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THE ADDISON OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow up and complaint investigation survey on November 9, 10 and 12, 2021.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure that 7 of 7 exit doors that were accessible to a resident with known cognitive impairment and a recent history of elopement, were equipped with sounding devices that activated and sounded when the exit doors were opened to alert staff for 1 of 2 sampled residents (#6) on the Assisted Living (AL) unit. Review of the facility's Missing Person Response Procedure Policy dated 10/04/21 revealed for	D 067		

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communities that were equipped with door alarms, and the door alarm sounded, the staff were to search the area immediately adjacent to the door and initiate a head count to ensure that all residents were present.

Review of Resident #6's current FL-2 dated 04/20/21 revealed:
-Diagnoses included mild cognitive impairment.
-She was intermittently confused and ambulatory with a cane and walker as needed.

Review of Resident #6's undated Elopement Risk Review Tool revealed:
-She wandered inside the community but did not express the desire to leave.
-She was occasionally disoriented to time and place.

Review of a progress notes for Resident #6 dated 08/09/21 at 7:00pm revealed:
-She wandered off from the facility and made it two houses down the main highway.
-Another resident alerted staff Resident #6 left the facility grounds and the staff went and brought Resident #6 back to the facility.
-The Administrator and the Health and Wellness Director (HWD) were notified of the incident.

Observation of the exit door on the end of A-Hall on 11/10/21 at 6:27am-6:29am revealed:
-The exit door was opened at 6:27am and there was no audible alarm that sounded.
-There was a medication aide (MA) at the nursing station on the A-Hall and she did not respond to the door being opened from 6:27am - 6:29am.

Observation of the exit door on the end of B-Hall on 11/12/21 from 9:36am-9:50am revealed:
-The exit door was propped open with a wooden

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object.
-No staff checked the exit door or removed the wooden object from the door.
-There was no audible door alarm sounding.

Observation of the exit door in the Media Room on 11/10/21 at 6:29am revealed:
-The door was locked with a deadbolt lock.
-When the deadbolt lock was turned, the door unlocked and opened.
-There was no audible door alarm sounded.

Interview with the former HWD on 11/12/21 at 9:56am revealed:
-There were residents who resided on the AL unit that had a diagnosis of dementia.
-The doors did not alarm when they were opened.
-The PCAs and MAs were to wear pagers that should sound when the exit doors were opened.

Observation of the exit doors on the AL unit and two different pagers on 11/12/21 from 11:24am-11:31am revealed:
-An exit door on the B-Hall was opened and there was no alert sent to either pager.
-A second door on the B-hall was opened and there was no alert sent to either pager.
-The exit door to the screened porch on the A-Hall was opened and there was no alert sent to either pager.

Interview with a MA on 11/10/21 at 6:36am revealed:
-The MAs and PCAs wore pagers during their shifts that alerted them when a resident used their call light or when an exit door was opened.
-There were no audible alarms that sounded when the facility's exit doors were opened.
-She was not wearing her pager because her shift would be ending at 7:00am.

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D 067	Continued From page 3 Interview with a second MA on 11/12/21 at 11:04am revealed she did not wear a pager when she worked the AL unit. Interview with a PCA on 11/10/21 at 3:52pm revealed: -She was a contract PCA through a staffing agency. -She was not wearing a pager. -She did not know how the pager system at the facility operated. Telephone interview with Resident #6's family member on 11/09/21 at 3:50pm revealed: -Resident #6 resided on the AL unit of the facility since April 2021. -On 08/09/21 at approximately 6:30pm she was notified Resident #6 had exited the front door and walked off facility grounds. -The Administrator informed her Resident #6 was trying to go to the bathroom, became confused and left the facility. -Resident #6 liked to sit outside on the screened porch and staff were to encourage her not to go outside of the screened porch. -She visited the facility several days a week prior to the facility being on quarantine for COVID-19 and she was not aware of the facility having alarms on the exit doors. Interview with the Maintenance Director on 11/09/21 at 8:44am revealed: -He did not know why the door alarms on the AL unit did not alarm. -He did not think any of the doors on the AL unit alarmed. Interview with the Administrator on 11/12/21 at 11:23am revealed it was the responsibility of the	D 067		

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D 067	Continued From page 4 MAs and the PCAs to wear pagers that alerted them when the facility exit doors were opened. _____ The facility failed to ensure 7 of 7 exit doors on the Assisted Living (AL) Unit were equipped with a sounding device alerting staff when activated with a resident who resided on the AL, known to be disoriented, with a recent history of elopement from the facility without staff knowledge on 08/09/21 (Resident #6). This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/12/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 27, 2021.	D 067		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 2 of 3 sampled staff (A, B) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire.	D 137		

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D 137	Continued From page 5 The findings are: 1. Review of Staff A's personnel record revealed: -There was no hire date documented for Staff A. -There was no documentation of a HCPR check being completed. Interview with Staff A on 11/10/21 at 8:55am revealed she had worked at the facility for approximately 6 weeks. 2. Review of Staff B's personnel record revealed: -There was no hire date documented for Staff B. -There was no documentation of a HCPR check being completed. No further documents were provided prior to survey exit on 11/12/21.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (A) had a criminal background check completed upon hire. Review of Staff A's personnel record revealed: -There was no hire date documented for Staff A. -The criminal background check was completed on 11/12/21.	D 139		

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D 139	Continued From page 6 Interview with Staff A on 11/10/21 at 8:55am revealed she had worked at the facility for approximately 6 weeks. No further documents were provided prior to survey exit on 11/12/21.	D 139		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)	D 188		

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D 188	Continued From page 7 (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure there was an accurate record of staff on duty to meet the needs of the residents including a minimum of 16 hours of aide duty for first, second and third shifts for a census between 31 to 40 for 8 sampled days. The findings are: Review of a facility census dated 11/09/21 revealed there were 37 residents on the assisted living (AL) side of the facility. Interview with the Administrator on 11/09/21 at 1:45pm revealed: -An agency staff was assigned to work as a medication aide (MA) on 11/09/21 for first shift. -The agency staff did not want to work as a MA and left. -The Resident Care Coordinator (RCC) worked third shift 11/08/21 and stayed over for first shift on 11/09/21 to administer medications. -A second MA came in for a few hours the morning of 11/09/21 to administer medications and was no longer at the facility.	D 188		

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D 188	Continued From page 8 A request was made for the following information on 11/09/21 at 1:28pm specific to staffing hours on the assisted living (AL) side from 11/02/21 through 11/09/21: all staff time cards including titles, daily census, staff schedule/assignment, missed punches and any administrative/management staff direct care hours. A request was made on 11/10/21 at 10:42am for the daily census, staff schedule/assignment, staff job titles and hours worked by agency staff specific from 11/02/21 through 11/09/21. A request was made on 11/12/21 at 8:51am for the staff schedule/assignment, staff job titles and hours worked by agency staff and not available for review. Review of the staff schedule for 11/06/21 (received 11/12/21 at 2:00pm) revealed there were two staff scheduled to work for the entire building, one assigned to the special care unit (SCU) and the second to the assisted living (AL) side. Upon request on 11/09/21, 11/10/21 and 11/12/21 staff job titles and hours worked by agency staff from 11/02/21 and 11/09/21 were not available for review. Due to delayed receipt of staffing schedules and not receiving job titles and hours worked by agency staff, the review was unable to determine the actual number of staffing hours for each shift on the AL side from 11/02/21 through 11/09/21. Interview with a PCA on 11/10/21 at 6:30am revealed: -He worked as a PCA since May 2021.	D 188		

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D 188	Continued From page 9 -He worked both the AL and SCU at least once a week due to a shortage of staff. -Agency staff had been hired to help provide enough staff for all shifts. Observations of the facility on 11/12/21 from 3:00pm - 6:00pm revealed: -There was 1 MA assigned to work both the AL unit and the SCU and the total census for the facility was 55. -There was 1 PCA assigned work to the AL unit with a census of 38. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision]	D 188		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation of screening for tuberculosis symptoms and/or testing for tuberculosis (TB) in accordance with control measures adopted by the Commission for Public Health for 2 of 5 sampled residents (#1	D 234		

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and #2).

The findings are:

1. Review of Resident #2's current FL-2 dated 04/30/21 revealed diagnoses included left femur fracture, Alzheimer's dementia, hypertension, hypothyroidism, depression and anxiety.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 06/30/21.

Review of Resident #2's record revealed there was no documentation of tuberculosis (TB) symptom screening or testing.

Attempted interview with the Health and Wellness Director (HWD) on 11/12/21 at 5:30pm was unsuccessful.

Refer to interview with the Resident Care Coordinator (RCC) on 11/12/21 at 5:20pm.

Refer to interview with the Administrator on 11/12/21 at 5:54pm.

2. Review of Resident #1's current FL-2 dated 09/08/21 revealed:
-Diagnoses included Parkinson's Disease, hypertension (HTN), chronic kidney disease, hyperlipidemia and history of kidney stones.
-There was no admission date documented.

Review of Resident #1's Resident Register dated 07/21/20 revealed she was admitted to the facility on 08/10/20.

Review of Resident #1's undated tuberculin (TB) skin test record revealed:
-There was no documentation that a 1st step TB

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D 234	Continued From page 11 skin test was administered or read; here was no documentation that a 2nd step TB skin test was administered or read. -It was noted on Resident #1's TB skin test record that TB skin test would be done on site. Refer to interview with the Resident Care Coordinator (RCC) on 11/12/21 at 5:20pm. Refer to interview with the Administrator on 11/12/21 at 5:54pm. Attempted interview with the HWD on 11/12/21 at 5:30pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 11/12/21 at 5:20pm revealed it was the responsibility of the Health and Wellness Director (HWD) to ensure that a resident's TB skin tests were complete. Interview with the Administrator on 11/12/21 at 5:54pm revealed it was the responsibility of the HWD to ensure that a resident's TB skin tests were complete.	D 234		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	D 269		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to provide toileting assistance and incontinence care according to the residents needs and care plan for 1 of 5 sampled residents (#3).

The findings are:

Review of Resident #3's current FL-2 dated 08/19/21 revealed diagnoses included dementia, hypothyroidism, hypertension, atrial fibrillation and aphasia.

Review of Resident #3's current care plan dated 08/24/21 revealed:
-She was oriented to self only, ambulatory with a walker and uncooperative with care at times.
-She had daily bladder incontinence and occasional bowel incontinence.
-She needed staff supervision with toileting and dressing and limited assistance with bathing.

Observations of Resident #3's room on 11/09/21 from 8:42am until 8:53am revealed:
-The first bed was unmade and had sheets that were wet from the pillow area approximately two feet from the foot of the bed.
-There was a strong odor of urine.

Interview with the personal care aide (PCA) on 11/09/21 at 8:53am revealed:
-She had not yet been in the room and was not aware Resident #3's bed linens were saturated with urine.
-The PCA who worked third shift the night before should have cleaned the bed and changed the linens because she had gotten Resident #3 up and dressed that morning.
-The PCA who worked third shift the night before

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frequently left residents wet and soiled at the end of her shift.

Interview on 11/10/21 at 6:35am with the PCA who worked third shift on 11/08/21 revealed:
-She had gotten Resident #3 up and dressed on 11/09/21 because she was awake when the PCA went to assist Resident #3's roommate.
-Her bed was left wet with urine and unmade because it was for first shift staff to change.
-Resident #3 was currently still sleeping so the first shift staff for 11/10/21 would get her up and dressed.
-She last checked her 30 minutes ago (5:55am on 11/10/21).
-Incontinence care was provided every two hours on third shift.
-She last changed her two hours ago (4:35am on 11/10/21).

Observation on 11/10/21 at 6:50am revealed the third shift PCA left the SCU with her personal handbag and a large bag of trash.

Observations on 11/10/21 at 7:05am revealed:
-The third shift PCA was exiting Resident #3's room with her personal handbag and small bag of trash.
-There was a strong odor of urine in the room.
-There was a plastic bag at the foot the resident's bed with a saturated bed sheet.
-Resident #3 was coming out of the bathroom ambulating with a walker.
-She was agitated and said it was not a good day and she was tired.

Interview with the third shift medication aide (MA) on 11/10/21 at 7:07am revealed:
-She was in Resident #3's room about one hour ago to administer medications.

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D 269	Continued From page 14 -Resident #3 did not get up to take the medications because she said she was wet from incontinence. -The PCA changed Resident #3 one hour ago (6:05am). -Resident #3 was a heavy wetter and needed incontinence care again at 7:00am and was the reason the sheets were saturated. Interview with the Resident Care Coordinator (RCC) on 11/10/21 at 8:55am revealed: -She worked third shift on 11/08/21 as the Supervisor and was responsible for making sure personal care aides (PCAs) were completing rounds. -There was a problem with lack of incontinence care on all shifts. -The facility had a lot of agency staff working. -She was addressing the problem by asking Supervisors on each shift to stay on the care staff to complete rounds. -She told PCAs to make sure residents were clean and dressed. -Outgoing and oncoming PCAs were expected to round on all residents and check all rooms at shift change. -Most of the time she verified shift change rounds were done and checked residents if staff reported finding a problem. -Issues with the PCA who worked third shift on 11/08/21 and 11/09/21 leaving residents wet had been previously reported to her. -Staff were expected to remove wet and soiled linens immediately after providing incontinence care and put in the laundry. -The first shift PCA for 11/09/21 should have checked Resident #3's room on rounds that morning. -Staff were expected to provide incontinence care every two hours, especially on the SCU.	D 269		

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D 269	Continued From page 15 -She contacted the agency regarding the third shift PCA who worked 11/08/21 and 11/09/21 twice the week of 11/01/21. -Resident #3 needed assistance with incontinence care at night. -MAs on duty were responsible for letting agency PCAs know what each resident's needs were at the start of every shift. Interview with the Administrator on 11/12/21 at 8:55am revealed: -She had received one to two complaints about the third shift agency PCA leaving residents wet. -The third shift agency PCA was no longer working at the facility. -The RCC reported the complaints. -The RCC was responsible for oversight of PCAs providing care to residents. -The RCC was expected to round on residents every two hours and check behind staff. -Third shift on 11/08/21 the RCC was working as the Supervisor/MA. -The Supervisor/MA on duty each shift was responsible for telling agency staff the needs of residents and monitoring care provided by agency staff. -If there was a problem with agency staff, the Supervisor/MA was expected to report to her, the RCC or the Health and Wellness Director. -Staff were expected to round on residents every two hours, check for incontinence and change if needed. -It was not acceptable for urine saturated sheets to have been left behind for the next shift. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	D 269		

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 6 sampled residents (#2, #6) who had a history of falls with injuries including bone fractures and continued to fall and experience facial bruising and abrasions (#2), and a resident with confusion and wandered at times (#6). The findings are: Review of Resident #2's current FL-2 dated 04/30/21 revealed diagnoses included left femur fracture, Alzheimer's dementia, hypertension, hypothyroidism, depression and anxiety. Review of Resident #2's current care plan dated 08/24/21 revealed: -She was oriented to self only, received hospice services and was uncooperative with care at times. -She was non-ambulatory and used a wheelchair for mobility. -She needed extensive assistance with ambulation and transfers. -There was no documentation of supervision needs and fall prevention interventions.	D 270		

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D 270	Continued From page 17 Review of hospital discharge dated 05/29/21 for Resident #2 revealed she was seen post fall for an open left radial, ulnar and first metacarpal fracture. Telephone interview with Resident #2's Responsible Person (RP) on 11/10/21 at 11:02am revealed: -Resident #2 experienced falls between June 2021 and October 2021 which did not result in any fractured bones. -The falls always happened at night. -Resident #2 fell last week and the night of 11/08/21 and hit her face resulting in a black eye and her nose being "all tore up." Upon request on 11/09/21 and 11/10/21, there were no progress notes dated June 2021 through 10/02/21 for Resident #2 available for review. Review of an electronic progress note dated 10/03/21 at 9:30am for Resident #2 revealed she was found on rounds sitting on her bottom in her room with a knot on the left posterior side of her head and evaluated by emergency medically services (EMS). Review of an accident/incident report dated 10/03/21 at 8:40am for Resident #2 revealed she was found on rounds sitting on her bottom in her room with a knot on the left posterior side of her head. Review of a Hospice Nurse visit note for Resident #2 dated 10/04/21 revealed: -The resident fell out of the bed that morning and had an abrasion and bruise to her right forehead. -The Hospice Nurse reviewed use of the fall mat with staff.	D 270		

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D 270	Continued From page 18 Review of a Hospice Nurse visit note for Resident #2 dated 10/19/21 revealed the resident constantly tried to get out of wheelchair and facility staff had to stay near to her at all times. Review of an electronic progress note dated 11/03/21 at 12:00pm for Resident #2 revealed she was found on the floor between 11:00pm and 7:00am with an abrasion to her nose and was seen by the Hospice Nurse. Review of an electronic progress note dated 11/07/21 at 10:30pm for Resident #2 revealed she fell face first from her wheelchair while being pushed by staff to her room sustaining a lump on the middle of her head and was seen by the Hospice Nurse. Review of a Hospice Nurse visit note for Resident #2 dated 11/07/21 at 11:53pm revealed: -The resident was experiencing increased falls. -She was seen after a fall face first from her wheelchair. -The Hospice Nurse cleaned dried blood from the bridge of the resident's nose and saw a small scrap staff reported was from a separate fall. -The resident had reddened skin between her eyebrows and a healing bruise to her left eyebrow area. Review of an electronic progress note dated 11/08/21 at 11:45am for Resident #2 revealed she was found on the floor mat next to her bed before lunch. Observation of Resident #2 on 11/09/21 at 8:32am revealed the resident was seated in a regular wheelchair at a dining room table and had a large purplish bruise encircling her right eye	D 270		

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with reddened abrasions on her nose.

Interview with a personal care aide (PCA) on 11/09/21 at 8:32am revealed:
-Resident #2 fell frequently.
-The Administrator and agency nurse told staff to sit one to one with Resident #2 one day last week.
-There were three PCAs working for first shift on 11/09/21 and one was supposed to remain with Resident #2 while the other two assisted other residents.
-If staff did not constantly watch Resident #2 then she would fall onto the floor.

Observation of Resident #2's room on 11/09/21 at 8:53am revealed a fall mat on the floor half under the bed with no table or furniture next to the bed.

Observations of the special care unit (SCU) dining room on 11/09/21 from 11:44am until 11:58am revealed:
-At 11:44am, Resident #2 was seated in a regular wheelchair at a dining room table.
-One PCA was in the dining room preparing beverages for the lunch meal.
-The two other PCAs were assisting residents from the halls and common are to the dining room.
-At 11:58am, a PCA sat down to assist Resident #2 with eating the lunch meal.

Observations on the SCU on 11/09/21 from 12:22pm until 12:36pm revealed:
-At 12:22pm, Resident #2 remained seated in a wheelchair in the dining room.
-There were three PCAs on the SCU and they were cleaning dishes and the third was assisting another resident in the hallway.
-At 12:36pm, Resident #2 was seated in a regular

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wheelchair in the common area.
-There was a PCA seated next to Resident #2.

Observation of Resident #2 on 11/10/21 at 6:27am revealed:
-She was sitting in a regular wheelchair in the common area on the SCU with fading to her facial bruises.
-A PCA was in the hallway near the common area.

Interview with a third shift PCA on 11/10/21 at 6:35am revealed:
-She checked residents every two hours on third shift.
-It was more like every hour because she was constantly up and down the hall.
-Resident #2 "was one to one" or to clarify, staff had to check on her frequently because she had a lot of falls.

Observations of Resident #2 on 11/10/21 from 7:05am until 7:17am revealed:
-Resident #2 was seated in a regular wheelchair in the common area on the SCU.
-There were no staff in common area or nearby hallway.

Based on review of Resident #2's current care plan, electronic progress notes and accident/incident reports dated from 10/03/21 and 11/08/21, there was no documentation of increased supervision or other measures to prevent falls.

Observation of Resident #2 on 11/12/21 at 11:03am revealed:
-She was sitting in a tilt back wheelchair in the common area on the SCU.
-She had a new red bruise and swelling around

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her left eye.
-There were 11 residents in the common area including Resident #2.
-No staff were in the common area.
-A PCA was at the desk area on the SCU.

Interview with a second PCA on 11/12/21 at 11:03am revealed:
-She was working with one other PCA who was on a 15 minute break.
-The MA for the SCU was on the assisted living (AL) side.
-There was a hospice nurse seeing a resident on the SCU.
-She did not know what happened to cause the new bruise to Resident #2's left eye.
-Staff had to check on Resident #2 at all times because she did not sit still and had many falls.

Interview with Resident #2's Hospice Nurse on 11/12/21 at 11:32am revealed:
-Hospice was contacted for two falls the night of 11/10/21.
-Resident #2 fell in the evening around 9:00pm from the couch in the common area and again around 11:00pm from her bed onto the floor mat.
-She did not know how Resident #2 injured her eye in the falls.
-A Hospice on call nurse saw Resident #2 at 2:00am on 11/11/21.
-Staff were instructed to use the tilt back wheelchair in the tilted position at all times.
-Resident #2 should have been in the tilt back wheelchair while in the common area and not the couch.

Review of a handwritten statement by agency staff dated 11/10/21 at 8:55pm revealed:
-Resident #2 fell sideways from the couch hitting her head.

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D 270	Continued From page 22 -The staff did not witness the fall. Review of an undated handwritten statement by agency staff revealed: -Resident #2 was laying on the couch. -The staff turned to put a face mask back on and the resident fell on the left side on the floor. Review of an electronic progress note for Resident #2 dated 11/10/21 at 10:01pm revealed she fell off the couch in common area at 8:55pm. Review of an accident/incident report dated 11/10/21 for Resident #2 revealed she had an unwitnessed fall from the couch hitting her head with bruises, swelling and redness. Review of an electronic progress note for Resident #2 dated 11/11/21 at 2:00am revealed she fell at shift change and was seen by a Hospice Nurse. Review of a second accident/incident report dated 11/10/21 at 11:00pm for Resident #2 revealed she had an unwitnessed fall from the couch. Review of an electronic progress note for Resident #2 dated 11/11/21 at 5:16am revealed the Hospice Nurse recommended a bed alarm for the resident. Telephone interview with the former Resident Care Coordinator (RCC) on 11/12/21 at 8:30am revealed: -Resident #2 had a lot of falls from trying to get up unassisted. -She had a tilt back wheelchair and fall mat to help prevent falls and injuries. -The tilt back wheelchair and fall mat were	D 270		

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ordered by hospice.
-Staff were expected to round on Resident #2 every hour at night.
-During waking hours, she was kept in the common areas where staff could see her.

Interview with the current RCC on 11/12/21 at 5:20pm revealed:
-Staff had been sitting one to one with Resident #2 since she returned from the rehabilitation center in May 2021.
-Staff sometimes placed Resident #2 on the couch in the common area to give her a break from the wheelchair.
-Resident #2 should not be left alone on the couch.
-Staff called her after the first fall on 11/10/21 and she instructed them to stay with Resident #2.
-She was not called after the second fall on 11/10/21.

Telephone interview with Resident #2's primary care provider (PCP) on 11/10/21 at 10:26am revealed:
-She was Resident #2's PCP and the resident was also seen by hospice.
-For the falls, she had a tilt back wheelchair at one time provided by hospice.
-She had not seen the resident in the tilt back wheelchair on recent visits at the facility.
-She told staff to make sure they were watching her because she would constantly try to get up.
-She was not aware of all of Resident #2's falls because sometimes staff notified hospice first.

Second telephone interview with Resident #2's PCP on 11/12/21 at 2:30pm revealed:
-It was hard to fall out of a tilt back wheelchair.
-The fall mat should have helped some in preventing injury.

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-She could not say how Resident #2 would have injured her left eye from the falls on 11/10/21.

Interview with the Administrator on 11/12/21 at 5:50pm revealed:
-She started at the facility on 11/02/21 and was working on training staff on personal care and supervision.
-She did not know if increased supervision was implemented after Resident #2 had the first fall on 11/10/21.
-She always saw staff right there with Resident #2 whenever she went on the SCU.

Attempted interview with Resident #2's Hospice Provider on 11/12/21 at 9:56am was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

2. Review of the facility's Missing Person Response Procedure Policy dated 10/04/21 revealed:
-If a missing resident was located and returned to the Community seemingly uninjured or not seriously injured monitoring of the resident's whereabouts should be completed by instituting a 24-hr monitoring schedule of the resident of intervals no longer than at 15 - 30 minutes.

Review of Resident #6's current FL-2 dated 04/20/21 revealed:
-Diagnoses included diabetes type II (DMII), hypertension (HTN), hyperlipidemia, seasonal allergies and mild cognitive impairment.
-She was intermittently confused.
-She was ambulatory using a cane or walker as needed.

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D 270	Continued From page 25 Review of an undated Elopement Risk Review Tool for Resident #6 revealed: -She wandered inside the community at times, but did not express desire to leave or try to leave. -She was occasionally disoriented to time and place and was reoriented easily. Review of Resident #6's current care plan dated 09/09/21 revealed: -She was alert and oriented x2 and needed reminders at times. -There were no wandering behaviors noted on the current care plan. Review of a progress note for Resident #6 dated 08/09/21 at 7:00pm revealed: -She wandered off from the facility and made it to the second house on the main highway. -A resident alerted the staff that she left the facility grounds and the staff went and brought her back to the facility. -The Administrator and the Health and Wellness Director were notified of the incident. Observation of the exit door on the end of A-Hall on 11/10/21 at 6:27am - 6:29am revealed: -The exit door was opened at 6:27am - 6:29am and there was no audible door alarm sounding. -There was a medication aide (MA) at the nursing station on the A-Hall and she did not respond to the door being opened. Observation of the exit door on the end of the B-Hall on 11/12/21 from 9:36am - 9:50am revealed: -The exit door was propped open using a wooden object. -No staff checked the exit door or removed the wooden object from the door.	D 270		

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-There was no audible door alarm sounding.

Telephone interview with Resident #6's family member on 11/09/21 at 3:50pm revealed:
-Resident #6 had been living on the Assisted Living (AL) unit at the facility since April 2021.
-She received a call from the former Administrator on 08/09/21 at approximately 6:30pm advising her that Resident #6 had walked off the facility's grounds, from the front door, and Resident #6 had been transported back to the facility by the staff.
-The former Administrator stated that Resident #6 was trying to go to the bathroom, became confused, leading to her leaving the facility.
-Resident #6 was placed on the Special Care Unit (SCU) when she returned to the facility on 08/09/21.
-Resident #6's primary care provider (PCP) assessed her the next day (08/10/21) and thought that this was an isolated incident.
-Resident #6 was transferred back to the AL unit on 08/10/21 per orders from her PCP.
-She was not aware of Resident #6 having any exit seeking behaviors prior to the incident on 08/09/21 and she was not aware of Resident #6 having any exit seeking behaviors after 08/09/21.
-Resident #6 liked to sit outside on the screened porch on the A-Hall of the AL unit and the staff were to encourage her not to go outside of the screened porch.
-The staff were to check on Resident #6 more often, but she was not sure how frequent those checks were.
-She visited the facility several days a week prior to the facility being on quarantine for COVID-19 and she was not aware of the facility having alarms on the exit doors.

Telephone interview with the former Health and

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THE ADDISON OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

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D 270	Continued From page 27 Wellness Director (HWD) on 11/12/21 at 9:56am revealed: -She was aware of Resident #6 leaving the facility without assistance and staff's knowledge a few months ago. -She was not at the facility at the time of the incident and was notified via telephone by the former Administrator. -She was advised by the former Administrator that this was not considered an elopement because Resident #6 did not have a diagnosis of dementia. -The exit doors at the facility did not alarm when they were opened. -There were residents who resided on the AL unit that had a dementia diagnosis, but she was not aware of any of the residents having exit seeking behaviors. Interview with a MA on 11/10/21 at 6:36am revealed: -She primarily took care of the residents on the AL unit. -There was a resident (not Resident #6) who resided on the A-Hall of the AL unit that would sometimes get up in the middle of the night and walk around the AL unit. -She was not aware of this resident having exit seeking behaviors, but she would keep an eye on her while she was up walking around. -She was not aware of any elopements from the facility. -She did not think that Resident #6 was an elopement risk because she mostly sat in her room. -Resident #6 would come to the dining room for meals but she would go back to her room after eating. -She was not aware of Resident #6's elopement on 08/09/21.	D 270		

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D 270	Continued From page 28 -She would check on all residents on the AL unit every 1 - 2 hours during her shift to monitor them for safety and assist with ADL care. -The MAs and the personal care aides (PCA) wore pagers during their shifts that alerted them when a resident used their call light or when an exit door was opened. -There were no audible alarms that sounded when the facility's exit doors were opened. -She was not wearing her pager at the time because she had just taken it off at approximately 6:30am because staff from the 1st shift were coming on duty. -It was the responsibility of the staff to search the inside of the facility and the perimeter if an elopement occurred. -It was the responsibility of the MA to notify the police if a resident could not be found while searching the facility grounds. -It was the responsibility of the MA to notify the Administrator, the resident's family member and the resident's PCP if an elopement occurred. Observation of the exit doors on the AL unit on 11/12/21 from 11:24am - 11:31am revealed: -There were 2 different pagers being used during the observations. -Both pagers displayed the incorrect date and time on the display screen; 1 pager displayed the date as 10/20/16 and the time as 2:29pm and the other pager displayed the date as 10/29/16 and the time as 5:06pm. -An exit door on the B-Hall was opened and there was no alert was sent to either pager. -A second door on the B-Hall was opened and there was no alert was sent to either pager. -The exit door to the screened porch on the A-hall was opened and there was no alert went to either pager.	D 270		

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D 270	Continued From page 29 Interview with a second MA on 11/10/21 at 3:32pm revealed: -She worked with the facility through a staffing agency. -A former staff told her about the level of care that some of the residents required but not all the residents. -She learned about the level of care that other residents required by trial and error. -She was not aware of any residents on the AL unit having wandering or exit seeking behaviors. Interview with a 2nd PCA on 11/10/21 at 3:59pm revealed: -He was not aware of any residents on the AL unit with wandering or exit seeking behaviors. -He was not aware of any residents on the AL unit that required increased supervision or increased monitoring. -It was the responsibility of the MAs and the PCAs to check in on residents every 2hrs and as needed, to offer assistance with ADLs and monitor their safety. -The residents had a call light pendant that they used to alert staff when they need assistance. -When the residents used the call light pendant it alerted the staff's pagers and the computers at the nursing stations. -The pagers also alerted staff when the exit doors to the facility were opened. Interview with a 3rd PCA on 11/10/21 at 4:08pm revealed: -He was not aware of any residents on the AL unit with wandering or exit seeking behaviors. -He was not aware of any residents on the AL unit that required increased supervision or increased monitoring. -Resident #6 was alert and oriented to herself and surroundings and he was not aware of	D 270		

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D 270	Continued From page 30 Resident #6's elopement on 08/09/21. -Resident #6 would go outside and sit on the screened porch on the A hallway but was not exit seeking. -He checked on Resident #6 during routine rounding and assisted with ADLs as needed. -The staff educated Resident #6 not to go outside of the screened porch. -It was the responsibility of the MAs and the PCAs to check in on residents every 2hrs and as needed to monitor their safety. -The residents had a call light pendant that they used to alert staff when they need assistance. -When the residents used the call light pendant it alerted the staff's pagers and the computers at the nursing stations. -The pagers also alerted staff when the exit doors to the facility were opened. Telephone interview with Resident #6's PCP on 11/10/21 at 10:05am revealed: -She was notified by the former Administrator that Resident #6 eloped from the facility on 08/09/21 and had been located and returned to the facility without injury. -Resident #6 was placed on the SCU when she returned on 08/09/21 for safety. -She assessed Resident #6 at the facility either on 08/10/21 or 08/11/21 and determined that Resident #6 was safe to return to the AL unit. -She spoke with Resident #6's family member and was made aware that Resident #6 liked to go for walks and went for a walk on 08/09/21. -Resident #6 had no elopement behaviors prior to 08/09/21 and she felt that Resident #6 left the facility to go for a walk and was not exit seeking. -Resident #6 leaving the facility without assistance could have been dangerous for her safety.	D 270		

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D 270	Continued From page 31 Interview with the Administrator on 11/12/21 at 8:12am revealed: -She was made aware of Resident #6's elopement from 08/09/21 approximately 2 days prior to the facility's survey. -She was not aware of any other residents on the AL unit with wandering or exit seeking behaviors. -She was not familiar with the facility's elopement policy. -She expected the MAs and the PCAs to monitor residents with wandering behaviors or increased risk for elopement every 15 - 30 minutes. -It was the responsibility of the MAs and the PCAs to communicate acute changes in a resident's status and discuss the level of care the residents needed during the change of shift report. -It was the responsibility of the MAs to document acute changes in a resident's status in the 24hr communication books on the AL unit and the SCU. A second interview with the Administrator on 11/12/21 at 11:23am revealed it was the responsibility of the MAs and the PCAs to wear pagers that alerted them when the exit doors of the facility were opened. Based on observations, record review, and interviews it was determined that Resident #6 was not interviewable. _____ The facility failed to provide supervision for two sampled residents, Resident #2 who had a history of falls with injuries including bone fractures which resulted in 6 documented falls from 10/03/21 through 11/11/21 and the resident experiencing facial and head bruises and swelling with 5 of the falls; and Resident #6 with a known	D 270		

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D 270	Continued From page 32 history of confusion and wandering behaviors who had left the facility on 08/09/21 unsupervised and without the staff's knowledge. The facility's failure to provide adequate supervision was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/12/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 27, 2021.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure referral and follow up for 3 of 5 sampled residents (#1, #4 and #5) as evidenced by failure to notify the endocrinologist of high fingerstick blood sugar (FSBS) results that exceeded the prescribed parameters (#4), the primary care provider of multiple medication refusals (#5), and failure to ensure that a referral for physical therapy (PT) was implemented (#1). The findings are: 1. Review of Resident #4's current FL-2 dated	D 273		

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D 273	Continued From page 33 02/18/21 revealed diagnoses included diabetes. Review of the facility's medication policy dated 06/22/21 revealed: -Significant reactions and changes in behavior shall be reported to the resident's physician and responsible party. -A resident's physician should be contacted by the Health and Wellness Director (HWD), or designee, with any questions, concerns, or observations related to the supervised medications. -Signification changes in the resident's health or behavior should be reported to the resident's physician and responsible party. -Document the time of reports, the reason for reporting, and the physician's orders/response in the resident's record. Follow the physician's orders and document. Review of Resident #4's physician orders dated 02/17/21 revealed: -There was an order to obtain the residents fingerstick blood sugar (FSBS) before meals and at bedtime and to notify the endocrinologist if FSBS was above 400. Review of Resident #4's September 2021 electronic medication administration record (eMAR) revealed: -Resident #4's blood sugar on 09/28/21 at 12:00pm was documented as 442. -There was no documentation noted on the eMAR that the endocrinologist was notified. Review of Resident #4's October 2021 eMAR revealed: -Resident #4's blood sugar on 10/07/21 at 12:00pm was documented as 467. -Resident #4's blood sugar on 10/15/21 at	D 273		

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8:00pm was documented as 438.
-Resident #4's blood sugar on 10/24/21 at 12:00pm was documented as 428.
-Resident #4's blood sugar on 10/26/21 at 12:00pm was documented as 552.
-Resident #4's blood sugar on 10/26/21 at 8:00pm was documented as 457.
-There was no documentation noted on the eMAR that the endocrinologist was notified.

Review of Resident #4's November 2021 eMAR revealed:
-Resident #4's blood sugar on 11/01/21 at 12:00pm was documented at 406.
-There was no documentation noted on the eMAR that the endocrinologist was notified.

Interview with the Clinical Operations Specialist on 11/12/21 at 5:18pm revealed:
-Resident #4's FSBS frequently ran high because she ate several snacks during the day.
-She expected MAs to follow physician orders and notify Resident #4's endocrinologist when her FSBS was over 400.
-If it was a weekend or after hours the MAs were expected to fax the endocrinologist to report Resident #4 FSBS were over 400.
-If it was during the endocrinologist's regular hours the MAs were expected to call the endocrinologist and report any FSBS that was over 400.
-The MAs had been trained to follow all physician orders.
-She expected the MAs to document a progress note that they notified Resident #4's endocrinologist when her FSBS was over 400.
-She expected the MAs to notify the RCC and Health and Wellness Director (HWD) when her FSBS were over 400.

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D 273	Continued From page 35 Interview with a medication aide (MA) on 11/12/21 at 8:33am revealed: -She contacted Resident #4's endocrinologist when her FSBS was over 400 by fax or telephone call. -She was not sure why there were not any progress notes in Resident #4's record that she had contacted the endocrinologist. -She thought she had documented when she contacted the endocrinologist but must have forgotten to document. -She should have documented her communication with the endocrinologist so there was a record and to help with communicating any concerns or changes with the next shift. Interview with the Resident Care Coordinator (RCC) on 11/12/21 at 4:06pm revealed: -The MAs were expected to fax Resident #4's endocrinologist a monthly report of her FSBS results. -The MAs were expected to contact Resident #4's endocrinologist when her FSBS was over 400. -The MAs were expected to follow orders from the endocrinologist. -She was not aware that the MAs had failed to contact Resident #4's endocrinologist when her FSBS was over 400. -There was a system in place to track notifications to doctors which included a date and time stamp on the fax notification. -The facility also had the capabilities to email the endocrinologist of a FSBS over 400. -The MAs should have documented in the electronic progress note that they notified Resident #4's endocrinologist of her FSBSs that were over 400. -She did not know why there were no faxed notifications or emailed notifications to Resident #4's endocrinologist.	D 273		

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D 273	Continued From page 36 -She did not know why there were not any electronic progress notes that the endocrinologist had been notified of Resident #4's FSBS over 400. Telephone interview with Resident #4's nurse with her endocrinologist on 11/12/21 at 1:53pm revealed the endocrinologist faxed a letter to the facility on 04/30/21 with directions to contact the endocrinologist if Resident #4's blood sugar was over 400. Telephone interview with a nurse practitioner (NP) with Resident #4's endocrinologist on 11/12/21 at 1:43pm revealed: -She visited Resident #4 on 11/09/21 at the facility. -She requested Resident #4's FSBS reports from either a MA or the RCC on 11/09/21 and the facility did not provide any documentation. -She needed Resident #4's FSBS reports in order to assess if any changes were needed to her diabetes management medication. -The nurse from the endocrinologist office had called the facility several times since 11/09/21 to request Resident #4's FSBS reports. -As of 11/09/21 at 1:43pm the NP had not received documentation from the facility of Resident #4's FSBS. -There was an order for the facility to notify the endocrinologist if Resident #4's FSBS was over 400. -She and the endocrinologist had not received any notification from the facility of Resident #4's FSBS being over 400. -She expected staff to notify her or the endocrinologist when Resident #4's FSBS were over 400. -She was concerned that the facility had not followed orders to notify the endocrinologist when	D 273		

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Resident #4's FSBS were over 400; due to the negative effects it could have on the resident.
-Resident #4 was at higher risk of complications from uncontrolled diabetes including cardiovascular disease, nerve, kidney, eye and foot damage.

Interview with the Administrator on 11/12/21 at 5:08pm revealed:
-The MAs were expected to follow physician orders.
-She expected the MAs to notify the endocrinologist when Resident #4's FSBS were over 400.
-The MAs were expected to document a progress note that they notified Resident #4's endocrinologist of FSBSs that were over 400.
-She did not understand why the MAs had not notified Resident #4's endocrinologist of FSBS that were over 400.
-She was concerned that failure to notify Resident #4's endocrinologist of FSBS's over 400 could have been fatal to the resident.

2. Review of Resident #5's current FL-2 dated 07/15/21 revealed diagnoses included chronic pain, dementia and depression

Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed:
-There was documentation Donepezil HCl Oral tablet 10mg was refused at 8:00pm on 09/12/21, 09/14/21, 09/16/21, 09/18/21, 09/19/21, 09/22/21, 09/24/21, 09/28/21 (Donepezil was used to treat Alzheimer's disease).
-There was documentation Megestrol Acetate Oral Suspension 40mg/ml was refused at 9:00am on 09/06/21- 09/09/21, 09/17/21,

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09/21/21-09/22/21, 09/25/21-09/26/21, 09/28/21-09/29/21 (Megestrol Acetate was used to treat loss of appetite, malnutrition and weight loss).
-There was documentation Polyethylene Glycol Powder 17gm was refused at 9:00am on 09/06/21- 09/09/21, 09/17/21, 09/21/21-09/22/21, 09/26/21, 09/28/21-09/29/21 (Polyethylene Glycol Powder was used to treat constipation).
-There was documentation Senna tablet 8.6mg was refused at 8:00pm on 09/12/21, 09/14/21, 09/16/21, 09/18/21- 09/19/21, 09/22/21, 09/24/21, 09/28/21 (Senna was used to treat constipation).
-There was documentation Buspirone tablet 5mg was refused at 2:00pm on 09/12/21 and 8:00pm on 09/12/21, 09/14/21, 09/16/21, 09/18/21-09/19/21, 09/22/21, 09/24/21, 09/28/21 (Buspirone was used to treat anxiety).
-There was documentation Divalproex 125mg was refused at 8:00pm on 09/28/21 (Divalproex was used to treat bipolar disorder).

Review of Resident #5's October 2021 eMAR revealed:
-There was documentation Buspirone tablet 5mg was refused at 8:00pm on 10/11/21- 10/12/21, 10/17/21- 10/19/21.
-There was documentation Divalproex 125mg was refused at 8:00pm on 10/05/21-10/08/21, 10/12/21, 10/16/21- 10/19/21.
-There was documentation Donepezil HCl Oral tablet 10mg was refused at 8:00pm on 10/05/21-10/08/21, 10/11/21- 10/12/21, 10/16/21- 10/19/21.
-There was documentation Megestrol Acetate Oral Suspension 40mg/ml was refused at 9:00am on 10/01/21, 10/05/21, 10/07/21, 10/09/21-10/10/21.
-There was documentation Olanzapine tablet 2.5mg was refused at 8:00pm on 10/05/21-10/08/21, 10/11/21- 10/12/21, 10/16/21- 10/19/21 (Olanzapine was used to treat mental disorders).

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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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-There was documentation Polyethylene Glycol Powder 17gm was refused at 9:00am on 10/04/1-10/05/21, 10/07/21, 10/09/21.
-There was documentation Senna tablet 8.6mg was refused at 8:00pm on 10/05/21- 10/08/21, 10/11/21- 10/12/21, 10/16/21- 10/19/21.
-There was documentation Aspirin low dose 81mg was refused at 9:00am on 10/22/21 (Aspirin was used to treat pain and reduce risk of heart attack).
-There was documentation Buspirone tablet 5mg was refused at 8:00pm on 10/05/21- 10/07/21.

Review of Resident #5's November 2021 eMAR revealed:
-There was documentation Divalproex 125mg was refused at 8:00pm on 11/05/21, 11/08/21.
-There was documentation Donepezil HCl Oral tablet 10mg was refused at 8:00pm on 11/05/21 and 11/08/21.
-There was documentation Megestrol Acetate Oral Suspension 40mg/ml was refused at 9:00am on 11/08/21 and 11/09/21.
-There was documentation Olanzapine tablet 2.5mg was refused at 8:00pm on 11/05/21 and 11/08/21.
-There was documentation Polyethylene Glycol Powder 17gm was refused at 9:00am on 11/08/21 and 11/09/21.
-There was documentation Senna tablet 8.6mg was refused at 8:00pm on 11/05/21 and 11/08/21.

Interview with a medication aide (MA) on 11/10/21 at 6:42am revealed:
-Resident #5 refused medications "all the time."
-She documented Resident #5's medication refusals in the eMAR system.
-She attempted multiple times to administer medications to Resident #5 and she refused.
-She did not notify the Primary Care Physician

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(PCP) of Resident #5's medication refusals.
-She was not told by anyone she had to notify the PCP when Resident #5 refused her medications.

Interview with a second MA on 11/10/21 at 5:31pm revealed:
-She attempted to administer medications 3 times to Resident #5 before she marked it as a refusal in the eMAR system.
-She did not notify the PCP or family when residents refused their medications.
-She was never trained to notify the PCP of medication refusals.

Interview with the Resident Care Coordinator (RCC) on 11/10/21 revealed:
-The family was aware Resident #5 refused her medications.
-The MA was responsible for informing the PCP, family, RCC and HWD that residents were refusing medications.
-She expected the MA to notify the RCC or HWD of medication refusals and document in the residents' record.
-She thought the home health agency informed the PCP of the medication refusals.

Interview with the Executive Director (ED) on 11/10/21 at 3:32pm revealed:
-The medication aides were responsible for notifying the PCP when a resident missed doses of a medication or refused a medication.
-The MAs were expected to document notification of the PCP in the resident's record.
-She expected the HWD to monitor the medication refusals of residents and ensure the PCP and family members were notified.
-She was not aware Resident #5 was refusing medications as often as it was documented in the eMAR system.

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-She expected to be notified of the medication refusals because she was responsible for the well-being of the residents.

Attempted interview on 11/10/21 with the HWD was unsuccessful.

Telephone interview with the PCP on 11/10/21 at 9:57am revealed:
-She was aware Resident #5 was refusing medications but was not aware she was refusing medications as often as she was.
-She was concerned Resident #5 refusing medications could potentially interfere with the resident not eating, how well she dealt with other residents and staff and if she would allow staff to provide personal care.
-She felt if she was made aware of all the medication refusals it would help with Resident #5 receiving the proper care that she needed in the facility.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.
3. Review of Resident #1's current FL-2 dated 09/08/21 revealed diagnoses included Parkinson's Disease, hypertension (HTN), hyperlipidemia and history of kidney stones.

Review of Resident #1's Resident Register dated 07/21/20 revealed she was her own responsible party.

Review of Resident #1's record on 11/09/21 at 12:34pm revealed:
-There was a referral from Resident #1's neurologist dated 09/15/21 for Physical Therapy (PT) to evaluate and treat related to gait abnormality and Parkinson's Disease.

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-There were special instructions for "LSVT/BIG training for Parkinson's." (Lee Silverman Voice Treatment are exercise based programs used to improve or slow the progression of motor symptoms for people diagnosed with Parkinson's Disease).

Interview with Resident #1 on 11/09/21 at 9:16am revealed:
-She lived at the facility since August 2020.
-She went to a neurology appointment on 09/15/21 and received a new order for a PT referral.
-She provided the facility with a copy of the PT referral when she came back from the neurologist on 09/15/21.
-No one from the facility had followed up with her related to the PT referral.
-She spoke with the home health Program Manager regarding the PT referral but was not sure of the exact date.
-The home health Program Manager had not followed up with her regarding the PT referral.
-She was concerned that not receiving the PT would affect her independence.

Telephone interview with a home health Clinical Manager on 11/12/21 at 8:45am revealed:
-The home health company received the physical therapy (PT) referral for Resident #1 on 09/22/21.
-It was documented in their system that Resident #1 was not admitted for services because they unable to provide the PT services that were ordered.
-It was the responsibility of the home health company to respond to referrals within 48hrs.

Telephone interview with the home health Program Manager on 11/12/21 at 9:43am revealed:

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-He received the PT referral dated 09/15/21 from Resident #1 while he was in the facility on 09/22/21.
-He discussed the PT referral with the home health therapist, and it was determined that they could not provide the PT services ordered.
-He informed the former Health and Wellness Director (HWD) on 09/23/21 at 8:37am, via email, that they were not able to provide the recommended PT services for Resident #1.
-He did not get a response from the former HWD via email.
-He spoke with the HWD at the facility to ensure that she received the email about not being able to provide the PT services for Resident #1.
-He was not sure of the exact date he spoke with the HWD at the facility related to the PT referral for Resident #1.
-Resident #1 asked him while he was in the facility on 11/09/21 if the home health company received the PT referral dated 09/15/21.
-It was the responsibility of the facility to notify Resident #1 and the PCP that the home health company was not able to provide the PT services as ordered.

Telephone interview with the former Health and Wellness Director (HWD) on 11/12/21 at 9:56am revealed:
-She notified the home health Program Manager of Resident #1's PT referral dated 09/15/21.
-She was informed by the home health company that they did not offer the PT services ordered for Resident #1.
-The home health company notified Resident #1's family and the family decided to take her to an outpatient agency for the ordered PT services.
-It was the responsibility of the HWD to send referrals to the appropriate agencies for ordered services.

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D 273	Continued From page 44 A second interview with Resident #1 on 11/12/21 at 10:39am revealed: -She spoke with the home health Program Manager on 11/09/21 and was informed that they were unable to provide the PT services ordered on 09/15/21. -Prior to 11/09/21, she had not been notified by the home health company or the facility that the home health company could not provide her with the PT services ordered on 09/15/21. Telephone interview with Resident #1's family member on 11/12/21 at 11:43am revealed: -She had not had any contact with home health, or the facility related to Resident #1's PT referral dated 09/15/21. -Resident #1 was alert and oriented and had made an effort to learn as much as she could about Parkinson's Disease ever since she was diagnosed. -Resident #1 was aware of the disease process and wanted to remain as independent as possible. Attempted telephone interview with Resident #1's neurologist on 11/12/21 at 9:11am and was unsuccessful. _____ The facility failed to ensure referral and follow up for 3 of 5 sampled residents by not notifying the endocrinologist of high fingerstick blood sugars (FSBS); failure to notify the PCP of multiple medication refusals and failure to ensure that a PT referral to manage a resident's Parkinson's Disease was received. This failure resulted in serious risk of physical harm which constitutes an A2 violation. _____ The facility provided a plan of protection in	D 273		

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D 273	Continued From page 45 accordance with G.S. 131D-34 on 11/12/21 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 12, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician orders were implemented for 2 of 6 (#4, #5) sampled residents regarding physician orders to check finger stick blood sugar (FSBS) daily (#4) and with an order for weekly weights (#5). The findings are: 1. Review of Resident #4's current FL-2 dated 02/18/21 revealed diagnoses included diabetes. Review of Resident #4's physician orders dated 02/17/21 revealed: -There was an order to obtain the residents fingerstick blood sugar (FSBS) before meals and at bedtime and to notify the endocrinologist if FSBS was above 400.	D 276		

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D 276	Continued From page 46 Review of Resident #4's September 2021 electronic medication administration record (eMAR) revealed: -There was no documentation for FSBS on 09/01/21 to 09/03/21 at 8:00am, 12:00pm, 5:00pm or 8:00pm, 09/04/21 at 8:00am, 12:00pm or 5:00pm, 9/05/21 at 8:00am and 12:00pm, 09/06/21 at 8:00am, 12:00pm, 5:00pm and 8:00pm, 09/07/21 at 8:00am, 12:00pm and 8:00pm, 09/08/21 at 8:00am and 12:00pm, 09/09/21 at 8:00am and 8:00pm, 09/10/21 at 8:00am and 12:00pm, 09/11/21 at 8:00am, 5:00pm and 8:00pm, 09/12/21 at 5:00pm and 8:00pm, 09/13/21 at 8:00am, 12:00pm and 8:00pm, 09/14/21 at 5:00pm, 09/16/21 at 8:00am and 12:00pm, 09/17/21 at 5:00pm and 8:00pm, 09/18/21 at 5:00pm, 09/19/21 at 8:00am and 12:00pm, 09/20/21 at 5:00pm and 8:00pm, 09/21/21 at 8:00pm, 09/24/21 at 8:00am, 12:00pm and 5:00pm, 09/25/21 at 8:00pm, 09/26/21 at 5:00pm and 8:00pm, 09/27/21 at 8:00am, 12:00pm, 5:00pm and 8:00pm, 09/28/21 at 8:00pm, and 09/30/21 at 5:00pm and 8:00pm. Review of Resident #4's October 2021 eMAR revealed: -There was no documentation for FSBS on 10/01/21 at 8:00am, 5:00pm and 8:00pm, 10/02/21 to 10/03/21 at 8:00am, 12:00pm, 5:00pm and 8:00pm, 10/04/21 to 10/05/21 at 5:00pm and 8:00pm, 10/06/21 at 5:00pm, 10/08/21 at 8:00am and 12:00pm, 10/09/21 to 10/10/21 at 5:00pm and 8:00pm, 10/11/21 at 8:00pm, 10/12/21 at 12:00pm and 8:00pm, 10/13/21 at 8:00am and 8:00pm, 10/14/21 at 8:00pm, 10/23/21 at 8:00pm and 10/29/21 at 5:00pm and 8:00pm. Interview with a medication aide (MA) on 11/12/21 at 8:33am revealed:	D 276		

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D 276	Continued From page 47 -Resident #4 had her FSBS checked four times a day; prior to meals and at bedtime. -The MAs were expected to document on the eMAR, and progress note the reason Resident #4 did not have her FSBS checked. -Resident #4 never refused to have her FSBS checked. -She did not know why she had not documented FSBS's for Resident #4; she probably got busy and forgot to document it. Interview with the Resident Care Coordinator (RCC) on 11/12/21 at 4:06pm revealed: -The MAs were expected to document any refusals Resident #4 had for FSBS's. -The MAs were expected to document a reason why her FSBS was not checked on the eMAR. -Resident #4's FSBS should have been checked per physician orders to manager her diabetes. -She did not know why her FSBS was not checked so many times in September 2021 and October 2021. Telephone interview with a nurse practitioner (NP) with Resident #4's endocrinologist on 11/12/21 at 1:43pm revealed: -She was not aware that Resident #4 had missed numerous FSBS in September 2021 and October 2021. -The residents' FSBS was ordered to be checked prior to meals and at bedtime. -She was concerned that Resident #4 could have complications from MAs not checking her blood sugar. -The resident could experience complications such as cardiovascular disease, nerve, kidney, eye and foot damage. -She expected the MAs to follow physician orders and to document FSBS results so she could help manage the residents' diabetes.	D 276		

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D 276	Continued From page 48 Interview with the Clinical Operations Specialist on 11/12/21 at 5:18pm revealed: -She was not aware that Resident #4 had so many missed FSBS in September 2021 and October 2021. -There was no excuse for the MAs failure to document the residents FSBS as ordered by the physician. -The MAs were expected to follow all physician orders. -Resident #4 was at risk of complications from her diabetes due to FSBS not being completed by MAs. Interview with the Administrator on 11/12/21 at 5:08pm revealed: -The MAs were expected to follow physician orders. -The HWD and RCC were expected to monitor eMARS at least once a month. -She did not know why the MAs had not documented her FSBS's. -She was concerned that Resident #4's FSBS's were not monitored because it could have led to complications. Attempted interview on 11/12/21 at 5:05pm with the Health and Wellness Director (HWD) was unsuccessful. 2. Review of Resident #5's current FL-2 dated 07/15/21 revealed diagnoses included chronic pain, dementia and depression. Review of Resident #5's physician's orders dated 08/17/21 revealed weekly weights. Observation of the Resident Care Coordinator (RCC), Activities Director and the Health and	D 276		

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D 276	Continued From page 49 Wellness Director (HWD) revealed there were no documented weights. Interview with the Executive Director on 11/10/21 at 1:00pm revealed the weights should have been recorded in the electronic MAR (eMAR) system. Interview with the RCC on 11/10/21 at 3:23pm revealed: -She could not find the weight book. -She thought the HWD had the weight book in her office. Interview with the ED on 11/12/21 at 10:50am revealed: -The residents' weights should have been kept in a weight book and accessible to facility staff to document before or after documenting the weights in the eMAR system. -The PCAs and MAs were responsible for recording the weights in the weight book. -The weights for residents were done monthly and based on the residents' orders from their PCP. -She did not know why the weight book could not be located upon request on 11/10/21. Interview with the ED on 11/12/21 at 11:40am revealed: -She was not aware Resident #5 had an order for weekly weights. -She did not know why Resident #5's weekly weights were not done. -The HWD was responsible for ensuring weights were done and recorded. -She expected weights to be completed monthly or as ordered by the PCP. Attempted interview on 11/10/21 at 3:25pm with the HWD was unsuccessful.	D 276		

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D 276	Continued From page 50 Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.	D 276		
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, interviews and record reviews, the facility failed to administer as ordered by the prescriber for 2 of 5 sampled residents (#2 and #3) which included glaucoma pressure reducing eye drops (#3), an antibiotic and anti-anxiety medications (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 04/30/21 revealed diagnoses included left femur fracture, Alzheimer's dementia, hypertension, hypothyroidism, depression and anxiety. a. Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for clonazepam 1mg twice daily at 9:00am and 8:00pm with a start date of 10/14/21. (Clonazepam is used to treat anxiety.)	D 358		

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-There was no documentation doses were administered from 10/14/21 at 9:00am through 10/23/21 at 9:00am.
-There was no documentation for the reason doses were not administered.

Upon request on 11/09/21 and 11/10/21 an order for clonazepam for Resident #2 was not available for review.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/12/21 at 9:46am revealed:
-The pharmacy received an order dated 10/12/21 for clonazepam 1mg twice daily at 8:00am and 2:00pm for Resident #2.
-The pharmacy dispensed 28 tablets on 10/13/21.
-The facility had a new eMAR system where medications did not appear on the eMAR and could not be administered until they were approved by facility staff.
-The clonazepam was not approved in the system until 10/23/21.

Observation of medications on hand for Resident #2 on 11/10/21 at 3:58pm revealed a bubble pack of clonazepam 1mg tablets with a pharmacy label indicating 28 tablets were dispensed on 10/13/21 and 9 tablets remained.

Interview with an agency medication aide (MA) on 11/12/21 at 4:33pm revealed:
-She was told as an agency MA she was not allowed to verify medications orders or controlled drugs.
-She did not remember clonazepam 1mg for Resident #2 because the resident had several orders for clonazepam.

Interview with the Resident Care Coordinator

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(RCC) on 11/12/21 at 5:20pm revealed:
-She did not know why there was a 10 day delay in initiating the order for clonazepam 1mg BID for Resident #2.
-The resident had multiple bubble packages of clonazepam on the medication cart.
-She did not know if the primary care provider (PCP) was notified.
-Notification to the PCP would have been documented in the resident's progress notes.

Telephone interview with Resident #2's PCP on 11/12/21 at 2:30pm revealed:
-She was not aware of the increased dose of clonazepam for Resident #2.
-The hospice provider might have written the order.

Attempted interview with Resident #2's Hospice Provider on 11/12/21 at 3:19pm was unsuccessful.

b. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for nitrofurantoin 100mg twice daily at 8:00am and 8:00pm with a start date of 11/05/21. (Nitrofurantoin is an an antibiotic used to treat urinary tract infections.)
-There was documentation doses were administered 11/05/21 at 8:00pm through 11/09/21 at 8:00am.
-There was no documentation doses were administered on 11/03/21 and 11/04/21.

Upon request on 11/09/21 and 11/10/21, an order for nitrofurantoin for Resident #2 was not available for review.

Telephone interview with a pharmacy technician

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from the facility's contracted pharmacy on 11/12/21 at 9:46am revealed:
-The pharmacy received an order dated 11/02/21 for nitrofurantoin 100mg twice daily for Resident #2.
-The pharmacy dispensed the nitrofurantoin on 11/03/21.
-She could not say why there was a 2 day delay in administering the nitrofurantoin to Resident #2.

Observations of medications on hand for Resident #2 on 11/10/21 at 3:58pm revealed nitrofurantoin was on hand.

Interview with an agency medication aide (MA) on 11/12/21 at 4:33pm revealed:
-She saw nitrofurantoin on the medication cart last week (11/01/21) for Resident #2 and did not see it on her eMAR.
-She told the Health and Wellness Director (HWD) the same day or the next day the nitrofurantoin was on the cart for Resident #2 and there was no order entered on the resident's eMAR..

Interview with the Resident Care Coordinator (RCC) on 11/12/21 at 5:20pm revealed:
-There might have been a delay in sending the order for nitrofurantoin to the pharmacy for Resident #2 which delayed starting the medication.
-She remembered the nitrofurantoin was either not on the medication cart or not entered on the eMAR until 11/05/21.

Telephone interview with Resident #2's primary care provider (PCP) on 11/12/21 at 2:30pm revealed:
-The Hospice Nurse contacted her with concerns Resident #2 had symptoms of a urinary tract

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infection (UTI) including strong smelling urine and a low fever.
-She ordered the nitrofurantoin to treat for a possible UTI since the resident had a fever.
-A two day delay in administering antibiotics could worsen the UTI.
-An untreated UTI could spread to the blood stream which would be serious.

Review of a Hospice Nurse visit note for Resident #2 dated 11/01/21 revealed:
-The resident had a temperature of 100.7 degrees Fahrenheit (F).
-The PCP and RCC were notified.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Refer to interview with the Resident Care Coordinator (RCC) on 11/12/21 at 5:20pm.

Refer to interview with the Administrator on 11/12/21 at 5:50pm.

Refer to interview with the Clinical Operations Specialist on 11/12/21 at 5:55pm.

2. Review of Resident #3's current FL-2 dated 08/19/21 revealed:
-Diagnoses included dementia, hypothyroidism, hypertension, atrial fibrillation and aphasia.
-There was an order for latanoprost 0.005% one drop in each eye every evening. (Latanoprost is used to treat glaucoma.)

Review of Resident #3's September 2021, October 2021 and November 2021 electronic medication administration records (eMARs) revealed an entry for latanoprost 0.005% one

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drop in each eye every evening with documentation a dose was administered at 8:00pm daily from 09/02/21 through 11/08/21.

Observation on medications on hand for Resident #3 on 11/09/21 at 12:39pm revealed there were no latanoprost eye drops.

Interview with the Activity Director (AD) on 11/09/21 at 12:39pm revealed:
-She worked as a medication aide (MA) at times to help out with staffing issues.
-There were no latanoprost eye drops on the medication cart or in the medication refrigerator for Resident #3.

Interview with an agency medication aide (MA) on 11/12/21 at 4:33pm revealed:
-She was told as an agency MA she was not allowed to request refills from the pharmacy.
-She made a list every day she worked of medications she could not give because the medications were not on the medication cart.
-She gave the list to the oncoming MA if they were a facility staff or left the list on the Resident Care Coordinator's (RCC's) desk.
-She believed latanoprost eye drops for Resident #3 were on her list.

Interview with the RCC on 11/12/21 at 5:20pm revealed:
-Creams and eye drops were not on automatic cycle fill; they needed to be requested from the pharmacy.
-She did not know how the bottle of latanoprost eye drops dispensed on 05/03/21 lasted until October 2021 where her initials were documented as administering doses on the eMAR.
-Hers were not the only initials on the eMAR for administering the latanoprost.

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D 358	Continued From page 56 -She was pretty sure the latanoprost eye drops were on the medication cart. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/09/21 at 3:44pm revealed: -The pharmacy was filling a refill request by staff for Latanoprost eye drops for Resident #3 on 11/09/21. -Prior to 11/09/21, Latanoprost was last filled for Resident #3 on 05/05/21. -The pharmacy dispensed 2.5ml of Latanoprost which was a 25 day supply. -Refills for Latanoprost had to be requested by facility staff and were not on an automatic cycle fill. Telephone interview with Resident #3's primary care provider (PCP) on 11/10/21 at 10:26am revealed: -Latanoprost eye drops were used to treat glaucoma and worked to decrease pressure in the eye and preserve vision. -She was not aware the resident had not been receiving the eye drops as ordered. -Not getting the drops could cause increased pressure and possible vision loss. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. Refer to interview with the Resident Care Coordinator (RCC) on 11/12/21 at 5:20pm. Refer to interview with the Administrator on 11/12/21 at 5:50pm. Refer to interview with the Clinical Operations Specialist on 11/12/21 at 5:55pm.	D 358		

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D 358	Continued From page 57 Interview with the Resident Care Coordinator (RCC) on 11/12/21 at 5:20pm revealed: -New medication orders went to the Heath and Wellness Director (HWD) and she faxed them to the pharmacy. -The HWD called the pharmacy to verify orders were received and the pharmacy entered new orders on the resident's eMAR. -She just started being able to verify orders on the new eMAR system approximately one week ago (11/05/21). -The new system was implemented before she returned to work at the facility six weeks ago (10/01/21). -The primary care provider (PCP) sent the facility copies of orders sent electronically to the pharmacy. -She or the HWD filed verified orders in the resident's chart. -Verified orders were marked with a date stamp by the staff who verified the order. Interview with the Administrator on 11/12/21 at 5:50pm revealed: -The HWD had to approve medications before they would show up on the eMAR. -The Clinical Operations Specialist covered the responsibilities of the HWD when the HWD was not available. Interview with the Clinical Operations Specialist on 11/12/21 at 5:55pm revealed: -There were problems with only certain staff being able to verify medications. -This led to medications being on the cart without being on the eMAR or medications being on the eMAR on not on the medication cart. -The PCP should be notified of delays in initiating medications.	D 358		

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D 368	10A NCAC 13F .1004 (k) Medication Administration 10A NCAC 13F .1004 Medication Administration (k) The facility shall have a system in place to ensure the resident is identified prior to the administration of any medication or treatment. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure there was a system in place to properly identify a resident prior to the administration of any medication, that a resident was given medication in a plastic medication cup with another residents name written on it (#4) and a medication aide (MA) asking residents in the Special Care Unit (SCU) to identify themselves prior to administering medications (#2). The findings are: 1. Review of Resident #4's current FL-2 dated 02/18/21 revealed: -Diagnoses included diabetes, unspecified dementia, malignant neoplasm (a cancerous tumor), excision of right breast (removal of the breast lump with surrounding normal tissue) and dorsalgia (severe back pain). Interview with Resident #4 on 11/09/21 at 9:35am revealed: -She received her morning medication in a plastic medication cup from the Resident Care Coordinator (RCC) on 10/26/21.	D 368		

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D 368	Continued From page 59 -The RCC left her room before she took her medications. -She took half of her medication and when she began to take the remaining medication, she noticed another residents' name written on the outside of the plastic medication cup. -Another resident's name was handwritten on the side of the plastic medication cup for a resident that lived on the same hall. -She was scared she was given the wrong medications and was afraid because her name was not written on the plastic medication cup. -She called her family member to report her concern and he came to the facility. -She also notified the RCC that she had been given the wrong medication. Interview with Resident #4 on 11/10/21 at 8:46am revealed: -When another resident's name was written on the plastic medication cup after she had taken half of the pills on the morning of 10/26/21, she was afraid she was going to die. -It was the first time she had received medications from the RCC. -When her family member arrived, he instructed her to give him the cup with the remaining medication so he could speak with management. -Once she realized there was another resident's name written on the medication cup she was scared. Interview with the RCC on 11/10/21 at 8:55am revealed: -She had worked at the facility for one year as the RCC. -She had worked at the facility previously as the RCC but did not pass medications. -She had been back for approximately 6 weeks as the RCC.	D 368		

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-She wrote each resident's name on a plastic medication cup prior to placing medication in the cup to help her ensure she had administered all residents their medications.
-She made a mistake and placed Resident #4's medications in a plastic medication cup with another resident's name written on the cup.
-She gave Resident #4 the cup with medications in it and left her room.
-She did not observe Resident #4 take her medications.
-She returned to Resident #4's room after her family member arrived.
-Resident #4 took all the medication from the cup except for 6 pills.
-The Health and Wellness Director (HWD) and Administrator verified the 6 pills remaining in the cup belonged to Resident #4 with the family member present.
-The HWD and Administrator compared the 6 pills that remained in the plastic medication cup with the medication for the resident's name that was written on the cup.
-She took a photograph of the 6 remaining pills in the cup on 10/26/21.
-The HWD or the Administrator notified the primary care physician (PCP).
-The HWD directed staff to increase monitoring and had personal care aides (PCA) check on her more often to ensure the resident was not experiencing anxiety.
-She checked on the resident more often during the morning shift but could not remember how often.
-The Clinical Operations Specialist completed the medication pass for the remainder of the day.
-She had been trained to write names on the plastic medication cups and place on top of medication cart.
-She would then place a resident's medications in

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D 368	Continued From page 61 the cup with their name and administer the medication immediately. Observation of a photograph on 11/10/21 at 9:39am revealed: -The photograph of the 6 remaining pills in a plastic medication cup was on the RCC's cell phone. -There was a date and time stamp of 10/26/21 at 4:27pm. -There was a photograph of the 6 remaining pills in a plastic medication cup with a handwritten note of the medications listed that were in the cup. -The medications listed were Requip (2 pills), Carbidopa Levodopa (1 pill), Acetaminophen (1 pill), Magnesium Oxide (1 pill) and Lasix (1 ½ pill). Telephone interview with Resident #4's family member on 11/10/21 at 9:52am revealed: -Resident #4 had resided at the facility for approximately 6 years. -He received all call from a family member that Resident #4 had been given the wrong medication. -When he arrived at Resident #4's room, he took the plastic medication cup with the remaining pills in it to the Administrator. -The Administrator and HWD informed him that the resident took all but 6 pills. -The Administrator and HWD reviewed the resident's medication with him to ensure that the resident had taken her medications. -He was frustrated and concerned for Resident #4's safety when this mistake was made. -He expressed his concern to the Administrator and the HWD that the RCC should not have labeled a plastic medication cup with each resident's name.	D 368		

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D 368	Continued From page 62 -He communicated to the Administrator and the HWD that the actions of the RCC put Resident #4 at risk and caused her undue fear. Interview with the HWD on 11/10/21 at 10:27am revealed: -On 10/26/21, the RCC had written the names of residents on plastic medication cups and placed them on top of the medication cart. -The RCC placed Resident #4's medications in a medication cup with another residents name written on the cup and took the medications to Resident #4. -The RCC dispensed a resident's medication into a medication cup which had another resident's name handwritten on the side of the cup and then administered the medication to that resident. -She and the Administrator reviewed the medications that were remaining in the medication cup and compared the pills with her electronic medication administration record (eMAR). -She and the Administrator met with the resident and her family member to apologize for the confusion, informed them that the resident received the correct medication and that the mistake would not happen again. -She and the Administrator provided education to the RCC on the importance of not labeling medication cups with residents' names. -She expected the RCC and medication aides (MAs) to follow the proper procedures when dispensing medications. -She conducted eMAR reviews every other week and at least monthly with the pharmacy. -The RCC notified Resident #4's PCP about the incident. Interview with the Administrator on 11/12/21 at 5:08pm revealed:	D 368		

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-The RCC should not have labeled plastic medication cups on 10/26/21.
-She and the HWD met with Resident #4's family member and reviewed the 6 remaining medications that were in the medication cup labeled with another resident's name.
-She and the HWD compared the 6 medications in the cup with the resident's eMAR.
-The remaining medications in the plastic medication cup belonged to Resident #4.
-She expected staff to follow proper medication administration guidelines when administering medications.
-The RCC contacted the resident's PCP to report the incident.

Telephone interview with a Medical Assistant at Resident #4's PCP office on 11/10/21 at 3:30pm revealed:
-The RCC contacted the PCP on 10/26/21 at 5:05pm to report the resident was given medications with another resident's name written on the medication cup on the morning of 10/26/21.
-The RCC left a message that the Administrator and HWD reviewed the resident's medications, compared them with the eMAR and verified that the resident was provided with the correct medications and the family member was notified.
-The facility faxed a list of medications the resident took and the six medications that were in the plastic cup that she took later.

2. Review of Resident #2's current FL-2 dated 04/30/21 revealed diagnoses included left femur fracture, Alzheimer's dementia, hypertension, hypothyroidism, depression and anxiety.

Observation of a medication aide (MA) on 11/10/21 at 6:37am revealed:

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D 368	Continued From page 64 -She was at the nurse's station on the Assisted Living (AL) side with the Resident Care Coordinator (RCC). -She reported to the RCC that she had not passed out any medication this morning on the special care unit (SCU) due to the phone ringing. Observation of the MA on the SCU on 11/10/21 at 6:55am revealed: -She had a small plastic medication cup in her hand with a spoon in the cup. -She walked from the medication cart into the lounge where 6 residents were sitting. -She spoke to the 6 residents and asked each Resident if they were Resident #2 by calling Resident #2's name. -She stated, "I think it's one of these." -She walked up to 4 different residents and asked if they were Resident #2. -She approached a 5th resident and asked if she was Resident #2. -The 5th resident stated yes, the MA confirmed that the resident said yes and then the resident said no. -The MA returned to the medication cart with the small clear medication cup for Resident #2. -She expressed frustration that she was not sure which Resident was resident #2. -She looked at the resident's photograph on the electronic medication administration record (eMAR). -She said the photograph was too small to see what Resident #2 looked like. -She went to a room that had a sign with resident #2's name on the door. -A personal care aide (PCA) from the AL unit was on the SCU and told the MA that the sign on the door was incorrect. -The PCA told the MA that Resident #2 did not reside in that room.	D 368		

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THE ADDISON OF KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(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 368	Continued From page 65 -The PCA identified Resident #2 for the MA. Interview with the MA on 11/10/21 at 7:05am revealed: -This was her first time working at the facility and she was agency staff. -She was not sure which resident was Resident #2 and had difficulty identifying the resident from her photograph on the eMAR because the photograph was so small. -She needed to correctly identify each resident before administering their medications. Interview with the Administrator on 11/12/21 at 5:08pm revealed: -The RCC took photographs of all SCU residents on 11/10/21 to ensure agency staff could properly identify residents. -The MAs were expected to ask the RCC, Health and Wellness Director (HWD) or herself if they had questions or concerns about a resident. -The MAs were expected to identify each resident before administering medication.	D 368		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter:	D 433		

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D 433	Continued From page 66 (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation of contact and/or visit notes with licensed providers and written orders were maintained in the residents' records for 2 of 5 sampled residents (#2 and #6). The findings are: Interview with the Administrator on 11/09/21 at	D 433		

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8:27am revealed:
-She started working at the facility on 11/02/21.
-She did not have access to the electronic system due to issues with her password.
-She was unable to provide requested information for the survey due to lack of access and knowledge of location of documents not filed electronically.
-A non-local corporate staff was on the way to assist with providing records.

A request for the following information was made on 11/09/21 at 10:55am revealed: sampled residents #1 - #5 records including primary care provider (PCP) medication and treatment orders, electronic medication administration records (eMARS) for September, October and November 2021 and progress notes 06/01/21 - present.

1. Review of Resident #2's current FL-2 dated 04/30/21 revealed diagnoses included left femur fracture, Alzheimer's dementia, hypertension, hypothyroidism, depression and anxiety.

Review of Resident #2's record revealed there were no primary care provider (PCP) visit notes and progress notes dated June 2021 through 11/09/21.

Review of Resident #2's record and electronic medication administration record (eMAR) revealed there were no orders for medications started, discontinued and changed.

Interview with the Clinical Operations Specialist on 11/09/21 at 1:28pm revealed:
-She was working on printing eMARs for the sampled residents.
-She did not find hand written or electronic progress notes for Resident #2 dated June 2021

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through 10/02/21.
-There were electronic progress notes for 10/03/21 through 11/08/21.

Interview with the Clinical Operations Specialist on 11/10/21 at 11:00am revealed:
-Medication orders requested for Resident #2 on 11/10/21 at 8:45am would need to be obtained from the pharmacy because the facility did not have copies of the orders.
-She had contacted the PCP's office to request visit notes for Resident #2.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/09/21 at 3:44pm revealed she was unable to print and fax copies of dispensing and order history.

Upon request of the facility on 11/09/21 and 11/10/21, PCP visit notes for Resident #2 were not available for review.

Interview with the Clinical Operations Specialist on 11/12/21 at 6:15pm revealed:
-Medication orders were sent directly to the pharmacy.
-The Health and Wellness Director (HWD) and Resident Care Coordinator (RCC) were equally responsible for contacting the pharmacy for copies of the orders.
-The HWD and RCC were responsible for ensuring documentation was in the residents' records.

2. Review of Resident #6's current FL-2 dated 04/20/21 revealed diagnoses included diabetes type II (DMII), hypertension (HTN), hyperlipidemia, seasonal allergies and mild cognitive impairment.

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D 433	Continued From page 69 Upon request of the facility on 11/09/21 at 1:15pm, 11/09/21 at 3:49pm, and 11/10/21 at 7:55am the progress note from Resident #6's facility visit by the primary care provider (PCP) on 08/10/21 was not available for review. [Refer to tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision] [Refer to tag 358, 10A NCAC 13F .1004(a) Medication Administration]	D 433		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a completed 24 hour report was submitted to the Health Care Personnel Registry (HCPR) followed by an investigation and 5 Day report for injuries of unknown origins including a bruise above the eye and bruises on the left inner arm for 1 of 1 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 04/30/21 revealed diagnoses included left femur fracture, Alzheimer's dementia, hypertension, hypothyroidism, depression and anxiety.	D 438		

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Review of a Hospice Nurse visit note for Resident #2 dated 08/28/21 revealed the resident had a quarter sized dark purple area above her left eye.

Review of a Hospice Nurse visit note for Resident #2 dated 09/04/21 revealed the resident had a bruise on her left inner arm and the medication aide (MA) was notified.

Telephone interview with the former Resident Care Coordinator (RCC)/Health and Wellness Director (HWD) on 11/12/21 at 8:30am revealed:
-She was the RCC from December 2020 until 10/08/21.
-She did not know about Resident #2 having a bruise above her eye on 08/28/21.
-She saw the bruise on Resident #2's left inner arm documented on 09/04/21 by the Hospice Nurse and reported it to the former Administrator.
-There should have been an accident/incident report.
-Any investigation would have been done by the former Administrator.

Interview with the Clinical Operations Specialist on 11/12/21 at 5:15pm revealed:
-There was no accident/incident report or HCPR 24 hour and 5 Day reports for the bruise found above Resident #2's eye on 08/28/21.
-There was no accident/incident report or HCPR 24 hour and 5 Day reports for the bruise found on Resident #2's inner arm on 09/04/21.
-The former HWD would have been responsible for investigating injuries of unknown origin and reporting.
-The corporate area nurse would have been responsible of oversight for the HWD.

Attempted interview with Resident #2's Hospice Nurse on 11/12/21 at 9:56am was unsuccessful.

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D 438	Continued From page 71 Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.	D 438		
D 452	10A NCAC 13F .1212(b)(c) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (b) Notification as required in Paragraph (a) of this Rule shall be by a copy of the death report completed according to Rule .1208 of this Subchapter or a written report that shall provide the following information: (1) resident's name; (2) name of staff who discovered the accident or incident; (3) name of the person preparing the report; (4) how, when and where the accident or incident occurred; (5) nature of the injury; (6) what was done for the resident, including any follow-up care; (7) time of notification or attempts at notification of the resident's responsible person or contact person as required in Paragraph (e) of this Rule; and (8) signature of the administrator or administrator-in-charge. (c) The report as required in Paragraph (b) of this Rule shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident.	D 452		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure accident and incident reports were completed and included the name of the staff who discovered the accident/incident, when the accident/incident occurred and signature of the administrator for 2 of 6 sampled residents (#2 and #5).

The findings are:

Review of Resident #2's current FL-2 dated 04/30/21 revealed diagnoses included left femur fracture, Alzheimer's dementia, hypertension, hypothyroidism, depression and anxiety.

Review of an accident/incident report dated 10/03/21 at 8:40am for Resident #2 revealed:
-There was no documentation of who discovered the accident/incident.
-The report was not signed by the Administrator.

Review of an accident/incident report dated 11/03/21 for Resident #2 revealed:
-There was no documentation when the accident/incident occurred.
-There was no documentation of who discovered the accident/incident.
-The report was not signed by the Administrator.

Review of an accident/incident report dated 11/07/21 for Resident #2 revealed:
-There was no documentation when the accident/incident occurred.
-There was no documentation of who discovered the accident/incident.
-The report was not signed by the Administrator.

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D 452	Continued From page 73 Review of an accident/incident report dated 11/10/21 for Resident #2 revealed: -There was no documentation when the accident/incident occurred. -There was no documentation of who discovered the accident/incident. -The report was not signed by the Administrator. Review of a second accident/incident report dated 11/10/21 at 11:00pm for Resident #2 revealed: -There was no documentation of who discovered the accident/incident. -The report was not signed by the Administrator. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. Refer to interview with the Resident Care Coordinator (RCC) on 11/10/21 at 8:55am. Refer to interview with the Administrator on 11/12/21 at 8:55am. 2. Review of Resident #5's current FL-2 dated 07/15/21 revealed diagnoses included chronic pain, dementia and depression. Interview with a medication aide (MA) on 11/10/21 at 5:31pm revealed: -She saw Resident #5's right hand wound on 10/19/21. -She did not complete an incident and accident report because she assumed someone else had completed it. -The MA who was on duty at the time of the incident was responsible for completing the incident and accident report.	D 452		

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D 452	Continued From page 74 Interview with the Resident Care Coordinator (RCC) on 11/10/21 at 5:00pm revealed: -The MAs were responsible for completing incident and accident reports. -An incident and accident report should have been completed for Resident #5's right hand. -She did not know why the incident and accident report was not completed. Interview with the Clinical Operations Specialist on 11/12/21 at 9:13am revealed: -There was not an incident and accident report completed for Resident #5's right hand. -There should have been an incident and accident report completed; family should have been notified and the PCP should have been notified. -She did not know why an incident and accident report was not completed. Refer to interview with the Resident Care Coordinator (RCC) on 11/10/21 at 8:55am. Refer to interview with the Administrator on 11/12/21 at 8:55am. _____ Interview with the Resident Care Coordinator (RCC) on 11/10/21 at 8:55am revealed: -Accident/incident reports were completed electronically. -Medication aides (MAs) on duty were responsible for completing accident/incident reports. -MAs were supposed to include when the accident/incident occurred and who discovered it. -The electronic form marked required areas in red which included when and name of staff. -The Health and Wellness Director (HWD) reviewed completed accident/incident forms and	D 452		

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D 452	Continued From page 75 was able edit the electronic form. Interview with the Administrator on 11/12/21 at 8:55am revealed: -Staff were expected to include when the accident/incident occurred, what happened, injuries and who discovered the accident/incident on accident/incident forms. -Completed accident/incident forms were reviewed by the RCC or Health and Wellness Director (HWD). -Following review by the RCC/HWD, she checked accident/incident forms to ensure they were completed. -She was responsible for making sure accident/incident reports were sent to the Department of Social Services (DSS).	D 452		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure accurate documentation verifying minimum staffing ratios of 1 staff per 8 residents on first and second shifts and 1 staff per 10 residents on third shift were maintained to meet the needs of residents	D 465		

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on the special care unit at all times for 8 sampled days from 11/02/21 through 11/09/21.

The findings are:

Observations during tour of the special care unit (SCU) on 11/09/21 from 8:32am until 9:25am revealed there were three personal care aides (PCAs) and 17 residents.

Observations of the facility on 11/12/21 from 3:00pm - 6:00pm revealed:
-There was 1 medication aide (MA) assigned to work both the AL unit and the SCU with the total census of the facility at 55.
-There were 2 PCAs assigned to work the SCU with 17 residents.

Interview with a MA on 11/12/21 at 4:24pm revealed:
-She was the only MA for the AL unit and the SCU for the 2nd shift on 11/12/21.
-The Administrator had been doing the staff schedule with the assistance of the Resident Care Coordinator (RCC).

Interview with a agency PCA on 11/12/21 at 4:23pm revealed:
-She worked at the facility through a staffing agency.
-She signed up for vacant shift using an app provided by the staffing agency and she was not sure who completed the staff schedule at the facility.
-She was still trying to figure out the daily assignments at the facility because the assignments were not available.

Interview with a PCA on 11/09/21 at 12:18pm revealed the facility had staff shortages involving

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a shortage of medication aides (MAs) on the first shift and PCAs on the second and third shifts.

Interview with the Administrator on 11/09/21 at 1:45pm revealed:
-An agency staff was assigned to work as a medication aide (MA) on 11/09/21 for first shift.
-The agency staff did not want to work as a MA and left.
-The Resident Care Coordinator (RCC) worked third shift 11/08/21 and stayed over for first shift on 11/09/21 to administer medications.
-A second MA came in for a few hours the morning of 11/09/21 to administer medications and was no longer at the facility.

Observation of the common area on the SCU on 11/12/21 at 11:03am revealed:
-A resident was sitting in a tilt back wheelchair in the common area on the SCU.
-She had a new red bruise and swelling around her left eye.
-There were 11 residents in the common area including the resident with the bruised eye.
-No staff were in the common area.
-A PCA was at the desk area on the SCU.

Interview with the PCA on 11/12/21 at 11:03am revealed:
-She was working with one other PCA who was on a 15 minute break.
-The MA for the SCU was on the assisted living (AL) side.
-There was a hospice nurse seeing a resident on the SCU.
-She did not know what happened to cause the bruise to the resident's eye.
-Staff had to check on the resident with the bruise at all times because she did not sit still and had many falls.

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D 465	Continued From page 78 A request was made for the following information on 11/09/21 at 1:28pm specific to staffing hours on the special care unit (SCU) from 11/02/21 through 11/09/21: all staff time cards including titles, daily census, staff schedule/assignment, missed punches and any administrative/management staff direct care hours. A second request was made on 11/10/21 at 10:42am for the following information which was not provided as a result of the first request: daily census, staff schedule/assignment, staff job titles and hours worked by agency staff specific from 11/02/21 through 11/09/21. A second request was made on 11/12/21 at 8:51am for the following information which was not provided as a result of the first and second requests: staff schedule/assignment, staff job titles and hours worked by agency staff. Review of the staff schedule for 11/06/21 (received 11/12/21 at 2:00pm) revealed there were two staff scheduled to work for the entire building, one assigned to the special care unit (SCU) and the second to the assisted living (AL) side. Upon request on 11/09/21, 11/10/21 and 11/12/21 staff job titles and hours worked by agency staff from 11/02/21 and 11/09/21 were not available for review. Due to delayed receipt of staffing schedules and not receiving job titles and hours worked by agency staff, the review was unable to determine the actual number of staffing hours for each shift on the SCU from 11/02/21 through 11/09/21.	D 465		

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	HAL092220	A. BUILDING: _____ B. WING _____	R-C 11/12/2021

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D 465	Continued From page 79 Interview with the RCC on 11/10/21 at 8:55am revealed: -The Business Office Manager (BOM) was responsible for managing staff timecards. -The Administrator and Clinical Operations Specialist were responsible for completing the staff schedule. Telephone interview with a family member on 11/10/21 at 11:02am revealed: -She visited the facility often and had concerns there were either not enough staff or the staff was not caring for residents. -She told the former Administrator about seeing an agency staff watch movies on her cellular phone during the day on weekends multiple times in the special care unit (SCU). -The last time that happened was three weekends ago (10/23/21). -The former Administrator said they would investigate it, but the agency staff was still at the facility. -She did not want to see staff fired, but the residents needed to be taken care of. Interview with the Administrator on 11/12/21 at 8:55am revealed: -She started working at the facility on 11/02/21. -She did not know about the complaint related to an agency PCA watching movies on her cellular phone during work hours on the weekend. Interview with a second shift agency PCA on 11/12/21 at 4:21pm revealed: -She was working on the SCU by herself on 11/12/21 for second shift. -There was a call out and management was working on moving a staff from the assisted living (AL) side.	D 465		

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D 465	Continued From page 80 Interview with a PCA on 11/10/21 at 6:30am revealed: -He had worked as a PCA since May 2021. -He had to work both the AL and SCU at least once a week due to a shortage of staff. -Agency staff had been hired to help provide enough staff for all shifts. -There were more agency staff than regular employees working at the facility. Interview with a MA on 11/10/21 at 7:45am revealed: -She was a MA at the facility and the Activity Director. -The Health and Wellness Director (HWD) and RCC also helped administer medications when there were not enough MAs in the facility. -There had been several times in the past 3 months that the facility had a shortage of MAs. -There was more agency staff than regular employees that worked at the facility due to staffing shortages. Interview with a second MA on 11/12/21 at 8:33am revealed: -The facility had a shortage of MAs several times a month. -She was called in often when she was off to work as a MA due to staff shortages. Telephone interview with the former Health and Wellness Director (HWD) on 11/12/21 at 9:56am revealed the facility had been using staff from staffing agency for about a year on all shifts. Interview with a PCA on 11/12/21 at 4:30pm revealed the Administrator completed the staff schedule for the facility and the RCC assisted when needed.	D 465		

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D 465	Continued From page 81 Interview with the RCC on 11/12/21 at 5:20pm revealed: -She assisted the Administrator with the staff schedules. -She felt that there was an oversight that there was only 1 MA assigned to work the AL unit and the SCU for 2nd shift on 11/12/21. -If there was a shift that was short staffed, the facility would reach out to other staff to cover the vacancies. -It was the responsibility of the managers, that included the Administrator, the RCC, the SCU Director and the Activities' Director, to work the medication carts when the facility was short staffed. Interview with the Administrator on 11/12/21 at 5:54pm revealed it was the responsibility of the Administrator to complete the staff scheduling. [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal and Supervision] [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal and Supervision]	D 465		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record	D912		

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D912	Continued From page 82	D912		

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, health care and physical environment.

The findings are:

1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 6 sampled residents (#2, #6) who had a history of falls with injuries including bone fractures and continued to fall and experience facial bruising and abrasions (#2), and a resident with confusion and wandered at times (#6). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].

2. Based on observations, interviews and record reviews, the facility failed to ensure referral and follow up for 3 of 5 sampled residents (#1, #4 and #5) as evidenced by failure to notify the endocrinologist of high fingerstick blood sugar (FSBS) results that exceeded the prescribed parameters (#4), the primary care provider of multiple medication refusals (#5), and failure to ensure that a referral for physical therapy (PT) was implemented (#1). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].

3. Based on observations, interviews and record reviews, the facility failed to ensure that 7 of 7 doors that were accessible to a resident with known cognitive impairment were equipped with sounding devices that were activated and sounded when the exit doors were opened to alert staff for 1 of 2 sampled residents on the on the Assisted Living (AL) unit who was disoriented

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D912	Continued From page 83 with a recent history of elopement (#6). [Refer to Tag .0067, 10A NCAC 13F .0305 (h)(4) Physical Environment (Type B Violation)].	D912		