staff put the glasses on Resident #1.
-If the family had not made suggestions, she was not sure anything would have been done for Resident #1 to prevent falls.
-At no time did the facility inform the POAs Resident #1 had been assessed for falls.
-Resident #1's family had many discussions and meetings with the ADRC, Administrator and the Special Care Unit Coordinator (SCUC) regarding keeping Resident #1 safe.
-The response usually was they would do as the family requested.
-The facility never suggested any methods or techniques to try to keep Resident #1 from ending up on the floor or safe from injuries.
-On 04/02/21, she asked the ADRC about Resident #1's shoes being missing.
-She informed the ADRC that she preferred Resident #1 had on shoes because the socks might be causing the falls. Resident #1 still did not have shoes on each time she visited.

Telephone interview with Resident #1's third POA on 07/15/21 at 11:07am revealed:
-Upon admission to the facility Resident #1 was not identified as a fall risk.
-Resident #1's home where he lived prior to being

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admitted to the facility was two stories.
-Resident #1 walked up and down the stairs in his house daily, several times per day and required no assistance.
-Prior to his admission to the facility, Resident #1 was able to dress himself, put on his own shoes, and he walked 2 plus miles every day.
-Resident #1 did 100% of his activities of daily living without assistance.
-When she visited with Resident #1 on 03/24/21, she observed him lying on the couch in the common sitting area; he was half-side ways with his feet hanging off the couch and he was very lethargic.
-She emailed the Administrator and told her about how they observed Resident #1.
-The family requested that they meet with the PCP to review Resident #1's medications, because they had never observed Resident #1 in that condition and they were concerned the medications caused the resident to fall.
-Being lethargic and falling was not normal for Resident #1.

Telephone interview with Resident #1's previous home health aide on 07/16/21 at 12:25pm revealed:
-Resident #1 was diagnosed with Alzheimer's at least one year prior to moving into the facility.
-She last saw Resident #1 on 03/12/21; the day before he moved into the facility, and he appeared to be healthy and he walked independently.
-It was common for Resident #1 to walk over 2 miles almost every day.
-Resident #1 did not fall or even stumble when she cared for Resident #1.
-Resident #1's home was two story and Resident #1 was up and down the steps frequently and did not fall or require supervision.

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D 270	Continued From page 9 Interview with a PCA on 07/15/21 at 2:30pm revealed: -It was the facility's protocol after a fall to monitor the resident every 15 minutes for four hours; then every 30 minutes for 4 hours, and then every hour for four hours. -Monitoring the resident was not documented on a form; he verbally told the MA when he last observed the resident. -The monitoring was done for one day after the resident had a fall. -He was unable to recall if Resident #1 was monitored more than 24 hours. Interview with a MA on 07/16/21 at 3:16pm revealed: -She was aware Resident #1 had a fall but was unable to recall if the resident had falls when she worked. -It was the facility's policy after a resident fell for staff to monitor the resident every 30-minutes for one day. -She was unable to recall doing 30-minute checks on Resident #1. -She had observed that Resident #1 was unstable when he walked. -When she worked, she tried to watch Resident #1 more closely by keeping him in the room with her. -She did not document she watched the resident more closely. -After Resident #1 fell and broke his wrist the resident he went from walking independently to using a wheelchair. -Resident #1 was put in a wheelchair to keep him from falling because he was unstable on his feet. -Resident #1 still tried to get up out of the wheelchair and he still had falls. -Resident #1 was not put on increased monitoring	D 270		

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unless he had a fall.

Interview with a second MA on 07/16/21 at 3:41pm revealed:
-Resident #1 was always walking around like he was going somewhere.
-Resident #1 would not sit still and would say "I wanted to get out."
-Resident #1 had falls but she was unable to recall the exact dates of the falls.
-After a fall, Resident #1 was monitored every 15 minutes for four hours, every 30 minutes for four hours, once every hour.
-The monitoring was stopped after 24 hours.
-There was no system put in placed that provided continued monitoring of Resident #1.

Interview with the ADRC on 07/15/21 at 4:40pm revealed:
-When Resident #1 was admitted to the facility on 03/22/21 he was walking independently.
-After the fall on 03/22/21 the facility started putting Resident #1 in a wheelchair.
-After the resident fell, his family requested physical therapy and it was ordered.
-It was suggested to lower the mattress in case that caused the fall on 03/22/21.
-Resident #1 continued to have falls.
-Resident #1 was monitored according to the facility's policy, which was for 24 hours after a fall.
-The monitoring of Resident #1 was not continuous, she was unable to recall exactly how long a resident was monitored, she thought the monitoring was done for one day.
-She thought there had been no discussion to monitor Resident #1 more frequently than the facility's policy required.
-Staff were aware they had to keep a close eye on Resident 1.
-She or the Registered Nurse (RN) were

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responsible for completing the fall assessment for Resident #1.
-She was responsible for the SCU and the RN was responsible for the assisted living unit.
-Resident #1 was so agitated, she focused on the agitation.

Interview with the Activity Director on 07/15/21 at 2:50pm revealed:
-She worked three times per week as a MA or PCA.
-If a resident hit their head, then the resident had to go to the emergency department.
-The MA called emergency medical services (EMS), and then checked the resident's vital signs.
-After the resident returned to the facility, they were monitored every 15 minutes for 4 hours, then every 30 minutes for 4 hours.
-The monitoring was for one week or maybe "four days, can't recall exactly."
-There was a monitoring sheet the MA gave to the PCA who was assigned to the hall where the resident resided.
-When her shift was over, she gave the monitoring sheet to the PCA on the next shift.
-This process was to be followed for every fall regardless if there were injuries.
-She was unable to recall if monitoring was completed for Resident #1 after each one of his falls.

Interview with the Administrator on 07/15/21 at 4:50pm revealed:
-The facility usually monitored residents every 30 minutes for 24 hours following a fall.
-Systems were put in place after each of Resident #1's falls, like asking the PCP to review the resident's medications, physical therapy and lowering the resident's bed.

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-After Resident #1's fall on 03/22/21, the resident was checked for a urinary tract infection.
-Resident #1 was monitored for 24 hours.
-She was unable to located the documentation which showed Resident #1 was assessed according to the facility's fall policy after the fall on 03/22/21.
-Outside of the 24 hour monitoring, no increased supervision was put in place for Resident #1.
-After the fall on 03/24/21, Resident #1's family requested physical therapy.
-If there was no documentation she was unable to confirm a falls assessment was completed according to the facility's policy.
-There was no documentation Resident #1 was monitored according to the facility's policy for 24 hours after the fall.
-There was no increased supervision or monitoring put in place for Resident #1.
-After the fall on 03/27/21, the family requested Resident #1's medications be reviewed and the family met with the PCP to discuss Resident #1's medication.
-After Resident #1's falls on 04/08/21 and 04/10/21 there was no documentation Resident #1 was monitored for 24 hours according to the facility's policy following a fall.
-There was no documentation a fall assessment was completed for Resident #1 according to the facility's policy.
-The ADRC was responsible for completing the fall assessment and there should be documentation when the assessment was completed.
-If the ADRC was unable to complete the assessment, then there should be documentation why the assessment was not completed.

Attempted telephone interview with the MA who assisted Resident #1 on 03/22/21 on 07/16/21 at

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D 270	Continued From page 13 1:52pm was unsuccessful. Attempted telephone interviews with Resident #1's PCP on 07/19/21 at 10:17am, 10:34am, 4:46pm, 6:01pm and on 07/20/21 at 1:41pm and 2:36pm were unsuccessful. Attempted telephone interviews with Resident #1's MHP on 07/19/21 at 10:27am, 10:36am and 1:43pm were unsuccessful. 2. Review of Resident #6's current FL2 dated 07/01/21 revealed: -Diagnoses included dementia with Lewy bodies, major depressive disorder, essential hypertension, gastroesophageal reflux disease, and nonrheumatic aortic valve stenosis. -Resident #6 was constantly disoriented and non-ambulatory. -Resident #6's current level of care was Special Care Unit (SCU). Review of Resident #6's care plan dated 06/20/21 revealed: -She was non-ambulatory and used a high back wheelchair. -She had limited range of motion and limited strength in her upper extremities. -She was dependent upon staff for all activities of daily living. -She had a chair cushion, a chair alarm, a hospital bed, a scoop mattress, and a fall mat. Incident and Accident reports for Resident #6 were requested on 07/15/21 at 4:15pm, but were not provided. Review of Resident #6's Resident Service Notes dated 01/08/21 revealed: -She had an unwitnessed fall and was found on	D 270		

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the floor in the living room.
-She had gotten up out of her chair.
-Staff called Resident #6's family member and hospice provider.
-She had a skin tear on her left arm.

Interview with the medication aide (MA) who documented the 01/08/21 note on 0719/21 at 12:03pm revealed:
-Resident #6 was a high fall risk and had a history of multiple falls.
-After a fall, staff were supposed to take residents' vital signs (blood pressure, temperature, pulse, and respiration rate) every 15 minutes for 1 hour, every 30 minutes for 2 hours, and then every 1 hour for 4 hours.
-Staff used to complete 30-minute checks after a fall, but during the pandemic, the facility switched from the 30-minute checks to only checking vital signs.
-She could not remember the details of the fall on 01/08/21 and did not remember if there was any increased supervision after the fall.

Documentation of increased supervision or vital sign checks after Resident #6's fall on 01/08/21 was requested on 07/16/21 at 4:47pm, but was not provided.

Review of Resident #6's Resident Service Notes dated 01/09/21 at 1:00pm revealed:
-Resident #6 was found laying on the floor in the activity room.
-There were no injuries.
-Resident #6's hospice provider and family member were notified.

Interview with the MA who documented the 01/09/21 note on 07/19/21 at 2:14pm revealed:
-She did not observe the fall on 01/09/21 and she

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did not remember the details of the fall.
-Residents were usually placed on 30-minute checks after a fall for 24 hours and staff were to check vital signs starting with every 15 minutes, then every 30 minutes and then every hour.
-She did not remember if any increased supervision or vital sign checks were put in place after the fall.

Documentation of increased supervision or vital sign checks after Resident #6's fall on 01/09/21 was requested on 07/16/21 at 4:47pm, but was not provided.

Review of Resident #6's Resident Service Notes dated 01/13/21 at 1:15pm revealed:
-A personal care aide (PCA) reported that Resident #6 had bruising from her left calf down to her foot.
-Resident #6's hospice provider and the Assistant Director of Resident Care (ADRC) were informed.
-The hospice nurse visited with Resident #6 on 01/13/21.

Interview with the MA who documented the 01/13/21 note on 07/19/21 at 2:14pm revealed:
-She observed Resident #6 with bruising from the calf of her left leg down to her left foot.
-The bruise looked new, so she did not think it was the result of her fall from 01/09/21.
-She had not noticed any bruising or discoloration on Resident #6's leg prior to 01/13/21.
-She did not know how Resident #6 obtained the bruise observed on 01/13/21.
-She did not think there was any increased supervision or vital sign checks after observing the new bruise on Resident #6's leg on 01/13/21.

Review of Resident #6's Resident Service Notes dated 01/18/21 at 10:00pm revealed:

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D 270	Continued From page 16 -Resident #6 slid out of her wheelchair and scraped her lower back on her wheelchair (location of fall not documented). -Resident #6's Primary Care Provider (PCP) and hospice provider were contacted. -Staff would continue to monitor. Interview with the MA who documented the 01/18/21 note on 07/19/21 at 3:20pm revealed: -She thought Resident #6 was sitting in the dining room when she tried to get up. -She was in the medication room looking through the window into the dining room when she saw Resident #6 slide out of her wheelchair. -She did not remember any staff in the dining room with Resident #6. -She did not remember hearing Resident #6's chair alarm sound. -Resident #6 had 30-minute checks and vital sign checks for 3 days after her fall on 01/18/21. -She did not not know if any other interventions were implemented. Documentation of increased supervision or vital sign checks after Resident #6's fall on 01/18/21 was requested on 07/16/21 at 4:47pm, but was not provided. Review of Resident #6's Resident Service Notes dated 01/19/21 revealed: -Resident #6 had a fall on the floor (location not documented) and had a knot on her forehead. -Resident #6's family member and hospice provider were called, and the PCP was faxed. Interview with the MA who documented the 01/19/21 fall on 07/19/21 at 12:03pm revealed: -She did not remember the details of Resident #6's fall on 01/19/24. -She did not remember if 30-minute checks and	D 270		

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D 270	Continued From page 17 vital sign checks were implemented for Resident #6 after her fall on 01/19/21. Documentation of increased supervision or vital sign checks after Resident #6's fall on 01/19/21 was requested on 07/16/21 at 4:47pm, but was not provided. Review of Resident #6's Resident Service Notes dated 02/04/21 revealed: -She had bruising on her right arm, behind her left ear, on her left thigh, and on her right chin from an unknown source. -Resident #6's family member and the ADRC were informed. Interview with the MA who documented the 02/04/21 note on 07/19/21 at 2:14pm revealed: -Resident #6 used a wheelchair, but she continued to be a high fall risk. -She noticed bruising to Resident #6's arm, ear, thigh, and chin during her shift on 02/04/21, but she did not know what happened to cause the bruising. -The bruising could not have come from Resident #6's last fall on 01/19/21 because the last fall had occurred more than 2 weeks prior to the bruising on 02/04/21. -The bruising on 02/04/21 looked to be new bruising. -She thought she contacted Resident #6's PCP, hospice provider, the ADRC and family member. -She was not sure if 30-minute checks or vital sign checks were implemented for Resident #6 after observing new bruising on 02/04/21. Review of Resident #6's Resident Service Note dated 02/19/21 revealed: -Resident #6 had a fall on first shift (location not documented) with no injuries to report.	D 270		

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D 270	Continued From page 18 -Resident #6's hospice provider was notified. Documentation of increased supervision or vital sign checks after Resident #6's fall on 1st shift on 02/19/21 was requested on 07/16/21 at 4:47pm, but was not provided. Review of Resident #6's Resident Service Note dated 02/19/21 at 8:00pm revealed: -Resident #6 slid out of her wheelchair (location not documented) and there were no concerns. -Staff would continue to monitor Resident #6 closely. -Resident #6's family member, hospice provider, and PCP were notified. Telephone interview with the MA who documented the 02/19/21 (at 8:00pm) note on 07/19/21 at 3:28pm revealed: -Resident #6 was sitting in the living room and slid out of her wheelchair. -She did not observe Resident #6 sliding out of her wheelchair. -It was reported to her by one of the PCAs. -Resident #6 had a chair alarm in place and was supposed to be placed on 30-minute checks. Documentation of increased supervision or vital sign checks after Resident #6's fall on 02/19/21 at 8:00pm was requested on 07/16/21 at 4:47pm, but was not provided. Review of Resident #6's Resident Service Notes dated 02/24/21 revealed: -Resident #6 had a fall on the evening of 02/24/21 (location not documented). -She had a knot over her left eye. -Resident #6's family member, hospice provider and the ADRC were notified. -Resident #6's vital signs were checked, and a	D 270		

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document was faxed to Resident #6's PCP.
-She was given a Tylenol for pain.

Interview with the MA who documented the 02/24/21 noted on 07/19/21 at 12:03pm revealed:
-She did not remember the details of Resident #6's fall on 02/24/21.
-She did not remember if 30-minute checks and vital sign checks were implemented for Resident #6 after her fall on 02/24/21.

Documentation of increased supervision or vital sign checks after Resident #6's fall on 02/24/21 was requested on 07/16/21 at 4:47pm, but was not provided.

Review of Resident #6's Resident Service Note dated 02/27/21 revealed Resident #6 had a black eye that "most likely" came from the bump on her head obtained from her fall on 02/24/21.

Review of Resident #6's Resident Service Note dated 03/20/21 at 9:50pm revealed:
-Resident #6 fell from her wheelchair to the floor (location not documented).
-Resident #6 had a skin tear on her left knee and a knot on her left eyebrow.
-Staff would continue to monitor.

Interview with the MA who documented the 03/20/21 note on 07/19/21 3:28pm revealed:
-She did not remember the details of Resident #6's fall on 03/20/21.
-She did not see Resident #6 fall on 01/30/21.
-Thirty-minute checks and vital sign checks had to be implemented for 3 days for all residents after a fall.
-The 30-minute checks and vital sign checks should be in a notebook in the ADRC's office.

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Documentation of increased supervision or vital sign checks after Resident #6's on 03/20/21 was requested on 07/16/21 at 4:47pm, but was not provided.

Review of Resident #6's Resident Service Note dated 04/16/21 revealed:
-Resident #6 had a fall from her wheelchair (location not documented).
-Resident #6 had a small knot on her forehead as well as a skin tear.
-The ADRC was called and Resident #6's PCP was called and faxed.
-The MA completed the vital sign check sheet.

Interview with the MA who documented the 04/16/21 note on 07/19/21 at 12:03pm revealed:
-Resident #6 was found on the floor in the living room on 04/16/21.
-Resident #6 had been sitting in the recliner in the living room and a PCA was also present.
-The PCA left the living room to take a break, left Resident #6 alone, and Resident #6 fell.
-PCAs who were assigned to her care were responsible for supervising Resident #6 during their shift.
-If the PCA had to leave the room, then the PCA should have let another staff person know.
-After Resident #6's fall on 04/16/21, vital signs were checked every 15 minutes for 1 hour, every 30 minutes for 2 hours, and then every hour for 4 hours.
-Staff used to complete 30-minute checks for residents after a fall, but the 30-minute checks were replaced by the vital sign check sheet.

Review of Resident #6's vital sign logs revealed there was documentation Resident #6's vital signs were checked on 04/16/21 every 15 minutes from 11:10pm to 11:55pm, every 30

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minutes from 12:30am to 2:00am, and every hour between 3:00am to 6:00am.

Review of Resident #6's Resident Service Notes dated 05/24/21 at 6:30am revealed:
-Resident #6 was found on the bathroom floor of her bedroom.
-Resident #6 was scooting on the floor.
-There were no bruising, cuts, or scrapes observed.
-Staff would continue to monitor Resident #6 closely.
-The family member, the ADRC, and Resident #6's PCP were notified.

Telephone interview with the MA who documented the 05/24/21 note on 07/19/21 at 3:28pm revealed:
-As Resident #6 declined, she continued to attempt walk.
-On 05/24/21, she found Resident #6 in her bathroom, scooting on her bottom on the bathroom floor.
-Resident #6 had a low bed and a bed mat in place.
-She must have gotten out of her bed and scooted to the bathroom in her room.
-Vital sign checks and 30-minute checks were put in place for 24 hour for Resident #6 after her fall on 05/24/21.

Review of Resident #6's vital sign logs revealed there was documentation Resident #6 vital signs were checked on 05/24/21 every 15 minutes from 6:30am to 7:15am, every 30 minutes from 7:45am to 9:15am, and every hour between 10:15am to 1:15pm.

Review of Resident #6's Resident Service Note dated 05/26/21 revealed Resident #6 had a new

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D 270	Continued From page 22 skin tear on her left elbow area. Review of Resident #6's Resident Service Note dated 06/05/21 revealed Resident #6 had a skin tear on her right shin. Review of Resident #6's Resident Service Note dated 06/08/21 revealed Resident #6 had a skin tear on her left leg. Review of Resident #6's Resident Service Note dated 06/19/21 revealed Resident #6 had a tiny cut on her right point finger. Review of Resident #6's Resident Service Note dated 06/20/21 revealed: -Resident #6 was observed on the floor in front of her wheelchair (location not documented). -Resident #6's chair alarm was in place and no injuries were noted. -Resident #6's PCP, hospice provider and family member were notified. Interview with the ADRC, who documented the 06/20/21 note, on 07/19/21 at 7:48pm revealed: -She was a licensed practical nurse (LPN) and was worked primarily in the SCU overseeing resident care services. -On 06/20/21, a PCA found Resident #6 on the floor in front of her wheelchair, but she did not remember where. -Thirty-minute checks and vital sign checks should have been implemented and staff tried to implement the checks after each fall. -She did not know if 30-minute checks or vital sign checks were implemented on 06/20/21. -After staff completed 30-minute checks and vital sign checks, they should have submitted documentation of the checks to her. -She was not able to find 30-minute checks and	D 270		

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vital sign checks for Resident #6 after each of her falls.
-She was not sure how Resident #6 obtained bruises and skin tears when she did not have a fall.
-Bruises usually developed within 24 hours after a fall.
-Resident #6 could have gotten bruises and skin tears by hitting herself on her wheelchair.

Documentation of increased supervision or vital sign checks after Resident #6's fall on 06/20/21 was requested on 07/16/21 at 4:47pm, but was not provided.

Review of Resident #6's Resident Service Note dated 06/24/21 at 7:12pm revealed:
-Resident #6 fell out of her wheelchair onto the dining room floor.
-No injuries were noted from the fall.
-Resident #6 had no cues or complaints of pain.
-Resident #6's hospice provider, family member, and the ADRC were notified.
-Staff would continue to monitor Resident #6.

Review of Resident #6's Resident Service Note dated 06/24/21 at 10:17pm revealed:
-A knot had formed on the left side of Resident #6's head where she fell.
-Resident #6's hospice provider, family member and the ADRC were notified.

Interview with the MA who documented the 06/24/21 note on 07/19/21 at 5:47pm revealed:
-Resident #6 fell out of her wheelchair in the dining room on 06/24/21.
-There was a new PCA assisting Resident #6 to eat.
-When the PCA got up to get more food, she left Resident #1 at the table by herself and she fell

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onto the floor.
-Resident #6 developed a knot on her head that evening and she notified Resident #6's family, hospice provider and the ADRC.

There was documentation Resident #6 vital signs were checked on 06/24/21 every 15 minutes from 5:00pm to 5:45pm, every 30 minutes from 6:00pm to 7:30pm, and every hour between 8:00pm to 11:00pm. There was no documentation of any 30-minute checks.

Review of Resident #6's Resident Service Note dated 06/27/21 at 3:20pm revealed:
-Staff reported Resident #6 fell from her wheelchair onto the floor on her right side.
-Resident #6's wheelchair alarm, wheelchair cushion and side cushion were all in place.
-There were no injuries or bruising observed.
-Resident #6's PCP, hospice provider, family member, and the ADRC were notified.

Telephone interview with the PCA who found Resident #6 on 07/19/21 at 3:48pm revealed:
-He was the only staff in the living room where Resident #6 was present.
-He was assisting another resident by pushing the other resident to a table and had his back to Resident #6 when he heard Resident #6 fall.
-Resident #6's vitals were check during his shift.

There was documentation Resident #6 vital signs were checked on 06/27/21 every 15 minutes from 3:02pm to 3:48pm, every 30 minutes from 4:03pm to 5:33pm, and every hour between 6:03pm to 9:03pm. There was no documentation of any 30-minute checks.

Review of Resident #6's record revealed there was not a Morse fall risk evaluation tool or

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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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documentation of the fall investigations available for review for Resident #6's falls from 01/08/21 through 06/27/21.

Review of Resident #6's hospice notes revealed:
-There was documentation on 01/19/21 Resident #6 sustained a fall on 01/18/21 with abrasions on her back, and bruising to Resident #6's left lower leg of unknown origin was noted the previous week.
-There was documentation on 01/28/21 Resident #6 sustained 7 falls since her admission to services on 11/27/20; Resident #6 now had a chair alarm in place and a high/low bed had been ordered for interventions due to falls.
-There was documentation on 03/03/21 the hospice chaplain observed Resident #6 had a large darkened bruise over her left eye from a fall on 02/24/21
-There was documentation on 03/20/21 the hospice nurse made an on-call visit with Resident #6 due to a fall.
-There was documentation on 03/30/21 the hospice nurse made a visit to follow-up on a fall on 03/30/21; Resident #6 had bruising to her left forehead; An order was placed for a chair/bed alarm per the facility's request.
-There was documentation on 04/14/21 the hospice nurse made a follow-up visit for mobility and safety.
-There was documentation on 04/14/21 the hospice chaplain observed Resident #6 looked to be visibly thinner and weaker, increased sliding down and slouched in wheelchair, and needed repositioning more.
-There was documentation on 04/26/21 Resident #6 had a fall from her wheelchair; a wedge cushion was in place and a physical therapy consult for wheelchair positioning was pending.
-There was documentation on 04/27/21 Resident

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D 270	Continued From page 26 #6 sustained 4 falls during the recertification period (not specified); new orders were obtained for a wedge cushion; Resident #6 was no longer able to hold herself upright and required the use of a pillow for additional support in the high back wheelchair. -There was documentation on 05/11/21 by the hospice social worker Resident #6 was slumped in her wheelchair during the visit and the hospice nurse repositioned her. -There was documentation on 05/11/21 physical therapy recommendations were in place to increase patient safety; A wedge cushion and neck cushion were being used by staff. Staff were reclining Resident #6's wheelchair more often to allow Resident #6 to be in a more relaxed position and used footrests. -There was documentation on 05/25/21 by the hospice social worker Resident #6 was slumped in her wheelchair during the visit and was repositioned by the hospice nurse; Resident had an unwitnessed fall on 05/24/21. -There was documentation on 05/26/21 Resident #6 sustained a fall from her wheelchair and was found in her bathroom floor. Observation of Resident #6's room on 07/16/21 at 3:55pm revealed: -Resident #6 was laying in bed on her left side with her bottom close to the right-side edge of the bed. -Resident #6 was awake. -The bed was in the low position and the fall mat was in place in front of the bed. Interview with a MA on 07/16/21 at 3:56pm revealed Resident #6 was able to get to sit up in the bed and would try to get out of the bed. Interview with a PCA on 07/19/21 at 6:01pm	D 270		

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revealed:
-She had been in the living room with Resident #6, but she could not remember when.
-She left the living room where Resident #6 was to take a break, but she did not tell anyone.
-During the time when she was on break, Resident #6 had a fall in the living room.

Interview with the Special Care Unit Coordinator (SCUC) on 07/20/21 at 11:59am revealed:
-She knew Resident #6 had falls, but she was not aware of all of Resident #6's falls since January 2021.
-She thought 30-minute checks and vital sign checks were put in place for Resident #6 after each fall.
-There were multiple interventions put in place for Resident #6.
-She did not know why Resident #6 continued to fall with interventions in place.

Interview with the Administrator on 07/19/21 at 7:06pm revealed:
-She was aware of Resident #6's multiple falls.
-Facility staff worked with Resident #6's hospice provider to implement interventions for Resident #6.
-She did not know why Resident #6 continued to fall with multiple interventions in place including a high back wheelchair, wheelchair footrests, wheelchair pillows and cushions, chair/bed alarm, low bed, scoop mattress, floor mat, and non-skid socks.
-After Resident #6's falls, staff should have implemented 30-minute checks for 3 shifts and vital sign checks for 7 hours.
-The 30-minute checks and vital sign checks should have been documented and given to the ADRC to keep in a binder.
-Staff tried to sit with Resident #6 during their

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shift, but the facility did not have enough staff to provide one-on-one supervision.

Attempted telephone interview with the MA who documented the 02/19/21 note on 07/16/21 at 3:14pm was unsuccessful.

Attempted telephone interviews with Resident #6's PCP on 07/19/21 at 10:17am, 10:34am, 4:46pm, 6:01pm and on 07/20/21 at 1:41pm and 2:36pm were unsuccessful.

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

3. Review of Resident #9's current FL2 dated 01/22/21 revealed:
-Diagnoses included dementia with behavioral disturbances and memory loss.
-The recommended level of care for Resident #9 was the Special Care Unit (SCU).
-The disorientation status for Resident #9 was constantly confused.
-She was incontinent of bladder and bowel and needed extensive assistance with toileting.
-She required personal care assistance with feeding, dressing and bathing.

Review of Resident #9's SCU Profile dated 04/30/21 revealed:
-The resident's wandering patterns were the resident wandered with agitation/aggression and sundowning.
-The resident's cognition was lack of orientation to place, lack of orientation to time, impaired short-term memory and impaired long-term memory.
-Her physical abilities were partial assistance with dressing, grooming and toileting.

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D 270	Continued From page 29 -She required total assistance with bathing and was independent with ambulation and transferring. Review of Resident #9's Care Plan dated 02/10/21 revealed: -She required supervision reminders with eating. -She required extensive assistance with toileting, dressing and grooming. -She was independent with ambulation and transferring. Observation of both dining rooms during lunch meal on 07/14/21 from 12:20pm through 1:10pm revealed: -There were two dining rooms on either side of the kitchen. -In the dining room on the left side of the kitchen there were two personal care aides (PCAs), providing feeding assistance to residents. -In the dining room on the right side of the kitchen there was one PCA walking back and forth between the two dining rooms. -Resident #9 was seated in the dining room on the left side of the kitchen at the table with two other residents. -Before the food was served, the PCAs put tablecloths on all the tables. -Resident #9 and another resident's meal were served and left on the table for the residents to begin eating. -Resident #9 did not eat much of her food. -She started to pull the tablecloth off the table, causing one resident's plate to move in the direction where Resident #9 was rolling up the tablecloth. -The other resident told Resident #9 to stop and pulled the tablecloth back. -A PCA tried to stop Resident #9, but she continued to try to take the tablecloth off the table.	D 270		

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D 270	Continued From page 30 -The PCA walked away and continued to serve other residents' their meal. -Resident #9 started again trying to pull the tablecloth off the table. -After 3 to 4 minutes, a PCA came to Resident #9's table and provided feeding assistance to one of the resident's seated at Resident #9's table. -Resident #9 tried several more times to pull the tablecloth off the table. -The PCA moved both of the resident's plates and allowed Resident #9 to take the tablecloth off the table. -After successfully taking the tablecloth off the table Resident #9 wrapped her own plate up in the tablecloth. -When Resident #9 wrapped her plate up in the tablecloth she still had the majority of her food left on the plate. -Resident #9 got up from the table carrying her plate wrapped in the tablecloth. -She walked out of the dining to the other the dining room on the right. -There was one PCA in the dining room. -The PCA was observed serving plates and walking back and forth between the two dining rooms. -In the second dining room, Resident #9 sat down at the table where two other residents were seated with their plates on the table. -There was a third plate on the table where a resident had previously been seated. -After Resident #9 sat down at the table she put the tablecloth with her plate wrapped inside on the table. -Resident #9 started to roll up the tablecloth causing both of the residents plates to move in the direction of Resident #9. -One resident started yelling at Resident #9 saying, "stop, stop." -The PCA did not hear the resident yelling for	D 270		

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Resident #9 to stop because he was clearing dishes off the tables.
-The surveyor called the attention of the PCA to what Resident #9 was doing.
-The PCA stopped Resident #9 from pulling the tablecloth off the table, and the PCA left Resident #9 at the table and continued doing other things in the dining room.
-Resident #9 started trying to grab the food off one of the other resident's plate.
-The resident put his hands over his food and told Resident #9 to go away.
-The resident yelled at Resident #9 to stop and leave the table.
-The PCA did not see Resident #9 because he was still walking back and forth between the dining rooms.
-The surveyor got the attention of the PCA so he could stop Resident #9 from trying to take the other resident's food.
-The PCA stopped Resident #9 and told her to sit down and eat, and then he pushed the plate that was on the table in front of Resident #9.
-The surveyor informed the PCA that the plate on the table was not Resident #9's plate, but the plate belonged to a resident that had left the table.
-The surveyor informed the PCA that Resident #9's plate was wrapped up in the tablecloth lying on the table.
-The PCA took Resident #9's plate out of the tablecloth and took the plate that belonged to another resident off the table.
-The PCA asked Resident #9 if she wanted to go to the activity room.
-Resident #9 sat down in the chair and did not leave the table.
-Resident #9 stood up and moved the chair away from the table pushing the chair into the wall.
-Resident #9 moved the chair back again back to

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the table and then started to climb over the arm of the chair and stood up in the chair.
-The PCA turned around and saw Resident #9 standing in the chair and he grabbed Resident #9 and helped her to the floor.
-The PCA asked the resident if she wanted to go to the activity room.
-Resident #9 continued sitting at the table and did not move.
-The PCA was still busy clearing plates off the tables in both dining rooms.
-Resident #9 took the roll off another resident's plate and started to walk out of the dining room.
-The surveyor got the PCA's attention and told him that the dinner roll in Resident #9's hand was taken off another resident's plate.
-The PCA took the roll from Resident #9, and Resident #9 left the dining room.
-The PCA did not attempt or try to get Resident #9 another plate.
-The PCA did not give the resident who's dinner roll was taken by Resident #9 another roll.

Interview with the PCA on 07/14/21 at 2:10pm revealed:
-It was not uncommon for Resident #9 to take her own plate and wrap it up in a tablecloth.
-Resident #9 often tried to take food from off other resident's plates.
-Most residents that were alert often got angry with Resident #9 and yelled at Resident #9 for trying to take their food, tablecloth or napkin.
-Staff usually redirected Resident #9 because she continually tried to take the tablecloths and napkins off the tables.

Interview with a PCA on 07/19/21 at at 6:40pm revealed:
-Resident #9 would eat her food, then get up from the table and she tried to grab food off other

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residents plate.
-Staff tried to redirect Resident #9 to stop her from annoying other residents.
-The other residents got upset when Resident #9 took their food.
-Resident #9 took tablecloths and napkins off the table even residents were sitting at the table.
-They tried to watch Resident #9, but it was not easy when attending to all the residents in the dining room.

Telephone interview with a MA on 07/20/21 at 10:43am revealed:
-Resident #9 was always busy during meals, walking the dining room trying to take the tablecloths and napkins off the tables.
-Resident #9 tried to take food from other residents.
-Some days Resident #9 sat down to eat her meals and some days she did not sit down but continually walked from table to table taking food, tablecloths or napkins.
-Usually, all staff were in the dining room was to assist with the meal which included supervising Resident #9.
-The staff that was assigned to work on the hallway where Resident #9 resided was responsible for watching the resident in the dining room.
-Sometimes there was not enough staff in the dining room to help watch all the residents during the meal.
-Most times there were two PCAs and one MA in the dining room to observe residents and serve the meal.
-The set-up in the dining was that all residents who required assistance with eating were seated at one table and one PCA provided assistance.
-The other two PCAs walked around to see which residents needed verbal cueing to eat.

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D 270	Continued From page 34 Interview with the MA supervisor on 07/15/21 at 10:34am revealed: -When it was mealtime, all the staff were supposed to be in the dining room. -The staff present in the in the dining room were three personal care aides (PCAs) and the medication aide (MA). -They initially served plates to each table and then they assisted resident's who needed assistance with eating. -Resident #9 sometimes would sit and eat, but most times she walked around between the two dining rooms. Interview with the Activity Director on 07/15/21 at 10:48am revealed: -Resident #9 was always busy walking around trying to remove tablecloths off the table or taking other residents' food. -Some days, Resident #9 did not want to sit down and eat. -It was not uncommon for Resident #9 to take food from other residents' plates. -Resident #9 moved from table to table and it really annoyed the other residents. Interview with the Special Care Unit Coordinator (SCUC) on 07/15/21 at 9:25am revealed: -Resident #9 would sit sometimes and eat, but it was hard. -Resident #9 sometimes walked around the dining room during the meals. -Staff were supposed to continually redirect Resident #9, and try to get her to sit and continue her meals. Telephone interview with the Assistant Director of Resident Care (ADRC) on 07/20/21 at 10:39am revealed:	D 270		

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D 270	Continued From page 35 -Sometimes she was present for the meals, but not every day. -The SCUC and the activity person were supposed to be in the dining room to assist and supervise with meals. -She was aware that Resident #9 was "all over the place." -Resident #9 liked to walk around throughout the dining room. -Staff in the dining room should be monitoring Resident #9 to ensure she was not interrupting other residents' meals. Interview with the Administrator on 07/19/21 at 7:25pm revealed: -The MA usually supervised the more independent side of the dining room. -She expected staff to provide as much supervision as possible in the dining room. -She did not monitor the dining room in the SCU. -The the SCUC and the activity person were in and out of the dining room "keeping an eye on things." _____ The facility failed to provide supervision to 3 of 7 sampled residents (#1, #6 and #9) residing in the SCU resulting in Resident #1 having multiple falls, sustaining a fractured wrist and skin tears; Resident #6 who had multiple falls which resulted in a knot on the forehead, skin tears, bruises and injuries of unknown origin; and Resident #9 taking food off the plates of other residents and removing tablecloths off the tables during meal service. This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/19/21 for this violation.	D 270		

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D 270	Continued From page 36 CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 19, 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 A1 VIOLATION Based on interviews and record reviews, the facility failed to notify the primary care provider (PCP) for 3 of 7 sampled residents (Resident #1) who continued to decline and was not eating, had a broken wrist with a cast with swollen fingers and hand that turned purple (#1); and two residents who did not eat meals and had weight loss (#7 and #8). The findings are: 1. Review of Resident #1's current FL2 dated 03/11/21 revealed: -Diagnoses included dementia, seizure, anxiety, and sensorineural hearing loss. -Resident #1 was intermittently disoriented, ambulatory, and recommended level of care was Special Care Unit (SCU). Review of Resident #1's Resident Register revealed an admission date of 03/13/21. Review of Resident #1's current care plan dated 03/14/21 revealed:	D 273		

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D 273	Continued From page 37 -He resided in the SCU. -The resident was independent with eating, toileting, ambulation, dressing, grooming and transferring. -He required supervision with bathing. Review of Resident #1's preadmission screening titled "Resident Services - Level of Care Program Review" that was completed by the Assistant Director of Resident Care (ADRC) on 01/14/21 revealed: -He was independent with ambulation, transfer, and dining/meals scored 0 points. -Resident #1 bathing, grooming, continence management, and health and wellness services scored 1 point indicating the resident needed stand-by supervision; set-up, verbal cues and/or reminders to complete the task. -He needed stand-by assistance with part of dressing; required continuous direction/encouragement to dress, and assistance with clothing selection. -He was moderately confused and may have some unpredictable behaviors or required moderate emotional support. Review of Resident #1's SCU Resident Profile dated 03/12/21 revealed: -His score was "NA." -His behavior pattern was "sadness" -Resident #1 had impaired short-term memory. -Resident #1's physical abilities were checked as independent and the resident was able to provide self-help with dressing grooming, toileting, eating, ambulation and transferring. -Resident #1 required supervision by providing cueing/redirection. a. Review of Resident #1's Resident Service Notes revealed:	D 273		

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-On 03/13/21 (no time documented), Resident #1 refused dinner.
-On 03/14/21 at 1:44pm, Resident #1 ate 50% of lunch.
-On 03/16/21 at 2:30pm, Resident #1 ate 25% of his lunch.
-On 03/28/21 (no time documented), Resident #1 ate 50% of his meal.
-On 04/06/21 (no time documented), Resident #1 would not eat dinner.
-On 04/09/21 at 12:00pm, Resident #1 refused breakfast.
-On 04/11/21 at 3:00pm, Resident #1 refused to eat (meal not specified).

Review of Resident #7's hospital report dated 04/11/21 revealed:
-Resident #1 was in the emergency department (ED) and
looked weak and frail.
-Resident #1 did not respond when spoken to.
-His diagnoses were failure to thrive, severe dehydration (primary), acute renal failure (primary), anorexia, hypernatremia (low sodium level) and severe protein-calorie malnutrition.
-The ED physician documented Resident #1's acute renal failure "most likely was due to dehydration."
-The ED physician documented Resident #1's hypernatremia was severe secondary to poor oral intake and dehydration.
-The ED physician documented Resident #1 had severe weakness and encephalopathy due to deficits in nutrition, hydration, and electrolytes.
-Resident #1 was referred to hospice for end of life care.

Review of Resident #1's Resident Service Notes there was no documentation Resident #1's Primary Care Provider (PCP) was contacted and

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made aware the resident was declining and had started refusing to eat meals and his caloric intake had significantly decreased.

Review of Resident #1's Physician Visit Form there was no documentation Resident #1's PCP was contacted and made aware the resident was declining and had started refusing to eat meals and his caloric intake had significantly decreased.

Review of Resident #1's Physician Order Request revealed there was no documentation Resident #1's PCP was contacted and made aware the resident was declining and had started refusing to eat meals and his caloric intake had significantly decreased.

Interview with Resident #1's Power of Attorney (POA) on 07/15/21 at 11:07am revealed:
-She documented each time facility staff told her that Resident #1 did not eat his meals.
-She called the facility on 03/24/21 at 7:45pm to check on Resident #1 and the medication aide (MA) told her Resident #1 ate no dinner.
-She called on 03/28/21 and the Special Care Unit Coordinator (SCUC) told her Resident #1 ate 50% of breakfast.
-On 04/02/21, the MA told her Resident #1 did not eat due to agitation.
-On 04/03/21, she tried to call the facility several times and no one answered the phone.
-On 04/06/21, the MA told her Resident #1 did not eat.
-On 04/08/21, the facility staff told her Resident #1 did not each much.

Telephone interview with Resident #1's first POA on 07/16/21 at 10:07am revealed:
-Prior to Resident #1's admission to the facility, he was totally independent with eating and had a

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good appetite.
-Resident #1 was admitted to the SCU because he left home a couple of times and he needed the locked unit to keep him safe.
-The facility staff did not contact or communicate with Resident #1's PCP unless the family suggested it.
-The family had to tell the facility Assistant Director of Resident Care (ADRC), who was a Licensed Practical Nurse (LPN) that Resident #1 was losing weight, he was not eating and it was a concern.
-She had to ask the ADRC for a nutritional supplement because Resident #1 was not eating and losing weight.
-The ADRC told her the facility could provide nutritional supplements.
-She was not sure if Resident #1 ever got the nutritional supplements..
-She also requested Resident #1 to be weighed weekly because she noticed he had lost weight since he was admitted to the facility, and she wanted to know how much weight he had lost.
-The ADRC told her Resident #1 had not been weighed since he was admitted to the facility.
-The only time she heard from the Director of Resident Care (DRC) was when the DRC called her was after Resident #1 was taken out of the facility to the hospital on 04/11/21.
-She arrived at the facility on Sunday, 04/11/21 at 3:00pm she observed Resident #1 was in the activity room sitting in his wheelchair.
-There was a table pushed directly in front of Resident #1's wheelchair.
-Resident #1's head was bent over and lying on the table.
-The staff told her the table was pushed against the wheelchair to keep Resident #1 from falling out of the wheelchair.
-The MA told her, she put the towel on the table

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because Resident #1 was not holding his head up and kept hitting his head on the table.
-No one at the facility called her to say they were concerned about Resident #1's health, not eating or weight loss.
-No one at the facility called to inform Resident #1 would not sit in a wheelchair or that he was hitting his head because he could not hold his head up.
-Instead they restrained him with the table pushed in front of him.
-When Resident #1 arrived at the hospital on 04/11/21 the hospital staff told her that Resident #1's blood levels from his labs were abnormal.
-The doctor at the hospital told her the Resident #1 was so bad the next step was hospice.
-After Resident #1 broke his right wrist she asked staff if they could remember to cut-up Resident #1's food, then maybe he would eat.
-At various times she came to the facility and found Resident #1's plate sitting on the table and no staff attempting to feed Resident #1.
-She asked staff on several occasions to give Resident #1 water throughout the day.

Interview with Resident #1's second POA on 07/16/21 at 9:06am revealed:
-On 03/13/21, when Resident #1 was admitted to the facility he was ambulatory and walked without assistance.
-On 03/13/21, the facility staff suggested they were not to visit Resident #1 for two weeks to give the resident time to adjust to the new environment.
-She did not visit but family called every day, several times per day to inquire about Resident #1's adjustment to the facility and the resident's health.
-The ADRC told her that Resident #1 was adjusting very well, and the family did not have to stay away for the full two weeks.

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D 273	Continued From page 42 -She was told Resident #1 fell on 03/22/21, getting out of bed. -Prior to 03/22/21, they had not seen Resident #1 since 03/13/21 and they were shocked and amazed at how much weight Resident #1 had lost in such a short period of time. -On 04/06/21, she talked with the ADRC and asked if they would give Resident #1 water and/or an electrolytes sports drink, so he would not get dehydrated. -The family purchased an electrolytes sports drink and left it at the facility. -She discussed with the ADRC that she noticed Resident #1 was getting very thin and asked what could be done? -The ADRC said they would start Resident #1 on the house brand supplement in the morning and evening snack. -On 04/07/21 she asked for a meeting with the Administrator, ADRC and the DRC. -She made the Administrator, ADRC and DRC aware that it was hard for Resident #1 to eat with a broken right wrist because he was right-handed and asked if they would give Resident #1 finger foods. -Resident #1 was never weighed at the facility even after her request to weigh him. -The family continually had to intervene to request health care services for Resident #1. -If Resident #1's family had not intervened the facility would not have done anything for Resident #1. Telephone interview with Resident #1's third POA on 07/15/21 at 11:07am revealed: -Resident #1 moved into the facility's SCU on 03/13/21. -Resident #1 did 100% of his activities of daily living without assistance prior to admission. -Resident #1 ate three meals per day; he sat at	D 273		

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the table, pulled up his own chair and ate without assistance or reminders.
-Resident #1 would go to the refrigerator and pantry to get his own snacks.
-When Resident #1 was not eating, the family called the facility often to asked staff about Resident #1's food intake.
-On 04/10/21, she arrived at the facility 3:45pm, and tried giving Resident #1 something to drink using a straw.
-Resident #1 was weak and he was unable to hold his head up and he could not use his facial muscles to drink from the straw.
-At 4:30pm, the MA told her that her time was up and she had to leave.
-She asked the staff if they wanted her to stay and assist Resident #1 with his dinner.
-The staff told her she had to leave because she had already stayed 15 minutes past the allowed 30 minutes for visits during COVID-19.
-Later that evening they tried to call the facility twice to check on Resident #1 and no one answered the phone.
-Facility staff knew Resident #1 was weak, but had done nothing to help Resident #1.
-Resident #1 had a significant decline from about 03/22/21 to 04/11/21.
-Three weeks after admission Resident #1 was hospitalized and diagnosed with anorexia, severe malnutrition, dehydration, and acute kidney failure.
-When Resident #1 went to the hospital on 03/22/21, anorexia was not put on the paperwork, but when Resident #1 went back to the hospital on 04/11/21, anorexia was one of his diagnoses.
-Resident #1 was so thin his ribs were very visible and his bones were protruding.
-She wanted to know why they were not told Resident #1 was losing weight.

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Telephone interview with Resident #1's previous primary care provider on 07/16/21 at 12:25pm revealed:
-Resident #1 was independent with eating and dressing.
-He would sometimes get confused, but he was healthy and he ate well.
-Resident #1 walked almost every day.
-Resident #1's eating habits were great, there was no problem getting him to eat meals.
-Resident #1 was diagnosed with Alzheimer's disease at least one year prior to moving into the facility.
-She last saw Resident #1 on 03/12/21; the day before he moved into the facility, and he appeared to be healthy.

Interview with a second shift MA on 07/15/21 at 3:10pm revealed:
-Resident #1 would not sit down, and sometimes she had to call in his partner.
-Resident #1 was not a good eater.
-She sometimes called Resident #1's family to see if they could get him to eat.
-Resident #1 was not eating and he had weight loss.
-Resident #1 was a slim man when he came to the facility and he dropped weight fast.
-She did not remember informing Resident #1's PCP about the resident was not eating and had weight loss.
-If she had called the PCP it would be documented in Resident #1's record.
-The ADRC and Special Care Unit Coordinator (SCUC) were aware Resident #1 was not eating.

Interview with a MA on 07/16/21 at 3:16pm revealed:
-After Resident #1 fell and broke his wrist he declined and went from walking independently to

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being in a wheelchair and not eating.
-Resident #1 always said he was not hungry and would not eat.
-When she worked, she tried to get Resident #1 to eat.
-Sometimes she was able to get Resident #1 to eat but she had to sit with the resident for 1 to 2 hours to assist him with meals.
-She noticed Resident #1 had lost weight and she told another MA.
-She did not contact Resident #1's PCP because she thought the MA was going to tell the ADRC.

Interview with a MA on 07/19/21 at 12:15pm revealed:
-Resident #1 would not eat.
-She called the POA to come to the facility and to try to get the resident to eat.
-Sometimes Resident #1 would take a couple of bites and then spit it out.
-The PCA would tell the MA about the resident not eating.
-The ADRC knew Resident #1 was not eating because she was present and observed Resident #1 was not eating.
-She could not tell if Resident #1 had lost weight.
-After Resident #1 fell and broke his wrist she could barely get water in his system.
-The ADRC was responsible for contacting Resident #1's PCP.

Telephone interview with the MA supervisor on first shift on 07/20/21 at 11:48am revealed:
-Resident #1 sometimes refused to eat meals.
-Someone had to be with Resident #1 all the time.
-Resident #1 had declined but she did not contact the PCP.

Interview with the SCUC on 07/15/21 at 3:03pm

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D 273	Continued From page 46 revealed: -They never obtained a weight on Resident #1 because he would not cooperate in order for staff to obtain his weight. -She did not know if there was documentation which showed they tried to obtain a weight on Resident #1. -Sometimes Resident #1 ate and sometimes he did not. -There was no one monitoring Resident #1's weight because this was assisted living and they were not required. -When they had "at risk" meetings every Tuesday, residents with concerns were discussed. -She did not recall if Resident #1 was discussed. -Resident #1 also required assistance with eating. -The care plan was not updated to show the resident's current status. -The DRC would have been responsible for updating Resident #1's care plan to show the resident's current health care needs. Interview with the ADRC on 07/15/21 at 2:55pm revealed: -She was an LPN and she usually worked in the SCU. -Sometimes the resident would be so agitated it would be hard to get Resident #1 to sit down and eat. -Resident #1's eating habits were dependent on his mood. -When Resident #1 was agitated, he would not eat. -Sometimes if he was approached a little while later, he might eat a little. -Resident #1's weight upon admission was not obtained because Resident #1 was agitated. -She completed the initial paperwork for Resident #1's admission to the facility.	D 273		

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-She completed Resident #1's Care Plan but was unable to recall if a physical assessment was completed upon admission to the facility.
-She called Resident #1's PCP each time the family requested.
-She was unable to recall if she initiated any call to the PCP with concerns regarding Resident #1's decline in his health and weight loss.

Telephone interview with the ADRC on 07/20/21 at 10:39am revealed:
-She contacted Resident #1's PCP on 04/07/21, because Resident #1's family was concerned that Resident #1 was not eating and losing weight.
-The family asked for nutritional supplement shakes and weekly weights.
-Prior to Resident #1's family contacting her on 04/07/21, she had not contacted Resident #1's PCP regarding the resident's weight loss and/or not eating.
-She contacted Resident #1's PCP with the request made by the family, and asked for a medication to increase the resident's appetite.
-She did not remember where she documented the contact with Resident #1's PCP.
-She did not put any systems in place for staff to assist Resident #1 with eating meals, but she knew staff helped Resident #1 if he needed help.
-She thought after Resident #1 broke his wrist Resident #1 still went through the motions of feeding himself.
-She did not weigh Resident #1; she thought it was during the time they were having problems with their scale.
-Resident #1's agitation made it difficult to obtain an accurate weight.
-If the PCP was notified, then there should be documentation in the resident's record to show contact with the PCP and the outcome.
-She was not sure if Resident #1's PCP had been

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D 273	Continued From page 48 contacted specifically to address his decline and weight loss. Telephone interview with the Registered Nurse (RN) at Resident #1's PCP office on 07/20/21 at 1:44pm revealed: -There was no documentation in the record regarding Resident #1's weight loss. -The PCP's first encounter with Resident #1 was 03/22/21. -The second encounter was on 03/29/21, and the last encounter was on 04/05/21. -The PCP was in the facility weekly but did not see Resident #1 unless the facility staff made him aware of a specific concern regarding Resident #1. -The PCP's last face-to-face encounter with Resident #1 was on 04/05/21 and medication changes were made at that time. -On 04/08/21, there was a telephone encounter with someone from the facility stating Resident #1's family was concerned about the resident's decrease in appetite and wondered if the medication cyproheptadine (used to increase appetite) would be appropriate for increasing the resident's appetite. -The PCP ordered cyproheptadine 4mg half-tablet (2mg) once a day at bedtime for 42 days. -There was also a request for a nutritional supplement twice daily between meals and weekly weights. Telephone interview with the nurse from Resident #1's hospice provider on 07/16/21 at 11:53am revealed: -Resident #1 was admitted to the care of hospice on 04/20/21. -His admitting diagnoses was protein-calorie severe malnutrition.	D 273		

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D 273	Continued From page 49 -Resident #1 passed away on 05/13/21. Interview with the Administrator on 07/15/21 at 12:28pm revealed: -The facility did not have any documented weights for Resident #1 from 03/13/21 through 04/11/21. -The facility contacted Resident #1's PCP and the PCP was in the facility weekly. -There was no documentation Resident #1's PCP was notified. -The PCP office had a report dated 04/08/21 that showed the ADRC contacted them regarding getting a medication to increase Resident #1's appetite. -Resident #1's behaviors were so bad and that was mainly what they focused on, trying to control the resident's behaviors. b. Review of Resident #1's Resident Service Notes revealed: -On 03/22/21, Resident #1 had a fall and fractured his right wrist. -On 03/22/21, Resident #1 went to an orthopedic specialist to have a cast put on his hand. Review of Resident #1's Resident Service Notes revealed: -On 03/23/21 at 1:30pm, Resident #1 complained of pain in his right arm. -On 03/26/21 at 1:00am, bruising was observed on Resident #1's right arm above the cast and his fingers on this right hand had some swelling. Interview with Resident #1's second POA on 07/16/21 at 9:06am revealed: -Resident #1 went to the hospital on 03/22/21 because he fell and fractured his right wrist. -On 03/27/21, she came to see Resident #1 and his hand was swollen and purple in color.	D 273		

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D 273	Continued From page 50 -She asked the medication aide (MA) what was wrong with Resident #1's hand. -The MA told her, Resident #1's swollen hand "looked better today than it did yesterday." -The MA was aware of how swollen Resident #1's hand was and it was turning dark purple, but she did not contact the family or Resident #1's PCP. -She called the orthopedic specialist and was told the cast needed to come off because Resident #1's hand was swelling, and the cast was cutting off the circulation. -The orthopedic specialist suggested getting some medical provider to cut the cast off. -While making calls to find someone to cut the cast off the MA informed them that their 30 minutes visitation was up and they had to leave the facility. -She left the facility but continued to try to find someone to cut off Resident #1's cast. Telephone interview with Resident #1's third POA on 07/15/21 at 11:07am revealed: -During the visit on 03/24/21, they noticed Resident #1's hand was very swollen and purple in color. -They asked the medication aide (MA) "what was wrong with Resident #1's hand and the reason it was swollen and purple in color?" -The MA said, Resident #1's hand "looked better today than it did yesterday because there was more swelling yesterday." -The MA informed the POA she did not contact Resident #1's PCP but thought it was normal for a fracture to swell. -They took a picture of Resident #1's hand to send to the hand specialist to find out if the swelling and purple color was normal. -The hand specialist told her the cast needed to be cut off because Resident #1's hand was swelling.	D 273		

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D 273	Continued From page 51 -Instead of resolving the issue, facility staff told them their 30 minutes visitation time was up and they needed to leave because that was their COVID-19 policy. -They tried to explain to the MA that they were concerned about Resident #1's hand and were trying to find someone to cut the cast off as the hand specialist recommended. -The MA's response was they still had to leave the facility due to the COVID-19 policy. -She left the facility but continued to call to find someone to help relieve the pressure on Resident #1's hand. -After multiple unsuccessful attempts, the family contacted the hand specialist, who agreed to see Resident #1 the same evening in his office to have the cast adjusted. -Each time Resident #1 needed health care services the family had to initiate contacting the health care provider. Interview with a MA on 07/19/21 at 12:15pm revealed: -She recalled when Resident #1's cast was too tight. -The PCP was not notified about the cast being tight. -She never faxed the PCP about Resident #1's cast being too tight because that was the ADRC's responsibility. Attempted telephone interview with the medication aide (MA) that worked on 03/27/21 on 07/16/21 at 1:52pm was unsuccessful. 2. Review of the facility's weight policy revealed: -Weights were to be obtained upon move-in and every 3 months thereafter. Weights were to be documented on the vital sign and weight record. -If the weight shows a loss/gain of 7.5% or more	D 273		

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from the prior weight recorded, another staff member reweighs the resident within 24 hours.
-The resident's physician/healthcare provider was notified of any significant weight loss/gain.
-The resident and/or responsible party was notified of weight loss/gain of 5% or more.
-A referral to a dietician for consult is considered to assess the resident needs and concerns and to provide resident specific nutritional guidance.
-Significant weight loss/gain is addressed by updating the service plan and documenting in the resident record.

Review of Resident #7's current FL2 dated 03/26/21 revealed:
-Diagnoses included dementia without behaviors, muscle weakness, anemia, heart disease, anxiety, non-rheumatic aortic valve stenosis, tremor, amnesia, cardiac murmur.
-Resident #7's disorientation, ambulatory, continent status was not addressed on the current FL2.
-Resident #7's weight on the FL2 was 142 pounds (lbs).
-Resident #7 was ordered a regular diet with no added salt (NAS).

Review of Resident #7's Resident Services - Level of Care Program review dated 06/18/20 revealed Resident #7 scored 0 points for dining/meals indicating Resident #7 could eat independently or with meal set up only.

Review of Resident #7's Care Plan dated 01/18/21 revealed Resident #7 required supervision during meals with "reminders."

Observation of Resident #7's lunch meal on 07/14/21 from 12:15pm through 1:10pm revealed:
-Resident #7 dropped most of her food on the

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table, on her clothes and on the floor.
-Resident #7 was successful in getting a very small amount of food in her mouth.
-Resident #7 did not attempt to drink her water or tea.
-Resident #7 had a roll in her hand and took one bite off the roll and then she dropped the roll on the floor.
-Resident #7 consumed 10% of her meal.
-The resident dropped 40% of her food on the table, herself and the floor.
-She left 50% of her food remaining on the plate.
-Resident #7 ate 100% of the brownie and was then taken out of the dining room by staff.

Review of Resident #7's monthly weights May 2021 through July 2021 revealed:
-Resident #7's weight obtained in May 2021 (date weight obtained was not provided) was 144.4.
-Resident #7's weight obtained in June 2021 (date weight obtained was not provided) was 122.
-Resident #7 had a 22.4 pound weight loss (15.5%) from May 2021 through June 2021.
-According to the facilty's policy this was a significant weight loss.
-The facility's policy required the resident to be re-weighed; the resident's primary care provider (PCP) be contacted and the resident's family/guardian be contacted.
-There was no documentation the facility's weight loss policy was followed.
-In July 2021 (date weight obtained was not provided), Resident #7's weight obtained was 119.6, which was an additional 2.4 pound weight loss.
-The resident's total weight loss from May 2021 through July 2021 was 24.8 pound weight loss (17.2%).
-According to the facilty's policy this was a significant weight loss.

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-The facility's policy required the resident to be re-weighed; the resident's primary care provider (PCP) to be contacted and the resident's family/guardian be contacted.
-There was no documentation the facility's weight loss policy was followed.

Observation of Resident #7's weight obtained on 07/15/21 at 4:56pm revealed Resident #7's current weight was 123 pounds.

Interview with the PCA on 07/15/21 at 2:30pm revealed:
-He noticed Resident #7 lost weight, but he thought it was a normal part of the aging process so he did not tell the MA.
-He thought Resident #7 did better eating solid foods, but he had not mentioned that to anyone.
-The MA was the immediate supervisor, so if he had something to report he would tell the MA.
-He did not tell the MA that he noticed Resident #7 had lost weight.

Interview with Resident #7's Power of Attorney (POA) on 07/19/21 at 5:49pm revealed:
-The POA did not see Resident #7 that often, she had not seen Resident #7 since COVID-19 started.
-On 07/15/21, the Special Care Unit Coordinator (SCUC) called and informed her Resident #7 was being referred to physical therapy and speech therapy.
-The SCUC told her staff were going to start monitoring Resident #7's weight.
-She did not tell her that Resident #7 had weight loss.
-She would like to be informed about the weight loss if it was significant.

Interview with a second PCA on 07/19/21 at

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D 273	Continued From page 55 6:34pm revealed: -Resident #7 usually spilled her food and did not eat much. -She weighed Resident #7 every month and wrote the weight on a piece of paper. -When she weighed Resident #7 last month, she noticed the resident had lost weight. -She did not verbally tell the SCUC about the resident's weight loss, but she gave the paper with the weight results to the SCUC. Interview with a third PCA on 07/16/21 at 3:58pm revealed: -Resident #7 usually moved her food around on her plate. -The resident might eat a few bites of food, then tried to leave the dining room. -She told the MA a few weeks ago that Resident #7 appeared to have lost weight. -The facility's policy was that she reported concerns to the MA, the MA reported to the SCUC or the Assistant Director of Resident Care (ADRC). Interview with a MA on 07/16/21 at 3:30pm revealed: -Resident #7 ate about 25% of her food at the dinner meal and would then try to leave the dining room. -Resident #7's legs were normally swollen, and she had not noticed the resident had lost weight. Interview with the SCUC on 07/15/21 at 9:25am revealed: -She did not realize Resident #7 had lost weight. -The facility did not have a system of monitoring food intake to identify resident's with weight loss. -Weights were obtained monthly and given to the ADRC. -She did not contact Resident's #7's primary care	D 273		

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provider (PCP); if the PCP was contacted it was done by the ADRC.

Interview with the ADRC on 07/15/21 at 4:55pm revealed:
-She was not sure if someone was doing weight monitoring.
-When she received weights she documented the weights in the facility's weight log on the computer.
-She did not check the resident's weight to ensure accuracy.
-The MA, she or the DRC would have contacted the resident's PCP.
-She was not sure Resident #7's weight of 144.4 was an accurate weight.
-She did not check the weight to see if it was accurate or if Resident #7 had weight loss.
-She did not contact Resident #7's PCP about the weight.

Interview with the Administrator on 07/15/21 at 5:44pm revealed:
-There was a period of time when staff were not properly weighing residents because the scale needed to be calibrated.
-She purchased a new scale and it was delivered to the facility on 04/12/21.
-Resident #7's weight of 144.4 was obtained on 05/23/21, after the new scale was in place.
-The ADRC or Director of Resident Care (DRC) was responsible for monitoring weights and contacting the PCP.

Based on observation, record review and interviews it was determined that Resident #7 was not interviewable.

Attempted telephone interviews with Resident #7's PCP on 07/15/21 at 3:01pm and on 07/16/21

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D 273	Continued From page 57 at 10:17am, 4:46pm and 6:01pm were unsuccessful. 3. Review of Resident #8's current FL2 dated 07/01/21 revealed: -Diagnoses included Alzheimer's disease, atherosclerotic heart disease, benign prostatic hyperplasia and chronic kidney disease. -Resident #8 was constantly disoriented, semi-ambulatory with a wheelchair, incontinent of bladder and bowel. -Resident #8 was ordered a regular diet. Review of Resident #8's Care Plan dated 06/20/21 revealed Resident #8 required supervision with eating. Review of Resident #8's Senior Living Resident Evaluation dated 03/29/21 revealed: -Resident #8 needed verbal cues/reminders to attend meals. -The caregivers were supposed to offer the resident choices regarding mealtime, menu selection and dining location. Observation of Resident #8's lunch meal on 07/14/21 at 12:21pm revealed: -At 12:20pm Resident #8's meal was placed on the table and staff walked away. -Resident #8 did not eat any of his meal. -After 28 minutes of not eating his food or drinking his water or tea the PCA took Resident #8 out of the dining room, sliding him backwards in his wheelchair because the resident could not lift his feet up off the floor. Review of Resident #8's documented weights revealed: -In the month of May 2021 Resident #8's weight was 179.	D 273		

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D 273	Continued From page 58 -In the month of June 2021 Resident #8's weight was 171. -In the month of July 2021 Resident #8's weight was 172.8. Observation of Resident #8's weight obtained on 07/16/21 at 3:05pm revealed Resident #8's current weight was 171.2 pounds. Interview with a personal care aide (PCA) on 07/15/21 at 2:38pm revealed: -He mentioned to the PCA who was assigned to assist Resident #8, that Resident #8 had lost weight. -He did not tell the MA or any other management staff, only the PCA. Interview with a second shift PCA on 07/16/21 at 3:58pm revealed: -Resident #8 normally took time eating. -If she had time, she provided feeding assistance. -Resident #8 physically appeared to have lost weight. -Last week she told the medication aide (MA) about the weight loss. Interview with the MA on 07/16/21 at 3:39pm revealed: -The PCAs gave her Resident #8's weights but she did not notice if the resident had lost weight. -She gave weights to the Special Care Unit Coordinator (SCUC) or Assistant Director of Resident Care (ADRC) and if there was a problem, they would follow-up. -She did not recall the PCA telling her that Resident #8 had lost weight. Interview with the SCUC on 07/15/21 at 9:25am and 3:03pm revealed: -Staff gave her Resident #8's weight results and	D 273		

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she gave them to the ADRC.
-The ADRC was responsible for logging the weights into the system.
-If there was a weight loss, then she thought the ADRC would follow-up on that.

Interview with the ADRC on 07/15/21 at 2:55pm revealed:
-There was no system of monitoring the residents' food intake and reporting weight loss to the provider.
-She had reported Resident #8's weight loss the PCP.

Based on observation, record review and interviews it was determined that Resident #8 was not interviewable.

Attempted telephone interviews with Resident #7's PCP on 07/15/21 at 3:01pm and on 07/16/21 at 10:17am, 4:46pm and 6:01pm were unsuccessful.

Interview with the Administrator on 07/19/21 at 6:50pm revealed:
-The ADRC was assigned to the SCU and she was supposed to look at weights.
-If the ADRC thought there was a discrepancy in weights, then she was to have staff re-weigh residents.
-There should be documentation to show this was done.

_____

The facility failed to ensure the PCP was notified regarding a resident that declined due to not eating meals and drinking beverages resulting in the resident being diagnosed with anorexia, dehydration, severe malnutrition, acute kidney failure and passed away 29 days later (#1); a resident having a 24.8 pound weight loss from

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D 273	Continued From page 60 May to July 2021 (#7), and a resident with an 8 pound weight loss from May to June 2021 (#8). This failure resulted in serious physical harm, neglect and death which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/16/21. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 19, 2021.	D 273		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assist and prompt residents who resided in the Special Care Unit (SCU) with eating meals, resulting in residents leaving the dining without eating and residents who spilled their food on the table, their cloths and the floor. The findings are: 1. Review of Resident #7's current FL2 dated 03/26/21 revealed: -Diagnoses included dementia without behaviors,	D 312		

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muscle weakness, anemia, heart disease, anxiety, non-rheumatic aortic valve stenosis, tremor, amnesia, cardiac murmur.
-She was disorientation, ambulatory, continent status was not addressed on the current FL2.
-She was ordered a regular diet with no added salt (NAS).

Review of Resident #7's Resident Services - Level of Care Program review dated 06/18/20 revealed Resident #7 could eat independently or with set up only.

Review of Resident #7's Care Plan dated 01/18/21 revealed Resident #7 required supervision during meals with "reminders."

Observation of Resident #7's lunch meal service on 07/14/21 from 12:20pm to 1:10pm revealed:
-Resident #7 was seated in the dining room located on the right side of the kitchen.
-Resident #7 had one tablemate.
-At 12:21pm Resident #7's food was placed on the table and staff walked away.
-Resident #7 was served mixed vegetables, rice, shrimp and a roll.
-Using her fork, Resident #7 attempted several times to eat her rice and mixed vegetables.
-Resident #7 dropped the majority of her food on the table, on her clothes and on the floor.
-Resident #7 was successful in getting a very small amount of food in her mouth.
-Resident #7 did not attempt to drink her water or tea.
-Resident #7 had a dinner roll in her hand and took one bite of the roll and then she dropped the roll on the floor.
-Resident #7 attempted several times to pick the roll up off the floor, but was unsuccessful.
-There was one personal care aide (PCA) in the

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dining room where Resident #7 was eating.
-The PCA walked back and forth between both dining rooms.
-The PCA did not ask Resident #7 if she needed assistance with her meal.
-The PCA did not communicate with Resident #7 at all during the observation of the meal.
-Resident #7 dropped 40% of her food on the table, herself and the floor.
-Resident #7 left 50% of her food remaining on the plate.
-A PCA who had been assisting another resident with eating in the other dining room came into the dining room where Resident #7 was eating and started clearing plates off the tables.
-At 12:58pm the PCA took away Resident #7's plate, cleaned the table and got the food off the floor.
-The PCA gave Resident #7 a brownie to eat.
-Resident #7 ate 100% of the brownie and was then taken out of the dining room.

Interview with the medication aide (MA) supervisor on 07/15/21 at 3:10pm revealed:
-When Resident #7 was ready or wanted to eat, she ate her food.
-If any resident was not eating, the staff in the dining should be cueing the resident frequently.

Interview with the PCA on 07/15/21 at 2:30pm revealed:
-Resident #7 normally spilled her food all over the table and herself at every meal.
-When he tried to assist Resident #7, she sometimes resisted and looked confused.
-When he tried to physically assist Resident #7 with eating, she reached for the fork herself, so he thought she did not want feeding assistance.
-He thought that Resident #7 did better eating solid foods, like finger foods, but had not

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CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 312	Continued From page 63 mentioned that to anyone. Interview with the Activity Director on 07/15/21 at 10:48am revealed: -At least three days per week, she worked as a PCA and MA. -When it was mealtime, all staff were supposed to be in the dining room to assist residents with their meal. -Resident #7 could feed herself; staff did not provide the resident assistance with eating. -Resident #7 spilled her food all the time. -Resident #7 spilled her food on table, herself and the floor. -At least three days per week Resident #7 wasted her food and dropped her drinking glasses on the floor. -She did not get Resident #7 more food when she spilled her food. Interview with the Special Care Unit Coordinator (SCUC) on 07/15/21 at 9:25am revealed: -When staff were in the dining, they were supposed to monitor the residents' in the dining room to see who was not eating. -Resident #7 should have been assisted with her meal. -If staff were unable to assist Resident #7, then they should have let someone else know to provide Resident #7 assistance with the meal. -Sometimes Resident #7 said she did not need assistance. -Staff was supposed to attempt several times to help Resident #7 with her meal. -She was not sure if there was a monitoring system to identify resident's who needed assistance with eating. Based on observation, record review and interviews it was determined that Resident #7	D 312		

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D 312	Continued From page 64 was not interviewable. Attempted telephone interviews with Resident #7's PCP on 07/15/21 at 3:01pm and on 07/16/21 at 10:17am, 4:46pm and 6:01pm were unsuccessful. Refer to telephone interview with a MA on 07/20/21 at 10:43am. Refer to interview with the Administrator on 07/19/21 at 6:50pm. 2. Review of Resident #8's current FL2 dated 07/01/21 revealed: -Diagnoses included Alzheimer's disease, atherosclerotic heart disease, benign prostatic hyperplasia and chronic kidney disease. -Resident #8 was constantly disoriented, semi-ambulatory with a wheelchair, incontinent of bladder and bowel. -Resident #8 was ordered a regular diet. Review of Resident #8's Care Plan dated 06/20/21 revealed Resident #8 required supervision with eating. Review of Resident #8's "Resident Evaluation" dated 03/29/21 revealed he needed verbal cues/reminders to attend meals. Observation of Resident #8's lunch meal service on 07/14/21 from 12:20pm to 1:10pm revealed: -At 12:20pm, staff set Resident #8's plate on the table and walked away. -Resident #8's meal consisted of mixed vegetables, rice, shrimp and a roll. -Resident #8 did not eat any of this meal. -No staff were observed cueing Resident #8 to eat his meal or asking the resident if he needed	D 312		

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assistance with eating.
-Another resident took Resident #8's dinner roll from off his plate and walked away.
-Resident #8 looked at the resident and did not say anything.
-The surveyor informed the PCA that a resident had taken Resident #8's dinner roll from off his plate.
-The PCA retrieved the roll from the resident and threw it away but did not get Resident #8 another roll.
-After 28 minutes of not eating his food or drinking his water or tea the PCA took Resident #8 out of the dining room, sliding him backwards in his wheelchair because the resident could not lift his feet up off the floor.
-Resident #8 did not consume any of his meal.

Interview with a personal care aide (PCA) on 07/15/21 at 2:38pm revealed:
-Resident #8 did not eat his food unless he was provided continual reminders.
-Sometimes they had to sit and assist Resident #8 with eating his meal.

Interview with the medication aide (MA) on 07/15/21 at 3:10pm revealed:
-Resident #8 took his time eating his food.
-Resident #8 was supposed to be cued at every meal when he was not eating.
-She cued Resident #8 to eat his meal and then she left the dining room to assist another resident.
-The PCA in the dining should have continued reminding/cueing Resident #8 to eat his food.

Interview with the MA supervisor on 07/15/21 at 10:34am revealed:
-All the staff were supposed to be in the dining room during mealtimes.

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D 312	Continued From page 66 There should be three PCAs and a MA present in the dining room during meals. Interview with the Special Care Unit Coordinator (SCUC) on 07/15/21 at 9:25am and 3:03pm revealed: -Staff should have offered to assist Resident #8 with his meal. -If the resident said that he did not need help but did not eat, then staff should have continually approached Resident #8 to ask if he needed feeding assistance. -Sometimes during the lunch meal, she was in the dining room. -Staff were supposed to observe resident's in the dining room during the meals. -If a resident was not eating cueing or feeding assistance should be provided. Interview with the Activity Director on 07/15/21 at 10:48am revealed: -Most times, Resident #8 slept in his wheelchair during mealtimes. -She used to assist Resident #8 with his meals, but most times he was asleep. -She previously tried to feed Resident #8, but he did not open his mouth. -Some days Resident #8 ate his food if she reminded him to eat. Based on observation, record review and interviews it was determined that Resident #8 was not interviewable. Attempted telephone interviews with Resident #8's PCP on 07/15/21 at 3:01pm and on 07/16/21 at 10:17am, 4:46pm and 6:01pm were unsuccessful. Refer to telephone interview with a MA on	D 312		

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D 312	Continued From page 67 07/20/21 at 10:43am. Refer to interview with the Administrator on 07/19/21 at 6:50pm. _____ Telephone interview with a MA on 07/20/21 at 10:43am revealed: -Sometimes there were not enough staff in the SCU dining room to supervise all the residents during the meal. -Most times there were two PCAs and one MA in the dining room to observe residents and serve the meal. -The dining rooms were set-up so that all residents who needed assistance with eating their meals were seated at one table and one PCA provided assist with the meal. -The other two PCAs walked around the dining room to see which residents needed verbal cueing. -She did not know why this process was not followed during the lunch meal on 07/14/21. Interview with the Administrator on 07/19/21 at 6:50pm revealed: -The MA should be supervising the dining room for residents who needed assistance during mealtime. -If for some reason the MA was not in the dining room, then staff should observe which residents needed assistance with eating their meal or cueing. -If all staff were sitting down assisting residents with eating, then the activity director and the SCUC were supposed to be cycling in the dining room. -Her expectation was that all staff were present in the dining room to supervise and provide assistance as needed.	D 312		

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 2 residents (Resident #10) sampled during the 8:00am medication pass on 07/15/21 and 3 of 5 residents (Residents #1, #3, and #4) sampled for record review related to an anti-convulsant medication (#1), anti-seizure medications, an anti-hypertensive medication, and an eyedrop medication, medications used to treat seizures (#3), anti-depressant medications, a pain medication, and an earwax lubricant (#4). The findings are: 1. Review of Resident #3's current FL2 dated 07/15/21 revealed diagnoses included hypertension, type 2 diabetes, hyperlipidemia, and chronic obstructive pulmonary disease. a. Review of Resident #3's previous FL2 dated 01/10/20 revealed an order for Dilantin 30mg (used to treat seizures) 1 capsule at bedtime. Review of Resident #3's Medication	D 358		

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D 358	Continued From page 69 Administration Record (MAR) for May 2021 revealed: -There was an entry for Dilantin 30mg 1 capsule at bedtime scheduled for administration at 8:00pm. -There was documentation Dilantin 30mg was not administered for 11 of 31 opportunities between 05/01/21 through 05/31/21. -There was no documentation on the back of the MAR indicating why Dilantin 30mg was not administered. Review of Resident #3's MAR for June 2021 revealed: -There was an entry for Dilantin 30mg 1 capsule at bedtime scheduled for administration at 8:00pm. -There was documentation Dilantin 30mg was not administered for 2 of 30 opportunities between 06/01/21 through 06/30/21. -There was no documentation on the back of the MAR indicating why Dilantin 30mg was not administered. Observation of Resident #3's medication available for administration on 07/15/21 at 4:00pm revealed Dilantin 30mg 1 capsule at bedtime was dispensed by the pharmacy on 06/15/21 with a quantity of 30 capsules and 3 capsules were remaining. Interview with a pharmacist at Resident #3's pharmacy on 07/15/21 at 11:18am revealed: -Resident #3 had an order for Dilantin 30mg 1 capsule at bedtime. -Dilantin 30mg was dispensed to the facility on 05/14/21 and 06/15/21 with a quantity of 30 tablets on each dispense date. -The facility had to call to reorder all of Resident #3's medications.	D 358		

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D 358	Continued From page 70 -Once a medication was reordered, most of the time the medication was delivered the same day. -There was no delivery service on Saturday or Sunday, so if a medication was reordered late on Friday, Saturday or Sunday, it would not be delivered until the following Monday. Interview with a medication aide (MA) on 07/15/21 at 4:58pm revealed: -She circled her initials on the MAR when a medication was not available for administration and when she did not administer the medication to a resident. -She circled her initials on the MAR in May 2021 for Resident #3's Dilantin 30mg because the medication was not in the facility. -She should have called or faxed the pharmacy to see why Resident #3's Dilantin 30mg had not been delivered to the facility. -She did not know if she called the pharmacy regarding Resident #3's Dilantin 30mg. -Medications should be reordered when the bubble pack was down to the last column of medication. Interview with Resident #3 on 07/16/21 at 11:04am revealed: -She did not know the names of her medication, but she knew she was on a medication for seizures. -The facility sometimes ran out of medication. -The staff sometimes told her they were waiting on the pharmacy to send medications. -She had not had any seizures within the last year. Interview with a nurse at Resident #3's neurologist's office on 07/16/21 at 1:01pm revealed: -Resident #3 had physician's orders for Dilantin	D 358		

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30mg 1 capsule at bedtime for seizures.
-The facility had not made the neurologist aware Resident #3 missed multiple consecutive doses of Dilantin 30mg in May and June 2021.
-The neurologist office expected to the facility to let them know if they had trouble obtaining medication from the pharmacy.
-The neurologist's staff would have assisted the facility with contacting the pharmacy to get Dilantin refilled or to give a verbal order to the pharmacy if needed.
-Resident #3 could have had a seizure as a result of missing multiple consecutive doses of Dilantin 30mg.

Refer to interview with the MA on 07/15/21 at 6:30pm.

Refer to telephone interview with another MA on 07/20/21 at 11:10am.

Refer to interview with the Assistant Director of Resident Care (ADRC) on 07/19/21 at 7:40pm.

Refer to interview with the Administrator on 07/19/21 at 6:50pm.

b. Review of Resident #3's previous FL2 dated 01/10/20 revealed an order for Dilantin kapseal 100mg (used to treat seizures) 3 capsules at bedtime.

Review of Resident #3's Medication Administration Record (MAR) for May 2021 revealed:
-There was an entry for Dilantin kapseal 100mg 3 capsules at bedtime scheduled for administration at 8:00pm.
-There was documentation Dilantin kapseal 100mg was not administered for 1 of 31

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opportunities between 05/01/21 through 05/31/21.
-There was no documentation on the back of the MAR indicating why Dilantin 30mg was not administered.

Review of Resident #3's MAR for June 2021 revealed:
-There was an entry for Dilantin kapseal 100mg 1 capsule at bedtime scheduled for administration at 8:00pm.
-There was documentation Dilantin kapseal 100mg was not administered for 1 of 30 opportunities between 06/01/21 through 06/30/21.
-There was no documentation on the back of the MAR indicating why Dilantin kapseal 100mg was not administered.

Review of Resident #3's MAR for July 2021 revealed:
-There was an entry for Dilantin kapseal 100mg 1 capsule at bedtime scheduled for administration at 8:00pm.
-There was documentation Dilantin kapseal 100mg was not administered for 7 of 14 opportunities between 07/01/21 through 07/14/21.
-There was no documentation on the back of the MAR indicating why Dilantin kapseal 100mg was not administered.

Observation of the medication available for Resident #3 on 07/15/21 at 4:00pm revealed:
-Dilantin kapseal 100mg was not available for administration.
-The MA looked in the overstock medications on the medication cart where she found Dilantin kapseal 100mg.
-Resident #3's Dilantin 100mg had been dispensed on 07/12/21 with a quantity of 90 tablets and 90 tablets were remaining.

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D 358	Continued From page 73 Interview with the pharmacist at Resident #3's pharmacy on 07/16/21 at 2:55pm revealed: -Resident #3 had an order for Dilantin kapseal 100mg 3 capsules at bedtime. -Dilantin kapseal 100mg was dispensed to the facility on 02/24/21 with a quantity of 30 tablets and 04/26/21 with a quantity of 30 tablets. -Dilantin kapseal 100mg was dispensed to the facility on 05/27/21 with a quantity of 30 capsules and on 07/12/21 with a quantity of 30 tablets. -The facility had to call to reorder Resident #3's Dilantin kapseal. -Once a medication was reordered, most of the time the medication was delivered the same day. -There was no delivery service on Saturday or Sunday, so if a medication was reordered late on Friday, Saturday or Sunday, it would not be delivered until the following Monday. Interview with Resident #3 on 07/16/21 at 11:04am revealed: -She did not know the names of her medication, but she knew she was on a medication for seizures. -The facility sometimes ran out of medication. -The staff sometimes told her they were waiting on the pharmacy to send medications. -She had not had any seizures within the last year. Interview with a MA on 07/15/21 at 4:58pm revealed: -She circled her initials on the MAR when a medication was not on the medication cart and she did not administer the medication to a resident. -If a medication was not located with a resident's daily medications, she first looked behind the medications to see if there were any extra bubble packs turned backwards and then she looked in	D 358		

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the overstock drawer on the medication cart which was the very last drawer on the bottom.
-She checked behind the daily medications and in the overstock drawer on the medication cart and did not see the Dilantin kapseal when she administered Resident #3's medication on 07/14/21.
-She called and faxed the pharmacy regarding Dilantin 100mg on 07/08/21, but she did not follow up with the pharmacy to see when the medication would be delivered to the facility.
-She was not sure when the pharmacy delivered medication once the medication was ordered.
-Medications should be reordered when the bubble pack was down to the last column of medication.

Interview with a MA on 07/20/21 at 1:26pm revealed:
-She circled her initials on the MAR on 07/12/21 because Dilantin kapseal was not administered to Resident #6.
-Medications were usually delivered from the pharmacy on first or second shift.
-She worked second shift and Resident #6's Dilantin kapseal was not delivered on her shift.
-She checked the overstock on the medication cart for Dilantin kapseal 100mg on 07/12/21, but it was not there.
-She left a note for the third shift staff that Dilantin kapseal was not available for administration.
-She faxed the pharmacy on 07/12/21 regarding Dilantin kapseal, but she did not remember whether she called the pharmacy to check on the medication.

Interview with a nurse at Resident #3's neurologists office on 07/19/21 at 1:01pm revealed:
-Resident #3 had physician's orders for Dilantin

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kapseal 100mg 3 capsule at bedtime for seizures.
-The facility had not made the neurologist aware Resident #3 missed 7 consecutive doses of Dilantin kapseal 100mg in July 2021.
-Resident #3 could have had multiple seizure as a result of missing 7 consecutive doses of Dilantin kapseal 100mg.
-The neurologist office would have expected to the facility to let them know if they had trouble obtaining medication from the pharmacy.
-The neurologist office would have assisted the facility with contacting the pharmacy to get Dilantin kapseal refilled or to give a verbal order to the pharmacy if needed.
-Seven days was a long time for Resident #3 to go without her seizure medication.
-There had not been any reports of Resident #3 having had a seizure.

Refer to interview with the MA on 07/15/21 at 6:30pm.

Refer to telephone interview with another MA on 07/20/21 at 11:10am.

Refer to interview with the Assistant Director of Resident Care (ADRC) on 07/19/21 at 7:40pm.

Refer to interview with the Administrator on 07/19/21 at 6:50pm.

c. Review of Resident #3's previous FL2 dated 01/10/20 revealed an order for metoprolol tartrate 50mg (used to treat high blood pressure) 1 tablet twice daily.

Review of Resident #3's Medication Administration Record (MAR) for May 2021 revealed:
-There was an entry for metoprolol tartrate 50mg

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1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation metoprolol tartrate 50mg was not administered for 8 of 62 opportunities between 05/01/21 through 05/31/21.
-There was documentation dated 05/04/21 on the back of the MAR the pharmacy was called regarding metoprolol tartrate.
-There was no other documentation why metoprolol tartrate was not administered.

Review of Resident #3's MAR for June 2021 revealed:
-There was an entry for metoprolol tartrate 50mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation metoprolol tartrate 50mg was not administered for 5 of 60 opportunities between 06/01/21 through 06/30/21.
-There was documentation dated 06/25/21 at 8:00am metoprolol tartrate was not available for administration.
-There was no other documentation why metoprolol tartrate was not administered.

Observation of Resident #3's medication available for administration on 07/15/21 at 4:00pm revealed:
-There were 2 bubble packs of Metoprolol tartrate 50mg 1 tablet twice daily dispensed by the pharmacy on 06/25/21 with 2 bubble packs of 30 tablets for a total quantity of 60 tablets.
-There were 23 tablets remaining in the first bubble pack and 30 tablets remaining in the second bubble pack.

Interview with a pharmacist at Resident #3's pharmacy on 07/15/21 at 11:18am revealed:
-Resident #3 had an order for metoprolol tartrate 50mg 1 tablet twice daily.

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-Metoprolol tartrate was dispensed to the facility on 04/12/21, 05/05/21, and 06/25/21 with a quantity of 60 tablets on each dispense date.
-The facility had to call to reorder all of Resident #3's medications.
-Once a medication was reordered, most of the time the medication was delivered the same day.
-There was no delivery service on Saturday or Sunday, so if a medication was reordered late on Friday, Saturday or Sunday, it would not be delivered until the following Monday.

Interview with a MA on 07/15/21 at 4:58pm revealed:
-She circled her initials on the MAR when a medication was not available for administration and she did not administer the medication to a resident.
-She circled her initials on MAR in May 2021 for Resident #3's metoprolol tartrate because the medication was not in the facility.
-She should have called or faxed the pharmacy to see why metoprolol tartrate had not been delivered to the facility.
-She did not know if she called the pharmacy regrading Resident #3's metoprolol tartrate.
-Medications should be reordered when the bubble pack was down to the last column of medication.

Interview with Resident #3 on 07/16/21 at 11:04am revealed:
-She did not know the names of her medication.
-The facility sometimes ran out of medication.
-The staff sometimes told her they were waiting on the pharmacy to send medications.

Interview with a MA on 07/20/21 at 11:24am revealed:
-He remembered Resident #3 being out of

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metoprolol, but he did not remember if he called the pharmacy to see why the medication had not been delivered to the facility.
-Sometimes he just told the ADRC who would contact the pharmacy regarding the medication.

Interview with Resident #3's PCP on 07/15/21 at 2:45pm revealed:
-The facility had not called to report any issues with getting metoprolol tartrate from the pharmacy or Resident #3 had missed doses of metoprolol tartrate.
-If Resident #3 missed too many doses of metoprolol tartrate, it could cause her blood pressure to become unregulated.

Refer to interview with the MA on 07/15/21 at 6:30pm.

Refer to telephone interview with another MA on 07/20/21 at 11:10am.

Refer to interview with the Assistant Director of Resident Care (ADRC) on 07/19/21 at 7:40pm.

Refer to interview with the Administrator on 07/19/21 at 6:50pm.

d. Review of Resident #3's current FL2 dated 07/15/21 revealed an order for Akwa tears 1.4% (used to treat dry eyes) instill 2 drops in both eyes every 4 hours.

Interview with a pharmacist at Resident #3's pharmacy on 07/15/21 at 11:18am revealed:
-Resident #3 had an order for Akwa tears 1.4% instill 2 drops in both eyes every 4 hours.
-The order for Akwa tears was received from Resident #3's previous pharmacy, but he could not confirm the date.

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D 358	Continued From page 79 -Akwa tears was dispensed to the facility on 06/23/21. -The facility had to call to reorder all of Resident #3's medications and Akwa tears was not dispensed by this pharmacy prior to 06/23/21. -Once a medication was reordered, most of the time the medication was delivered the same day. -There was no delivery service on Saturday or Sunday, so if a medication was reordered late on Friday, Saturday or Sunday, it would not be delivered until the following Monday. Review of Resident #3's Medication Administration Record (MAR) for May 2021 revealed: -There was an entry for Akwa tears 1.4% eyedrops instill 2 drops in both eyes every 4 hours scheduled for administration at 2:00am, 6:00am, 10:00am, 2:00pm, 5:00pm, and 10:00pm. -There was documentation Akwa tears was not administered for 4 of 180 opportunities between 05/01/21 through 05/31/21. -There was no documentation why metoprolol tartrate was not administered. Review of Resident #3's MAR for June 2021 revealed: -There was an entry for Akwa tears 1.4% eyedrops instill 2 drops in both eyes every 4 hours scheduled for administration at 2:00am, 6:00am, 10:00am, 2:00pm, 5:00pm, and 10:00pm. -There was no documentation Akwa tears was administered for 74 of 180 opportunities between 06/30/21 through 06/30/21. -There was documentation on 06/02/21 at 10:00am, 2:00pm, 2:00am, and 6:00am "not on cart, waiting on pharmacy." -There was documentation on 06/03/21 at	D 358		

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D 358	Continued From page 80 2:00am, 6:00am, and 10:00am and on 06/04/21 at 10:00am, 2:00pm, and 8:00pm "not on cart." -There was documentation "not on cart and pharmacy" on 06/02/21 at 10:00am, 2:00pm, 2:00am, and 6:00am; 06/03/21 at 2:00am, 6:00am, and 10:00am; 06/04/21 at 10:00am, 2:00pm, and 8:00pm; 06/05/21 at 2:00am and 6:00am; 06/06/21 at 2:00am and 6:00am; 06/08/21 at 2:00am, 6:00am, and 10:00am; 06/09/21 at 2:00am, 6:00am, 10:00am, and 2:00pm; 06/10/21 at 2:00am and 6:00am, 06/12/21 at 2:00am and 6:00am; 06/15/21 at 2:00am, 6:00am, 10:00am, and 2:00pm; and 06/16/21 at 2:00am and 6:00am. Observation of Resident #3's medication available for administration on 07/15/21 at 4:00pm revealed: -Akwa Tears was not on the medication cart, but there was a yellow, over the counter box of artificial tears on the medication cart. -Resident #3's name was written on the box. -The handwritten directions were every four hours, but there was no documentation of how many drops should have been instilled. Interview with a MA on 07/15/21 at 4:58pm revealed: -She circled her initials on the MAR when a medication was not on the medication cart and she did not administer the medication to a resident. -She did not administer Akwa tears to Resident #3 in June 2021 because the name of the medication on the MAR was different than the medication on the medication cart. -The medication had been swapped out for an equivalent over the counter medication, but she did not know until someone wrote it in on the MAR.	D 358		

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D 358	Continued From page 81 -She did not call the pharmacy or ask the ADRC which eye drop she should administer to Resident #3. -The ADRC told her on 06/13/21 which eyedrop she needed to use for Resident #3 and she began administering the eyedrops again. Interview with Resident #3 on 07/16/21 at 11:04am revealed: -She did not know the names of her medication, but she was administered a daily eyedrop. -She thought the eyedrops were administered twice daily. -The facility sometimes ran out of medication. -The staff sometimes told her they were waiting on the pharmacy to send medications. -She did not remember the facility being out of eye drops. Interview with Resident #3's PCP on 07/15/21 at 2:45pm revealed: -The facility had not called to report any issues with getting Akwa tears from the pharmacy or Resident #3 had missed doses of Akwa tears. -If Resident #3 missed doses of Akwa tears, her eyes could become more itchy and drier than usual. -Akwa tears were the same as over the counter artificial tears. Refer to interview with the MA on 07/15/21 at 6:30pm. Refer to telephone interview with another MA on 07/20/21 at 11:10am. Refer to interview with the Assistant Director of Resident Care (ADRC) on 07/19/21 at 7:40pm. Refer to interview with the Administrator on	D 358		

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D 358	Continued From page 82 07/19/21 at 6:50pm. 2. The medication error rate was 7% as evidenced by the observation of 2 errors out of 27 opportunities during the 8:00am medication pass on 07/15/21. Review of Resident #10's current FL2 dated 05/27/21 revealed diagnoses included difficulty walking, adjustment disorder, hypertension, anemia. a. Review of Resident #10's current FL2 dated 05/27/21 revealed there was an order for senna plus (treats constipation) 8.5-50mg 2 tablets twice daily. Review of Resident #10's subsequent physician's order dated 06/24/21 revealed an order for senna plus 8.6-50mg 1 tablet every evening as needed for constipation. Observation of the 8:00am medication pass on 07/15/21 at 9:30am revealed: -The medication aide (MA) prepared 13 oral medications, including senna plus (for constipation) 8.6-50mg 2 tablets, a pain patch, and a nasal spray. -The medication aide (MA) administered medications to the resident at 9:47am. -The MA placed her initials on the MAR after administering Resident #10's medication. Observation of medication on hand for administration for Resident #10 on 07/15/21 at 9:50am revealed: -There was a partial bubble pack of senna plus 8.6-50mg with 1 tablet in each bubble. -The label had instructions to administer 1 tablet every evening as needed for constipation.	D 358		

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D 358	Continued From page 83 Review of Resident #10's July 2021 medication administration record (MAR) revealed: -There was an entry for senna plus 8.5-50mg 2 tablets twice daily scheduled for 8:00am and 8:00pm. -There was not an entry for senna plus 8.6-50mg 1 tablet every evening as needed for constipation. Telephone interview with a representative from Resident #10's Primary Care Provider (PCP) on 07/15/21 at 3:15 pm revealed the only order she saw for senna plus was on 06/24/21 documenting the resident could have 1 tablet daily as needed for constipation. Interview with the MA who administered Resident #10's medication during the 8:00am medication pass on 07/15/21 on 07/15/21 at 6:30pm revealed: -She worked as a MA and a personal care aide (PCA). -She had filled in on the cart recently and did not pass medications daily. -She recalled Resident #10 had several medications to be administered on 07/15/21. -She read the instructions for senna plus on the label but when a medication did not match the MAR, she administered the medications per the instructions on the MAR. -She had not seen any orders indicating the resident had a medication change, but she did recall the resident had some recent episodes of diarrhea. Interview with the ADRC on 07/15/21 at 6:54pm revealed she did not recall seeing an order to change Resident #10's senna plus to as needed instead of scheduled.	D 358		

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D 358	Continued From page 84 Refer to interview with the Administrator on 07/19/21 at 6:50pm. Refer to interview with the ADRC on 07/15/21 at 6:54pm. b. Review of Resident #10's current FL2 dated 05/27/21 revealed there was an order for Spiriva Respimat (used to treat asthma and chronic obstructive pulmonary disease) 2 puffs daily. Observation of the 8:00am medication pass on 07/15/21 at 9:30am revealed: -The medication aide (MA) prepared 13 oral medications, including senna plus (a laxative), a pain patch, and a nasal spray. -The medication aide (MA) administered medications to the resident at 9:47am. -Spiriva was not administered with the medication pass. -The MA placed her initials on the MAR after administering Resident #10's medication. -After she placed her initials on the entry for Spiriva, she circled her initials and documented on the back of the MAR that Spiriva was not on the medication cart. Observation of medication on hand for administration for Resident #10 on 07/15/21 at 9:50am revealed there was no Spiriva available for Resident #10 on the medication cart. Interview with the MA who administered Resident #10's medication during the 8:00am medication pass on 07/15/21 on 07/15/21 at 6:30pm revealed: -She worked as a MA and a personal care aide (PCA). -She had only filled in on the cart recently and did not pass medications daily.	D 358		

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D 358	Continued From page 85 -She recalled Resident #10 had several medications to be administered on 07/15/21. -Spiriva was not on the medication cart because there had been some issues with insurance coverage for the medication. Interview with the ADRC on 07/15/21 at 6:54pm revealed: -She did not know Spiriva was not available for administration on the medication cart. -She knew there had been issues with insurance paying for Resident #10's Spiriva. Telephone interview with a representative from the facility's contracted pharmacy on 07/20/21 at 11:00am revealed: -Spiriva had a high co-pay so the pharmacy had to reach out to get approval from the responsible party (RP). -The pharmacy received a refill request on 07/16/21 and immediately reached out to the RP and obtained permission to fill the prescription. -The Spiriva was sent to the facility on the evening of 07/16/21. Refer to interview with the Administrator on 07/19/21 at 6:50pm. Refer to interview with the ADRC on 07/15/21 at 6:54pm. 3. Review of Resident #4's FL2 dated 11/25/20 revealed diagnoses included COVID-19, chronic heart failure, atrial fibrillation, major depression, and hypothyroidism. a. Review of Resident #4's physician's orders dated 12/02/20 revealed an order for divalproex (used to treat depression) 125mg twice a day.	D 358		

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D 358	Continued From page 86 Review of Resident #4's May 2021 medication administration record (MAR) revealed: -There was an entry for divalproex 125mg twice a day scheduled for administration at 6:00am and 8:00pm. -There was documentation divalproex was not administered on 05/10/21 at 6:00am and 8:00pm with no reason being documented. -There was no documentation of administration of divalproex on 05/05/21 at 6:00am, 05/08/21, and 5/14/21 at 8:00pm with no documentation for reason of omission. Observation of medication on hand for administration for Resident #10 on 07/15/21 at 6:20pm revealed: -There was 57 of 60 tablets of divalproex 125mg available for administration. -The divalproex was dispensed on 07/05/21. -The label had instructions to administer 1 tablet twice a day. Interview with a medication aide (MA) on 07/15/21 at 6:30pm revealed: -She worked on the evenings of 05/08/21 and 05/14/21 and administered Resident #4's medication. -She could not recall whether she administered divalproex. Telephone interview with another MA on 07/20/21 at 11:10am revealed: -She had administered medications to Resident #4. -She had worked with Resident #10 on the morning of 05/05/21 and the evening of 05/10/21. -On 05/05/21 at 6:00am she did not recall if she administered Resident #10's divalproex. -On 05/10/21 at 8:00pm, she did not recall why she did not administer divalproex.	D 358		

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D 358	Continued From page 87 Attempted interview with Resident #4's PCP on 07/14/21 at 2:14pm and 07/19/21 at 4:46pm was unsuccessful. Refer to interview with the MA on 07/15/21 at 6:30pm. Refer to telephone interview with another MA on 07/20/21 at 11:10am. Refer to interview with the ADRC on 07/19/21 at 7:40pm. Refer to interview with the Administrator on 07/19/21 at 6:50pm. b. Review of Resident #4's FL2 dated 11/25/20 revealed an order for duloxetine (used to treat depression) 20mg at bedtime on Mondays, Wednesdays, and Fridays. Review of Resident #4's May 2021 medication administration record (MAR) revealed: -There was an entry for duloxetine 20mg at bedtime on Mondays, Wednesdays, and Fridays scheduled for administration at 8:00pm. -There was no documentation of administration of duloxetine on 05/05/21, 05/07/21, 05/14/21, 05/19/21, and 05/28/21 at 8:00pm with no documentation for reason of omission. Observation of medication on hand for administration for Resident #10 on 07/15/21 at 6:20pm revealed: -There was 6 of 30 tablets of duloxetine 20mg available for administration. -The duloxetine was dispensed on 07/05/21. -The label had instructions to administer 1 tablet every Monday, Wednesday, and Friday at	D 358		

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bedtime.

Interview with a medication aide (MA) on 07/15/21 at 6:30pm revealed:
-She worked on the evening of 05/14/21 and administered Resident #4's medication.
-She could not recall whether she administered duloxetine.

Telephone interview with another MA on 07/20/21 at 11:10am revealed:
-She had administered medications to Resident #4.
-She had worked with Resident #10 on the evenings of 05/05/21, 05/07/21, and 05/19/21.
- She did not recall if she administered Resident #10's duloxetine but thought she did.

Attempted interview with Resident #4's PCP on 07/14/21 at 2:14pm and 07/19/21 at 4:46pm was unsuccessful.

Refer to interview with the MA on 07/15/21 at 6:30pm.

Refer to telephone interview with another MA on 07/20/21 at 11:10am.

Refer to interview with the ADRC on 07/19/21 at 7:40pm.

Refer to interview with the Administrator on 07/19/21 at 6:50pm.

c. Review of Resident #4's FL2 dated 11/25/20 revealed an order for lamotrigine (used to treat depression) 100mg daily.

Review of Resident #4's May 2021 medication

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 89	D 358		

administration record (MAR) revealed:
-There was an entry for lamotrigine 100mg daily scheduled for administration at 8:00pm.
-There was no documentation of administration of lamotrigine on 05/06/21, 05/08/21, and 05/14/21 at 8:00pm with no documentation for reason of omission.

Observation of medication on hand for administration for Resident #10 on 07/15/21 at 6:20pm revealed:
-There were 2 of 30 tablets of lamotrigine 100mg available for administration that were dispensed on 06/03/21.
-There were 30 of 30 tablets of lamotrigine 100mg available for administration that were dispensed on 07/05/21.
-The label had instructions to administer 1 tablet every night at bedtime.

Interview with a medication aide (MA) on 07/15/21 at 6:30pm revealed:
-She worked on the evenings of 05/06/21, 05/08/21, and 05/14/21 and administered Resident #4's medication.
-She could not recall whether she administered lamotrigine because she had been working extra hours.

Attempted interview with Resident #4's PCP on 07/14/21 at 2:14pm and 07/19/21 at 4:46pm was unsuccessful.

Refer to interview with the MA on 07/15/21 at 6:30pm.

Refer to telephone interview with another MA on 07/20/21 at 11:10am.

Refer to interview with the ADRC on 07/19/21 at

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D 358	Continued From page 90 7:40pm. Refer to interview with the Administrator on 07/19/21 at 6:50pm. d. Review of Resident #4's physician's orders dated 05/17/21 revealed an order for gabapentin (used to treat pain) 100mg at 8:00am and 2:00pm daily. Review of Resident #4's June 2021 medication administration record (MAR) revealed: -There was an entry for gabapentin 100mg scheduled for administration at 8:00am and 2:00pm. -There was no documentation of administration of gabapentin on 06/10/21, 06/25/21, and 06/26/21 at 8:00am with documented reasons being it was too late to administer, it was not on the medication cart, and it was ordered from pharmacy. -There was no documentation of administration of gabapentin on 06/26/21 at 2:00pm with the reason being documented as not on the medication cart. -There was no documentation of administration of gabapentin and 5/14/21 at 8:00pm with no documentation for reason of omission. Observation of medication on hand for administration for Resident #10 on 07/15/21 at 6:20pm revealed: -There was 32 of 60 tablets of gabapentin 100mg available for administration. -The gabapentin was dispensed on 06/26/21. -The label had instructions to administer 1 tablet twice daily at 8:00am and 2:00pm. Interview with a medication aide (MA) on 07/15/21 at 6:30pm revealed:	D 358		

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D 358	Continued From page 91 -She worked on the evening 06/14/21 and administered Resident #4's medication. -She could not recall whether she administered gabapentin. Attempted interview with Resident #4's PCP on 07/14/21 at 2:14pm and 07/19/21 at 4:46pm was unsuccessful. Refer to interview with the MA on 07/15/21 at 6:30pm. Refer to telephone interview with another MA on 07/20/21 at 11:10am. Refer to interview with the ADRC on 07/19/21 at 7:40pm. Refer to interview with the Administrator on 07/19/21 at 6:50pm. e. Review of Resident #4's physician's orders dated 05/24/21 revealed an order for mineral oil (used to soften hardened ear wax) 2 drops each ear weekly at bedtime for ear wax impaction. Review of Resident #4's June 2021 medication administration record (MAR) revealed: -There was an entry for mineral oil 2 drops each ear weekly scheduled for administration at 8:00pm. -There was no documentation of administration of mineral oil on 06/02/21, 06/09/21, and 06/30/21 at 8:00pm with no documentation for reason of omission. Observation of medication on hand for administration for Resident #10 on 07/15/21 at 6:20pm revealed there was an opened bottle of mineral oil available for administration.	D 358		

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D 358	Continued From page 92 Telephone interview with another MA on 07/20/21 at 11:10am revealed: -She had administered medications to Resident #4. -She had worked with Resident #10 on the evenings of 06/02/21, 06/09/21, and 06/30/21. - She did not recall if she administered Resident #10's mineral oil but thought she did. Attempted interview with Resident #4's PCP on 07/14/21 at 2:14pm and 07/19/21 at 4:46pm was unsuccessful. Refer to interview with the MA on 07/15/21 at 6:30pm. Refer to telephone interview with another MA on 07/20/21 at 11:10am. Refer to interview with the ADRC on 07/19/21 at 7:40pm. Refer to interview with theAdministrator on 07/19/21 at 6:50pm. 4. Review of Resident #1's current FL2 dated 03/11/21 revealed: -Diagnoses included dementia, seizure, anxiety, and sensorineural hearing loss. -There was an order for lamictal 100mg, take one tablet twice daily (used to treat mood disturbances). Review of Resident #1's physician's order dated 04/05/21 revealed there was an order to decrease lamictal 100mg to one tablet at bedtime. Review of Resident #1's Primary Care Provider	D 358		

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D 358	Continued From page 93 (PCP) progress note dated 04/05/21 revealed: -Resident #1 was being seen Monday, (04/05/21) because the resident had a fall over the weekend. -The PCP noted that he reduced lamictal 100mg to once daily at bedtime due to concerns with sedation causing falls. -The PCP documented Resident #1's current medications included lamictal 100mg one tablet once a day. Review of Resident #1's Resident Service Note dated 04/06/21 at 4:36pm revealed the Assistant Director of Resident Care (ADRC) documented that she notified Resident #1's family regarding the decrease in lamictal. Review of an email sent from the Assistant Director of Resident Care (ADRC) on 04/07/21 Resident #1's POA revealed Resident #1's current medications included lamictal 100mg once daily. Review of Resident #1's April 2021 medication administration record (MAR) revealed: -There was an entry for lamictal 100mg one tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation lamictal 100mg was administered twice daily from 04/01/21 through 04/11/21. -There was no entry for lamictal 100mg one tablet at bedtime. Telephone interview with a representative from the facility's contracted pharmacy on 07/20/21 at 12:11pm revealed: -The pharmacy received an order on 04/05/21 that changed lamictal 100mg from twice daily to once daily at bedtime. -The pharmacy did not dispense the medication	D 358		

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D 358	Continued From page 94	D 358		

again because the facility could administer the current medication to comply with the order.
-A new MAR would not be printed until next month, so facility staff had to change the order on their current MAR.

Telephone interview with the medication aide (MA) supervisor on 07/20/21 at 11:48am revealed:
-When she received an order, she faxed the order to the pharmacy and transcribed the order onto the MAR.
-She wrote the order in the order tracking form.
-She did not know why lamictal was not changed on the MAR.

Interview with the Assistant Director of Resident Care (ADRC) on 07/19/21 at 7:12pm revealed:
-It appeared that Resident #1's lamictal 100mg was administered twice daily from 04/05/21 through 04/11/21, and not changed to once daily at bedtime as ordered.
-When orders were received the MA should fax the order to the pharmacy and document the new order on the MAR.

Telephone interview with the ADRC on 07/20/21 at 10:39am revealed:
-When the physician left an order, the MA was supposed to take the order and fax it to the pharmacy, then transcribe the order onto the MARs.
-She tried to go behind the MA to check all the orders to make sure they were done correctly.
-She tried to check the orders weekly to make sure they were done correctly.
-She did not know what happened with Resident #1's order for lamictal.

Interview with the Administrator on 07/19/21 at

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D 358	Continued From page 95 7:15pm revealed: -The ADRC was responsible for auditing the MARs for errors. -She checked behind the ADRC but had not checked anything this year. -The third shift MA also checked the MARs and the medication cart. -The ADRC or the Director of Resident Care (DRC) should have caught that Resident #1's lamictal was not administered correctly. Refer to interview with the MA on 07/15/21 at 6:30pm. Refer to telephone interview with another MA on 07/20/21 at 11:10am. Refer to interview with the ADRC on 07/19/21 at 7:40pm. Refer to interview with the Administrator on 07/19/21 at 6:50pm. _____ Interview with a medication aide (MA) on 07/15/21 at 6:30pm revealed: -When a new order was received by a physician, the MA would fax the order to the pharmacy, transcribe the order on the MAR, and fill out a new order tracking form and place it in the Assistant Director of Resident Care (ADRC) or the Director of Resident Care (DRC) folder. -The ADRC or the DRC would follow up using the medication tracking form to ensure the medication was transcribed to the MAR. -When current medications were changed, the MAs were supposed to place a change of direction sticker on the medication label, indicating the dosage had changed. -When orders were duplicated, the MAs had to request a clarification.	D 358		

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D 358	Continued From page 96 -She did not know if the medication carts were audited. -The MAs tried to let each other know when medications were missed and not on the medication cart. -MA's were responsible for reordering residents' medications when they had around 8 doses remaining. -The MAs did not audit the MARs for holes at shift change when they counted controlled substances and signed the log. Telephone interview with another MA on 07/20/21 at 11:10am revealed: -Sometimes she forgot to initial all the medications she administered because she had to work the floor as a personal care aide and pass medications. -When initials on the MAR were circled it meant the medication was not given. -The MAs were supposed to document the reason as to why a medication was not administered. -Sometimes the MAs did not have time to document the reason why a medication was not administered and sometimes they left blanks. -She did not know if anyone audited MARs. -The MAs did not audit the MARs for holes at shift change when they counted controlled substances and signed the log. Interview with the ADRC on 07/19/21 at 7:40pm revealed: -The MAs were responsible for reordering medications when there were 7 days remaining. -The facility did not receive their medications on a cycle fill so they had to reorder each medication individually. -She tried to audit MARs for holes and circled medications.	D 358		

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D 358	Continued From page 97 -If a medication was not on the medication cart, she expected the MA to call the pharmacy and find out if the medication had been reordered and when it would arrive at the facility. -She thought the MAs audited the MARs for holes at shift change when they counted controlled substances and signed the log. Interview with the Administrator on 07/19/21 at 6:50pm revealed: -The MAs were responsible to administer medications as ordered on the MAR. -Medications were supposed to be reordered by the MA when there were 8-10 days remaining of the medication. -The ADRC or the DRC were responsible for double checking the MARs to ensure they were correct. -The ADRC was responsible for checking the MARs to ensure medications were administered as ordered. -When the DRC was out of the facility, the ADRC had to fill in and try to keep up with all the orders and ensuring the MARs were correct. -She thought the ADRC and DRC had been auditing MARs regularly until recently. -She sometimes spot checked the MARs but had not done so this year. -The DRC last audited the Mars in May 2021. -The PCP should be notified of 2 missed doses of medication regardless of the reason missed.	D 358		
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	D912		

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D912	Continued From page 98 regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations 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 in accordance for 3 of 7 sampled residents (#1 and #6), residing in the Special Care Unit (SCU) related to a resident who had multiple falls with injuries including a fractured right wrist and skin tears (#1) a resident who had thirteen falls resulting in a bump on the forehead, black eye, bruises, skin tears and multiple injuries of unknown origin (#6), and a resident who wandered throughout the dining room during the lunch meal taking food off other residents' plates and taking the tablecloths off the table (#9). [Refer to Tag D-0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).]. 2. Based on interviews and record reviews, the facility failed to notify the primary care provider (PCP) for 3 of 7 sampled residents (Resident #1) who continued to decline and was not eating, had a broken wrist with a cast with swollen fingers and hand that turned purple (#1); and two residents who did not eat meals and had weight loss (#7 and #8). [Refer to Tag D-0273, 10A NCAC 13F .0902(b) Health Care (Type A1	D912		

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D912	Continued From page 99 Violation).].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and	D935		

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D935	Continued From page 100	D935		

procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 4 sampled staff (Staff D) who administered medications had passed the written medication aide exam within 60 days of completing the medication clinical skills competency validation checklist.

The findings are:

Review of Staff D's, medication aide (MA)/personal care aide (PCA), personnel record revealed:
-Staff D was hired on 02/19/19.
-There was a certificate of completion dated 10/08/20 for the 15-hour state approved medication aide training for Staff D.
-There was documentation of a medication clinical skills competency validation checklist completed for Staff D dated 11/19/20.
-There was no documentation Staff D had successfully passed the written medication aide exam.

Review of residents' medication administration records for May, June and July 2021 revealed:
-Staff D documented administration of medications for 19 of 31 days in May 2021.
-Staff D documented administration of medications for 18 of 30 days in June 2021.
-Staff D documented administration of medications for 10 of 14 days from 07/01/21

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D935	Continued From page 101 through 07/14/21. Interview with Staff D on 07/16/21 at 4:00pm revealed: -Staff D thought that she was trained on the medication cart sometime in December 2020. -She was trained for one week on the medication cart by the Director of Resident Care (DRC). -She had not taken the written medication aide exam. -Every time she tried to sign up for the exam online, the classes were full. -Her 60-day time limit for taking the written medication aide exam ended in January 2021. Interview with the Administrator on 07/16/21 at 4:05pm revealed: -Staff D was removed from medication cart duties during the week of 07/14/21 through 07/16/21. -Staff D informed the Administrator that she could not find a class for the written medication aide exam. -She "forgot about it" in reference to Staff D signing up for and successfully passing the written exam. -The Administrator was responsible to ensure MA written testing was scheduled and completed by staff. Attempted interview with the DRC on 07/16/21 at 4:15pm unsuccessful.	D935		