Division of Health Service Regulation

Received via email 03-21-22, KHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041052	A. BUILDING: _____ B. WING _____	R 02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

(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 a follow-up survey on 02/16/22 through 02/18/22, and 02/21/22, with an exit via telephone on 02/21/22.	{D 000}		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#4 and #3) residing in the Special Care Unit (SCU) related to a resident who exhibited inappropriate sexual behaviors and aggressive behaviors towards other residents in the SCU (#4), and a resident who had multiple falls (#3). The findings are: 1. Review of Resident #4's current FL2 dated 06/01/21 revealed diagnoses included hypertension, Alzheimer's dementia, diabetes mellitus, obstructive sleep apnea, depression, and benign prostatic hyperplasia. Review of Resident #4's Resident Register revealed an admission date of 06/18/21.	{D 270}	1. An incident report was completed for resident per the Five Star Policy for the event on February 23, 2022, by the Director of Resident Care (DRC). Resident #4 was discahrged from community February 25, 2022 2. All staff have been interviewed to determine any addidtional incident report needs. Completed on Febraury 25, 2022 and any intervention needed have been put into place and put on residents service plan. 3. All staff have been educated on reporting out of the ordinary events and adverse events including what is an adverse event, when, who and how to report. Completed on Feb 25, 2022. All incident reports have been reviewed for interventions and have been updated to be reflected on the service plan. 4. All Incident reports have been logged and brought to morning meeting for an at risk discussion and signature and documentation needs. The log will be reviewed weeekly by the ecxecutive director (ED)/RSD/designee for accuracy and service plan updates for four (4) weeks	3/21/2022

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael W [illegible]

TITLE: ED

(X6) DATE: 3-21-22

Acknowledged and Accepted 03/24/22 KHH

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{D 270}	Continued From page 1 Review of Resident #4's care plan dated for 07/14/21 revealed: -He was independent for transferring, ambulation, and eating. -He required minimal assistance with toileting, bathing, dressing and grooming. Review of Resident #4's progress notes and incident and accident reports revealed Resident #4 had six documented instances of sexual behavior towards female residents and aggressive behaviors towards residents between 10/6/21 and 12/16/21. Review of Resident #4's progress note dated 12/17/21 revealed: -Resident #4 walked past a female resident and "rubbed her breast." -The female resident removed Resident #4's hands. -Resident #4 picked up his walker and hit the female resident with his walker. -The incident was reported to the Resident Services Director (RSD) and the RSD called both residents' responsible parties. -There was no documentation of interventions or increased supervision for Resident #4 following the incident. Review of Resident #4's December 2021 Medication Administration Record (MAR) revealed that Resident #4 did not receive any PRN medications for agitation on 12/17/21. Review of Resident #4's incident report form dated 01/24/22 revealed: -Resident #4 banged on the Special Care Unit (SCU) doors around 3:00pm. -A nurse attempted to redirect Resident #4. -Resident #4 became physically and verbally	{D 270}		

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{D 270}	Continued From page 2 aggressive and hit the nurse in the head. -Facility staff called the police, and police suggested to have the resident involuntarily committed. -Resident #4 was evaluated at the local hospital and released back to the facility in less than 24 hours. -The RSD and a medication aide (MA) attempted to notify Resident #4's family member but were unsuccessful. Interview with a personal care aide (PCA) on 02/18/22 at 11:18am revealed -Staff was able to tell when Resident #4 was getting agitated. -Resident #4 would speak louder when agitated. -Staff attempted to redirect Resident #4 when he became agitated. Interview with another PCA on 02/18/22 at 11:30am revealed: -There were usually two PCAs and one MA working on the SCU. -Resident #4 exhibited behaviors about twice a week. -Resident #4 would sometimes touch other female residents, say things, or hit people if agitated. -She was able to tell when Resident #4 was upset. -Resident #4 was able to be redirected. -Staff told the Special Care Unit Coordinator (SCUC) when Resident #4 had behaviors. -Staff were supposed to redirect Resident #4 when he had behaviors. -If Resident #4 was unable to be redirected, staff would inform the SCUC or SCU Health and Wellness Coordinator. -The SCUC would attempt to redirect Resident #4.	{D 270}		

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{D 270}	Continued From page 3 -If the SCUC was unable to redirect Resident #4, she would inform the Executive Director (ED). Interview with the SCUC on 02/18/22 at 1:20pm revealed: -All the residents wandered in the SCU. -Resident #4's behaviors varied; sometimes he would have a bad week. -There was no consistent pattern to Resident #4's behaviors, it just depended on the day. -Resident #4 exhibited inappropriate sexual behaviors and became aggressive with other residents sometimes. -She thought that Resident #4 exhibited behaviors sometimes shortly after waking up or if he was hungry. -Resident #4 was redirectable some days and other days he was not redirectable. -SCU staff would typically let the RSD and the ED know if Resident #4 had behaviors. -There were no interventions in place for Resident #4. Review of Resident #4's progress notes dated 01/30/22 at 4:00pm revealed: -Resident #4 went into another resident's room to use the restroom. -The MA attempted to redirect Resident #4 and told him it was not his room. -Resident #4 became combative and started swinging his walker. -Resident #4 spit in the face of the MA. -The MA reported the incident to the RSD and Resident #4's family member. -There was no documentation of interventions or increased supervision for Resident #4. Review of Resident #4's progress notes dated 02/03/22 at 7:00pm revealed: -Resident #4 was inappropriate and told a female	{D 270}		

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{D 270}	Continued From page 4	{D 270}		

resident to "touch his private part."
-Facility staff redirected Resident #4 to another room.

Review of Resident #4's incident report form dated 02/17/22 at 9:00pm revealed:
-A female resident entered Resident #4's room.
-Resident #4 punched the female resident in the nose because he wanted the resident to get out of his room.
-Resident #4 laughed about the female resident being injured.
-The female resident had a bloody nose.
-Emergency Medical Services (EMS) personnel and law enforcement were called.
-A meeting with the Resident's family member was scheduled for 02/21/22 at 12:00pm.
-There was no documentation of interventions or increased supervision for Resident #4.

Telephone interview with a second shift MA on 02/21/21 at 11:59am revealed:
-Resident #4 went into another resident's room on 01/30/21.
-She talked to the RSD about the incident and called Resident #4's family member.
-Resident #4 hit a female resident on 02/17/22 around 9:00pm.
-The PCAs found the female resident on the floor in Resident #4's room.
-The female resident had a bloody mouth and nose.
-Resident #4 laughed that he had hurt the other resident.
-The female resident was sent to the hospital.
-She informed the RSD and the RSD informed the ED of the incident on 02/17/22.
-She was unaware if anyone had discussed additional measures to increase supervision for Resident #4's behaviors.

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{D 270}	Continued From page 5 -Resident #4 had several medication changes over the last few months in response to his behaviors. -She did not think that the medication changes were effective. -Resident #4 was aggressive at times and went into other residents' rooms. Telephone interview with a second shift PCA on 02/21/22 at 3:40pm revealed: -The residents in the SCU frequently wandered. -A female resident wandered into Resident #4's room on 02/17/22 around 9:00pm. -Resident #4 punched the female resident and knocked her on the floor. -The female resident's nose and top lip were bleeding badly. -She did not move the female resident. -She yelled for the MA to come to Resident #4's room. -They called EMS and the police. -The police asked Resident #4 why he hit the female resident. -Resident #4 stated, "because she was in my room." -Resident #4 did not seem aware of his actions. -She was the first staff to find both residents in Resident #4's room. -She heard "a scuffle" from the hallway. -Resident #4 had been aggressive towards residents before. -She was not sure how often staff were expected to check on the residents. -There were some residents that she checked on more often, including Resident #4, every 30 minutes to one hour. -She did not know if anyone had discussed additional measures to increase supervision for Resident #4's behaviors. -She did not know if there were any additional	{D 270}		

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{D 270}	Continued From page 6 protocols or interventions to supervise residents who exhibited behaviors. Telephone interview with Resident #4's family member on 02/21/22 at 11:12am revealed: -Facility staff informed her of the incident on 02/17/22 that involved Resident #4. -She received a phone call on the night of 02/17/22 in which the caller told her that Resident #4 hit another resident in the face, and both residents were going to the hospital. -She was informed the next day that the other resident went into Resident #4's room while Resident #4 was asleep. -The other resident was sent to the hospital. -Resident #4 was not sent to the hospital. -She suggested to facility staff to move Resident #4 closer to the nurses' station in order to increase his supervision. -Resident #4's current room was down the hallway and around the corner from the nurses' station. -Other residents were often in Resident #4's room when family members visited. -She had a meeting scheduled with the ED on 02/21/22. -She felt that supervision of the residents including Resident #4 was an issue. -Resident #4 said inappropriate sexual remarks to some of the female residents. -Some of the female residents approached Resident #4 often. -Staff needed to redirect Resident #4 or the other residents to stop incidents from occurring. -Staff had not suggested additional interventions to supervision for Resident #4. Review of Resident #4's progress notes dated 02/17/22 at 9:00pm revealed: -Resident #4 hit a female resident because she	{D 270}		

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{D 270}	Continued From page 7 came into his room. -The female resident was sent out to the hospital due to being hit in the face. -Resident #4's family member, the RSD, the ED, and the police were called. -Resident #4 was told to stay in his room by facility staff. Interview with the MA on 02/18/22 at 11:01am revealed: -She checked on the residents every 30 minutes to 1 hour. -Resident #4 was not seen by a mental health provider. -Resident #4 was not always able to be redirected when he exhibited behaviors. -Resident #4 used to have an as needed (PRN) Ativan medication (used to treat agitation). -The PRN Ativan was discontinued and PRN Haldol (used to treat mental/mood disorders) was started for Resident #4 by the Primary Care Provider (PCP) on 11/03/21. -Resident #4 did not need the PRN Haldol most of the time. -Resident #4 was more likely to have behaviors at nighttime. -The PCAs or MA would redirect Resident #4 to his room if he went to other residents' rooms. -Resident #4 had touched female residents inappropriately in the past. -If staff saw this happen, they would try to redirect Resident #4 to his room. -Resident #4 hit another resident on the night of 02/17/21. Attempted telephone interview with Resident #4's PCP on 02/18/22 at 3:53pm was unsuccessful. Observation of Resident #4 on 02/18/22 from 4:21pm and 4:38pm revealed:	{D 270}		

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{D 270}	Continued From page 8 -At 4:21pm, Resident #4 was sleeping in his bed in his room. -Another resident was sleeping in the recliner chair in Resident #4's room. -At 4:36pm, Resident #4 was sitting in a chair in the hallway. -At 4:38pm, the other resident was still sleeping in Resident #4's room in the recliner chair. -There was no staff around Resident #4's room at the time of the observation. Interview with a third PCA on 02/18/22 at 4:29pm revealed: -Resident #4 was verbally aggressive but she had not seen him hit anyone. -Two other residents would frequently go into Resident #4's room. -She had to get another resident out of Resident #4's room for most of her shift. -She constantly checked the residents' rooms "every ten minutes or so." -Resident #4 was normally in his room. Interview with a fourth PCA on 02/18/22 at 4:47pm revealed: -A female resident wandered into the other residents' rooms and would lay down in their beds. -Staff would have to redirect the resident to get her out of other residents' rooms. -The female resident was hit by Resident #4 on 02/17/22. Based on observations, record reviews and interviews, it was determined that Resident #4 was not interviewable. Second interview with the SCUC on 02/18/22 at 5:25pm revealed: -SCU staff tried to ensure the residents were in	{D 270}		

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{D 270}	Continued From page 9	{D 270}		

their sight.
-SCU staff redirected the residents as necessary.
-All the residents wandered, so it was difficult for staff to keep an eye on the residents.

Attempted interview with the SCU Health and Wellness Coordinator on 02/18/22 at 6:30pm was unsuccessful.

Review of Resident #4's PCP visit notes dated 01/26/22 revealed:
-The PCP saw Resident #4 at the request of the facility for a hospital follow-up visit.
-Resident #4 presented to the emergency room on 01/24/22 for concern for involuntary commitment.
-Resident #4 was involuntarily committed because he was aggressive towards other residents.
-Resident #4 was medically cleared, cleared by psychiatry, and discharged back to the facility.
-Resident #4 had multiple episodes of aggressive behaviors toward residents and sexual behaviors towards female residents.
-Resident #4 had multiple emergency room visits for similar situations.
-The PCP managed all of Resident #4's medications.
-The PCP recommended that staff continue to target unfavorable aggressive behaviors with behavioral tactics and pharmacological management.
-The PCP instructed facility staff to provide frequent redirection and reorientation.
-The PCP educated the facility staff on the methods of approach in the dementia patient with behavioral disturbances.
-The hospital provider made no changes to Resident #4's medication regimen.

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{D 270}	Continued From page 10 Review of Resident #4's PCP visit notes dated 02/02/22 revealed: -Resident #4 had a history of inappropriate sexual behaviors. -The facility sent Resident #4 to the hospital twice recently for aggressive behaviors. -The PCP recommended that the facility continue "safety, redirection, distraction, supportive, and pharmacological efforts for management of cognitive disease." -The PCP recommended that the facility "continue to target unfavorable behaviors with behavioral tactics and pharmacological management as current." Second telephone interview with Resident #4's family member on 02/21/22 at 1:54pm revealed the resident had not been provided with mental health services and there were no plans for the facility to suggest a referral for mental health services to Resident #4's PCP. Telephone interview with the Resident Services Director (RSD) on 02/21/22 at 2:34pm revealed: -She was aware of Resident #4's behaviors. -Staff would normally contact the PCP if residents had behavior issues. -Resident #4's PCP was contacted regarding behavior issues twice sometime during the week of 01/26/22 to 02/02/22. -Staff were expected to redirect residents with behaviors, including Resident #4, as much as possible. -If staff were unable to redirect a resident, then staff were expected to inform the RSD or ED. -Staff informed the RSD when Resident #4 was unable to be redirected. -If the RSD was unable to redirect Resident #4, she would let the ED know. -Staff were expected to check on the residents at	{D 270}		

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{D 270}	Continued From page 11 least every two hours in the SCU per policy. -Some residents may be checked on more frequently if they had a physician's order or request. Telephone interview with the Corporate Nurse (CN) on 02/21/22 at 5:45pm revealed: -She thought the ED was aware of Resident #4's behaviors. -She expected staff to intervene, redirect, and monitor residents who exhibited behaviors to prevent reoccurrence. -She expected facility staff to check on the residents in the SCU frequently based on the residents' needs and behaviors. -There was not an exact minimum time interval that staff were expected to check on the residents in the SCU. -Staff talked with Resident #4's PCP about his behaviors. -Resident #4's PCP had inquired about a psychiatric provider referral for Resident #4 on 10/13/21. -There was no order for a referral to a mental health provider for Resident #4. -The facility's contracted home visit medical practice team did not have a psychiatric provider at the facility in October 2021. -No one had addressed the mental health provider referral for Resident #4 since October 2021 until 02/18/22. -The inquiry regarding the mental health provider referral that was made in October 2021 came from the PCP's notes and was not in the resident's record at the facility. -There was a chain of emails from the PCP sent to the facility on 02/18/22 regarding the mental health provider referral inquiry. -Staff in the SCU were responsible for supervising the residents in the SCU.	{D 270}		

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{D 270}	Continued From page 12 The Executive Director was unavailable for interview on 02/21/22. Interview with a PCA on 02/18/22 at 4:30pm revealed: -She had worked at the facility two weeks. -She observed Resident #4 was verbally aggressive, cursing at other residents if they went into his room. -A female resident went into Resident #4's room the majority of her shift. -There was another male resident that liked to go into Resident #4's room and sleep in his recliner chair. -When the female resident went into this room, Resident #4 got aggressive and yelled and cursed at her. -The first night she worked on 02/08/22, the female resident got into Resident #4's bed with him. -The female resident did not remember where her room was located and always went to Resident #4's room to go to bed. -She tried to check on all the residents in the SCU every 10 minutes. Interview with the Special Care Unit Coordinator (SCUC) on 02/18/22 at 5:22pm revealed: -It had been "awhile" since Resident #4 physically touched a female resident, but he talked about it every day. -Resident #4 said things to the female residents like: he wanted to take the resident down a dark ally and do something with her. -Resident #4 would say he wanted the female resident to touch his penis. -He would ask the female resident was it okay if he touched her private area. -Resident #4 once touched a female resident on	{D 270}		

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{D 270}	Continued From page 13 her breast and she hit him with her walker. -Resident #4's behaviors had been discussed with the resident's family member. -The family had been searching for another facility for Resident #4. -In December 2021, Resident #4 went into another female resident's room and she was upset and started yelling at Resident #4. 2. Review of the facility's falls management and investigation policy dated 09/01/18 revealed: -The facility was to complete the "Morse Fall Risk Score," which was a tool for fall risk identification and assessment to determine extrinsic risk factors such as: bed safety, improper footwear, improper use or fit of walking aids, and lighting, clutter, and noise. -A service plan regarding falls should be developed post-fall addressing potential risk factors and suggested interventions. -The Morse Fall Risk Evaluation Tool should be completed post fall incident. If the score on the tool indicates risk, this prompted discussion of a referral to an outside rehabilitation consult. -A resident identified as high fall risk at any time during his/her stay remains a fall risk for the duration of his/her stay. -The Resident Services Director (RSD) was responsible for supervising the process of review, management and monitoring procedures of residents at risk for falls. -Post fall procedures included the service plan was reviewed and revised with interventions with the resident/family participation and changes communicated to staff. -Fall interventions were reviewed for continued effectiveness by the RSD. -The Executive Director (ED) was responsible for post fall investigations using the post fall investigation form.	{D 270}		

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{D 270}	Continued From page 14 -Facility staff verbalized the facility had a protocol set-up for monitoring residents for 72 hours following a fall. -The frequency for the monitoring system was determined by the RSD. Review of Resident #3's current FL2 dated 05/25/21 revealed: -Diagnoses included Alzheimer's disease, closed right hip fracture, hypertension and pulmonary embolism. -The resident was constantly disoriented, incontinent of bowel and bladder. Review of Resident #3's care plan dated 03/11/21 revealed: -The resident required extensive assistance with dressing and bathing. -The resident required limited assistance with grooming. -The resident was independent in eating, toileting, ambulation and transferring. Review of Resident #3's senior living evaluation dated 01/21/22 revealed: -The resident was a moderate or high fall risk based on fall assessment. -The resident would be encouraged to stay in common areas and promote more supervision. -Interventions included visual checks, hourly checks, night checks, additional safety monitoring and additional health monitoring. -The assessment was prepared prior to the fall on 01/24/22. -When requested, another assessment was not provided during the survey. The last fall assessment completed for Resident #3 was after a fall on 11/27/21. Review of Resident #3's incident report dated	{D 270}		

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{D 270}	Continued From page 15 01/24/22 at 7:00pm revealed: -Resident #3 had an unwitnessed fall. No injuries were noted. -The resident was found on the floor in another resident's room. -There was no documentation the resident was supervised for 72 hours after the fall. -There was no documentation of increased supervision for Resident #3. -There was no documented a fall risk evaluation was completed for Resident #3. -There was no documentation a Morse Fall Risk Tool evaluation was completed for Resident #3. -There was no documentation Resident #3's service plan was updated after the fall on 01/24/22. Review of Resident #3's physician's visit notes from the Primary Care Provider (PCP) dated 01/26/22 revealed: -Resident #3 had a fall on 01/24/22. -Resident #3 had advance dementia and was unable to provide detailed or specific information. -The resident was unable to use assistive devices to assist with walking due to advanced dementia. -Continue fall prevention care, advise increase monitoring of the resident's whereabouts. Interview with the medication aide (MA) on 02/18/22 at 4:45pm revealed: -She was on duty when Resident #3 fell on 01/24/22. Resident #3 had falls and they should be documented in the resident's record. -On 01/24/22, the PCAs were doing resident checks and found Resident #3 on the floor in another resident's room. -She was not sure how long the resident had been in the room or how long the resident was on the floor.	{D 270}		

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{D 270}	Continued From page 16 -The facility's protocol was that following a fall a resident was placed on frequent checks for 72 hours. -The management decided the frequency of the checks. -There was no system in place for documenting the frequent checks. -To her knowledge, Resident #3 was not placed on frequent checks following the fall on 01/24/22. Review of Resident #3's incident report dated 01/29/22 at 7:30pm revealed: -Resident #3 had two unwitnessed falls 15 minutes apart. -The last fall resulted in the resident hitting her head. No injuries were noted. -There was no documentation the resident was supervised for 72 hours after the fall. -There was no documentation of increased supervision for Resident #3. -There was no documented a fall risk evaluation was completed for Resident #3 post fall. -There was no documentation a Morse Fall Risk Tool evaluation was completed for Resident #3 post fall. -There was no documentation Resident #3's service plan was updated after the two falls on 01/29/22. Review of Resident #3's physician's visit notes from the PCP dated 02/02/22 revealed: -The resident was seen on 02/02/22 because the resident had a fall. -The facility staff reported the resident had two unwitnessed falls and the resident was found on the floor twice on 01/29/21. -The resident had advanced dementia and was unable to provide detailed and specific information. -The resident expressed left arm pain with	{D 270}		

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{D 270}	Continued From page 17 movement and no bruises visible. -Continue fall prevention care (two unwitnessed falls this week). Interview with the MA on 02/18/22 at 4:45pm revealed: -She was on duty when Resident #3 fell on 01/29/22. -On 01/29/22, the PCA told her Resident #3 fell on the floor twice within 15 minutes. -Resident #3 walked continually and some days did not want to sit down. -She told the PCAs to try to get the resident to rest but they were unable to get her to sit down. -No instructions had been given regarding increased supervision for Resident #3. -After Resident #3's falls on 01/29/22, there was no increased supervision put in place. -Management made the decision on the frequency of increased supervision. -She told staff to try and keep an eye Resident #3 and keep her in the common area unless the resident was ready to go to bed. -Some days, Resident #3 would not sit and rest, which caused her hip to hurt due to a previous hip fracture. -When the resident's hip hurt, she leaned to one side. -The leaning appeared to be painful. -When Resident #3 started to lean that usually was a sign that a fall was going to happened. -When staff observed the resident leaning they tried to get her to sit down. Review of Resident #3's hospice visit notes from 05/26/21 through 02/10/22 revealed: -The resident was disoriented and confused. -The resident required assistance with all activities of daily living (ADLs). -Resident #3 was a "high" fall risk.	{D 270}		

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{D 270}	Continued From page 18 -At each visit, facility staff were educated on how to keep the resident safe. -The resident had a level 7 pain when walking and leaning to the right side. -On 11/20/21, facility staff verbalized they were afraid the resident was going to fall because she was leaning to the right side. -At each visit, the hospice nurse noted that she identified safety issues and educated staff on safety precautions to prevent falls and/or injury. -On 12/14/21, the facility informed hospice the resident had a fall. -There was no documentation hospice was notified of the falls on 01/24/22 and on 01/29/22. Telephone interview with Resident #3's family member on 02/21/22 at 12:57pm revealed: -Resident #3 had previously fallen and broken her right hip, she thought it was in May 2021. -Since May 2021, no one at the facility informed her that Resident #3 had falls. -If Resident #3 had falls, she was not informed about the fall. -Resident #3 was very active and loved to walk. -Due to mental status decline and confusion, when Resident #3 walked she did not look down at her feet. -The resident was unable to realize when she needed to step up or over something and her feet got entangled, causing her to fall. -If Resident #3 was still having falls, she supposed the resident needed to be watched more frequently, but that had never been discussed with her. Interview with a first shift MA on 02/18/22 at 11:02am revealed: -Resident #3 had previously fallen in the hallway and broke her hip. -Most days, it was normal for Resident #3 to	{D 270}		

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{D 270}	Continued From page 19 continually walk. -The resident leaned to one side causing her to lose her balance and fall. -Also, if Resident #3 did not get enough sleep, this would cause her to also lose her balance, stumble and fall. -The requirement for checking the residents was every two hours for incontinent care. -The facility had a system in place following a fall, a resident was supposed to be checked more frequently for 72 hours. -The frequency of the checks was set by management. -On the morning of 01/29/22, the third shift MA told her that Resident #3 did not sleep well the night before and had been awake most of the night. -On her shift, Resident #3 did not sleep, she was continually walking and leaning to the right side. -Resident #3 previously had two hip fractures and when the resident was tired, she leaned to the right side, which was the side that had the broken hip. -Usually, when the resident was tired and leaned to one side that resulted in a fall. -Because the resident would not sit down, staff had to watch her continually to keep her from falling. -At the end of her shift on 01/29/22, she told the second shift MA that Resident #3 did not have much sleep and she was leaning, so they needed to watch her because she would fall. Interview with a personal care aide (PCA) on 02/18/22 at 11:20am revealed: -Resident #3 was always up and walking around. -When the resident was in pain, she started leaning to one side. -The pain usually lasted 2 to 3 days, so they had to watch the resident, so she did not fall.	{D 270}		

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{D 270}	Continued From page 20 -No instructions had been given regarding increased supervision since the resident had falls. -Resident #3 required someone to lay eyes on her at least every 30 minutes. -She tried to lay eyes on the resident if she was not busy helping other residents. Interview with the Special Care Unit Coordinator (SCUC) on 02/18/22 at 5:22pm revealed: -Resident #3 fell in May 2021 and broke her right hip. -Resident #3 walked all the time. -The resident sometimes got tired and started to lean to one side. -The leaning usually ended in a fall. -Staff were supposed to check on Resident #3 if they did not see her. -On 01/29/22, Resident #3 had been up for a long time without sleep and was leaning to one side. -All Resident #3's falls happened on the second and third shift. -Initially, she thought Resident #3's falls were happening on days when agency staff worked. -Looking at the schedule she realized facility were present when the resident fell. -She had not talked with staff or suggested any interventions regarding the falls because the Resident Service Director (RSD) was the supervisor and made decisions regarding the residents. -She was not sure what was happening on those shifts when Resident #3 fell. Interview with a first shift personal care aide (PCA) on 02/18/22 at 11:40am revealed: -She had not seen Resident #3 have a fall. -Resident #3 walked constantly and sometimes leaned significantly to one side due to a previous hip fracture. -If she had not seen the resident for 15 to 20	{D 270}		

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{D 270}	Continued From page 21 minutes during her shift, she went to check where the resident was at. Telephone interview with Resident #3's Primary Care Provider (PCP) on 02/17/22 at 3:16pm revealed: -The facility had informed her of Resident #3's falls. -She suggested to the facility continue to provide safety supportive care by doing checks more frequently and keeping the resident engaged in activities or keeping the resident in common areas to be supervised. -Resident #3 was continually in pain due to a previous fall that resulted in a hip fracture. Interview with the nurse from hospice on 02/18/22 at 10:13am revealed: -Resident #3 was recertified with hospice every 8 weeks. -Hospice intervened in Resident #3's care following a fall in May 2021, that resulted in a hip fracture. -The hospice staff were not made aware of Resident #3's falls in January 2022. -She was in the facility two to three days per week and continually reminded staff to give Resident #3's as needed pain medications. -When she was in the facility, she educated the staff regarding keeping an eye on Resident #3 and monitoring the resident for pain. -When the resident was in pain, she leaned to one side, which contributed to falls. Telephone interview with the RSD on 02/21/22 at 5:15pm revealed: -She had worked at the facility 11/15/21 as the RSD. -She was the supervisor of all the MAs and PCAs.	{D 270}		

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{D 270}	Continued From page 22 -She tried to visit the SCU at least once daily. -The falls management scores were completed quarterly for all residents in the SCU. -She was not sure they were completed if a resident had a fall. -When a resident had a fall, staff notified her, filled out an incident report and documented in the resident's record. -If a resident had frequent falls, staff needed to investigate changing care and doing more frequent checks. -To her knowledge, this had not been done for Resident #3. -If frequent checks were completed on Resident #3, they should be documented but she thought staff may not be documenting. -Frequent checks, like 30 minute checks should be documented. -Resident #3 was not placed on 30 minutes checks. -When Resident #3 fell on 01/29/22, she was told the resident had been up for a long time and was tired which caused her to fall. -It was her understanding, when Resident #3 leaned to one side and fell the resident would not sit down, screamed and yelled out when staff tried to get her to sit down. -She did not do the fall risk evaluation on Resident #3 after the fall on 01/24/22 or after the falls on 01/29/22, because staff told her the falls happened because the resident was tired and had not slept. -She did not change the resident's service plan after the falls. Based on observations, record reviews and interviews, it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's	{D 270}		

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{D 270}	Continued From page 23 PCP on 02/18/22 at 3:53pm was unsuccessful. The facility failed to provide supervision for 2 of 5 sampled residents related to a resident with a history of behaviors and assaulted a female resident resulting in the resident bleeding from the nose and mouth and sent to the hospital (#4); and a resident with a history of two hip fractures with a tendency to lean toone side resulting in three unwitnessed falls in one week and hitting her head (#3). This failure to provide adequate supervision placed the residents at risk for serious physical harm and neglect which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/18/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 21, 2022.	{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: Based on observations, record reviews and interviews, the facility failed to ensure follow up with health care providers for 2 of 6 sampled residents (#8 and #3) including a resident who had orders for a fixed dose of a rapid-acting insulin with meals and no physician notification for holding insulin without parameters for low blood sugar values (#8); and not obtaining	{D 273}		

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{D 273}	Continued From page 24	{D 273}		

measurements for compression stockings and pharmacy recommendation for discontinuation of medications(#3).

The findings are:

1. Review of Resident #8's current FL-2 dated 10/08/21 revealed:
-Diagnoses included muscle weakness, history of falls.
-There was an order to check fingerstick blood sugar (FSBS) every morning and before meals.
-There was an order to inject 6 units of lispro (a rapid acting insulin used to lower elevated blood sugar levels) insulin subcutaneously with meals.

Review of Resident #8's signed physician's orders dated 11/12/21 revealed an order to inject 6 units of lispro insulin subcutaneously 3 times daily with meals.

Review of Resident #8's physician's orders revealed there was no order regarding parameters for administering lispro when low FSBS values obtained during the FSBS checks with meals.

Review of Resident #8's December 2021 medication administration record (MAR) revealed:
-There was a preprinted entry for inject 6 units of lispro insulin subcutaneously 3 times daily with meals scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-FSBS were documented at 6:00am, 11:00am and 5:00pm.
-Beginning on 12/20/21, FSBS values ranged from 73 to 171 at 6:00am; from 93 to 189 at 11:00am; and from 60 to 280 at 5:00pm.
-Resident #8's FSBS values on 12/27/21 at 11:30am was 93; lispro 6 units was documented

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{D 273}	Continued From page 25 by the medication aide (MA), with circled initials on the MAR, as held with documentation on the back of the MAR for "reason blood sugar (BS) 93" and "result- held" and the medication aide's signature. -Resident #8's FSBS values on 12/22/21 at 6:00am was 74; at 7:30am, lispro 6 units was documented by the same MA, as held with no documentation on the back of the MAR for "reason" or "result" for lispro not administered. Review of Resident #8's January 2022 MAR revealed: -There was a preprinted entry for inject 6 units of lispro insulin subcutaneously 3 times daily with meals scheduled for administration at 7:30am, 11:30am, and 4:30pm. -FSBS were documented at 6:00am, 11:00am and 8:00pm. -FSBS ranged from 56 (01/29/21) to 206 at 6:00am; from 86 to 227 at 11:00am; and 68 (01/26/22) to 301 at 8:00pm. -Resident #8's FSBS values on 12/27/21 at 11:30am was 56; lispro 6 units was documented by the same MA, as held with documentation on the back of the MAR for "reason BS 56" and "result- held" and the MA's signature. Review of Resident #8's February 2022 MARs revealed: -There was a preprinted entry for inject 6 units of lispro insulin subcutaneously 3 times daily with meals scheduled for administration at 7:30am, 11:30am, and 4:30pm. -FSBS were documented at 6:00am, 11:00am and 8:00pm from 02/01/22 to 02/17/22. -FSBS ranged from 82 (02/02/22 and 02/03/22) to 172 at 6:00am; from 81 to 189 at 11:00am; and 95 to 240 at 8:00pm. -Resident #8's FSBS values on 02/02/22 at	{D 273}		

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{D 273}	Continued From page 26 6:00am was 82; at 7:30am, lispro 6 units was documented by the same MA, as held with no documentation on the back of the MAR for "reason" or "result" for lispro not administered. -Resident #8's FSBS values on 02/03/22 at 6:00am was 82; at 7:30am, lispro 6 units was documented by the same MA, as held with no documentation on the back of the MAR for "reason" or "result" for lispro not administered. -Resident #8's FSBS values on 02/16/22 at 6:00am was 99; lispro 6 units was documented by the same MA, as held with documentation on the back of the MAR for "reason BS low" and "result- not given". -Resident #8's FSBS values on 02/02/22 at 6:00am was 83; lispro 6 units was documented by the same MA, as held with documentation on the back of the MAR for "reason BS low" and "result- not given". Review of Resident #8's facility notes, and faxes in the resident's record revealed there was no documentation Resident #8's primary care provider (PCP) was notified regarding low FSBS and the MA was holding 6 units of lispro insulin due to the low FSBS Telephone interview with a nurse at Resident #8's PCP's office on 02/18/22 revealed: -The were no parameters for holding the lispro insulin for low FSBS values ordered by the PCP. -The PCP had requested the facility fax FSBS values with the routine visit on 12/16/21. -There was no documentation for the facility faxing FSBS results as requested since 12/16/21. -The facility should call the PCP to report low FSBS values. -There was no documentation of contact from the facility regarding holding Resident #8's lispro due to low FSBS.	{D 273}		

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{D 273}	Continued From page 27 Interview with Resident #8 on 02/17/22 at 12:49pm revealed: -Staff checked her blood sugar first thing in the morning and then a couple of other times during the day, maybe late in the evening also. -She received an insulin shot before her meals most of the time. -Sometimes a MA would hold her mealtime insulin if her blood sugar was too low. -She could tell when her insulin was going low, and it had been low a few times in the last couple of months. -She had not been to the hospital for low blood sugar. -She kept some crackers, and sweets on the left side of her bed in case she felt like her sugar was dropping; then she would eat something. -Sometimes the staff brought her a snack or sandwich if she asked for it. -She routinely ate her meals. Interview with the Resident Services Director (RSD) on 02/17/21 at 1:00pm revealed: -MAs were responsible to notify the PCP if a medication was not administered. -She did not know a MA was holding Resident #8's lispro without contacting the PCP. -She was responsible to ensure medications were administered as ordered. -She had not completed audits for administration of residents' medication compared to the documentation on the MARs for residents because there were ongoing staffing shortages and she was staffing the medication carts. Interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm revealed: -She was responsible for overseeing several facilities in a different region for the corporation.	{D 273}		

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{D 273}	Continued From page 28 -She had started routine monitoring this facility for compliance with health care and medications within the last 2 weeks. -She discovered the facility had not put routine monitoring of the facility's medication management in place. -The RSD was not experienced and had not been auditing the resident's medications. -The CN started her own reviews and audits. -She had not had time to audit very many residents' records. Interview with a first shift MA on 02/18/21 at 11:58am revealed: -She routinely worked morning shifts (7:00am to 3:00pm). -She was responsible to administer Resident #8's lispro insulin with the morning meal and lunch. -She held Resident #8's lispro insulin scheduled at breakfast if the resident's FSBS was below 90 from past diabetic training, not because the resident had an order to hold the insulin if FSBS low. -She had informed the RSD that Resident #8's lispro insulin was held for low FSBS in the past (not sure of exact date). -She had not contacted Resident #8's PCP regarding low FSBS values and obtaining parameters for administering lispro insulin if the FSBS was low. Interview with the Executive Director (ED) on 02/18/22 at 6:00pm revealed: -The RSD and the Wellness Coordinator were responsible for monitoring the residents' medications and ensuring the facility was compliant with medication administration policy, rules and regulations. -The CN came to the facility to assist the RSD in auditing records and to ensure compliance with	{D 273}		

{D 273}	Continued From page 28	{D 273}		

-She had started routine monitoring this facility for compliance with health care and medications within the last 2 weeks.
-She discovered the facility had not put routine monitoring of the facility's medication management in place.
-The RSD was not experienced and had not been auditing the resident's medications.
-The CN started her own reviews and audits. -She had not had time to audit very many residents' records.

Interview with a first shift MA on 02/18/21 at 11:58am revealed:
-She routinely worked morning shifts (7:00am to 3:00pm).
-She was responsible to administer Resident #8's lispro insulin with the morning meal and lunch. -She held Resident #8's lispro insulin scheduled at breakfast if the resident's FSBS was below 90 from past diabetic training, not because the resident had an order to hold the insulin if FSBS low.
-She had informed the RSD that Resident #8's lispro insulin was held for low FSBS in the past (not sure of exact date).
-She had not contacted Resident #8's PCP regarding low FSBS values and obtaining parameters for administering lispro insulin if the FSBS was low.

Interview with the Executive Director (ED) on 02/18/22 at 6:00pm revealed:
-The RSD and the Wellness Coordinator were responsible for monitoring the residents' medications and ensuring the facility was compliant with medication administration policy, rules and regulations.
-The CN came to the facility to assist the RSD in auditing records and to ensure compliance with

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{D 273}	Continued From page 29	{D 273}		
	medication administration. -He was not routinely involved with clinical aspects of medication administration. 2. Review of Resident #3's current FL2 dated 05/25/21 revealed: -Diagnoses included Alzheimer's disease, closed right hip fracture, hypertension and pulmonary embolism. -The resident was constantly disoriented, incontinent of bowel and bladder. a. Review of Resident #3's nursing department note from the Primary Care Provider (PCP) dated 11/24/21 revealed: -The PCP noted to elevate the resident's bilateral legs when in sitting position as applicable. -Apply compression stockings to bilateral legs in the "AM" (morning) daily and remove at night. -Hospice nurse to measure if covered. Review of Resident #3's physician's visit notes dated 11/24/22 revealed: -The PCP noted facility staff reported Resident #3 legs and ankles were very swollen. -Upon examination the PCP noted Resident #3's ankles and feet had plus 1 non-pitting edema. -The resident had prior episodes of this edema. Review of Resident #3's December 2021, January and February 2022 medication administration records (MARs) revealed compression stockings were not listed. Review of Resident #3's hospice note dated 11/23/21 revealed: -The nurse documented Resident #3 had bilateral edema in her feet and ankles. -The resident had 2 plus bilateral lower leg edema.			

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{D 273}	Continued From page 30 -The nurse gave instructions to monitor swelling in the feet and elevate the resident's legs. Observation of Resident #3 on 02/16/22 at 3:40pm revealed: -The resident was not wearing compression socks. -Resident #3 was wearing white socks that came up mid-length between the resident's ankle and knee. -The socks left a slight impression in the resident's legs. -No pitting edema was observed. Telephone interview with Resident #3's Primary Care Provider (PCP) on 02/17/22 at 3:16pm revealed: -Resident #3 was on hospice but she still was the primary care provider. -On 11/24/21, facility staff told her that Resident #3 legs and ankles were swollen. -She ordered the compression stockings for on in the morning and off at night. -She was not aware the resident was wearing the compression stockings. -She had seen Resident #3 twice since she ordered the compression stocking and facility did not tell her the resident was not wearing the compression stockings. -When she ordered the compression stockings Resident #3 needed them. -She had not checked the resident's legs and ankles since she ordered the compression stockings. -The order should have been sent to the pharmacy, then they would have asked for measurements from hospice. -If she ordered compression stockings, she expected the facility to obtain them as ordered. -If there was a problem getting the stockings or	{D 273}		

{D 273}	Continued From page 31 hospice disagreed with the order then she should be notified. Interview with the nurse from hospice on 02/18/22 at 10:13am revealed: -Resident #3 was receiving hospice services and was still being seen by the facility's PCP. -During a visit in November 2021, she observed Resident #3 had some edema. -She was not aware the PCP had ordered compression stockings. -The facility should have made her aware of the order. Based on observations, record review, and interviews it was determined Resident #3 was not interviewable. b. Review of Resident #3's current FL2 dated 05/25/21 revealed there was an order for vitamin B12 once daily (a supplement used to treat low vitamin B12 levels) and Namenda 10mg twice daily (used to treat dementia). Review of Resident #3's medication regimen review dated 01/05/22 revealed the pharmacist completing the review recommended to discontinue vitamin B12 and Namenda. Review of Resident #3's January 2022 Medication Administration Record (MAR) revealed: -There was an entry for vitamin B12 scheduled for administration at 8:00am. -There was documentation vitamin B12 was administered at 8:00am daily from 01/01/22 through 01/31/22. Review of Resident #3's January 2022 MAR revealed:	{D 273}		

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{D 273}	Continued From page 32 -There was an entry for Namenda 10mg was scheduled for administration at 9:00am and 9:00am. -There was documentation Namenda 10mg was administered twice daily at 9:00am and 9:00pm from 01/01/22 through 01/31/22. Review of Resident #3's February 2022 MAR revealed: -There was an entry for vitamin B12 was scheduled for administration at 8:00am. -There was documentation vitamin B12 was administered twice daily at 8:00am from 02/01/22 through 02/17/22. Review of Resident #3's February 2022 MAR revealed: -There was an entry for Namenda 10mg was scheduled for administration at 9:00am and 9:00am. -There was documentation Namenda 10mg was administered twice daily at 9:00am and 9:00pm from 02/01/22 through 02/17/22. Interview with the pharmacist who prepared and observed the quarterly medication regimen review dated 01/05/22 revealed: -She recommended discontinuing vitamin B12 and Namenda because the resident was on hospice with a short life expectancy. -There was little benefit the medications would provide the resident. -She emailed the recommendation to the Resident Service Director (RSD) and the Executive Director (ED). -The facility staff should have sent the recommendation to the resident's PCP to clarify if the medications should be discontinued. Interview with the nurse from hospice on 02/18/22	{D 273}		

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{D 273}	Continued From page 33 at 10:13am revealed: -Hospice was providing services to Resident #3 and the facility's PCP still ordered medications. -If there were recommendations to discontinue a medication the facility should let hospice know as well as the PCP because some medications were ordered by hospital. -Also, a change in medications could affect the resident and she needed to know that. Based on observations, record review, and interviews it was determined Resident #3 was not interviewable.	{D 273}		
{D 306}	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure water was served, in addition to other beverages to each resident in the Special Care Unit (SCU). The findings are: Review of the facility's week-at-glance menus for regular diets revealed water was not listed on the menu.	{D 306}	1. Glasses were ordered and there is currently enough Glasses to serve water, beverage of choice and a milk to all Residents on Memory care for each meal. Water and milk has been added to menus/signage in the dining areas. Completed 2/25/2022. 2. Water, beverage of choice will be served to all Residents on Memory Care with Milk served twice a Day for breakfast and dinner. Menus and signs in the Dining areas reflect the ability to obtain water, beverage of choice and milk at all meals for all residents within the whole community. 3. Community staff have been educated on the requirements For beverage service, completed 2/25/2022. 4. The ED/DRC and other Management staff will do 3 x a week Walking audits during meals to ensure the beverage standard Continues to be met daily. Any opportunities for service will be Addressed immediately with care and dining staff and corrected	03/21/22

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{D 306}	Continued From page 34 Observation of the lunch meal service in the SCU on 02/16/22 between 12:10pm and 12:30pm revealed: -There were 11 residents present in the dining room and 4 residents in the open dining area and 3 residents wandering the hallway during the lunch meal service. -Residents were given 1 glass with juice or milk, no water was served. -There was bottled water in a gray tub that had ice at the bottom, but no resident was served water. Observation of the breakfast of meal service on 02/17/21 at 9:00am revealed: -There were 11 residents in the main dining room. -There were 6 residents in the open eating area. -There were 2 residents wandering the hallways and one resident in their room. -All residents seated for the meal were served juice and milk. -No water was served. -There was a gray tub with ice sitting on the counter in the kitchen that had six plastic bottles of water. -No resident was observed being served the plastic bottles of water. Interview with the Dietary Manager (DM) on 02/17/22 at 9:11am revealed: -All residents in the SCU should be served water in addition to other beverages at each meal. -The facility had more than enough glasses to serve water, juice and milk at each meal service. -She only put two glasses per resident on the food cart because there was not enough room for all the glasses and the food. -She always told the staff in the SCU to send another staff downstairs to the kitchen to obtain more glasses, but they never do.	{D 306}		

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{D 306}	Continued From page 35 Interview with the Special Care Unit Coordinator (SCUC) on 02/17/22 at 9:05am revealed: -The facility did not have enough glasses to serve residents three beverages at each meal. -She served juice and milk. -To serve residents water, she had to wait until the kitchen washed more glasses and brought the glasses to the SCU before she was able to serve residents water. -Plastic bottles of water were sent on the cart with each meal but not enough to give each resident their own bottle of water. -She was told glasses been ordered, maybe two weeks ago. The Executive Director/Administrator was not available for an interview on 02/21/22. Based on observations, interviews and record reviews revealed 21 of 21 residents in the SCU were not interviewable.	{D 306}		
{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: FOLLOW-UP TO TYPE B VIOLATION	{D 358}	1. The medication for resident #7 was assured of availability, The PCP was notified of the missed patch delivery and a patch Was assured in place for the resident by the DRC on February 23, 2022 2. An audit was conducted on February 24, 2022 by Omnicare Pharmacy to assure the availability of medication for all Residents. Any missing medications were obtained and any Omissions of delivery were reported to the PCP. 3. Audit conducted by the contracted pharmacy of Omnicare was completed on February 24, 2022. An order to MAR audit was completed by the RRCS on February 26, 2022 to assure compliance with PCP orders. All ordered medications were in place to assure resident medication routine adherence.	03/21/22

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{D 358}	Continued From page 36 Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 residents sampled (Residents #7 and #8) related to a narcotic topical pain medication (#7) and a long acting insulin (#8). The findings are: 1. Review of Resident #7's current FL2 dated 06/10/21 revealed: -Diagnoses included muscle weakness, iron deficiency, and major depressive disorder. -There was an order for fentanyl 25mcg/hour patch (a narcotic pain medication patch for moderate to severe pain) apply 1 patch onto the skin, change every 72 hours (transdermal). Review of Resident #7's signed physician's orders dated 12/01/21 revealed there was an order for fentanyl 25mcg/hour patch apply 1 patch to skin transdermally change every 72 hours. Review of the facility's Medication Management policy effective 04/01/19 revealed: -Medication administration was to be documented on the medication administration record (MAR) at the time the medication is administered. -Medication omissions or refusals are documented on the MAR. -The resident's physician/healthcare provider was to be notified of omissions or refusals. Review of the facility's Controlled Substances and Narcotics policy effective 04/01/19 revealed: -A separate controlled substance record was required for each individual medication container.	{D 358}	4. 4. DRC/Designee will review shift to shift report daily Monday thru Friday and follow up on issues. A DRC Daily Report will come to Morning Meeting to discuss the Issues and the resolution, and assure communication With families, and/or PCP. The DRC/Designee will conduct Twice weekly audits of MAR's to track blanks, circled meds And documentation omissions for 4 weeks and then weekly Thereafter. DRC and ED will receive the Pharmacy Report Via email monthly and will review the recommendations Monthly for completion in the Quality Assurance Process. The Pharmacy consult will notify the ED for any recommendations that have not been completed for a second recommendation period.

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{D 358}	Continued From page 37	{D 358}		
	-Prior to administration of a controlled substance, staff compare the quantity on hand to the controlled substance count sheet (CSCS) sent with a medication for accuracy. -Immediately after a dose of medication is removed from the container or blister pak, the medications is signed out on the CSCS. -The Director of Resident Care (identified as the Resident Services Director at this facility) is responsible for all processes related to controlled substances. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/17/22 at 9:49am regarding fentanyl 25mcg/hour patches dispensed for Resident #7 revealed: -The pharmacy sent a controlled substance count sheet (CSCS) with each dispensing of fentanyl 25mcg/hour patch to be used by the facility for documenting sign out of the controlled substance and inventory accountability. -On 11/09/21, there were 10 fentanyl 25mcg/hour patches dispensed for Resident #7. -On 12/22/21, there were 10 fentanyl 25mcg/hour patches dispensed for Resident #7. -On 2/10/22, there were 10 fentanyl 25mcg/hour patches dispensed for Resident #7. -The facility was responsible to order the fentanyl patches when the resident was running low. -There was no documentation for why fentanyl patches were not reordered every 30 days available for review. Review of Resident #7's December 2021 medication administration record (MAR) revealed: -There was an entry for fentanyl 25mcg/hr patch, apply 1 patch to skin and change every 72 hours scheduled for 8:00pm. -The MAR had every 3rd day marked with vertical lines for application with the days between			

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MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

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

{D 358}	Continued From page 38 marked out with a line. -Fentanyl 25mcg/hour patch was scheduled for application on 12/20/21, 12/23/21, 12/26/21, and 12/29/21. -Fentanyl patch was documented as not applied, as indicated by circled initials, on 12/20/21 at 8:00pm with no explanation for why the patch was not applied. -Fentanyl patch was not documented as applied on 12/29/21 and 12/31/21 and there was no reason for why the medication was not applied. Review of Resident #7's CSCS received from the facility's contracted pharmacy with 10 fentanyl 25mcg/hour patches dispensed on 11/09/21 compared to Resident #7's December 2021 MAR revealed: -There were 3 of 10 fentanyl 25mcg/hour patches documented as remaining on the CSCS on 12/01/21. -There were 3 fentanyl 25 mcg/hour patches signed out from 12/02/21 to 12/11/21 (on 12/02/21, 12/08/21, and 12/11/21) to leave a zero balance on 12/11/21. Review of Resident #7's CSCS received from the facility's contracted pharmacy with 10 fentanyl 25mcg/hour patches dispensed on 12/22/21 compared to Resident #7's December 2021 MAR revealed: -On 12/23/21 at 8:00pm, there was one fentanyl patch documented as applied on Resident #7's MAR and the patch was signed out on the CSCS. -On 12/26/21 at 8:00pm, there was one fentanyl patch documented as applied on Resident #7's MAR and there was no patch signed out on the CSCS for 12/26/21. -On 12/28/21 and 12/31/21, there was no fentanyl 25mcg/hour documented as applied on Resident #7's MAR and no patch signed out on the CSCS.	{D 358}		

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

{D 358}	Continued From page 39 -There were 3 scheduled doses (12/26/21, 12/28/21 and 12/31/21) of fentanyl 25 mcg/hour patch not documented as applied on the MAR. Review of Resident #7's January 2022 MAR revealed: -There was an entry for fentanyl 25mcg/hour patch, apply 1 patch to skin and change every 72 hours scheduled for 8:00pm. -The MAR had every 3rd day marked with vertical lines for application with the days between marked out with a line. -Fentanyl 25mcg/hour patch was scheduled for application at 8:00pm on 11 days as follows: on 01/01/22, 01/04/22, 01/07/22, 01/10/22, 01/13/22, 01/16/22, 01/19/22, 01/22/22, 01/25/22, 01/28/22, and 01/31/22. -Fentanyl patch was not documented on the MAR as applied on 4 of 11 opportunities from 01/01/22 to 01/31/22 (on 01/10/22, 01/16/22, 01/28/22, and 01/31/22). There was no reason documented for why the medication was not applied. Review of Resident #7's CSCS received from the facility's contracted pharmacy with 10 fentanyl 25 mcg/hour patches dispensed on 12/22/21 compared to Resident #7's January 2022 MAR revealed: -On 01/10/22 and 01/16/22, fentanyl 25mcg/hour patch was documented as applied on the MAR and was not signed out on the CSCS. -On 01/22/22 and 01/25/22, fentanyl 25mcg/hour patch was not documented as applied on the MAR and was signed out on the CSCS. -On 01/28/22 and 01/31/22, fentanyl 25mcg/hour patch was not documented as applied on the MAR and was not signed out on the CSCS. - There were 2 out of 11 scheduled doses of fentanyl 25mcg/hour patch signed out on the CSCS (01/10/21 and 01/16/22) but not	{D 358}		

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

{D 358}	Continued From page 40	{D 358}		
	documented as applied on the MAR. -There were 4 opportunities (01/10/22, 01/16/22, 01/28/22 and 01/31/22) when fentanyl 25 mcg/hour patches were not applied from 01/01/22 to 01/31/22. Review of Resident #7's February 2022 MAR revealed: -There was an entry for fentanyl 25mcg/hour patch, apply 1 patch to skin and change every 72 hours scheduled for 8:00pm. -There were no pre-scheduled days for application handwritten on the MAR for fentanyl 25mcg/hour patch and there was no scheduled time of application on the MAR. -One fentanyl 25mcg/hours patch was documented as applied on 02/15/22. -Based on documentation of application for one fentanyl 25 mcg/hour on the MAR for 02/15/22, fentanyl patches every 72 hours should have been applied at 8:00pm on 02/03/22, 02/06/22, 02/09/22, 02/12/22, and 02/15/22. Review of Resident #7's CSCS received from the facility's contracted pharmacy with 10 fentanyl 25 mcg/hour patches dispensed on 12/22/21 compared to Resident #7's February 2022 MAR revealed: -There were 2 of 10 fentanyl 25mcg/hour patches on the CSCS received from the pharmacy dispensed on 12/21/21 signed out 02/01/22 and 02/09/22 which completed accounting for 10 patches. -On 02/01/22, fentanyl 25mcg/hour patch was signed out on the CSCS at 8:00pm and not documented as applied on the MAR. -On 02/03/22, fentanyl 25mcg/hour patch should have been administered and was not signed out on the CSCS or documented on the MAR. -On 02/06/22, fentanyl 25mcg/hour patch should			

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{D 358}	Continued From page 41 have been administered and was not signed out on the CSCS or documented on the MAR. -On 02/09/22, fentanyl 25mcg/hour patch was signed out on the CSCS and not documented as applied on the MAR. Review of Resident #7's CSCS received from the facility's contracted pharmacy with 10 fentanyl 25 mcg/hour patches dispensed on 02/10/22 compared to Resident #7's February 2022 MAR revealed: -On 02/12/22, fentanyl 25mcg/hour patch should have been administered and was not signed out on the CSCS or documented on the MAR. -On 02/15/22, fentanyl 25mcg/hour patch documented as administered on the MAR and signed out on the accompanying CSCS. Observation of medication on hand for administration on 02/18/22 at 9:00am revealed Resident #7 had 9 fentanyl 25mcg/hour patches remaining for 10 patches dispensed on 02/10/22, matching the quantity that should have been remaining. Based on observations, interviews, and review of Resident #7's MARs and CSCS for fentanyl 25mcg/hour was not applied (administered) for 10 out of 19 opportunities from 12/20/21 to 02/14/22 as follows: -There were 3 scheduled doses (12/26/21, 12/28/21 and 12/31/21) of fentanyl 25 mcg/hour patch not documented as applied on the MAR. -There were 4 opportunities when fentanyl 25 mcg/hour patches were not applied at 8:00pm from 01/01/22 to 01/31/22 (01/10/22, 01/16/22, 01/28/22 and 01/31/22). -There were 3 opportunities when fentanyl 25 mcg/hour patches were not applied at 8:00pm from 02/01/22 to 02/3/22 (on 02/03/22, 02/06/22,	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 42 and 02/12/22). Interview with the RSD on 02/17/21 at 1:00pm revealed: -She was responsible to ensure medications were administered as ordered. -She had not completed audits for administration of residents' medication compared to the documentation on the MARs for residents because there were ongoing staffing shortages and she was staffing the medication carts. -Medication aides (MA) were responsible to order medications when the supply was low (one week). -MAs were responsible to fax the primary care providers (PCP) for new medication orders if the pharmacy notified the facility that a new signed order was required for controlled substances like fentanyl. -No MA had informed her Resident #7's fentanyl 25mcg/hour patch had multiple missed doses. Telephone interview with Resident #7's (PCP on 02/17/22 at 3:10pm revealed: -Resident #7 should be administered fentanyl 25mcg/hour patch routinely every 3 days. -The only reason Resident #7 should not have received fentanyl 25mcg/hour patch would be if the resident ran out of medication and the pharmacy had not notified the facility or the PCP in a timely manner. -The facility should be administering medications as ordered to make sure residents' medications were treating the residents effectively. Interview with Resident #7 on 02/18/22 at 3:00pm revealed: -She used the pain patches for pain in her hips. -She did not receive her pain patch properly. -There were several times when staff told her she	{D 358}		

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{D 358}	Continued From page 43	{D 358}		
	did not have medication to administer. -There were times when she did not get her patch changed on the day it was due to be changed and she was told she would have to wait until the day marked on the MAR before the medication could be administered. -When she did not receive her pain patch as ordered she had to lay in her bed and "deal with the pain". -She did not feel like getting up and could not sit at her sewing machine to do her quilt layers. Refer to interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm. Refer to interview with the Executive Director on 02/18/22 at 6:00pm. 2. Review of Resident #8's current FL-2 dated 10/08/21 revealed: -Diagnoses included muscle weakness, history of falls. -There was an order to check fingerstick blood sugar (FSBS) every morning and before meals. -There was an order to inject 6 units of lispro (a rapid acting insulin) insulin subcutaneously with meals. -There was an order for Lantus (a long acting insulin analog) insulin inject 38 units subcutaneously daily at 10:00am. Review of Resident #8's signed physician's orders dated 11/12/21 revealed an order for Lantus insulin 38 units subcutaneously (SQ) daily at 10:00am. Review of Resident #8's physician's orders revealed there was an order dated 12/14/21 to decrease Lantus to 34 units every morning.			

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{D 358}	Continued From page 44 Review of Resident #8's physician visit summary dated 12/16/21 revealed: -The visit was for a follow-up for diabetes mellitus and hypertension. -There was an order to reduce Lantus by 6 units. -Physician instructions included fax FSBS readings to the office (blood sugar reading not sent with resident). Review of Resident #8's December 2021 medication administration record (MAR) revealed: -There was a preprinted entry for Lantus 38 units SQ daily at 10:00am discontinued on 12/14/21. -There was a handwritten entry for Lantus 34 units SQ daily at 10:00am. -There was no entry for Lantus 28 units (34 units reduced by 6 units) SQ daily as ordered on 12/16/21. -Lantus 38 units SQ daily at 10:00am was documented as administered daily from 12/01/21 to 12/14/21. -Lantus 34 units SQ daily at 10:00am was documented as administered from 12/15/21 to 12/31/21. -FSBS were documented at 6:00am, 11:00am and 5:00pm and beginning on 12/16/21 ranged from 73 to 171 at 6:00am; from 93 to 189 at 11:00am; and from 60 to 280 at 5:00pm to 12/31/21. Review of Resident #8's January 2022 MAR revealed: -There was a preprinted entry for Lantus 34 units SQ daily every morning and scheduled for administration at 8:00am. -Lantus 34 units SQ was documented as administered daily from 01/01/22 to 01/31/22. -There was no entry for Lantus 28 units (34 units reduced by 6 units) on the MAR. -FSBS were documented at 6:00am, 11:00am	{D 358}		

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{D 358}	Continued From page 45 and 8:00pm. -FSBS ranged from 56 (lispro insulin held) to 206 at 6:00am; from 86 to 227 at 11:00am; and 68 (01/26/22) to 301 at 8:00pm from 01/01/22 to 01/31/22. Review of Resident #8's February 2022 MARs revealed: -There was a preprinted for Lantus 34 units SQ daily every morning and scheduled for administration at 8:00am. -Lantus 34 units SQ was documented as administered daily from 02/01/22 to 02/17/22. - There was no entry for Lantus 28 units (34 units reduced by 6 units) on the MAR. -FSBS were documented at 6:00am, 11:00am and 8:00pm from 02/01/22 to 02/17/22.. -FSBS ranged from 82 (lispro insulin held) to 172 at 6:00am; from 81 to 189 at 11:00am; and 95 to 240 at 8:00pm. Telephone interview with a nurse at Resident #8's primary care provider's (PCP) office on 02/18/22 revealed: -Resident #8 was at the office for a follow-up visit on 12/16/21. -There was an order to decrease Lantus by 6 units from 34 units. The current dose should be 28 units of Lantus daily. -The facility contacted the PCP's office today (02/18/22) before this phone call to inform the PCP that Resident #8's order to decrease Lantus to 28 units was not started. -The PCP advised since it had been so long and there were no current FSBS reading at the office, the facility should fax Resident #8's monthly FSBS values to the office and the PCP would determine if the Lantus should be decreased. - The were no parameters for holding the lispro insulin for low FSBS values: the facility should call	{D 358}		

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{D 358}		{D 358}		
	Continued From page 46 the PCP to report low FSBS values. Interview with Resident #8 on 02/17/22 at 12:49pm revealed: -She received a long acting insulin in the morning and an insulin shot before her meals. -She did not know how much Lantus insulin she was supposed to be receiving. -She remembered she had a PCP visit in December 2021 but did not know if her insulin changed. -She could tell when her insulin was going low, because she felt weak, sweaty, and dizzy; it had been low a few times in the last couple of months. -She had not been to the hospital for low blood sugar. -She kept some crackers, and sweets on the left side of her bed in case she felt like her sugar was dropping; then she would eat something. -Sometimes the staff brought her a snack or sandwich if she asked for it. -Staff checked her blood sugar first thing in the morning and then a couple of other times during the day, maybe late in the evening also. Interview with the Resident Services Director (RSD) on 02/17/21 at 1:00pm revealed: -She was responsible to ensure medications were administered as ordered. -She had not completed audits for administration of residents' medication compared to the documentation on the MARs for residents because there were ongoing staffing shortages and she was staffing the medication carts. Interview with a first shift medication aide (MA) on 02/18/21 at 11:58am revealed: -The MA working when a resident returned from a provider's visit was responsible to review the resident's paperwork, fax any orders to the			

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{D 358}	Continued From page 47 pharmacy, do a hand entry on the MAR, and place the orders in a plastic holder in the nurse's desk area for the next shift MA to review the order on the MAR for correctness. -The MA had never seen the order dated 12/16/21 to decrease Resident #8's Lantus by 6 units. -Since the order was filed in the resident's record, she thought the order got filed before it was processed. -She routinely worked the 7:00am to 3:00pm shift and the resident's visit summary noted an appointment at 4:00pm meaning the resident came back to the facility late in the day (evening shift). -She would hold Resident #8's lispro insulin scheduled at breakfast if the resident's FSBS was below 80 from diabetic training, not because the resident had an order to hold the insulin if FSBS low. -She had told the RSD that Resident #8's lispro insulin was held for low FSBS (not sure of exact date). Interview with the CN on 02/18/22 at 4:30pm revealed: -The facility had a stamp used to document when staff faxed an order to the contracted pharmacy. -Resident #8's order to decrease Lantus to 34 units every morning was stamped and initialed for faxed on 12/14/21. -Resident #8's order to decrease Lantus by 6 units dated 12/16/21 was not stamped or initialed as faxed to the pharmacy. -The order must have gotten filed in the resident's record without being processed by the facility or faxed to the contracted pharmacy. -The facility did not have a new order tracking system other than the staff on duty processing and placing in the nurse's office for the next shift	{D 358}		

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{D 358}		{D 358}		
	Continued From page 48 MA to check. -The RSD was supposed to take a final look at the order before the order was filed in the resident's record. Telephone interview with an order entry technician at the contracted pharmacy on 02/21/22 at 11:27am revealed: -The pharmacy had a faxed copy of Resident #8's Lantus order dated 12/14/21. -There was no documentation for the pharmacy receiving a faxed order dated 12/16/21 for Resident #8's Lantus insulin to decrease by 6 units from 34 units. Telephone interview with the RSD on 02/21/22 at 3:50pm revealed: -She did not see the order for Resident #8's Lantus to decrease by 6 units dated 12/16/21. -The order appeared to have been filed in the resident's record without being sent to the pharmacy or entered on the resident's MAR. Refer to interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm. Refer to interview with the Executive Director on 02/18/22 at 6:00pm. Interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm revealed: -She had started routine monitoring this facility for compliance with health care and medications within the last 2 weeks. -When she first came to the facility, she requested an update from the RSD regarding the facility's increased monitoring and auditing of medications issues identified during the recent survey. -She discovered the facility had not put routine			

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monitoring of the facility's medication management in place.
-The RSD was not experienced and had not been auditing the resident's medications.
-The CN started her own reviews and audits. -She planned to spend several days at the facility working closely with the RSD for monitoring medications and correcting any issues that were discovered.
-She had not had time to audit very many residents' records.

Interview with the Executive Director on 02/18/22 at 6:00pm revealed:
-The RSD and the WC were responsible for monitoring the residents' medications and ensuring the facility was compliant with medication administration policy, rules and regulations.
-The RSD was solely responsible due to the WC no longer working at the facility.
-The CN came to the facility to assist the RSD in auditing records and to ensure compliance with medication administration.
-He was not routinely involved with clinical aspects of medication administration.

The facility failed to ensure medications were administered as ordered for 2 of 7 sampled residents including a resident who was not administered pain patches for 10 of 19 doses resulting in the resident experiencing increased pain and discomfort and interfering with the resident's daily activity (#7); and a resident who did not have an long acting insulin dose reduced as ordered which could result in the resident experiencing hypoglycemia with symptoms of sweating, weakness, and even loss of consciousness (#8). This failure was detrimental to the health, safety, and welfare of the residents

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MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

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

{D 358}	Continued From page 50 which constitutes an Unabated Type B Violation. The facility provided a plan of correction in accordance with G.S. 131D-34 on 02/17/22 for this violation.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order;(3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the accuracy of medication administration records for 2 of 7 sampled residents (#7 and #8) related to a medication used for pain control (#7) and recording of fingerstick blood sugar (FSBS)	{D 367}	1. 1. Effected residents (#7, #8) had their medications Reviewed and confirmed with Primary Care Physician (PCP). The PCP was made aware of any missed doses And medication parameters were clarified. Completed February 25, 2022 2. Regional Resident Care Specialist, (RRCS) completed an An audit on February 26, 2022 off all resident orders to Medication Record (MAR) to confirm use and need. Omnicare, the contracted pharmacy completed a cart To MAR audit of all residents on February 24, 2022. All medication order changes and inaccurate transcription Was corrected by the DRC/RRCS and sent to Omnicare For updating in their system for net month MAR accuracy 3. DRC/Designee to receive a copy of resident orders and or After Visit Summary (AVS). The Medication Tech (MT), DRC/ Designee to ensure the order in transcribed To the MAR accurately and that the medication has Been delivered to community in a timely manner, Notification to PCP for any delays in delivery >3 business Days. All staff that administer medications will complete Education on documentation, PCP notification, Narcotic Sign out documentation and effectiveness of PRN meds. The reporting of medication issues via shift to shift Reporting and direct DRC notification by March 16, 2022 DRC/MT/Designee have an assignment of MAR/TAR That they are to review for accuracy prior to the MAR Monthly change over, all changes are to be completed And given to the DRC/designee for review.	03/21/22

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(D 367)		(D 367)	
	Continued From page 51 values (#8). The findings are: 1. Review of Resident #8's current FL-2 dated 10/08/21 revealed: -Diagnoses included muscle weakness, history of falls. -There was an order to check fingerstick blood sugar (FSBS) every morning and before meals. -There was an order to inject 6 units of lispro (a rapid acting insulin used to lower elevated blood sugar levels) insulin subcutaneously with meals. Review of Resident #8's December 2021 medication administration record (MAR) revealed: -There was a preprinted entry for check blood sugar every morning and before meals scheduled for administration at 6:00am, 11:00am, and 8:00pm. -The scheduled 8:00pm administration time had been handwritten to change the time to 5:00pm. -FSBS were documented at 6:00am, 11:00am and 5:00pm on the MAR. -From 12/20/21 to 12/31/21, FSBS values ranged from 73 to 171 at 6:00am; from 93 to 189 at 11:00am; and from 60 to 280 at 5:00pm. Review of Resident #8's January 2022 MAR revealed: -There was a preprinted entry for check blood sugar every morning and before meals scheduled for administration at 6:00am, 11:00am, and 8:00pm. -The 8:00pm administration time remained unchanged. -FSBS were documented at 6:00am, 11:00am and 8:00pm. -FSBS ranged from 56 (01/29/21) to 206 at 6:00am; from 86 to 227 at 11:00am; and 68		4. DRC/Designee will review shift to shift report daily Monday thru Friday and follow up on issues. A DRC Daily Report will come to Morning Meeting to discuss the Issues and the resolution, and assure communication With families, and/or PCP. The DRC/Designee will conduct Twice weekly audits of MAR's to track blanks, circled meds Hand written changes and documentation omissions for 4 weeks and then weekly thereafter.

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{D 367}	Continued From page 52 (01/26/22) to 301 at 8:00pm. Review of Resident #8's February 2022 MARs revealed: -There was a preprinted entry for check blood sugar every morning and before meals scheduled for administration at 6:00am, 11:00am, and 8:00pm. -The scheduled 8:00pm administration time remained unchanged. Interview with Resident #8 on 02/17/22 at 12:49pm revealed: -Staff checked her blood sugar first thing in the morning and then a couple of other times during the day, maybe late in the evening also. -She did not know when her physician had ordered for FSBS to be obtained. Interview with the Resident Services Director (RSD) on 02/17/21 at 1:00pm revealed: -MAs were responsible to check the upcoming month's MAR to accuracy and any changes when the pharmacy sent the MARs toward the end of each month. -She had not completed audits for administration of residents' medication compared to the documentation on the MARs for residents because there were ongoing staffing shortages and she was staffing the medication carts. Interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm revealed: -She was responsible for overseeing several facilities in a different region for the corporation. -She had started routine monitoring this facility for compliance with health care and medications within the last 2 weeks. -She discovered the facility had not put routine monitoring of the facility's medication	{D 367}		

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{D 367}		{D 367}		
	Continued From page 53 management in place. -The RSD was not experienced had not been auditing the resident's medications. -The CN started her own reviews and audits. -She had not had time to audit very many residents' records. -It looked like a staff made corrections for the time for collecting the supper FSBS from 8:00pm to 5:00pm on the December 2021 MAR. -It looked like staff failed to change Resident #8's time on the January 2022 and February 2022 MARs for the FSBS from 8:00pm to 5:00pm to correspond to the directions on the order entered on the MAR for FSBS with meals. -There was no meal at 8:00pm daily. Telephone interview with a nurse at Resident #8's primary care provider (PCP's) office on 02/18/22 at 11:58am revealed: -The PCP wanted FSBS values obtained in the morning for Resident #8, as ordered. -The PCP ordered FSBS before meals, meaning before lunch and supper (dinner). -The PCP did not order FSBS at bedtime for Resident #8. -The PCP did not routinely order FSBS at night. Telephone interview with an order entry staff member of the contracted pharmacy on 02/18/22 at 1:18pm revealed: -The pharmacy received the order for Resident #8's FSBS every morning and with meals dated 10/08/21. -The pharmacy showed the order was scheduled at 6:00am, 11:00am, and 8:00pm on the MAR. -The facility was responsible to check the preprinted MARs each month for accuracy. -The facility was responsible to notify the pharmacy for changes needed, including times of administration, or make handwritten changes to			

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(D 367)		(D 367)		

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the MAR.
-There was documentation the facility had contacted the pharmacy for changes to Resident #8's FSBS scheduled on the January 2022 or February 2022 MARs.

Interview with a second shift medication aide (MA) on 02/18/21 at 4:20pm revealed:
-She routinely worked evening shifts (3:00pm to 11:00pm).
-She obtained the FSBS for Resident #8 at 8:00pm when she worked because that was the time scheduled on the MAR.
-She overlooked the printed entry to check FSBS every morning and before meals and focused on the time scheduled on the MAR.

Interview with the Administrator on 02/18/22 at 6:00pm revealed:
-The RSD and the Wellness Coordinator were responsible for monitoring the residents' medications and ensuring the facility was compliant with medication administration policy, rules and regulations.
-The CN came to the facility to assist the RSD in auditing records and to ensure compliance with medication administration.
-He was not routinely involved with clinical aspects of medication administration.

2. Review of Resident #7's current FL2 dated 06/10/21 revealed:
-Diagnoses included muscle weakness, iron deficiency, and major depressive disorder. -There was an order for tramadol (a pain reliever for mild to moderate pain) 50mg take one tablet every 6 hours as needed (prn) for pain.

Review of Resident #7's signed physician's orders dated 01/01/21 revealed an order for

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{D 367}		{D 367}		
	Continued From page 55 tramadol 50mg one tablet every 6 hours prn pain. Review of Resident #7's physician's order dated 12/22/21 revealed an order for tramadol 100mg one tablet prn pain every 6 hours. Telephone interview an order entry representative at the facility's contracted pharmacy on 02/17/22 at 3:10pm revealed: -Resident #7 had tramadol 50mg one every 6 hours prn for pain dispensed on 08/29/21 for 10 tablets. -Resident #7 had tramadol 100mg one tablet every 6 hours prn for pain dispensed on 12/22/21 for 120 tablets. Observation of medication on hand for administration on 02/18/22 at 4:00pm revealed Resident #7 had 113 tramadol 100mg tablets available for administration. Review of Resident #7's December 2021 medication administration record (MAR) revealed: -There was an entry for tramadol 50mg one tablet every 6 hours as needed for pain. -There was no entry for tramadol 100mg to correspond to the order dated 12/22/21. Review of Resident #7's controlled substance count sheet (CSCS) for tramadol 100mg dispensed on 12/22/21 compared to Resident #7's December 2021 MAR revealed: -On 12/28/21 at 5:08pm, tramadol 100mg was signed out on the CSCS and documented on the December 2021 MAR for tramadol 50mg. -On 12/29/21 at 5:00pm, tramadol 100mg was signed out on the CSCS and documented on the December 2021 MAR incorrectly for tramadol 50mg with no documentation for the effectiveness of the medication.			

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Review of Resident #7's January 2022 MAR revealed:
-There was an entry for tramadol 50mg one tablet every 6 hours as needed for pain.
-There was no entry for tramadol 100mg to correspond to the order dated 12/22/21.

Review of Resident #7's CSCS for tramadol 100mg dispensed on 12/22/21 compared to Resident #7's January 2022 MAR revealed on 01/27/22 at 7:44am, tramadol 100mg was signed out on the CSCS and documented on the January 2022 MAR for tramadol 50mg with no documentation for the effectiveness of the medication. .

Review of Resident #7's February 2022 MAR revealed:
-There was no entry for tramadol 50mg every 6 hours as needed for pain on the MAR.
-There was an entry for tramadol 100mg every 6 hours as needed for pain.

Review of Resident #7's CSCS for tramadol 100mg dispensed on 12/22/21 compared to Resident #7's February 2022 MAR revealed there were 2 doses of tramadol 100mg signed out on the CSCS (02/05/22 and 02/06/22) and one dose (02/05/22) documented on the February 2022 MAR.

Interview with a morning shift medication aide (MA) on 02/17/22 at 11:59am revealed:
-When an order was received, the receiving MA was responsible to enter the order on the resident's MAR, fax the order to the pharmacy, and place the order in tray in the nurse's desk area for the next shift to review.
-The next shift was responsible to review the new

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{D 367}	Continued From page 57	{D 367}		

order entry on the MAR for accuracy and leave for a last check by the Resident Services Director (RSD) or Wellness Coordinator (WC) to do a final review.

Interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm revealed:
-She was responsible for overseeing several facilities in a different region for the corporation. -She had started routine monitoring this facility for compliance with health care and medications within the last 2 weeks.
-When she first came to the facility (no exact date given but around week of 02/07/22) she requested an update from the RSD regarding the facility's increased monitoring and auditing of medications issues identified during the recent survey.
-She discovered the facility had not put routine monitoring of the facility's medication management in place.
-The RSD was not experienced and had not been auditing the resident's medications.
-The CN started her own reviews and audits. -She planned to spend several days at the facility working closely with the RSD for monitoring medications and correcting any issues that were discovered.
-She had not had time to audit very many residents' records.

Interview with a second shift medication aide (MA) on 02/18/22 at 4:00pm revealed:
-The second shift MAs were routinely responsible for checking the new monthly MARs against the outgoing monthly MARS.
-The MA checked to see if any orders that were handwritten on the MARs were reflected on the new MAR.
-The MAs made any corrections onto the MAR

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before the MAR was started at beginning of the new month.

Telephone interview with the Resident Services Director (RSD) on 02/21/22 at 3:50pm revealed: -She did not know Resident #7's tramadol was incorrect on the January MAR.
-She had not been auditing the resident's MARs for accuracy due to increased workload and staffing issues.
-She was responsible to ensure medications were accurately entered on the MARs and administered as ordered.

Telephone interview with an order entry representative at the facility's contract pharmacy on 02/21/22 at 11:58am revealed:
-Resident #7's order for tramadol 100mg was received at the pharmacy 12/22/22.
-The pharmacy changed the tramadol order in their computer system on that date.
-The pharmacy routinely prints and sends out residents' MARs for the next month to the facility 7 to 10 days prior to the end of the current month.
-Resident #7's order for tramadol 100mg from 50mg would not have printed on the January 2022 MAR since it came into the pharmacy after the MAR were sent out for January 2022. -The facility would be responsible to change the order for tramadol on the January 2022 MAR or request another copy of Resident #7's MAR with the correct strength entered on the MAR.
-Resident #7's corrected entry for tramadol 100mg would be preprinted on the February 2022 MAR as was showing.
-There was no documentation the facility requested an updated copy or reprint of the Resident #7's January 2022 MAR with tramadol 100mg one every 6 hours as needed preprinted.

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{D 392}	Continued From page 59	{D 392}	
{D 392}	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record, including medication administration records (MARS) and controlled substances count sheet (CSCS) that accurately reconciled the receipt, administration, was maintained for 3 of 4 sampled residents (#3, #6, and #7) with physician orders for narcotic and non-narcotic pain medications (#3, #6, and #7) and an anti-anxiety medication (#7, and #3). The findings are: Review of the facility's Medication Management policy effective 04/01/19 revealed: -Medication administration was to be documented on the medication administration record (MAR) at the time the medication is provided or taken. -Medication omissions or refusals are documented on the MAR. -The resident's physician/healthcare provider was to be notified. Review of the facility's Controlled Substances and Narcotics policy effective 04/01/19 revealed:	{D 392}	03/21/22 1. The effective residents (#3, #6, #7) have had their Narcotic Count sheets reviewed and have been counted for accuracy Of medication availability, completed February 25, 2022 2. All residents have had their Narcotic medication use Reviewed and assured of accuracy of the order and the Availability of the medication. PCP for any resident with no use times 30 days has been Contacted for an order to stop medication. Refusals of Medications have been relayed to the PCP and family. 3. All staff that administer medication will receive Education for documenting appropriately to the MAR And the Narcotic count sheets. Education to include Accuracy of MAR, DEA requirements for Narcotic delivery And the filing of a completed count sheet. DRC has received education on the storage of the Narcotic Count sheet and the correlation of delivery to administering To completed count or send back documentation completed March 16, 2022. 4. DRC/ED/designee to conduct twice weekly audits times Four (4) to ensure accuracy of count to MAR documentation For delivery of classed medications. The weekly thereafter to Ensure continued compliance with the standard for medication Delivery and documentation.

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{D 392}	Continued From page 60 -A separate controlled substance record was required for each individual medication container. -Prior to administration of a controlled substance, staff compare the quantity on hand to the controlled substance count sheet (CSCS) sent with a medication for accuracy. -Immediately after a dose of medication is removed from the container or blister pak, the medications is signed out on the CSCS. -The Director of Resident Care (identified as the Resident Services Director at this facility) is responsible for all processes related to controlled substances. 1. Review of Resident #7's current FL2 dated 06/10/21 revealed diagnoses included muscle weakness, iron deficiency, and major depressive disorder. a. Review of Resident #7's current FL2 dated 06/10/21 revealed there was an order for tramadol (a pain reliever for mild to moderate pain) 50mg take one tablet every 6 hours as needed (prn) for pain. Review of Resident #7's signed physician's orders dated 01/01/21 revealed an order for tramadol 50mg one tablet every 6 hours prn pain. Review of Resident #7's physician's order dated 12/22/21 revealed an order for tramadol 100mg one tablet prn pain every 6 hours. Telephone interview with an order entry representative at the facility's contracted pharmacy on 02/17/22 at 9:49am revealed: -Resident #7 had tramadol 50mg one every 6 hours prn for pain dispensed on 08/29/21 for 10 tablets. -Resident #7 had tramadol 100mg one tablet	{D 392}		

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{D 392}	Continued From page 61 every 6 hours prn for pain dispensed on 12/22/21 for 120 tablets. Observation of medication on hand for administration on 02/18/22 at 4:00pm revealed Resident #7 had 113 tramadol 100mg tablets available for administration. Review of Resident #7's December 2021 medication administration record (MAR) revealed: -There was an entry for tramadol 50mg one tablet every 6 hours as needed for pain. -There was no entry for tramadol 100mg to correspond to the order dated 12/22/21. Review of Resident #7's controlled substance count sheet (CSCS) for tramadol 100mg dispensed on 12/22/21 compared to Resident #7's December 2021 MAR revealed on 12/31/21 at 5:00pm, tramadol 100mg was signed out on the CSCS with no documented administration or documentation for the effectiveness of the medication on the MAR. Review of Resident #7's January 2022 MAR revealed: -There was an entry for tramadol 50mg one tablet every 6 hours as needed for pain. -There was no entry for tramadol 100mg to correspond to the order dated 12/22/21. Review of Resident #7's CSCS for tramadol 100mg dispensed on 12/22/21 compared to Resident #7's January 2022 MAR revealed on 01/04/22 at 7:00pm, tramadol 100mg was signed out on the CSCS with no documented administration or documentation for the effectiveness of the medication on the MAR. Review of Resident #7's February 2022 MAR	{D 392}		

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MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

(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 392}		{D 392}		

Continued From page 62

revealed there was an entry for tramadol 100mg every 6 hours as needed for pain.

Review of Resident #7's CSCS for tramadol 100mg dispensed on 12/22/21 compared to Resident #7's February 2022 MAR revealed on 02/06/22 at 9:00am, there was one dose signed out on the CSCS with no documented administration or documentation for the effectiveness of the medication on the MAR.

Observation of medication ion hand for administration for Resident #7 revealed there were 107 of 120 tramadol 100mg tablets remaining from the dispensing on 12/21/21.

Based on interview, and review of Resident #7's CSCS for tramadol 100mg tablets and December 2021, January 2022, and February 2022 MARs, there were 3 tramadol 100mg not accurately accounted for on the CSCS compared to the resident's MARs.

Refer to interview with the Resident Services Director (RSD) on 02/17/21 at 1:00pm.

Refer to interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm.

Refer to interview with a second shift medication aide (MA) on 02/18/22 at 3:20pm.

Refer to interview with the Executive Director on 02/18/22 at 6:00pm.

b. Review of Resident #7's current FL2 dated 06/10/21 revealed an order for Alprazolam 1mg (used to treat anxiety) at bedtime.

Review of Resident #7's signed physician's

{D 392}	Continued From page 63 orders dated 12/01/21 revealed an order for Alprazolam 1mg (used to treat anxiety) at bedtime. Telephone interview with an order entry representative at the facility's contracted pharmacy on 02/17/22 at 9:49am revealed: -The pharmacy sent a controlled substance count sheet (CSCS) with each quantity dispensed to be used for accounting for the medication's administration, or return. -Resident #7 had alprazolam 1 mg one at bedtime dispensed on 12/21/21 for 30 tablets. -Resident #7 had alprazolam 1 mg one at bedtime dispensed on 01/14/22 for 30 tablets. -Resident #7 had alprazolam 1 mg one at bedtime dispensed on 02/13/22 for 30 tablets. Review of Resident #7's January 2022 medication administration record (MAR) revealed: -There was an entry for alprazolam 1mg at bedtime, scheduled for administration at 8:00pm each night. -There were 3 days, 01/03/22, 01/25/22, and 01/26/22, in which alprazolam 1mg was blank on the MAR for administration at 8:00pm. Review of Resident #7's CSCS for alprazolam 1mg dispensed on 12/21/21 and 01/14/22 compared to Resident #7's January 2022 MAR revealed on 01/03/22, 01/25/22, and 01/26/22, alprazolam 1 mg was signed out on the CSCS with no documented administration on the MAR and no explanation for the blank space on the MAR was documented on the back of the MAR. Review of Resident #7's February 2022 MAR revealed: -There was an entry for alprazolam 1mg at bedtime, scheduled for administration at 8:00pm	{D 392}		

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{D 392}	Continued From page 64	{D 392}		

each night.
-There was 1 day, 02/01/22, that alprazolam 1mg was blank for administration at 8:00pm.

Review of Resident #7's CSCS for alprazolam 1mg dispensed on 01/14/22 compared to Resident #7's February 2022 MAR revealed on 02/01/22, alprazolam 1 mg was signed out on the CSCS with no documented administration on the MAR and no explanation for the blank space on the MAR was documented on the back of the MAR.

Observation of medication on hand for administration for Resident #7 on 02/17/22 revealed 4 of 30 tablets remaining for alprazolam 1 mg dispensed on 01/14/22 and 30 of 30 alprazolam 1 mg remaining for alprazolam dispensed on 02/13/22.

Based on interview, and review of Resident #7's CSCS for alprazolam tablets and January 2022, and February 2022 MARs, there were 4 Alprazolam 1mg tablets not accurately accounted for on the CSCS compared to the resident's MARs. There were no CSCS missing from 12/22/21 to 02/17/22.

Refer to interview with the Resident Services Director (RSD) on 02/17/21 at 1:00pm.

Refer to interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm.

Refer to interview with a second shift medication aide (MA) on 02/18/22 at 3:20pm.

Refer to interview with the Executive Director on 02/18/22 at 6:00pm.

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{D 392}	Continued From page 65 2. Review of Resident #6's current FL2 dated 05/19/21 revealed diagnoses included diastolic heart failure, type II diabetes mellitus and muscle weakness. Review of Resident #6's signed physicians' orders dated 12/08/21 revealed an order for hydrocodone/acetaminophen 5/325 (a narcotic pain reliever for mild to moderate pain) one tablet every 4 hours as needed for moderate pain. Telephone interview with an order entry representative at the facility's contracted pharmacy on 02/17/22 at 9:49am revealed: -The pharmacy sent a controlled substance count sheet (CSCS) with each quantity dispensed to be used for accounting for the medication's administration, or return. -Resident #6 had hydrocodone/acetaminophen 5/325 quantity of 180 dispensed on 11/04/21. -Resident #6 had hydrocodone/acetaminophen 5/325 quantity of 180 dispensed on 01/12/22. Review of Resident #6's January 2022 medication administration record (MAR) revealed: -There was an entry for hydrocodone/acetaminophen 5/325 one tablet every 4 hours as needed for moderate pain.. -There were 30 doses documented as administered as needed on the MAR from 01/01/22 to 01/11/22 at 1:43pm. Review of Resident #6's CSCS for hydrocodone/acetaminophen 5/325 dispensed on 11/04/21 compared to Resident #6's January 2022 MAR revealed: -Thirty doses were signed out on the CSCS that corresponded to 30 doses documented for administration on the MAR. -There were 12 of 30 opportunities when the	{D 392}		

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{D 392}	Continued From page 66 outcome (or effectiveness) was not documented on the MAR. -Examples of doses of hydrocodone/acetaminophen 5/325 administered and the outcome not documented included on 01/04/22 at 8:00pm, 01/05/22 at 2:00pm, 01/07/22 at 8:00am, and 01/10/22 at 8:00pm. -There were 30 doses signed out on the CSCS with a balance of zero tablets remaining. Review of Resident #6's CSCS for one bingo card for 30 of 180 hydrocodone/acetaminophen 5/325 dispensed on 01/12/22 compared to Resident #6's January 2022 MAR revealed: -There were 12 of 29 opportunities when the outcome (or effectiveness) was not documented on the MAR from 01/13/22 to 01/24/22 at 9:10am. -Examples of doses of hydrocodone/acetaminophen 5/325 administered and the outcome not documented included on 01/13/22 at 8:00pm, 01/14/22 at 2:00pm, 01/17/22 at 8:00am, and 01/20/22 at 8:00pm. -Twenty nine of 30 doses were signed out on the CSCS that corresponded to 29 doses documented for administration on the MAR; one dose on 01/20/22 at 2:00pm was signed out on the CSCS and was not documented on the MAR. Review of Resident #6's CSCS for a second bingo card for 30 of 180 hydrocodone/acetaminophen 5/325 dispensed on 01/12/22 compared to Resident #6's January 2022 MAR revealed: -There were 13 of 21 opportunities when the outcome (or effectiveness) was not documented on the MAR from 01/24/22 at 3:00pm to 01/31/22 at 8:00pm. -Examples of doses of hydrocodone/acetaminophen 5/325 administered and the outcome not documented included on	{D 392}		

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{D 392}		{D 392}		
	Continued From page 67 01/24/22 at 8:00pm, 01/28/22 at 2:00pm, 01/28/22 at 8:00pm, and 01/31/22 at 8:00pm. -Twenty of 21 doses were signed out on the CSCS that corresponded to 20 doses documented for administration on the MAR; one dose on 01/27/22 at 8:48am was signed out on the CSCS and was not documented on the MAR. Review of Resident #6's February 2022 MAR revealed: -There was an entry for hydrocodone/acetaminophen 5/325 one tablet every 4 hours as needed for moderate pain.. -There were 9 doses documented as administered as needed on the MAR from 02/01/22 to 02/04/22 at 9:18am. -There were 28 doses documented as administered as needed on the MAR from 02/04/22 at 8:00pm to 02/14/22 at 8:00pm. Review of Resident #6's CSCS for a the second bingo card for 30 of 180 hydrocodone/acetaminophen 5/325 dispensed on 01/12/22 compared to Resident #6's February 2022 MAR revealed: -There were 4 of 9 opportunities when the outcome (or effectiveness) was not documented on the MAR from 02/01/22 to 02/04/22 at 9:12am. -Examples of doses of hydrocodone/acetaminophen 5/325 administered and the outcome not documented included on 02/01/22 at 8:00pm, 02/02/22 at 8:00pm, and 02/03/22 at 8:00pm. -Eight of 9 doses were signed out on the CSCS that corresponded to 8 doses documented for administration on the MAR; two doses were signed out on the CSCS but administration not documented on the MAR, on 02/03/22 at 9:30am one dose was signed out on the CSCS and was not documented on the MAR, and one dose on			

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{D 392}	Continued From page 68 02/04/22 at 9:12am was signed out on the CSCS and was not documented on the MAR. Review of Resident #6's CSCS for a the third bingo card for 30 of 180 hydrocodone/acetaminophen 5/325 dispensed on 01/12/22 compared to Resident #6's February 2022 MAR revealed: -There were 14 of 28 opportunities when the outcome (or effectiveness) was not documented on the MAR from 02/04/22 at 2:00pm to 02/14/22 at 8:00pm. -Examples of doses of hydrocodone/acetaminophen 5/325 administered and the outcome not documented included on 02/04/22 at 8:00pm, 02/05/22 at 8:00pm, 02/09/22 at 2:04pm, and 02/13/22 at 8:00pm. -Twenty-eight of 30 doses were signed out on the CSCS that corresponded to 28 doses documented for administration on the MAR; two doses were signed out on the CSCS but administration not documented on the MAR, with one dose on 02/04/22 at 2:00pm was signed out on the CSCS and was not documented on the MAR, and one dose on 02/07/22 at 1:47pm was signed out on the CSCS and was not documented on the MAR. Review of Resident #6's CSCS for a the fourth bingo card for 30 of 180 hydrocodone/acetaminophen 5/325 dispensed on 01/12/22 compared to Resident #6's February 2022 MAR revealed: -Four of 5 doses were signed out on the CSCS that corresponded to 4 doses documented for administration on the MAR; one dose on 02/15/22 at 1:00pm was signed out on the CSCS and not documented on the MAR Observation of medication on hand for	{D 392}		

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{D 392}	Continued From page 69 administration for Resident #6 on 02/17/22 revealed 55 of 180 tablets remaining for hydrocodone/acetaminophen 5/325 dispensed on 01/12/22 matching the quantity on hand. Based on interview, and review of Resident #6's CSCS for hydrocodone/acetaminophen 5/325 and January 2022, and February 2022 MARs, there were 7 hydrocodone/acetaminophen 5/325 not accurately accounted for on the CSCS compared to the resident's MARs. All CSCS dispensed with medication from the facility's contracted pharmacy were available for review. Refer to interview with the Resident Services Director (RSD) on 02/17/21 at 1:00pm. Refer to interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm. Refer to interview with a second shift medication aide (MA) on 02/18/22 at 3:20pm. Refer to interview with the Executive Director on 02/18/22 at 6:00pm. 3. Review of Resident #3's current FL2 dated 05/25/21 revealed diagnoses included closed Alzheimer's disease, right hip fracture, hypertension, and pulmonary embolism. a. Review of Resident #3's current FL2 dated 05/25/21 revealed there was an order for hydrocodone/acetaminophen 5/325 (a narcotic pain reliever used to treat moderate to severe pain) 1 to 2 tablets every 6 hours as needed (prn) for moderate pain. Review of Resident #3's signed physician's orders dated 01/05/21 revealed there was an	{D 392}		

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{D 392}	Continued From page 70 order for hydrocodone/acetaminophen 5/325 one tablet every 4 hours as needed (prn). Telephone interview with the pharmacist at Resident #3's pharmacy on 02/17/21 at 4:07pm revealed: -Resident #3 had hydrocodone/acetaminophen 5/325 one tablet every 4 hours as needed dispensed on 09/21/21 for 90 tablets. -Resident #3 had hydrocodone/acetaminophen 5/325 one tablet every 4 hours as needed dispensed on 01/27/22 for 90 tablets. Review of Resident #3's January 2022 medication administration record (MAR) revealed: -There was an entry for hydrocodone/acetaminophen 5/325 one tablet every 4 hours as needed for moderate pain.. -There were 10 doses documented as administered as needed on the MAR from 01/01/22 to 01/31/22. Review of Resident #3's CSCS for hydrocodone/acetaminophen 5/325 dispensed on 09/21/21 compared to Resident #3's January 2022 MAR revealed: -The beginning balance on the CSCS was 18 tablets of 30 remaining tablets on 01/01/22. -There were 2 of 13 opportunities when the outcome (or effectiveness) was not documented on the MAR; on 01/07/22 at 9:40am and on 01/09/22 at 9:10am. -There were 13 doses signed out on the CSCS with a balance of 5 tablets remaining. -Eleven of 13 doses were signed out on the CSCS that corresponded to 11 doses documented for administration on the MAR; two doses were signed out on the CSCS but administration not documented on the MAR, with one on 01/23/22 at 7:30pm was signed out on the	{D 392}		

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{D 392}	Continued From page 71 CSCS and was not documented on the MAR, and one dose on 01/29/22 at 2:00pm was signed out on the CSCS and was not documented on the MAR. Review of Resident #3's February 2022 MAR revealed: -There was an entry for hydrocodone/acetaminophen 5/325 one tablet every 4 hours as needed for moderate pain.. -There were 9 doses documented as administered as needed on the MAR from 02/01/22 to 02/16/22. Review of Resident #3's CSCS for hydrocodone/acetaminophen 5/325 dispensed on 09/21/21 and 01/27/22 compared to Resident #3's February 2022 MAR revealed: -There were 5 doses documented on the CSCS for 09/21/21 to complete the CSCS and all were documented as administered on the MAR. -There were 4 doses documented on the CSCS for 01/27/22 dispensing of 90 tablets and 4 doses were accurately documented on the MAR. Observation of medication on hand for administration on 02/17/22 revealed there were 86 tablet remaining that matched the CSCS quantity for 90 hydrocodone/acetaminophen tablets dispensed for Resident #3 on 01/27/22. Based on interview, and review of Resident #3's CSCS for hydrocodone/acetaminophen 5/325 and January 2022, and February 2022 MARs, there were 4 hydrocodone/acetaminophen 5/325 not accurately accounted for on the CSCS compared to the resident's MARs. Refer to interview with the Resident Services Director (RSD) on 02/17/21 at 1:00pm.	{D 392}		

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{D 392}	Continued From page 72 Refer to interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm. Refer to interview with a second shift medication aide (MA) on 02/18/22 at 3:20pm. Refer to interview with the Executive Director on 02/18/22 at 6:00pm. b. Review of Resident #3's current FL2 dated 05/25/21 revealed there was an order for alprazolam 0.25mg (used to treat anxiety) one tablet twice a day as needed (prn) for anxiety. Review of Resident #3's signed physician's orders dated 01/05/21 revealed there was an order alprazolam 0.25mg one tablet twice a day prn for anxiety. Telephone interview with the pharmacist at Resident #3's pharmacy on 02/17/21 at 4:07pm revealed Resident #3 had alprazolam 0.25mg one tablet twice a day prn for anxiety dispensed on 05/12/21 for a quantity of 60 tablets. Review of Resident #3's January 2022 medication administration record (MAR) revealed: -There was an entry for alprazolam 0.25mg one tablet twice a day prn for anxiety. -There were 5 doses documented as administered as needed on the MAR from 01/01/22 to 01/31/22. Review of Resident #3's CSCS for alprazolam 0.25mg one tablet twice a day prn for anxiety dispensed on 05/12/21 compared to Resident #3's January 2022 MAR revealed: -The beginning balance on the CSCS was 18 tablets of 30 remaining tablets on 01/01/22.	{D 392}		

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(D 392)	Continued From page 73 -There were 2 of 7 opportunities when the outcome (or effectiveness) was not documented on the MAR; on 01/07/22 at 8:00pm and on 01/11/22 at 8:00pm. -There were 7 doses signed out on the CSCS with a balance of 11 tablets remaining. -Five of 7 doses were signed out on the CSCS that corresponded to 5 doses documented for administration on the MAR; two doses were not documented on the MAR with one on 01/07/22 at 8:00pm that was signed out on the CSCS and was not documented on the MAR, and one dose on 01/15/22 at 8:00pm was signed out on the CSCS and was not documented on the MAR. Review of Resident #3's February 2022 MAR revealed: -There was an entry for alprazolam 0.25mg one tablet twice a day prn for anxiety. -There was 1 dose documented as administered as needed on the MAR from 02/02/22 at 11:20am. Review of Resident #3's CSCS for alprazolam 0.25mg one tablet twice a day prn for anxiety dispensed on 05/12/21 to Resident #3's February 2022 MAR revealed: -There was 1 dose documented on the CSCS matching one dose documented on the MAR on 02/22/22. -There were 10 of 30 tablets remaining on the CSCS accounting. Observation of medication on hand for administration on 02/17/22 revealed there were 10 tablet remaining that matched the CSCS quantity for 30 remaining Alprazolam 0.25mg labeled one tablet twice a day prn for anxiety dispensed on 05/12/21 for 60 tablets.	(D 392)		

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{D 392}		{D 392}		

Continued From page 74

Based on interview, and review of Resident #3's CSCS for Alprazolam 0.25mg and January 2022, and February 2022 MARs, there were 4 Alprazolam 0.25mg doses not accurately accounted for on the CSCS compared to the resident's MARs.

Refer to interview with the Resident Services Director (RSD) on 02/17/21 at 1:00pm.

Refer to interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm.

Refer to interview with a second shift medication aide (MA) on 02/18/22 at 3:20pm.

Refer to interview with the Executive Director on 02/18/22 at 6:00pm. _____

Interview with the Resident Services Director (RSD) on 02/17/21 at 1:00pm revealed:
-MAs were responsible document administration of controlled substances on the MAR and CSCS when the medications were administered.
-She had not completed audits for administration of residents' medication compared to the documentation on the MARs for residents because there were ongoing staffing shortages and she was staffing the medication carts. -She did not realize staff were not accurately documenting on both the CSCS and the residents' MAR for all prn medications that would include documenting the outcome or effectiveness for prn medications to complete controlled substance accounting per the facility policy.

Interview with the Corporate Nurse (CN) on 02/17/22 at 5:00pm revealed:

(D 392)		(D 392)		
	Continued From page 75 -She was responsible for overseeing several facilities in a different region for the corporation. -She had started routine monitoring this facility for compliance with health care and medications within the last 2 weeks. -She discovered the facility had not put routine monitoring of the facility's medication management, including documenting administration of controlled substances, in place. -The RSD was not experienced and had not been auditing the resident's medications. -The CN started her own reviews and audits. -She had not had time to audit very many residents' records. -The MAs were not documenting controlled substances ordered prn on the CSCS and the residents' MAR, including effectiveness of the prn medication according to the facility's policy. Interview with a second shift medication aide (MA) on 02/18/22 at 3:20pm revealed: -MAs were responsible to sign the CSCS and document all controlled substance on the residents' MARs. -She always signs out prn controlled medications on the CSCS in order to make the count correct when do narcotic counts at shift change. -She may get interrupted during medication administration and overlook documenting a prn controlled substance on the resident's MAR or forget to go back and document the effectiveness of the prn medication one hour later, but it was an oversight. -She was not responsible to audit residents' MARs for controlled substances signed out on the CSCS compared to the residents' MARs. -The RSD would be responsible for audits. Interview with the Executive Director on 02/18/22 at 6:00pm revealed:			

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{D 392}	Continued From page 76 -The RSD and the WC (position vacant at present) were responsible for monitoring the residents' medications and ensuring the facility was compliant with controlled substances administration policy, rules and regulations. -The CN came to the facility to assist the RSD in auditing records and to ensure compliance with medication administration, including controlled substance accounting. -He was not routinely involved with clinical aspects of medication administration.	{D 392}		
{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, record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 11 of 24 shifts sampled for 8 days from 01/20/22 to 02/05/22. The findings are: Review of the facility's 2021 license from the Division of Health Service Regulation revealed the facility was licensed for a Special Care Unit	{D 465}	1. Review of current census was conducted and staffing Scheduled per the regulation guidelines for Adult Care Homes. 2. Review of current staff and open staff positions to Determine need and availability of staff. Continued ads for staff through approved Corporate Venues such as Indeed and local entitles. Encourage Staff to invite and recommend for new employees. Schedule adjusted daily for holes and staff call off to Assure adequate staff coverage to assure compliance With standards. 3. Use of a daily schedule to assure accuracy of staff To resident ratio standards. DRC/ED to adjust as needed For changes to census or staff availability. Education provided to all staff on the standard requirements To assure that all management is aware and can Assist with any gaps in care coverage completed March 16, 2022 4. Staffing schedule reviewed daily in the Morning meeting For staffing needs over the next twenty-four (24) hours During business days and Fridays to cover the weekend and Staffing needs through Mondays.	03/21/22

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{D 465}		{D 465}		
	Continued From page 77 (SCU) with a capacity of 30 beds. Review of the facility's resident census dated 01/20/22 revealed there was a SCU census of 22 residents, which required 22 staff hours on first shift. Review of the individual time sheets dated 01/20/22 revealed 19.45 staff hours were provided in the SCU on first shift, leaving the shift short of 2.15 staff hours. Review of the facility's resident census dated 01/20/22 revealed there was a SCU census of 22 residents, which required 17.60 staff hours on third shift. Review of the individual time sheets dated 01/201/22 revealed 15.45 staff hours were provided in the SCU on third shift, leaving the shift short of 1.75 staff hours. Review of the facility's resident census dated 01/24/22 revealed there was a SCU census of 22 residents, which required 22 staff hours on first shift. Review of the individual time sheets dated 01/24/22 revealed 16.25 staff hours were provided in the SCU on first shift, leaving the shift short of 5.45 staff hours. Review of the facility's resident census dated 01/25/22 revealed there was a SCU census of 22 residents, which required 22 staff hours on first shift. Review of the individual time sheets dated 01/25/22 revealed 20.00 staff hours were provided in the SCU on first shift, leaving the shift			

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{D 465}	Continued From page 78 short of 2.00 staff hours. Review of the facility's resident census dated 01/25/22 revealed there was a SCU census of 22 residents, which required 22 staff hours on second shift. Review of the individual time sheets dated 01/25/22 revealed 19.45 staff hours were provided in the SCU on second shift, leaving the shift short of 2.15 staff hours. Review of the facility's resident census dated 01/29/22 revealed there was a SCU census of 22 residents, which required 22 staff hours on first shift. Review of the individual time sheets dated 01/29/22 revealed 17.65 staff hours were provided in the SCU on first shift, leaving the shift short of 4.35 staff hours. Review of the facility's resident census dated 01/30/22 revealed there was a SCU census of 22 residents, which required 22 staff hours on second shift. Review of the individual time sheets dated 01/30/22 revealed 14.30 staff hours were provided in the SCU on second shift, leaving the shift short of 7.70 staff hours. Review of the facility's resident census dated 02/04/22 revealed there was a SCU census of 22 residents, which required 22 staff hours on second shift. Review of the individual time sheets dated 02/04/22 revealed 20.00 staff hours were provided in the SCU on second shift, leaving the	{D 465}		

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(D 465)		{D 465}		
	Continued From page 79 shift short of 2.00 staff hours. Review of the facility's resident census dated 02/04/22 revealed there was a SCU census of 22 residents, which required 17.60 staff hours on third shift. Review of the individual time sheets dated 02/04/22 revealed 8.45 staff hours were provided in the SCU on third shift, leaving the shift short of 9.15 staff hours. Review of the facility's resident census dated 02/05/22 revealed there was a SCU census of 22 residents, which required 22 staff hours on second shift. Review of the individual time sheets dated 02/05/22 revealed 19.40 staff hours were provided in the SCU on second shift, leaving the shift short of 2.60 staff hours. Review of the facility's resident census dated 02/05/22 revealed there was a SCU census of 22 residents, which required 17.60 staff hours on third shift. Review of the individual time sheets dated 02/05/22 revealed 16.00 staff hours were provided in the SCU on third shift, leaving the shift short of 1.60 staff hours. Interview with the Special Care Unit Coordinator (SCUC) on 02/18/22 at 5:22pm revealed: -She had been advocating for the safety for all residents in the SCU. -Residents wandered and went into other resident's rooms, then it was difficult to find the resident. -The facility was short staffed at times, and it was			

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{D 465}	Continued From page 80 hard to keep an eye on a resident if you could not find them. Interview with a medication aide (MA) in the SCU on 02/18/22 at 12:10pm revealed: -The facility used to be short staffed frequently, but it not as often lately. -There had been times when it was just a MA and a personal care aide (PCA) on duty for the entire shift. -Most days, there was one MA and two PCAs on the first shift. -Some days it, was just the SCUC and PCAs. Interview with a PCA on 02/18/22 at 11:28am revealed: -The facility was short staffed at times. -On an average, there were two PCAs and one MA on duty on the first and second shifts. -The MA administered medications and sometimes was not able to help PCAs. -The PCAs usually had 10 to 12 residents a piece to care for. -The SCUC helped if she was not working as the MA.	{D 465}	
{D 611}	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at	{D 611}	1. Staff member with the wrong mask and inappropriate Use was immediately corrected and provided up to date Education on mask type and standard use. 2. All staff have been educated, completed February 25, 2022 on the appropriate mask use and the necessary type Of mask needed per current guidelines. 3. Correct mask use is posted at the time clock. An Example of the current mask in use is posted at the time Clock. Service Ambassador at the front door is aware of the Correct mask needed and has available mask to Hand out to visitors and employees to assure Compliance. 03/21/22

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{D 611}	Continued From page 81 https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection;(C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors	{D 611}	4. Walking rounds are conducted by all Leadership staff To ensure mask use, appropriate use and the correct type Of mask. Any findings outside the current guideline will be Immediately addressed with the employee/visitor and Followed up on by the ED/DRC for employees who will Be addressed per the Employee Disciplinary Process.

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{D 611}		{D 611}		

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regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working;
(6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak;
(7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and
(8) a process for updating policies and procedures to reflect guidelines and recommendations by the
CDC, local health department, and North Carolina Department of Health and Human Services
(NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina.

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

Based on observations, record reviews and interviews, the facility failed to report suspected or confirmed cases of COVID-19 to the local health department (LHD) immediately upon finding out the residents had been exposed with confirmed cases of positive COVID-19 testing and failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to Special Care Unit (SCU) residents

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{D 611}	Continued From page 83 during the global coronavirus (COVID-19) pandemic as related to staff wearing appropriate Personal Protective Equipment (PPE) (face masks/source control) and ensured their nose was covered. The findings are: Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) in Nursing Homes and Long-Term Care Facilities and Your Guide to Masks updated 01/21/22 revealed: -Source control measures were to be implemented for Healthcare Personnel (HCP). -Source control referred to the use of well-fitting facemasks to cover a person's mouth and nose to prevent the spread of respiratory secretions when the person was breathing, talking, sneezing, or coughing and wearing a mask over your nose and mouth was required. -Cloth masks are not appropriate PPE for use by healthcare personnel. -Fully vaccinated Health Care Provider (HCP) should wear source control when they are in areas of the healthcare facility where they could encounter patients. Review of the NCDHHS guidelines for prevention and spread of COVID-19 in LTC facilities updated 11/19/21 revealed facilities should adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure. Review of the facility's Coronavirus (Covid-19) Clinical/Infection Control Policy and Procedures dated updated on 10/04/21 revealed: -Homemade masks were not considered PPE and should not be used as PPE for healthcare	{D 611}		

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{D 611}	Continued From page 84 workers. -While surgical masks were available, cloth face masks were not to be worn in place of or instead of a surgical mask while in the community. -All team members may wear a surgical mask if county transmission rate is "low" or "moderate", if residents COVID-19 vaccination rate was greater than 70%, and if there were no active COVID-19 cases in the community over the last 14 days. a. Observation on 02/16/22 from 12:10pm to 2:30pm revealed: -A personal care aide (PCA) in the Special Care Unit (SCU) had on a cloth face mask. -The PCA was wearing the cloth face mask below her nose and only her mouth was covered by the cloth mask. -The PCA was observed to assist residents with incontinent care, dressing, redirecting with physical hand touch. b. Observation on 02/17/22 at 9:00am of the same PCA revealed: -The same PCA had on a brown cloth face mask with white writing. -The PCA was wearing the cloth face mask looped over each ear. -The PCA's nose was visible and only her mouth was covered. -The PCA was observed interacting with residents. Interview with the Resident Service Director (RSD) on 02/17/22 at 10:01am revealed: - She was not aware staff in the SCU were wearing cloth face masks. -Staff were told by the corporate nurse yesterday (02/16/22), that cloth face masks were not allowed. -The corporate nurse told all staff to put on	{D 611}		

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{D 611}	Continued From page 85 surgical face masks. -She tried to visit the SCU daily; when visiting the SCU she did not always see staff because they were busy helping residents with personal care. -She would remind the staff in the SCU they were to wear surgical face masks only when providing direct care to the residents. Interview with the Special Care Unit Coordinator (SCUC) on 02/17/22 at 11:48am revealed: -She had not paid much attention to the PCAs this morning because the SCU was short staffed. -She always wore KN95 face masks. -The PCAs should be wearing the appropriate PPE. Interview with the nurse at the local health department (LHD) on 02/17/22 at 1:35pm revealed; -At no time had she advised the facility that cloth face masks were acceptable as PPE for HCP. -The facility should be following CDC and DHHS PPE protocols for long-term care facilities. Interview with the facility's corporate nurse on 02/17/22 at 3:10pm revealed: -She was not aware staff were wearing cloth face masks. -Staff had not been told it was okay to wear cloth face masks. -The facility had many surgical masks, which was required for staff to wear. -Some staff wanted to wear cloth face masks under the surgical face masks, which was allowed, but no staff was given permission to wear cloth face masks. Interview with the PCA (wearing a cloth mask) on 02/18/22 at 11:28am revealed: -When the COVID-19 outbreak was active in the	{D 611}		

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{D 611}		{D 611}		

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SCU she was told to wear a KN95 face mask. - After about a week ago she was told (unable to recall who told her) she could wear a cloth face mask or a surgical face mask.
-This morning her intention was to wear the cloth face mask into the facility then change to the surgical face mask.
-She started helping residents and forgot to change to the surgical face mask.
-She was aware that when she entered the facility on the first floor (where she screened herself) there were surgical face masks available.
-Her plan was to obtain a surgical face mask from the office on the second floor (SCU).
-When she wore face masks, eventually they fell below her nose.
-She was not sure why the face mask did not stay above her nose.
-She did not want to touch the face mask, so she did not pull the face mask up.
-No one had ever told she that the face mask needed to cover her nose and mouth.

The Executive Director/Administrator was not available for an interview on 02/21/22.

2. Review of the current CDC guideline for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities dated 03/29/21 revealed the LHD should be notified immediately of a suspected or confirmed case of COVID-19.

According to North Carolina Department of Health and Human Services (NCDHHS) a COVID-19 outbreak was defined as two or more positive cases identified through positive molecular (PCR) or positive antigen test result. This was measured for 28 days after the latest date of onset in a symptomatic person or the first date of specimen

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	HAL041052	A. BUILDING: _____ B. WING _____	R 02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGVIEW AT IRVING PARK	3200 N ELM STREET GREENSBORO, NC 27408

(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 611}	Continued From page 87 collection from the most recent asymptomatic person, whichever was later. If another case was detected in a facility after an outbreak was declared over, the outbreak was reopened. It was counted as a case in congregate living settings, and if second case was detected withing 28 days in the same facility, it was considered a second, new outbreak in that facility. Review of the NCDHHS website for COVID-19 Ongoing Outbreaks in Congregate Living Settings on the morning of 02/15/22 revealed an update occurred on 02/08/22, and the facility was not listed on the dashboard as having confirmed positive COVID-19 cases. Review of the NCDHHS website for COVID-19 Ongoing Outbreaks in Congregate Living Settings on morning of 02/16/22 revealed an update occurred on 02/15/22, and the facility was not listed on the dashboard as having confirmed positive COVID-19 cases. Interview with the Resident Services Director (RSD) upon entrance to the facility on 02/16/22 at 8:45am revealed: -The facility had confirmed positive COVID-19 cases as recent as 01/27/22 and more confirmed COVID-19 positive cases on 02/03/22. -On 01/21/22, a resident in the Special Care Unit (SCU) had a fall and went to the hospital. -The hospital tested the resident for COVID-19 and the test results came back as positive on 01/23/22. -On 01/24/22, she had all residents in the SCU tested, and four additional residents came back positive for COVID-19, making a total of 5 positive COVID-19 cases in the SCU. -On 02/01/22, she had all residents in the Assisted Living (AL) and SCU tested for	{D 611}		

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{D 611}	Continued From page 88 COVID-19. -On 02/03/22, two more residents in the SCU tested positive for COVID-19, making a total of 7 positive residents with COVID-19 in the SCU. -She did not do any more testing of residents after 02/01/22, because she was not aware that she was required to test the non-positive residents again. -She did not contact the nurse at the LHD because she did not know she was required to do so. -She contacted the local county Department of Social Services (DSS) Adult Home Specialist (AHS) by email to inform of the positive COVID-19 cases in January 2022. -She thought contacting the AHS was all that she was required to do. -She thought the AHS was going to contact the LHD. -She had not contacted the DSS AHS or the LHD regarding confirmed positive COVID-19 cases on 02/03/22. Interview with the local county AHS on 02/16/22 at 12:42pm revealed: -The facility informed her on 01/27/22 or 01/28/22 of positive COVID-19 cases in the facility. -She talked with the Executive Director (ED) on one of the above dates and informed him to do a "line list" and report to the local health department. -If there were positive cases on 02/01/22 the facility did not make her aware of them. -The ED did not tell her if the positive COVID-19 cases were staff or residents, but she thought they were residents. -The ED did not tell her if the positive cases were in the SCU or Assisted Living (AL). -The facility had positive COVID-19 cases in the past and the ED was aware they were required to	{D 611}		

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{D 611}		{D 611}		
	Continued From page 89 contact the local county health department to obtain guidance during the COVID-19 outbreak. Interview with the nurse at the local LHD on 02/16/22 at 2:16pm revealed: -She was not aware the facility had an outbreak in January 2022 and February 2022. -The facility had positive COVID-19 cases previously in August and December 2021, and the ED called her to inform of the positive cases. -The facility, at least the ED, was aware the local health department needed to be notified of positive COVID-19 cases. -The facility needed to continue testing the non-positive residents every 3 to 7 days until there were no more positive cases for 14 days. -The facility needed to call her directly and report the positive cases and she would provide guidance. Interview with the ED on 02/16/22 at 2:30pm revealed: -The system that the facility had set-up was that he contacted the local DSS regarding the positive COVID-19 cases and the RSD was responsible for contacting the nurse at the LHD. -The RSD told him that she had contacted the LHD, he did not check to ensure it was done. -The facility did not do further testing after the second set of positive COVID-19 cases were confirmed on 02/03/22. The facility failed to follow the CDC and NCDHHS guidelines for notification of the local LHD of a suspected or confirmed COVID-19 diagnoses and to ensure HCP used appropriate PPE and their nose was covered which resulted in the facility not receiving time sensitive guidance from the LHD on measures for preventing and decreasing transmission and infection related to a			

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{D 611}	Continued From page 90 COVID-19 outbreak. This failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/18/22 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 7, 2022.	{D 611}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 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, infection prevention and control program, and medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#4 and #3) residing in the Special Care Unit (SCU) related to a resident who exhibited inappropriate sexual	{D912}		

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{D912}	Continued From page 91 behaviors and aggressive behaviors towards other residents in the SCU (#4), and a resident who had multiple falls (#3). [Refer to Tag D - 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 residents sampled (Residents #7 and #8) related to a narcotic topical pain medication (#7) and a long acting insulin (#8). [Refer to Tag D - 0358, 10A NCAC 13F .1004(a) Medication Administration (Type Unabated B Violation).] 3. Based on observations, record reviews and interviews, the facility failed to report suspected or confirmed cases of COVID-19 to the local health department (LHD) immediately upon finding out the residents had been exposed with confirmed cases of positive COVID-19 testing and failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to Special Care Unit (SCU) residents during the global coronavirus (COVID-19) pandemic as related to staff wearing appropriate Personal Protective Equipment (PPE) (face masks/source control) and ensured their nose was covered. [Refer to Tag D - 0611, 10A NCAC 13F .1801(b) Infection Prevention and Control Program (Type B Violation)].	{D912}		