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	HAL076027	A. BUILDING: _____ B. WING _____	02/07/2022

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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 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation from February 1, 2022 to February 4, 2022 with an exit via telephone on February 7, 2022.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure two exit doors (the smoking area and the staff breakroom exit doors) accessible by residents known to be disoriented and/or wandered, were equipped with a sounding device that was activated when the door was opened. The findings are: Observation of the employee breakroom on	D 067	RCC/Administrator will keep list of known wanderers and it will be available to staff. Administrator/SIC will ensure each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. Maintenance Director inspected all door alarms on 1/29/2022 to assure they were in working order. All alarms were working when inspected. Administrator retrained all staff on door alarms 1/29/2022 and keeping them activated. QI Director/Maintenance Director retrained all staff on protocols for checking door alarms. Administrator/Designee will test door alarms per the manufacturers recommendations at least monthly to assure they are working properly. If found that alarms are not working, vendor will be contacted immediately to repair. Administrator/RCC checked weekly x 5 weeks, then at least monthly thereafter, to see if door alarms are being answered as per company protocol.	2/8/2022 3/24/2022 2/8/2022 3/24/2022 3/24/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 3-28-22

Reviewed and Acknowledged. PD 03/29/22

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02/01/22 at 9:41am revealed:
-There was an opened door on the B Hall that entered into the staff breakroom.
-There was a door on the inside of the staff breakroom that exited the facility into a parking lot behind the facility.
-There was a vending machine inside the breakroom that was visible from the open hallway door.

Interview with a dietary aide on 02/01/22 at 9:41am revealed:
-The alarm to the door that she used to exit the facility from the employee breakroom had never gone off before today, 02/01/22.
-She was very surprised the alarm went off this morning when when she exited the facility from the breakroom door.
-She was used to coming and going outside of the facility through the breakroom door without having to notify anyone or to worry about the alarm.
-She had not been told to let anyone know she had set off the door alarm and she did not know how to disarm and reset the alarm.

Observation of the alarm panels on 02/01/22 at 8:39am and 9:33am revealed:
-There was an alarm panel located on the A Hall/B Hall area of the facility.
-There was an alarm panel located on the C Hall/D Hall area of the facility.
-On each panel, there was a piece of paper taped to the inside of the alarm cover which identified the door numbers and the door locations for the alarm system.
-There were doors numbered from #1 through #13.
-The front door was identified as #1.
-The back door (smoking area) and breakroom

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door were identified as #2.
-The D Hall exit door was identified as #9.
-The "nurse assistant prep room" was identified as #11.

Observation of the C Hall/D Hall alarm panel on 02/01/22 at 8:39am revealed:
-There was an audible high pitched alarm sounding from the alarm panel.
-The door identified was #9.

Interview with a resident on 02/02/22 at 6:30am revealed:
-She was usually up and in the front lobby by 5:00am every morning.
-She liked to get some fresh air early in the morning and the exit door to the smoking area (identified as exit door #2 on the panel) was always unlocked and not alarmed at 5:00am.
-She had resided at the facility for four months and that morning (02/02/22) was the first time the exit door to the smoking area (identified as exit door #2 on the panel) was alarmed.

Interview with a medication aide (MA) on 02/02/22 at 7:42am revealed:
-Whoever turned a door alarm off at the panel was supposed to go check the door to see why the alarm was going off.
-The door where residents went outside to smoke was not alarmed (identified as exit door #2 on the panel).
-There was a resident who smoked throughout the night.
-The break room door (also identified as exit door #2 on the panel) was not alarmed because staff used that door to frequently enter and exit the facility.
-The break room exit door and the exit door to the smoking area had the same code number (#2) on

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the control panel.
-She heard the break room door alarm (identified as exit door #2 on the panel) going off on 02/01/22, but those doors usually were not alarmed.

Observation on 02/03/22 from 1:32pm to 1:44pm revealed:
-At 1:32pm, the exit door alarm at the C Hall/D Hall was activated when the surveyor exited the facility; an alarm could be heard at the alarm panel.
-At 1:44pm, the Administrator was called on the telephone and requested to come to the C Hall.
-The Administrator opened the exit door (identified as exit door #11 on the panel) at the medication room on the C Hall.
-An audible alarm could be heard at the alarm panel.
-The surveyor requested the alarm not be disengaged and observed to see what door number was displayed.
-The alarm panel displayed exit door #1; this number was the identifier number for the front door not the door the surveyor exited or reentered.
-The alarm panel did not display exit door #11.
-The Administrator went back to exit door #11, reopened the door, and the panel displayed exit door #11 as opened.

Interview with the Administrator on 02/03/22 at 1:45pm revealed:
-She did not know why exit door #11 was not displayed on the panel when she opened the exit door to allow the surveyor back into the facility.
-She had been sitting in her office and had not heard a door alarm go off when the surveyor went out the door.
-She could not explain why exit door #11 was not

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displayed on the alarm panel when the surveyor returned inside the building.
-She would need to get the system checked.

Interview with the Resident Care Coordinator (RCC) on 02/01/22 at 9:23am revealed:
-There were no residents with dementia or who were confused so the facility had no need to alarm the exit doors.
-The facility alarmed the exit doors to help keep residents safe and let the facility staff know when a resident went outside.
-The staff breakroom had an exit door that was alarmed.
-Before staff went outside from the breakroom door, they were supposed to let someone know they were leaving so the door could be disarmed after they exited
-The exit door that led to the outside smoking area was also alarmed.

Interview with the Administrator on 02/01/22 at 4:56pm revealed the exit doors did not need to be alarmed because none of the residents were considered to wander or were exit seeking.

Review of current FL-2s, care plans, and care notes for 3 of 3 residents sampled (#1, #2, and #4) revealed the residents were intermittently confused and two residents had wandering behaviors (#1, #4).

The facility failed to have sounding devices on two exit doors to prevent three residents, who had a diagnosis of dementia, were confused, and/or had a history of wandering behaviors, from exiting the facility without staff knowledge. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

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D 067	Continued From page 5 The facility provided a plan of protection (POP) in accordance with G.S. 131D-34 on 02/01/22 for this violation. A POP addendum was added on 02/03/22 and 02/04/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 24, 2022.	D 067		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled residents received personal care assistance from 3rd shift staff including a resident (#11) who had skin irritation on his scrotum secondary to being in a soiled incontinence brief and required total assistance with toileting and a resident who did not receive assistance when she was vomiting and had diarrhea and was not able to get out of her bed without assistance (#12). The findings are:	D 269		

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D 269	Continued From page 6 1. Review of Resident #11's current FL-2 dated 08/26/21 revealed: -Diagnoses included acute cerebrovascular disease (CVA), fall, diabetes, and femoral neck fracture. -Resident #11 was semi-ambulatory with a wheelchair. -Resident #11 was incontinent of bowel and bladder. -Resident #11 required assistance with bathing and dressing. Review of Resident #11's care plan dated 08/26/21 revealed: -Resident #11 required extensive assistance with toileting, bathing, and dressing. -Resident #11 required limited assistance with transferring, ambulation, and personal hygiene/grooming. Interview with Resident #11 on 02/03/22 at 8:12am and 11:52am revealed: -He had left side paralysis. -He used his call bell to request assistance to go to the bathroom. -He used to get up at 6:00am, but now the PCAs said he had to get up earlier. -He was able to pull himself up to a sitting position in his bed, but it took him a long time because he could only use one arm. -He would wait to push his call bell once he was sitting on the side of the bed. -A [named] personal care aide (PCA) would come into his room, turn the call bell off, tell him she would be "right back" and did not come back for over an hour. -He could not sit on the edge of the bed for very long, so he would lay back down. -He would then have to get himself back to the edge of the bed before pushing the call bell	D 269	RCC/Designee identified/documented the needs of residents on the care plan and ensure staff are trained on each individual residents needs and location of care plans. Administrator/RCC retrained direct care staff on expectations of answering call lights in a timely manner. Direct Care staff that are not otherwise assisting residents, will proceed to the room with activated call light as soon as possible. SIC/RCC will supervise Aides to assure residents care needs are being met, rounds are completed and call lights are being answered in a timely manner. RCC/Administrator will conduct walk throughs of the facility x 5 days per week to assure that residents care needs are being met including that call bells are being responded to. Administrator/Designee will randomly speak with residents weekly to ensure they are receiving care and services which are adequate, appropriate and in compliance with rules and regulations.	3/21/2022 2/8/2022 3/21/2022 3/21/2022 3/21/2022 3/21/2022

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again.
-He pushed the call bell a second time, and the PCA got mad; he could tell by the way she acted towards him.
-He had a skin breakdown and it hurt "really bad" when he was soiled.
-Being in a soiled brief caused his bottom to burn.
-He knew when he was soiled because "it burned so bad."
-About 1-2 weeks ago he went all night without his brief being changed.
-The [named] PCA was the "main one" who left him in a soiled brief.
-When the PCAs pulled him up by his pants it hurt; "it cuts me" but the soiled brief was what made him burn really bad.
-He had voiced his concerns to the medication aides (MA).

Observation of a PCA assisting Resident #11 on 02/03/22 at 10:51am revealed:
-The PCA grabbed the back of Resident #11's pants and used the pants to pull him up and slide the resident into his wheelchair.
-The resident grimaced as the staff used his pants to pick him up and slide him into his wheelchair.
-The resident was taken into the bathroom to change his incontinence brief.
-The incontinence brief was stuck to the resident's scrotum.
-There was blood on the incontinence brief.
-Resident #11's scrotum area was red.

Interview with a PCA on 02/01/22 at 8:49am revealed:
-Resident #11 was usually soiled when she came in on the 1st shift.
-The 1st shift MAs knew Resident #11 had complained of the 3rd shift PCA not getting him

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D 269	Continued From page 8 up. Interview with another PCA on 02/01/22 at 9:37am revealed Resident #11 complained to her of not receiving assistance on the 3rd shift. Interview with a MA on 02/01/22 at 10:15am revealed: -Resident #11 had complained to her he pulled his call bell around 3:30am and the [named] PCA would cut the alarm off, told the resident she would be back, and then would not go back. -Resident #11 had skin breakdown in the past (she did not recall the date) from being left soiled in his incontinence brief. Telephone interview with a third shift PCA on 02/01/22 at 2:13pm revealed: -She would get Resident #11 up at 5:00am because it took her one hour to get him changed and dressed. -Resident #11 needed two staff to assist him out of bed but she had to care for him alone. -Resident #11 was always soiled when she got him up. Interview with another MA on 02/02/22 at 11:15am revealed: -Resident #11 had complained about staff not assisting him in a timely manner. -The RCC had discussed the expectations with Resident #11 in several staff meetings. -Resident #11 was to be kept dry, and not be pulled up by his pants. -When Resident #11 was soiled, and was pulled up by his pants, it hurt even worse. -The RCC reiterated when Resident #11 rung his bell, to not make him wait, get him up, and to not pull him by his pants. -She thought Resident #11's bottom was not	D 269		

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healing because the resident was being left in a soiled brief.

Telephone interview with third MA on 02/04/22 at 5:00am revealed:
-Resident #11 was dependent on staff for toileting.
-Resident #11 only pushed his call bell when he needed to be changed.
-Resident #11 complained a [named] PCA would go into his room after he pushed the call bell, cut the bell off, tell him she would be back, and not come back.
-Resident #11 would use the call bell to ask for assistance a second time, and when the MA went into the room, his needs still had not been addressed.
-Resident #11 had not complained to her that his bottom was hurting.
-A PCA reported to her a couple of weeks ago that Resident #11 had blood in his incontinence brief.
-She did not recall which PCA or what follow-up she provided.
-Resident #11's needs had been discussed at meetings and staff had been instructed on answering the call bell.

Telephone interview with the [named] PCA on 02/04/22 at 1:37pm revealed:
-She worked as a PCA on 3rd shift.
-Resident #11 had to be pulled up by his pants, slid into his wheelchair, and taken into the bathroom to change his incontinence brief.
-Resident #11 was supposed to be changed every 2-3 hours.
-Resident #11 did not want to be woken up during the night every 2-3 hours and she was told to wait until he rang his call bell.
-She had gone into Resident #11's room before,

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cut the call bell off, and told him she would be "right back" because she was with another resident.
-She no longer told residents she would be "right back" because she realized she did not know how long it might take so she would tell the resident she would be back but did not use the word "right" back.
-She had cut Resident #11's call bell off at the system panel because there was a piece missing out of the call bell in the room that allowed it to be cut off in the room.
-She would never "just cut the call bell off" without telling the resident she would be in the room as soon as she could.
-It was important to her to let the residents know what was going on and that she would be back instead of not answering the call bell for a longer period.
-She had forgotten to go back to address Resident #11's needs after cutting the call bell off because she got busy with other call bells.

Telephone interview with Resident #11's primary care provider (PCP) on 02/04/22 at 2:15pm revealed:
-She was not aware Resident #11 had complained of irritation with his bottom.
-If Resident #11's incontinence brief was staying soiled, his skin would be irritated.
-Resident #11 knew when he needed his incontinence brief changed and she expected staff to change his incontinence brief when he asked to be changed.
-If Resident #11 continued to stay in a soiled incontinence brief, he would have further breakdown of his skin.

Interview with the RCC on 02/04/22 at 3:04pm revealed:

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-A MA told her today, 02/04/22, that Resident #11's "scrotum area was burning and itching."
-She knew Resident #11 had complained of pain and irritation before, but thought it was related to the staff pulling him up by his pants.
-She was aware staff had seen blood in the toilet after Resident #11 had been toileted.
-She did not know the blood was coming from Resident #11's scrotum; she thought he may have had a hemorrhoid.
-She was aware Resident #11 had complained of being soiled throughout the night.
-Resident #11 reported he pushed his call bell, the call bell was cut off, and the staff did not return to assist him.
-She had a staff meeting to address staff answering resident call bells.
-Staff were told to take care of needs before leaving the room when a call bell had been pushed.
-Resident #11 was on 2-hour "wet checks."

Interview with the Administrator on 02/04/22 at 11:56am revealed:
-Resident #11 required assistance with bathing, dressing, toileting, and transferring out of his hospital bed.
-When Resident #11 was admitted to the facility he was able to assist with his transfers but was not able to at this time.
-She was not aware Resident #11 had ongoing complaints of needing assistance and the staff were not answering the call bell.
-She would talk to the RCC and see what the RCC had done related to the issue.
-She was concerned Resident #11 was not getting the assistance that he needed.
-It was not acceptable for Resident #11's call bell to not be answered.

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D 269	Continued From page 12 Refer to the confidential interview with three residents. Refer to the confidential interview with staff. Refer to the interview with two PCAs on 02/01/22 between 8:49am-9:37am. Refer to the interview with a MA on 02/01/22 at 10:15am. Refer to the telephone interview with the [named] PCA on 02/01/22 at 2:13pm. Refer to the telephone interview with three MAs on 02/02/22 between 10:41am-11:36am. Refer to the interview with a another PCA on 02/04/22 at 2:35pm. Refer to the interview with the RCC on 02/04/22 at 10:36am. Refer to the interview with the Administrator on 02/04/22 at 11:56am. 2. Review of Resident #12's current FL-2 dated 02/02/22 revealed: -Diagnoses included atrial-fibrillation, essential hypertension, osteoarthritis, and age-related osteoporosis with a current fracture. -Personal care assistance was needed with bathing and dressing. -She was semi-ambulatory and incontinent of bowel and bladder. Review of Resident #12's care plan dated 12/08/21 revealed: -Resident #12 required limited assistance with toileting, bathing, transferring, and dressing.	D 269		

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-Resident #12 ambulated using a rolling walker and her wheelchair at times due to weakness.

Review of Resident #12's medication aide (MA) care notes revealed:
-On 12/24/21, Resident #12 had been vomiting and having diarrhea all morning.
-Resident #12 was sent to the hospital around 1:45pm.
-There were no other care notes for December 2021.

Review of Resident #12's hospital discharge summary revealed:
-The summary was dated 12/24/21 at 4:41pm.
-Resident #12 was seen for nausea, vomiting, and diarrhea.

Interview with Resident #12 on 02/03/22 at 9:03am revealed:
-On 12/23/21, she went to bed around 8:00pm, started throwing up, and had diarrhea sometime during the night and no medication was offered to her for nausea, vomiting, or diarrhea until the next morning.
-She thought she was going to choke on her vomit.
-Every time the personal care aide (PCA) came into the room that night, the PCA would stand at the foot of her bed, wringing her hands, and would say, "I do not know what to do" and would leave the room.
-She thought the PCA was getting assistance to help her, but no one ever came.
-She pushed her call bell again because it had been over an hour since the PCA left the room.
-She had vomit and diarrhea all over her.
-She used her call bell again since no one had come to help her after the PCA left, and again the same PCA came into the room, and stood

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nervously at the end of the bed and said she did not know how to help her and left the room.
-"It was just a mess all over my bed."
-The PCA came to her room around 5:00am to get her out of the bed.
-The PCA did not change her sheets or clothes during the night when she was sick.
-She was administered Pepto-Bismol (used to treat nausea and diarrhea) by a MA.
-She did not know the name of the MA or the time, but it was light outside.
-She threw the Pepto-Bismol up before the MA even left the room.
-On another occasion, in the last 1-2 weeks, she rang the call bell for assistance and the same PCA answered the call bell.
-The PCA told her there were residents who needed more assistance than her and left the room.
-She waited and waited to go to the bathroom and the PCA never came back so she got up and went on her own.
-"I almost fell, and it scared me."
-The PCA never came back in, but the next day when she saw the PCA, she told her it better not happen again.
-She did not report the incident to the Resident Care Coordinator (RCC) or the Administrator because she had been complaining a lot and "they were tired of her complaining."

Interview with the RCC on 02/04/22 at 10:49am revealed:
-Resident #12 was new to the facility (12/08/21) and was not as mobile secondary to a fractured vertebra.
-Resident #12 was very timid with walking because the resident was afraid of falling.
-Staff assisted Resident #12 with getting in/out of her bed, walked behind her for reassurance, and

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assisted her off the toilet.
-Resident #12 needed "a whole lot" of stand-by assistance.
-Resident #12 still required stand-by assistance with going to the bathroom for peace of mind and safety.
-She was made aware of Resident #12 being sick the next day after the resident had been sent to the hospital.
-She would have expected the MA to have documented in Resident #12's record about the incident.
-She was not aware Resident #12 had used her call bell to get assistance when she was sick, and no one assisted her.
-Staff should have stayed with Resident #12 when she was sick.
-The PCA could have called the MA from the resident's room to alert the MA to the resident being sick.
-Staff should have never left Resident #12 by herself because the resident could have tried to get up by herself and fall.

Interview with the Administrator on 02/04/22 at 12:03pm revealed:
-She or the RCC should be notified of changes in a resident's condition.
-She did not recall being notified Resident #12 had been vomiting and had diarrhea during the night on 12/23/21.
-She was made aware of Resident #12 being sick the next morning (12/24/21).
-She did not think Resident #12 laid in the bed for hours without assistance.
-Resident #12 would have told her family member, and the family member would have told her about the incident.
-She would have expected the PCA to take care of the resident immediately and to tell the MA

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about the situation.
-She would have expected the PCA to get Resident #12 out of bed if she was vomiting so the resident did not aspirate.

Telephone interview with the [named] PCA on 02/02/22 at 1:17pm revealed:
-She was the 3rd shift PCA the night Resident #12 was sick (12/23/21).
-Resident #12 vomited about 10 times that night; the vomiting started after 11:00pm and did not stop until between 5:00am-6:00am.
-At first Resident #12 was vomiting hot dogs, but then the vomit was clear.
-After Resident #12 vomited the 7th time, "I got really scared."
-She told the MA about Resident #12 being sick and the MA administered Pepto-Bismol but the resident vomited the medication back up.
-The MA then administered a red medication, and the resident vomited it back up too.
-The MA administered the medications between 2:00am-3:00am.
-She helped Resident #12 out of the bed and changed the bedsheet.
-Resident #12 did not have diarrhea and did not soil her incontinence brief.
-Resident #12 sat in her wheelchair and vomited in a trash can.

Telephone interview with a MA on 02/04/22 at 1:51pm revealed:
-She was working the night Resident #12 was sick.
-She was told Resident #12 vomited several times that night.
-The PCA was able to handle the situation and did not ask for her assistance.
-If Resident #12 was laying on her bed sick she would have expected the PCA to tell her.

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-She did not know Resident #12 had diarrhea; the PCA only said the resident had vomited.
-She called Resident #12's family member about the resident being sick.
-She knew the PCA kept going to Resident #12's room to check on her.

Interview with Resident #12's family member on 02/04/22 at 2:21pm revealed:
-He did not receive a telephone call about Resident #12 being sick.
-When he went to visit Resident #12 on 12/24/21 at about 10:00am the resident was vomiting and had diarrhea.
-There was a PCA was with her when he arrived and while he was in the room.
-He agreed Resident #12 needed to be sent to the hospital because he was concerned, she was getting dehydrated.

Interview with a PCA on 02/04/22 at 2:35pm revealed:
-She worked 1st shift on 12/24/21.
-The 3rd shift PCA told her Resident #12 had been vomiting all night.
-Resident #12 had vomit on her bedsheet.
-Resident #12's incontinence brief was wet.
-She changed Resident #12's clothes and took the resident to the bathroom.
-Resident #12 told her the 3rd shift PCA came into her room but did not assist her.

Telephone interview with another MA on 02/04/22 at 4:53pm revealed:
-She worked 1st shift the morning after Resident #12 had been sick during the night.
-The 3rd shift MA reported to her Resident #12 had been sick and the family member refused to allow staff to send the resident to the hospital.
-When Resident #12's family member came in he

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told her he did not know anything about Resident #12 being sick during the night.
-She could not recall if she administered Resident #12 anything for nausea.
-She recalled giving Resident #12 ginger ale and at first it was helping, but then the resident started throwing up again, and that was when she talked to the family member, who was in the room, and sent the resident to the hospital.

Interview with Resident #12 on 02/04/22 at 5:11pm revealed:
-She was lying flat on her back when she became sick on the night of 12/23/21.
-She had tried to turn herself on her side but was not able to.
-She was not administered any medication until her family member was in the room, later that next morning (12/24/21).
-She did not remember who changed her bed linens that day, but it was light outside.

Refer to the confidential interview with three residents.

Refer to the confidential interview with staff.

Refer to the interview with two PCAs on 02/01/22 between 8:49am-9:37am.

Refer to the interview with a MA on 02/01/22 at 10:15am.

Refer to the telephone interview with the [named] PCA on 02/01/22 at 2:13pm.

Refer to the telephone interview with three MAs on 02/02/22 between 10:41am-11:36am.

Refer to the interview with a another PCA on

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D 269	Continued From page 19 02/04/22 at 2:35pm. Refer to the interview with the RCC on 02/04/22 at 10:36am. Refer to the interview with the Administrator on 02/04/22 at 11:56am. _____ Confidential interview with three residents revealed: -One resident stated when her roommate used the call bell on third shift it would take up to 30 minutes for someone to come. -She timed the call bell one night and when it had been 40 minutes she got out of bed and helped her roommate and then went to find staff. -Staff stayed together somewhere on third shift; she had to look for them but could not find them. -She complained about third shift staff not answering call bells to the Resident Care Coordinator (RCC), but she did not feel like anything was done. -She just started helping her roommate at night so her roommate would not have to wait for help. -Another resident stated she had heard a resident calling for help on third shift one night; she could not remember when or who. -The resident had fallen out of her wheelchair and had used her call bell for help. -The resident's cries for help woke her up; she got up and searched for staff to help the resident. -She found staff in the medication room on the opposite hallway. -A third resident stated when she pushed her call bell to get assistance with her brief on the 3rd shift, it took more than 30 minutes before a personal care aide (PCA) responded to the call bell. -A [named] PCA never checked on her when the PCA aide worked the 3rd shift.	D 269		

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-She had seen a [named] PCA asleep with her own two eyes.
-She had seen the PCA asleep as early as 11:30pm.
-The medication aide (MA) covered for the PCA.
-The MA had tried to wake up the PCA before, but the PCA was a "hard sleeper."

Confidential interview with staff revealed residents had complained to her call bells were going off on 3rd shift, and a [named] PCA was asleep.

Interview with two PCAs on 02/01/22 between 8:49am-9:37am revealed:
-When a [named] PCA worked 3rd shift, the residents were usually soiled when she came in on 1st shift.
-The [named] PCA had been reported to the RCC and she thought the PCA was "written up" about a month ago.
-A resident told her the [named] PCA slept on the 3rd shift.
-She had come in early before, could not find the named PCA, would start rounds without the PCA, and the PCA just "popped out of nowhere."
-Residents assigned to a [named] PCA were always soiled when the PCA worked the 3rd shift.
-When she spoke to the PCA about the residents' soiled incontinence briefs, the PCA would say, "Oh, I forgot."

Interview with a MA on 02/01/22 at 10:15am revealed:
-PCAs were supposed to round on the residents at least every 2 hours.
-Sometimes rounds did not get done by the PCAs.
-A [named] PCA would say she got everybody up and report the residents were dry and left the

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facility.
-When the 1st shift PCA made rounds, the PCAs would find the residents were soiled, and sometimes the residents' incontinence briefs were even soiled with stool.
-There was another named PCA who would sometimes not change the residents' incontinence briefs, but when "called out" on it, she would go change the residents.
-Third shift only had one PCA working and one MA.
-She had told the PCAs on her shift to not allow the [named] PCA to leave the facility if they found residents whose incontinence briefs were soiled.
-Supposedly the Administrator and RCC had told the [named] PCA she could not leave the facility until the residents were up and changed.
-She tried to talk to the Administrator about what she had heard about the named PCA and was told she could not report things she had "heard" because it could not be confirmed.
-A [named] resident had told her he had pulled his call bell, and no one came to his room.
-He went looking for the MA and saw the PCA asleep in the front parlor.
-He then found the MA asleep in another parlor.
-Another resident told her the call bell had gone off one night for about 45 minutes and no one ever cut the alarm off, so she went looking for staff and the PCA was asleep on the couch.
-A call bell could be "pushed in" at the panel, and that would disable the call bell from alarming.
-A MA reported to her the [named] PCA had been seen pushing in a call bell light.
-Call bells were not supposed to be cut off at the panel.
-Call bells were only supposed to be cut off in the resident's room where the call bell was activated.

Telephone interview with the [named] PCA on

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D 269	Continued From page 22 02/01/22 at 2:13pm revealed: -She had worked for the facility off and on since 2014; she always worked third shift. -There was only one PCA and one MA on third shift. -She did two-hour "wet" checks on the residents at 11:00pm, 1:00am, 3:00am and 5:00am if her time permitted her. -"Wet checks" were checking to make sure incontinent residents were dry. -She used to document the "wet checks" but had not had a paper to document the "wet check"s on since 01/20/22. -On a good night when residents did not ring the call bells or need care, she could do the two hours check on all the residents in about an hour. -On a bad night when the residents were ringing the call bells and required a lot of care, it would take her three to four hours to do the two hour checks on all the residents. -It was difficult to respond to call bells and provide resident care for all of the residents with only one PCA because the MA had to do her own responsibilities. -She told the MA when she had to respond to call bells and to attend to residents, so the MA knew where she was. -Some of the residents required more care or took more time to attend to. -Some of the residents took up to one hour to provide care when they had used their call bells. -Some residents used their call bells up to 15 times on her shift and she responded to each one. -She was responsible for getting nine residents up every morning. -She had to get the nine residents up, clean them if they needed it, changed their briefs, got them dressed, and made their beds. -She did not sleep at night; she did not have time	D 269		

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to sleep at night because she had too much to do.
-She had to do 2-hour resident "wet" or toilet checks, laundry, she had to mop the dining room, set the tables in the dining room for breakfast, and respond to call bells and any door alarms.

Telephone interview with three MAs on 02/02/22 between 10:41am-11:36am revealed:
-A resident had complained to her when the resident rang her call bell, no one came in.
-The resident rang the call bell again, and the [named] PCA went into the room, cut the call bell off, said she would be back, but did not go back.
-The resident rang the call bell again, and she (the MA) answered the call bell, and the resident told her what happened.
-When a [named] PCA worked, there were multiple residents who would be "soaked through to the bed."
-She had seen a named PCA asleep in the front parlor.
-She woke the PCA up and told her she could not sleep.
-The PCA got up and went to the laundry.
-She told the RCC about the incident and was directed to make sure the PCA was not asleep, and the PCA could not prop her feet up.
-There were no call bells going off when the PCA was asleep.
-She did not recall when the incident occurred.
-The PCA told her she had a long day when she spoke to her about sleeping.

Interview with a another PCA on 02/04/22 at 2:35pm revealed:
-When a [named] PCA worked, the residents always complained the PCA did not change their incontinent briefs.
-Sometimes the residents were soiled, and she

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could tell the resident had not been gotten up.
-The Administrator and RCC were aware of the issues with the [named] PCA because after they talked to the [named] PCA the PCA accused her of "snitching on her."

Interview with the RCC on 02/04/22 at 10:36am revealed:
-She supervised the PCAs.
-She had residents who complained they had been "wet for this amount of time on this day."
-She had addressed the issue with the PCA the resident had [named].
-Sometimes the issue was the resident needed more assistance and the PCA did not know that.
-She thought sometimes it was a breakdown in communication.
-She depended on staff who "knew" the residents to tell other staff what the residents' needs were.
-When she first started working at the facility, she made a list of what residents needed to be toileted every 2 hours, but she had not updated the list in a while.
-There were no residents who needed to be toileted more than every 2 hours.
-She was aware PCAs had cut the call bell off and told the residents they would come back and then did not go back.
-She had several staff meetings to address this issue.

Interview with the Administrator on 02/04/22 at 11:56am revealed:
-The RCC was responsible for supervising the PCAs.
-If a resident had an issue with a PCA, the resident would talk to the RCC.
-The RCC usually handled the issues but could ask her for input if needed.
-Staff were not supposed to cut the call bell light

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D 269	Continued From page 25 off until they had addressed the need. -She expected staff to leave the call bell light on until the resident's needs were addressed because the staff might forget to go back. -The issue with call bells was addressed "a lot." -She expected residents to be checked on every 2 hours. -If a resident needed to be checked on more often, she expected the staff to use "common sense" and check on the resident more often. -She was not aware of any call bell issues, residents not being checked on every 2 hours, or call bells not being addressed. -The RCC always took care of resident concerns, but if there was an ongoing issue, the RCC should notify her. The facility failed to ensure residents' personal care needs were met which resulted in a resident, who required total assistance with incontinence care, developing a skin irritation that was very painful due to not being toileted in a timely manner (#11) and a resident (#12), who was vomiting and had diarrhea, was not assisted by staff on the third shift. 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 02/04/22 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 21, 2022.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

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D 270	Continued From page 26 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews, interviews, and observations, the facility failed to provide supervision to ensure exit door alarms were monitored when activated when there were residents known to be confused, who exhibited exit seeking behaviors and had wandering behaviors (#1, #2, #4) including two residents who eloped from the facility without staff's knowledge (#1, #2) and did not provide increased supervision to a resident (#2) with multiple falls. The findings are: Review of the facility's license effective for 01/01/22 revealed: -The facility was licensed for 67 residents. -The facility was not licensed for a special care unit. 1. Review of the Missing Resident Policy provided by the facility revealed: -A resident was considered missing when they were not in the facility and staff cannot verify the resident's whereabouts and when there was reason to be concerned for the [missing] resident's safety. -When a resident was discovered missing the staff would immediately notify the supervisor. -Staff were to perform a hasty search of the	D 270	Administrator immediately conducted training with all staff regarding supervision of residents in accordance with each resident's needs as identified in their care plan.1/29/2022 Facility shall respond immediately in the case of an accident or incident involving a resident to provide care according to the needs of the residents, (such as obtaining assistive devices, increased supervision, seeking advice from physician/OT/PT/ST, etc.) Admin/QI Director/Maintenance Director retrained all staff on door alarm safety protocols for checking door alarms. Administrator/Designee will conduct stand up meeting 5 days/week with staff to follow up on resident personal care concerns/issues, supervision and other medical/physical conditions. Administrator will monitor supervision provided to residents based on need identified in the care plan x 5 days per week	2/8/2022 3/06/2022 2/8/2022 3/06/2022 3/06/2022

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building and the areas outside the building.
-If the resident was not found staff immediately notify 911, the resident's family and the county Department of Social Services.
-The facility would cooperate fully with law enforcement and the authority in charge of search and rescue.

Review of the Identification and Supervision of Wandering Residents Policy provided by the facility revealed:
-The facility would not admit residents who were wanderers or at high risk for wandering.
-Should a resident begin to exhibit signs of wandering the resident would be reassessed for appropriate placement and immediate discharge notice would be issued.
-The facility would identify resident who walked or wheeled around unrestricted and were a threat to leave the facility unattended due to their confusion.
-Implementation of a list of wandering residents; the list made available to staff.
-When a resident was admitted the staff would be informed of the potential for the resident to wander and as necessary if the potential exist for a resident to wander.
-Supervise and implement routine checks, monitoring devices and/or techniques according to the need of each resident.
-Environment safeguards included checking door alarms regularly to assure they were working properly.
-Notify staff when alarms failed and request staff to assure extra precautions for residents who were at risk of wandering.
-Repair [the] alarm system as soon as practicable.

Observation on 02/01/22 between

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8:32am-8:34am revealed:
-At 8:32am, the exit door alarm at the end of the D Hall (#9) was activated.
-The door alarm panel was located at the junction of the C Hall/D Hall and could be heard clearly at the exit door.
-At 8:34am a personal care aide (PCA) who was pushing a resident in a wheelchair down the hall, went to the alarm control panel, and turned the alarm off.
-The PCA went to another exit door (#11) outside the C Hall/D Hall medication room, looked out the paned window, turned away from the door, and continued down the D Hall.
-She did not go to the door at the end of the D Hall (#9), when the alarm had been activated.

Interview with this PCA on 02/01/22 at 8:34am and 8:49am revealed:
-She turned off the door alarm off before looking out the door.
-She looked out "that door" pointing toward (#11) because she thought the alarm panel displayed "that door."
-If the door alarm was going off, she would go to the alarm panel to see what door alarm was going off and go check the door.
-She did not go out the door to check, because if she went outside, she would get locked out of the facility.
-She always looked out the window of the door.
-There was an alarm panel on each end of the facility.
-When she looked at the control panel it displayed door #9 was alarmed.
-She thought she had checked exit door #9.

Confidential interview with a resident revealed:
-The resident used to live in the room next to the an exit door.

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-Staff stayed together somewhere on third shift; she had to look for them because her roommate needed care and could not find them.
-Residents and staff would go out of the exit door and get locked out.
-She could hear people knocking on the exit door to get back into the building and she would open the door to let them back in.
-The exit door was supposed to make a noise when it was opened so staff could check on it.
-She could not remember if the door made a noise each time it was opened or if the staff came to check.

Interview with another PCA on 02/01/22 at 9:37am revealed:
-When an exit door alarmed, staff were supposed to go outside and look around, and then turn off the alarm at the panel.
-Housekeepers could turn the alarms off at the panel, but they were supposed to go look at the door that was alarming.
-She had turned the door alarm off earlier without going to check the exit door because she thought another PCA was checking the door that had alarmed.
-Some doors staff had to go out and look around, but door #9 and the front door staff could look out the window without going outside because staff could see far enough out.
-There was a meeting about checking the door alarms after a resident was found outside the facility about 2-3 weeks ago.
-The meeting was mandatory, and the staff were told to check door alarms when the alarm went off.

Interview with a third PCA on 02/01/22 at 9:44am revealed:
-She was trained by another staff on how to

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respond to door alarms.
-She would look at the door alarm panel and check for the door number and then she would check the door.
-Sometimes she would check the door first and sometimes she would disarm and reset the door alarm before she checked the door.
-Some of the doors she could check by just looking straight down the hall and out of the window on the door.
-Some of the doors she had to go to and go out to look; the D Hall door and the front door were ones she had to physically go to before she could turn off the door alarm.

Interview with a MA on 02/01/22 at 10:15am revealed:
-Door alarms and call bells could be disarmed from one of two panels in the facility.
-There was a meeting to discuss the door alarms after a named resident was found outside the facility a couple of weeks ago.
-At the staff meeting, they were told to go to the alarm panel, look at the codes displayed, and go out the door that had alarmed to make sure no one was outside.
-If staff did not see anyone outside staff were supposed to make rounds to ensure all the residents were accounted for.

Observation of the control panel on the A Hall/B Hall on 2/01/22 at 11:27am revealed:
-An exit door alarm was sounding at the panel.
-A male staff was sitting in the gift shop across the hall from the A Hall/B hall alarm panel.
-The staff got up from his chair, walked to the panel, and keyed in numbers; the alarm was silent, and he went back to the chair in the gift shop.

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Interview with the male staff on 02/01/22 at 11:28am revealed:
-He was a housekeeper.
-He just learned today, 02/01/22, how to see what door alarms were going off.
-A PCA showed him how to identify which door alarm was going off.
-A PCA asked him earlier today (02/01/22) to check exit door #9 on the D Hall because the alarm had gone off.
-He looked out exit door #9 but did not go outside the door.
-He cut the alarm off on the A Hall/B Hall alarm panel when observed by the surveyor at 11:27am.
-He saw someone had just come through the front door (#1), so he pushed the code in to silence the alarm.
-He did not check to see what exit door codes were displayed on the control panel.

Interview with a second housekeeper on 02/01/22 at 11:48am revealed:
-He had turned the alarm panel off if the alarm had "rang for a really long time."
-He used to be able to turn the alarms off, but the Administrator told him yesterday, 01/31/22, to not turn the alarms off.

Telephone interview with a PCA on 02/01/22 at 2:15pm revealed:
-She worked 3rd shift and there was only one PCA and one MA on third shift.
-She was responsible for cleaning bathrooms in the common areas, taking out the trash from common areas, mopping the dining room floor and setting the tables for breakfast, and doing laundry.
-She could not hear the door alarms in the laundry room.

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D 270	Continued From page 32 Interview with another MA on 02/02/22 at 7:42am revealed: -The door where residents went outside to smoke was not alarmed (#2). -There was a resident who smoked at night. -The break room door (also identified as #2) was not alarmed because staff used that door. -She heard the break room door alarm (#2) go off on 02/01/22, but those doors usually were not alarmed. -Whoever turned a door alarm off at the panel was supposed to go check the door to see why the alarm was going off. Observation of the smoking area exit door on 02/02/22 from 5:56pm to 5:59pm revealed: -The door used to access the smoking area was opened. -An alarm immediately could be heard. -At 5:57pm, the alarm was silenced. -At 5:59pm, a PCA and a MA were seen in the hallway. -No staff checked the smoking area door. Observation of door alarm panel on 02/03/22 at 1:17pm revealed: -There was an audible door alarm. -The #2 was displayed on the alarm panel. -A PCA cut the alarm off using a four-digit code. -There was an audible door alarm again and #2 was displayed on the alarm panel. -The PCA cut the alarm off again but did not leave the area to go and check door #2. Telephone interview with another PCA on 02/04/22 at 1:26pm revealed: -There was a staff meeting to discuss if the door alarms were going off, to make sure staff look at the monitor to see what door alarm was going off, and check that door.	D 270		

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D 270	Continued From page 33 -There could be 2 door alarms going off at the same time, and staff were supposed to check both doors. Interview with the Resident Care Coordinator (RCC) on 02/01/22 at 9:23am revealed: -She had to enter a code at the door alarm keypad to disarm the alarm. -If the door was not properly closed, the alarm would go off until the door was properly closed. -The door alarm panel had a code that indicated which exit door was opened; each exit door was numbered. -The protocol was for staff to look at the panel and identify which exit door was alarming and to physically go to check the exit door indicated on the panel. -The staff were supposed to open the exit door and look outside to check and ensure a resident was not outside. -After the staff checked the area outside the exit door for a resident, they were to come back to the door alarm panel and enter a code to disarm and reset the door alarm. -Once an exit door was closed, it would lock from the outside and not be accessible for reentry; the only way to reenter the building was to go around to the front door. -Only the front door had an outside doorbell. -There were no residents with dementia or who were confused so the facility had no need to alarm the exit doors. -The facility alarmed the exit doors to help keep residents safe and let the facility staff know when a resident went outside. -Before staff went outside from the breakroom door, they were supposed to let someone know they were leaving so the door could be disarmed after they exited -Only PCAs, medication aides (MA), the RCC,	D 270		

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and the Administrator were allowed to disarm and reset the door alarms; housekeepers were not allowed to disarm and reset the door alarms.

Interview with the Administrator on 02/01/22 at 4:56pm revealed:
-A resident was found outside on 01/13/22 by the RCC when she came to work for the day.
-On 01/14/22, the RCC had a general meeting with all facility staff and discussed cold weather precautions for residents and responding to door alarms to ensure none of the residents went outside.
-The exit doors did not need to be alarmed because none of the residents were considered to wander or were exit seeking.
-None of the residents had been found outside of the facility in the last 3 to 9 months.

Review of three resident's records revealed:
-Resident #1 was intermittently disoriented and diagnoses included Alzheimer's dementia.
-Resident #2 was intermittently disoriented.
-Resident #4 wandered and diagnoses included dementia

a. Review of Resident #1 current FL-2 dated 09/23/21 revealed:
-Diagnoses included Alzheimer's dementia without behaviors, proximal atrial fibrillation, chronic diastolic and systolic heart failure, hypertension, chronic obstructive pulmonary disease (COPD), tobacco use, moderate focus regurgitation, and sick sinus syndrome.
-She was intermittently disoriented.

Review of Resident #1's care notes revealed:
-On 01/13/22, hospice was called due to Resident #1 falling outside.

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D 270	Continued From page 35 -Resident #1 did not have any injuries but was confused and talking about seeing people. -Resident #1 was helped back into the building. -Resident #1's behavior could be due to agitation. -On 01/14/22 at 9:00am, hospice was notified about Resident #1 being found outside on 01/13/22 and asked if extra supervision was needed for Resident #1. -The hospice nurse wanted the facility, to the best of their ability, to keep a close eye on the resident. -Resident #1 was ordered Risperdal (used to treat irritability) 0.25mg scheduled at bedtime for restlessness. -The facility was going to take Resident #1's walker away for the resident's safety and that staff would be available to assist the resident to the bathroom. -Resident #1's power of attorney (POA) was upset the facility had taken away Resident #1's walker and wanted it returned to her for her use. -On 01/16/22, Resident #1 was up several times on third shift walking the halls looking to put away linen and looking for the bathroom; staff helped Resident #1 back to bed several times. -On 01/17/22, Resident #1 was awake on third shift and talking about things that did not make sense. -On 01/18/22, the facility had taken away Resident #1's walker for safety reasons because of a fall Resident #1 had and that it was safer for the resident to not have her walker for use. -Resident #1's POA wanted the walker returned to the resident. -On 01/25/22 at 3:00am, Resident #1's roommate rang the call bell because she was in the roommate's bed; Resident #1 was very agitated. -Resident #1 was put back to bed but she refused to stay there or accept help from staff while ambulating.	D 270		

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-On 01/29/22 at 1:00pm, [staff] called and notified the primary care provider (PCP) Resident #1 was found outside and not breathing.

Review of the National Oceanic and Atmospheric Administration (NOAA) weather report for the area the facility was located revealed the temperatures ranged from 32 degrees Fahrenheit to 19 degrees Fahrenheit on 01/29/22.

Review of the 911 call log dated 01/29/22 revealed:
-The facility contacted 911 at 6:57am.
-The local emergency medical services (EMS) were dispatched at 6:58am and arrived at the facility at 7:09am.

Review of the local county EMS report dated 01/29/22 revealed:
-EMS responded to a call from the facility for the possible cardiac arrest of a resident on 01/29/22 at 7:00am.
-The resident was found lying on the sidewalk.
-Staff told EMS the resident was found normal during 4:00am rounds.
-The staff were unaware of how the resident got outside or how long she had been outside.
-The MA discovered the resident at 6:30am.
-The PCA told EMS she had not heard any door alarms going off to alert her of the door opening.
-Staff denied attempting to move the resident.
-The resident was laying on her back and was ice cold to the touch, pulseless and apneic (the transient cessation of respiration). Her skin was pale and there was mottling to her back.
-Her shoes were sitting next to her and her walker was lying about a foot away from her.
-The walker and her shoes were coated in snow and the snow was not disturbed.
-The resident had a DNR order (do not

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resuscitate) which was presented by the staff; time of death was called at 7:10am.
-The police department was called due to the suspicious nature of the scene.

Review of the local police department's report dated 01/29/22 revealed:
-Two police officers were dispatched to the facility at 7:00am.
-The police officers spoke to the personal care aide (PCA) who said she had checked on the resident between 4:00am and 5:00am and the resident was in her room asleep.
-The medication aide (MA) told the officers the resident was not in her room at 6:35am; the MA checked the hallways and the rooms going away from the resident's room but could not find the resident.
-The MA stated she looked outside the door at 6:57am and observed the resident lying outside on the concrete on her back; she immediately called 911.
-EMS stated the resident had passed away before they arrived.
-The staff reported the doors had alarms but neither had heard them go off.
-Staff also reported the resident had a mild case of dementia and was recently on antibiotics for a UTI (urinary tract infection).

Observation of Resident #1's previous room on the C Hall and her room on the D Hall on 02/04/22 at 4:57pm revealed:
-Resident #1 would have come out of her previous room on C Hall and turned left to go the area where the main hallway crossed the C and D Halls.
-From the area where the C and D Halls crossed, the main hallway the lobby and font lounge could be seen.

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-The main hallway led to the lobby, the front lounge area, the dining room, a front office and the exit doors to the front doors and the back-smoking area.
-Resident #1 would have come out of her second room located on the D Hall and taken a right, another right and a left to go to the area where the C and D Halls crossed the main hallway.
-Resident #1's room on the D Hall was one room away from the exit door for the D Hall.
-The exit door for the D Hall was located to the left of Resident #1's room.

Interview with a resident on 02/01/22 at 11:58am revealed:
-Resident #1 had a fall the week before she died right outside the same door.
-She asked Resident #1 later why she was outside, and Resident #1 told her she was going to the trailer park.

Interview with a PCA on 02/01/22 at 9:44am revealed:
-For the last month Resident #1 had talked about going home and was wandering.
-Resident #1 was always trying to leave the facility.
-There was a general meeting a couple of weeks ago and the staff were told to increase the 2-hour bathroom checks to 30-minute bathroom checks for Resident #1.
-Bathroom checks were done throughout the day and night to see if a resident needed to go to the bathroom or needed any other care.
-The staff were told to keep an eye on Resident #1; the 30-minute checks were not documented.
-The staff were told to go to the door and check every time the door alarm was heard.
-Resident #1's room was only two doors away from the D Hall exit door, door #9.

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-Resident #1 moved very slow when she used her walker; she took two little steps at a time and then would move her walker and repeat the process.
-Resident #1 walked slow enough for staff to see her at the D Hall exit door if they responded to the door alarm right away.
-Resident #1 did not try to exit the building when she first started working with her in October 2021.

Interview with another PCA on 02/04/22 at 3:04pm revealed:
-She was working on 01/13/22 when Resident #1 was found outside on the ground.
-She had pushed Resident #1 in her wheelchair back to her room after breakfast sometime between 8:30am and 8:35am.
-Resident #1 usually took an hour to hour and a half nap after breakfast.
-Resident #1 was talking about going to a trailer park and hearing a little boy screaming.
-She had noticed a change in Resident #1 about a week before; she was hearing and seeing things that were not there.
-She reported the change to the MA.
-Resident #1 had begun to get up without her walker and start to walk.
-She had found Resident #1 leaning against a bin in her bathroom; Resident #1 did not have her walker or her wheelchair.
-She called the MA and helped Resident #1 slide to the floor in the bathroom.
-Resident #1 could not get off the ground by herself; two staff would have to help her.
-Resident #1 was more confused after her room change a couple of month ago.
-Resident #1 was more confused as to where she was after her room was changed; she was found in her roommate's bed and chair.
-She had seen Resident #1 standing at the D Hall exit door looking out of the window.

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D 270	Continued From page 40 -She had not seen Resident #1 trying to go out of the D Hall door, so she did not try to redirect her. -She had taken Resident #1 out the exit door in the smoking area; Resident #1 liked to smoke and to sit outside in the smoking area. Telephone interview with a PCA on 02/01/22 at 2:13pm revealed: -She had worked for the facility off and on since 2014; she always worked third shift. -There was only one PCA and one medication aide (MA) on third shift. -She did two hour "wet" checks on the residents at 11:00pm, 1:00am, 3:00am and 5:00am if her time permitted her. -She used to document the "wet" checks but had not had a paper to document them on since 01/20/22. -On a good night when residents did not ring the call bells or need care, she could do the two hours check on all the residents in about an hour. -On a bad night when the residents were ringing the call bells and required a lot of care, it would take her three to four hours to do the 2-hour checks. -She would tell the MA when she had to respond to call bells and to attend to residents, so the MA knew where she was. -She did not sleep at night; she did not have time to sleep at night because she had too much to do. -She had to do 2-hour resident "wet" or toilet checks, laundry, she had to mop the dining room, set the tables in the dining room for breakfast and respond to call bells and any door alarms. -Resident #1 would get out of the bed to go to the bathroom on third shift. -Resident #1 had begun to talk to people that were not there. -Resident #1 was found in another resident's	D 270		

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room; she did not recall when.
-Resident #1 got out of bed at night and roamed around and had been found in "random rooms".
-She reported everything to the MA; the MA was responsible for documenting and reporting to the RCC.
-She worked as a PCA on 01/28/22 into the morning of 01/29/22.
-The last time she saw Resident #1 on 01/29/22 was between 3:45am and 5:00am.
-Resident #1 was in her room awake and was sitting up in her bed with a purple blanket over her.
-Resident #1 kissed her on her forehead.
-She was not instructed at any time to increase Resident #1's checks.
-The MA was in the medication room on the B Hall on the opposite side of the building; the MA was verifying the batch medication that was delivered the night before.
-The Kitchen Manager and a dietary aide had spent the night at the facility on 01/28/22 due to inclement weather.
-She did not hear the exit door alarm go off all night long; she was told later that the kitchen staff heard the door alarm going off at about 1:00am.
-She sat in the front parlor on a chair so she could hear the call bells go off; management had instructed her to sit in the parlor so she could hear the call bells.
-She sat in the parlor for about an hour the first time she sat and about five minutes the second time she sat; she thought she sat in the parlor the second time between 3:45am and 4:00am.
-One resident had a soiled herself and had to be changed; the resident's bed was also soiled had to be stripped and remade. She did not remember the time or how long she was with the resident.
-There was a resident that got herself up at

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4:30am and sat outside the door to the parlor.
-She got the first resident up for the day at 5:00am and had her sitting in her chair in her room.
-She got a second resident up at around 5:15am and then another resident rang the call bell, so she went to the third resident.
-She heard the exit door on D Hall going off around 6:45am when Resident #1 was found by the MA.
-She heard the exit door alarm going off and checked the panel for the door number; the number on the panel was #9 which was the D Hall exit door.
-She went to the D Hall exit door and the third shift MA was already there and told her to get the first shift MA that had already come to work.
-The MA said she found Resident #1 outside and she was not breathing.
-She thought Resident #1 had her walker taken away from her after she was found outside in the bushes a few weeks before.
-She did not know how Resident #1 got outside without staff knowing.

Interview with a MA on 02/01/22 at 10:15am revealed:
-Resident #1 walked the halls.
-Resident #1 was found in another resident's room when the resident pushed her call bell to complain about Resident #1 being in the room.
-She had seen Resident #1 wandering in the hallway looking for coffee.
-She was not aware Resident #1 was going to the exit doors until the incident a couple of weeks ago.
-Resident #1 was moved from a private room on the C Hall to a semi-private room on the D Hall because of insurance reasons.
-She thought moving Resident #1 had increased

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the resident's confusion.
-Another MA told her Resident #1 was found in other residents' rooms watching television.
-Resident #1 walked slowly with her walker, but if the resident was mad, she could get around easily.
-Resident #1 smoked 3 times a day.
-Resident #1 knew which door was the smoking door.
-The exit door Resident #1 was found outside of, was not the smoking door.

Interview with a first shift MA on 02/02/22 at 1:12pm revealed:
-She worked as a MA on first and second shift for the last year.
-She worked some eight hour shifts and some 12-hour shifts.
-Resident #1 "changed in her dementia over the last few weeks."
-Resident #1 could not have a conversation anymore; she spoke of going to a trailer park or to a local store.
-Resident #1 was found outside on 01/13/22 near the D Hall exit door.
-On 01/13/22 she heard the door alarm sounding sometime between 9:30am and 10:00am.
-She went to the door alarm panel but someone else had already turned it off, so she did not know which door was opened.
-She could no longer see the door code since the door had been disarmed, so she thought it was the front door.
-About five or ten minutes after the door alarm went off, the RCC called about Resident #1 being outside on the ground.
-The Administrator nor the RCC asked her how Resident #1 got outside unsupervised 01/13/22.
-She filled out an incident report and called Resident #1's power of attorney (POA); she did

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not call the primary care provider (PCP) or the hospice nurse.
-Resident #1 could not walk very far with her walker.
-She would tell you if she was too tired to go any farther and was unsteady on her feet.
-She could not walk from around the outside of the facility from the D Hall door to the front door because it was too far for her to walk.

Second interview with a first shift MA on 02/04/22 at 2:36pm revealed:
-She was working of first shift on 01/13/22.
-She remembered hearing the door alarm going off a little after breakfast.
-She and a PCA were in the medication room for the A and B halls.
-She did not know who turned off the door alarm.
-The RCC called her and told her to come outside because Resident #1 was outside on the ground and she needed a wheelchair and help to get the resident off the ground.
-Resident #1 would go outside to the smoking area so she and the PCA thought that was where she was when the RCC called.
-They called the RCC back and she told them the resident was in the front corner of the facility.
-Resident #1's walker was on the ground in front of her and she was sitting in the grass.
-It took three staff to get Resident #1 off the ground and into her wheelchair.
-Resident #1's room was changed from the C Hall to the D Hall sometime in December 2021.
-Resident #1 used to take a left out of her room on the C Hall and she would be in the main lobby.
-Resident #1 was more confused about where to go since her room was changed; her new room was farther away from the main lobby.
-Resident #1 seemed more confused after the room change and talked about going home and

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going to a trailer park.
-Resident #1 was trying to walk without her walker, and she was getting up without pulling the call bells after she was told to use them.

Telephone interview with a MA on 02/02/22 at 10:41am revealed:
-She worked 3rd shift on 01/28/22.
-She began her shift at 7:00pm on 01/28/22.
-There were two dietary staff in the facility that night because of the weather.
-She started her evening medication pass around 7:00pm and ended around 9:00pm.
-She had 9-10 totes of medication to verify and check in from the pharmacy delivery from the night before, so she worked most of the shift in the medication room on the A/B Hall.
-She began working on the batch medication around 9:30pm and finished around 5:30am.
-She heard the doorbell ring and let the pharmacy delivery driver into the facility around 1:00am.
-It was less than 5 minutes from the time she heard the doorbell ring until she let the driver inside.
-She saw the PCA about 1:30am near the dining room; the PCA was walking down from the C/D Hall towards the main lobby.
-She went back to the medication room after the pharmacy delivery.
-She did not hear an exit door alarm go off after the pharmacy delivery driver left the facility.
-She continued to work in the medication room until about 2:30 to 3:00am when she left to go to the bathroom.
-She returned to the medication room after she went to the bathroom; she did not see the PCA when she went to the bathroom.
-A [named] resident's call light went off at 3:30am and she responded to the call light.
-She saw Resident #1 at 3:30am when she

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responded to the call light of the resident across the hall from Resident #1.
-She noticed Resident #1's door was open, so she looked in on her.
-Resident #1 was laying on her bed, without covers, and her eyes were closed.
-She finished the medication verification at 5:30am and left the medication room; she did not see the PCA when she left the medication room.
-At 6:35am when she went to administer Resident #1's medications, the resident was not in her room.
-Resident #1's roommate was asleep.
-She checked all the rooms and bathrooms on the D Hall, and then checked the other halls in the facility for Resident #1.
-She returned to the D Hall and looked out of the window in D Hall exit door and saw Resident #1 outside on the sidewalk, laying on her back.
-She went out of the D Hall exit door to go to Resident #1; the exit door alarm went off when she opened the D Hall exit door.
-She checked Resident #1 and she was not breathing.
-She used her personal cell phone and called 911 around 7:00am
-She saw the PCA at the D Hall door and told her to get the first shift MA because Resident #1 was not breathing.
-Resident #1 did not feel like she had been outside long because she was not any colder than normal.
-She was not sure how Resident #1 got out of the facility without a door alarm going off.
-The residents were on 2-hour "wet" checks.
-The PCAs were responsible for "wet" checks.
-The only time she recalled having increased checks on a resident was when a resident was on hospice and was expected to die.

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D 270	Continued From page 47 Telephone interview with a representative from the facility's contracted pharmacy on 02/02/22 at 4:07pm revealed: -Their medication delivery staff were monitored by a GPS tracking system. -He had reviewed the driver's GPS tracking information for 01/28/22 for the facility. -The driver "pinged" at the facility at 11:34pm which was most likely when the driver entered the facility. -He talked to the driver and the driver waited outside the facility to be let in for 10-15 minutes after ringing the doorbell. -A MA signed for the medication delivery at 11:35pm. -The driver's GPS showed he was at another facility at 11:51pm that was approximately 15-20 minutes away from this facility. -The driver did not return to the facility that night. -Information for medication deliveries were captured digitally and were accurate. Telephone interviews with a dietary aide on 02/01/22 at 9:07am and 1:14pm revealed: -She stayed at the facility on 01/28/22 due to bad weather. -She was asleep in one of the empty resident rooms, and could not sleep, so she went out to the front parlor. -She thought it was around 1:00am. -She did not hear an alarm sounding when she went to the parlor. -She sat down on one of the two couches in the parlor. -There was someone asleep on the other couch, but she did not look to see who it was. -She could tell by the way the person was breathing that they were asleep. -After about 30-60 minutes she went back to her room.	D 270		

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-When she woke up the next morning and went back out to the parlor, before 5:30am, there was someone asleep on the couch, but she could not say who it was.
-She went to the kitchen around 5:30am.

Interview with the dietary manager on 02/01/22 at 9:07am revealed:
-She stayed overnight at the facility on 01/28/22 because the weather was predicted to be icy and she wanted to make sure she was at the facility to prepare meals.
-She and a dietary aide stayed overnight in rooms 32 and 34.
-She heard a door alarm going off, and it woke her up.
-She looked at her watch and it was 1:00am.
-She asked the MA about the 1:00am door alarm around 6:00am.
-The MA told her the pharmacy had delivered medications.
-At 5:45am, she was looking for the dietary aide and found the aide sitting on a couch in the front parlor.
-The 3rd shift PCA was laying down on the other couch in the parlor when she entered the parlor and began talking to the dietary aide.
-As soon as the PCA heard her talking, the PCA "jumped up."
-This was not the first time she had seen the PCA sleep; she had seen her before when she had come in early.
-She told the Administrator and the RCC the PCA was seen sleeping.

Interview with the dietary manager on 02/02/22 at 10:19am revealed:
-She had worked as a MA at the facility on 3rd shift.
-She thought the alarm was audible for about

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15-20 minutes on 01/29/22 when it sounded at 1:00am.
-There were pillows on the couch where the PCA was laying down.
-The dietary aide told her she had seen the PCA asleep on the couch in the parlor earlier that morning.
-She had seen the same PCA asleep on the couch prior to 01/28/22, with pillows and a blanket.
-She had a key to the facility, so she did not have to ring the doorbell.
-The MAs and PCAs were responsible for checking exit doors.
-Exit doors should have been checked because staff would not expect someone to go outside that time of night.
-When the alarm panel was going off, staff had to watch the display to see which exit door codes were going off.
-When the exit door alarm sounded, the code #01 for the front door automatically displayed; the panel would then display any additional door code numbers.
-If staff did not make sure there were no other doors alarming, staff would turn the alarm off without knowing what other exit door alarms may have been going off.
-The 3rd shift PCA was responsible for cleaning the hall bathroom and the breakroom bathroom, and the dining room.
-The 3rd shift PCA was also responsible for setting the dining room tables for breakfast.
-On the morning of 01/29/22, the dining room had not been cleaned nor set up for breakfast.

Telephone interview with Resident #1's POA on 02/04/22 at 11:35am revealed:
-She received a phone call from the RCC on 01/13/22 about Resident #1 being found outside

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on the ground near the front of the building.
-She was told Resident #1's walker caused her to fall so they wanted to take it away from her and have her use a transport wheelchair.
-She was not told of any other interventions that were put into place after Resident #1 was found outside on 01/13/22.
-After the fall outside on 01/13/22, the Administrator told her that it was Resident #1's fault she was outside because she had dementia.
-She did know Resident #1 could get out of an exit door on her own.
-She did not think Resident #1 could figure out how to get out of an exit door.
-She did not think Resident #1 could figure out how to get back inside after going out of an exit door.
-Resident #1 had only been out the front door or the door to the smoking area prior to 01/13/22.
-Resident #1 had a fall sometime after 01/13/22 but she could not remember the date; no interventions were discussed after the fall.
-Resident #1 was moved to another room but she did not recall if there was more confusion after the room change.
-Resident #1 was moved from a private room to a semiprivate room due to insurance reasons.
-Resident #1 had become more confused since she was admitted to the facility.
-On 01/29/22, she received a phone call from the facility staff that Resident #1 was outside and had probably fallen and hit her head.
-When she arrived at the facility Resident #1 was still outside on the ground.
-Resident #1's legs were on the ground and from her hips up she was on the sidewalk which had a covered roof.
-Resident #1's walker and slippers were covered in snow; Resident #1 was wet and cold to the touch; her ears had turned purple.

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Telephone interview with a Police Department Detective on 02/02/22 at 3:00pm revealed:
-The EMS staff reported Resident #1's body was cold to touch.
-The paramedics notified the police department of concerns Resident #1's death was suspicious because the staffs' "stories" did not match up.
-It was suspicious as to how Resident #1 "got out" and how long she had been outside.
-Resident #1's core body was cold and even under her arms was very cold.
-The Police Officers who arrived on the scene and the footage from their body cams was being reviewed.
-There was a buildup of snow on the walker, as well as on the legs of the resident.
-The weather report from the airport was snow started at 12:55am and stopped at 5:15am.
-Resident #1 had to have been outside long enough to have the snow not melt but build up on her lower legs.
-Based on the build-up of snow pattern, there did not appear to be any wind that evening.
-It was known that Resident #1 had wandered away before, the facility should have put an alarm on the door.
-Her biggest concern was residents were getting out and no one knew.
-The door could have locked behind her and she could not get back in.
-The door to the smoking area and breakroom door were not locked.

Telephone interview with Resident #1's hospice nurse on 02/03/22 at 10:20am revealed:
-Resident #1 had begun to decline over the past month or so.
-Resident #1's cognition had declined; she said she was going to go downstairs, and she spoke

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to people that had been dead.
-Resident #1 was found on the ground outside the facility on 01/13/22; she was notified of the fall on 01/14/22.
-Resident #1's Risperdal was increased after she was found outside on 01/13/22; it could take up to two weeks for the Risperdal to become effective.
-There was discussion about taking Resident #1's walker away from her so she would only use her wheelchair.
-When she used her walker, she had an unsteady gait, shuffled her feet and she leaned forward.
-Resident #1 could propel herself around the facility with her feet while in her wheelchair.
-Resident #1's POA did not want her walker taken away from her.
-The POA wanted Resident #1 to have her walker so she could go to the bathroom.
-The agreement with the POA was for the walker to remain in Resident #1's room and she would use the call bell to go to the bathroom.
-Resident #1 could walk about 10 to 15 feet and would need to rest.
-Hospice was contacted on 01/29/22 at 7:09am to inform them that Resident #1 was found outside and was unresponsive.

Telephone interview with Resident #1's hospice nurse on 02/04/22 at 11:24am revealed:
-When she spoke to the facility staff about Resident #1's fall on 01/13/22 she suggested a scoop mattress, or bed and chair alarms but she was told by the Administrator the facility did not allow them.
-The facility said they would increase the frequency of Resident #1's checks but did not discuss how frequent.
-She thought she remembered Resident #1 sliding out of her chair or her bed on 01/20/22 but interventions were not needed for a "slide", so

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D 270	Continued From page 53 none were discussed. -Resident #1 was weak and did not have a lot of strength in her upper body. Telephone interview with Resident #1's primary care provider (PCP) on 02/04/22 at 2:22pm revealed: -She was notified Resident #1 was found outside on 01/13/22 by staff. -Resident #1 did not have any injuries. -Resident #1 did not have any other falls after the 01/13/22 until 01/29/22. -Resident #1 had become weaker and could not stand up by herself or get off the ground by herself if she fell. -She thought the facility increased Resident #1's checks but she was not sure. -The staff were redirecting Resident #1 and encouraging her to use her wheelchair as much as possible. -Resident #1 was getting up at night more often and could walk to the bathroom on her own. -She noticed Resident #1 had become more confused after her recent room change. Interview with the RCC on 02/04/22 at 9:35am and 5:29pm revealed: -On 01/13/22, when she arrived at work around 9:15am, and she heard Resident #1 say "Hey, come help me". -Resident #1 was sitting on the ground in the grass outside the facility. -Resident #1 was dressed in a shirt and pants and fuzzy socks; the weather was not cold that day. -Resident #1's walker was tilted over on the ground near her. -She called the MA inside the building from her cell phone to report Resident #1 was outside on the ground.	D 270		

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-The MA and a PCA came outside and did an assessment of Resident #1 and took her back inside the facility.
-The MA and the PCA said they heard the door alarm but thought it was the RCC coming in the door because she usually came in that time of the day.
-No one knew who disarmed the door alarm.
-It was reported to her that the door alarm only went off about five minutes before she called the MA.
-Resident #1 could not tell her how long she had been on the ground.
-Resident #1 was confused and thought she had gone downstairs and had fallen.
-She filled out an incident report for a fall; it was not considered an elopement because Resident #1 did not leave the facility's property.
-She contacted hospice and asked them what they recommended to prevent another fall.
-Hospice suggested to continue two-hour checks to monitor Resident #1.
-No other interventions were put into place.
-She conducted a staff meeting on 01/14/22 about door alarms, and the dropping temperatures, and two-hour rounds.
-She discussed the temperatures dropping into the 30's and the teens and the safety of the residents due to the cold.
-She thought Resident #1 had another fall on or around 01/20/22 and a urine analysis was ordered but hospice did not want her on any antibiotics.
-On 01/29/22, Resident #1 was found outside on the ground by a MA; Resident #1 was not breathing.
-The MA called her about Resident #1 around 7:00am.
-She came to the facility after the MA called her.
-The facility's corporate office was investigating

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D 270	Continued From page 55 the fall that occurred on 01/29/22. Interview with the Administrator on 02/01/22 at 4:56pm revealed: -Resident #1 was found outside on 01/13/22 by the RCC when she came to work for the day. -On 01/14/22, the RCC had a general meeting with all facility staff and she discussed cold weather precautions for residents and responding to door alarms to ensure none of the residents went outside. -The exit doors did not need to be alarmed because none of the residents were considered to wander or were exit seeking. -None of the residents had been found outside of the facility in the last 3 to 9 months. -None of the staff slept while they were working at night; she had not gotten reports of staff sleeping. -The Kitchen Manager and a dietary aide had spent the night at the facility on 01/28/22 due to bad weather; so, there was a manager in the building on 01/29/22. Interview with the Administrator on 02/02/22 at 3:53pm revealed: -She arrived at the facility about 10:00am on 01/29/22. -She suspended the MA and the PCA while the corporate office conducted their investigation of Residents #1's death. -She only had one staff report a concern of staff sleeping on third shift before 01/29/22 and she reported it to the corporate human resources department. -The complaint was about one of the staff that worked on 01/29/22. -She had administered medication on third shift, and she had never witnessed staff sleeping. -Residents had not complained to her about staff sleeping on third shift.	D 270		

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Interview with the Administrator on 02/04/22 at 12:22pm and 4:57pm revealed:
-When Resident #1 was found on the ground outside the facility on 01/13/22 it was considered a fall and not an elopement.
-Resident #1 did not leave the facility so it was not an elopement.
-Resident #1 had used her walker to go outside on 01/13/22 so there was a discussion with the hospice nurse about taking Resident #1's walker away from her as an intervention to keep her from going outside to prevent her from falling.
-The staff would take the walker at night and place it in the facility's common living room.
-Resident #1 was pushed around the facility by staff in a transport wheelchair; she could not propel herself in her wheelchair.
-If she only had the transport wheelchair, she would not have been able to cross the threshold of the exit door.
-Resident #1's POA insisted she have her walker so she could ambulate.
-Resident #1's PCP was notified that the POA wanted the resident to have her walker to ambulate; the PCP said it was the resident's right to have the walker.
-Staff were instructed to be more diligent about responding to door alarms and to search for residents when they heard an exit door alarm.
-The staff were also instructed to look for anything "out of the norm" for a resident and to notify her or the RCC if they identified anything.
-The facility did not have a list of interventions or procedures to help prevent falls or wandering.
-She did not have any other interventions in place to prevent Resident #1 from falling or exiting the facility after 01/13/22 other than the frequent checks.
-Resident #1 was going to be discharged soon

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and admitted to a memory care facility so she was waiting for the resident to be moved.
-Resident #1 was the responsibility of the facility until she was discharged to another facility.
-All she knew about the fall on 01/29/22 was that Resident #1 was found outside and was not breathing.
-The facility's corporate office was conducting the investigation.
-Resident #1 was very sick and not doing well when she was admitted to the facility and was admitted into a private room on the C Hall.
-Resident #1 was moved from a private room on the C Hall to the room on the D Hall because she was thriving and doing well.
-She did not recall when Resident #1 was moved to the D Hall, but it should have been documented in her progress notes.
-She did not notice if Resident #1 was more confused after the move to D Hall.

Based on interviews and record reviews, there was no increased supervision or other interventions implemented for Resident #2 after the fall on 01/13/22 and as a result of the resident's increased confusion.

b. Review of Resident #2's current FL-2 dated 02/01/21 revealed:
- Diagnoses included blindness secondary to macular degeneration, osteopenia, and pulmonary fibrosis.
- Resident #1 was intermittently disoriented.

Review of Resident #2's care plan dated 09/23/21 revealed:
-Resident #2 was oriented.
-Resident #2's memory was adequate.
-Resident #2 required limited assistance with toileting, ambulation, bathing, dressing, and

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transferring.

Telephone interview with a third shift personal care aide (PCA) on 02/01/22 at 2:15pm revealed:
-Resident #2 got out of bed on her own.
-Resident #2 was either falling or roaming around.
-Resident #2 could answer questions but could not remember if she had eaten or not.
-Resident #2 did not sleep through the night and would get out of bed.
-About two weeks ago on her shift, Resident #2 was found sitting in the hallway in only an incontinence brief.
-Resident #2 was found in another resident's room; she did not recall the date, but she thought it might be in a care note done by the medication aide (MA).
-She checked on Resident #2 more often because she roamed during the night.
-Resident #2 had been found in random rooms when she was doing her room checks.
-Resident #2 was on 2-hour checks but she checked on her more often.
-No one told her to check on Resident #2 more often, she just did it.

Interview with Resident #2's roommate on 02/01/22 at 4:51pm revealed:
-Resident #2 was "here, there, and everywhere."
-She pushed her call bell when Resident #2 was trying to get out of the bed because she did not want the resident to get hurt.
-She had to wait as long as 30 minutes before someone came to answer the call bell.

Interview with a MA on 02/02/22 at 7:42am revealed Resident #2 was confused at times.

Interview with the Administrator on 02/04/22 at

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11:56am revealed:
-Resident #2 was ambulatory with her wheelchair.
-Resident #2 could transfer herself into her wheelchair.
-Resident #2 got confused at times.
-Resident #2 had good days and bad days.

Review of Resident #2 incident and accident report dated 05/18/21 revealed:
-Resident #2 was found outside of the facility on 05/18/21 at 5:20am.
-Type of event was an elopement and found on the ground.
-Location of the incident was the outside parking lot.
-Nature of the injury was a swollen wrist.
-Resident #2 was sent to the hospital.
-Interventions implemented were documented as 15-minute checks for the next 72 hours.
-The on-call primary care provider (PCP) was notified and was waiting for a return call.
-There was an addendum added by the Administrator the PCP called back at 2:00pm and ordered a urinalysis.

Review of Resident #2's 15-minute checks form revealed:
-The documentation began on 05/18/21 at 5:30pm.
-There was documentation Resident #2 was checked on every 15-minutes from 05/18/21 at 5:00pm through 05/19/21 at 6:45pm.
-There was no documentation Resident #2 was checked on at 7:00pm and 7:15pm on 05/19/21.
-There was no documentation Resident #2 was checked on every 15 minutes, 6 times between 12:00am-6:00am on 05/20/21.
-The last documentation on Resident #2's 15-minute check form was on 05/21/21 at 3:30pm.

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Review of Resident #2's facility medication aide (MA) care notes revealed:
-On 08/27/21, Resident #2 was looking for a pair of pants at 2:00am.
-Resident #2 went back to bed but was later found in another resident's room.
-On 09/21/21, Resident #2 was up most of the night feeling nauseous and lightheaded.
-Resident #2 was roaming the halls at 5:30am and was noted to be more confused.
-On 09/22/21, Resident #2 seemed very confused at 6:00am.
-Resident #2 was talking to people who were not there, confused about the time, thinking it was nighttime and she was going out with friends.
-On 09/26/21, Resident #2 went out the D Hall exit door at 12:20am.
-Resident #2 was brought back inside and went to bed and was noted to be confused.
-Resident #2 was put on 15-minute checks for the rest of the night to make sure she did not try to exit the facility again.
-On 09/26/21, at 3:10am, Resident #2 was caught trying to go out the exit door at the C/D Hall medication room.
-Resident #2 continued to be on 15-minute checks for confusion and exit-seeking behavior.
-Resident #2 tried to leave her room at 5:55am but was redirected by her roommate to go back to bed.
-At 6:50am, Resident #2's PCP returned the call and ordered ½ table of Ativan 0.25mg (used to treat anxiety) for exit-seeking behavior.
-On 01/08/22 at 4:30am, Resident #2 was trying to go out the D Hall exit door.
-Resident #2 was taken to the dining room area to better monitor until breakfast.

Interview with a MA on 02/01/22 at 10:15am

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revealed:
-Resident #2 was found "a while back" outside in the bushes with skin tears.
-She could not recall when the incident occurred.
-There was a meeting with the MAs after the incident about the incident reports not being completed correctly.
-There were no instructions given about increased supervision.
-One time Resident #2 had a fall and fractured her arm.

Interview with Resident #2 on 02/01/22 at 5:11pm revealed:
-She did not remember falling outside.
-She did go outside, "once in a while."
-She did not remember when the last time she went outside was.

Interview with another MA on 02/02/22 at 7:42am revealed:
-Resident #2 was confused at times.
-Resident #2 had fractured her wrist one night (May 2021) after going out the D-Hall door.
-The morning Resident #2 was found outside she heard a door alarm going off and asked the PCA why the door alarm was going off and the PCA said the panel was displaying the front door.
-She thought it was the dietary staff coming in to work.
-When the alarm panel went off again, she asked the PCA again, and the PCA looked out the front door and did not see anyone.
-They then checked the exit doors on the A/B Hall and the C/D Hall.
-When she checked the D Hall exit door, she could hear Resident #2 hollering.
-Resident #2 had gone down the sidewalk and had fallen on the pavement.
-Resident #2's wrist was swollen.

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D 270	Continued From page 62 -It was still dark outside, maybe 5:10am-5:20am. -When Resident #2 was found outside, the Administrator directed staff to check on Resident #2 every 15-minutes for 3 days. -She had caught Resident #2 trying to go out the exit door on the D Hall. -Resident #2 was checked on every 2 hours. Interview with a PCA on 02/03/22 at 5:08pm revealed: -She was working the morning Resident #2 had a fall outside the facility in May 2021. -When she first looked out the exit door, she did not see Resident #2 outside. -She opened the door and asked, "anybody out here?" and went back inside. -Resident #2 may have went around the building. -The second time the alarm went off, she checked outside the D Hall exit door was when Resident #2 was lying at the end of the sidewalk. -She remembered Resident #2's checks were increased to every 15-minutes for 3 days. Telephone interview with a third MA on 02/02/22 at 1:10pm revealed: -She knew Resident #2 had exited the building one time; she thought it was months back. -Resident #2 had been more confused. -When Resident #2 was found outside the building, the checks were increased to every 15-minutes for about a week, but then went back to 2-hour checks. -All residents were supposed to be checked every 2 hours. Telephone interview with a fourth MA on 02/03/22 at 9:00pm revealed: -She was working as a PCA one night when Resident #2 was not in her room during room checks.	D 270		

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-Resident #2 was found sitting in her wheelchair in the bathroom of a vacant room with the door closed to the bathroom.
-She did not recall when this incident occurred.

Interview with the Resident Care Coordinator (RCC) on 02/03/22 at 2:48pm revealed:
-Resident #2 might wander if she did not know where she was going.
-Resident #2 had to be directed to and from meals.
-She was aware Resident #2 was found across the hall, but thought the resident was looking for the bathroom.

Interview with Resident #2's PCP on 02/04/22 at 2:49pm revealed:
-She was not aware Resident #2 had a fall outside of the building and had a fractured wrist in May 2021.
-She was aware of the 2 incidents in September 2021 when Resident #2 was trying to exit the facility.
-When Resident #2 was found outside the building in September 2021, she was not that concerned because she thought it was a one-time event.
-She would have thought a resident going outside the building would only need to happen once, and the facility staff would automatically do something different.
-She did not know what the facility protocol was but assumed they had one.
-She thought the facility had alarms.

Interview with the Administrator on 02/04/22 at 11:56am revealed:
-Resident #2 wanted to go home with her every night when she left the facility.
-She must have known about Resident #2 exiting

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the facility and fracturing her wrist, but she could not recall the event.
-They probably "did something," but she could not recall what.
-She would have probably contributed it to an urinary tract infection (UTI) because Resident #2 did not go out without someone helping her.
-Resident #2 was not the only resident who went to other rooms to use the bathroom.
-She was aware Resident #2 had been found in other rooms.
-She was no aware Resident #2 had been found trying to get into other residents' beds.
-She would have considered this behavior to be out of Resident #2's norm and Resident #2 should have been checked for a UTI.
-When Resident #2 was really confused, they notified her PCP and treated her for a UTI, and that was the only thing they did.
-When Resident #2 was found outside the facility in September 2021, she might have had a UTI; she would have to look back and read the details of the event.
-She would look for the fall report to show what was done after Resident #2's exiting incident, but since it was last year, those records were closed out.

c. Review of Resident #4's current FL-2 dated 08/05/21 revealed:
-Diagnoses included dementia, insomnia, hypertension and leg edema.
-Resident #4 wandered.

Review of Resident #4's pre-admission documents date 05/01/19 revealed:
-She was alert and oriented times two.
-She was occasionally confused due to diagnosis of dementia.
-She was at a risk to wander.

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D 270	Continued From page 65 Review of Resident #4's progress notes dated 09/27/21 revealed she was wandering the hallways and was trying to call her daughter on the telephone. Observation of Resident #4 on 02/04/22 at 8:17am revealed: -Resident #4 was at the front entrance to the facility. -One of the state survey team approached the front door from the outside. -Resident #4 opened the front door before the surveyor got to the door and stepped outside. -Resident #4 verbally greeted the surveyor. -The state surveyor guided Resident #4 back inside the facility after she let him in. -A staff came to the front lobby and asked the surveyor if he had come through the front door. -The staff asked the surveyor who opened the door and let him inside and he told her Resident #4. -The staff told the surveyor that Resident #4 thought she was in her house and would open the door and let visitors inside the facility. Interview with Resident #4 on 02/04/22 at 11:20am revealed: -She liked to walk the hallways. -She did not go outside because it was too cold. -In the summer she would walk outside more. -She liked to walk down the road because there was not much traffic. -There was not a sidewalk to walk on so that was why she would walk on the road. -She did not have to let anyone know when she went outside because she could go out on her own. -She would let visitors and other people in the front door.	D 270		

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-If she heard the [door] bell she would open the door and greet people.
-She did not want anyone to have to wait outside.
-It was okay for her to "welcome people".
-She had never been told not to let people in the front door.

Interview with a medication aide (MA) on 02/02/22 at 1:12pm revealed:
-Resident #4 would wander around the facility and was very confused.
-Resident #4 would want to call her family member and talked about going home.

Telephone interview with Resident #4's power of attorney (POA) on 02/04/22 at 9:16am revealed:
-Resident #4 wanted to be back in her own home.
-Resident #4 liked to walk and walked the hallways as much as she could.
-Resident #4 used to go outside and sit on the front porch but she did not try to go outside anymore.
-She did not think Resident #4 thought about or wanted to go outside anymore.
-She did not think Resident #4 tried to open doors or let in visitors.

Interview with the RCC on 02/04/22 at 10:39am and 5:29pm revealed:
-Resident #4 refused medications and wanted to see her own physician; she could have a mind of her own.
-Resident #4 walked a lot but did not try to go outside.
-She had never seen Resident #4 open a door to let anyone inside the facility.
-She had seen Resident #4 sit on the back porch with the smokers.
-Resident #4 could be confused at times and thought the facility was her former house.

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-Resident #4 would say she did not live here and wanted to go home.
-Resident #4 would want to call her POA and would say she was sick and needed to call 911.
-Resident #4 would say she needed to call 911 to get out of here [the facility].
-The staff could redirect Resident #4 when she wanted to go home.

Interview with the Administrator on 02/01/22 at 4:56pm revealed she did not know Resident #4 was identified on her current FL-2 as a resident who wandered.

Attempted telephone interview with Resident #4's primary care provider on 02/04/22 at 9:00am was unsuccessful.

2. Review of the Falls Policy provided by the facility revealed:
-The policy was not dated.
-The policy was to provide guidance to residents and staff on fall prevention and education, steps to take when a fall occurred and actions for proper reporting.
-When a fall occurred an incident report would be completed.
-Procedures for what to do after a fall occurred would be based on case by case.

Confidential interview with a resident revealed "half-the falls around here would not happen if staff answered the call bells."

Review of Resident #2's current FL-2 dated 02/01/21 revealed:
- Diagnoses included blindness secondary to macular degeneration, osteopenia, and pulmonary fibrosis.
- Resident #2 was intermittently disoriented.

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Review of Resident #2's care plan dated 09/23/21 revealed:
-Resident #2 was oriented.
-Resident #2's memory was adequate.
-Resident #2 required limited assistance with toileting, ambulation, bathing, dressing, and transferring.

Review of Resident #2's incident and accident report dated 12/13/21 revealed:
-Resident #2 was found on the floor of her bathroom.
-There was a skin tear to her left elbow, right leg, and left foot.
-Intervention implemented was to remind the resident to use her call bell for assistance.
-There was an addendum added by the Administrator the primary care provider (PCP) for home health to be ordered to treat the skin tears.

Review of Resident #2's medication aide (MA) facility care notes revealed:
-On 09/02/21, Resident #2 had a fall by her bed.
-Resident #2 had a skin tear on her left arm.
-On 11/13/21, Resident #2 was found on the bathroom floor at 11:45pm.
-On 11/15/21, Resident #2 was found on the floor in the bathroom at 1:40am with a skin tear on her left finger, right ankle, and right elbow.
-On 12/11/21, Resident #2 was found on the floor beside her bed with a skin tear on her hand.
-On 12/27/21, Resident #2 was unresponsive (would not speak or open her eyes); the PCP was notified and was advised to send the resident to the hospital.
-On 12/28/21, the MA documented Resident #2 was admitted to the hospital and had been diagnosed with a UTI and low potassium.
-On 01/01/22, Resident #2 was found on the floor

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beside her bed, and 30 minutes later Resident #2 was found on the floor again.
-The hospice nurse was notified, and she was told to keep a close eye on Resident #2.
-On 01/02/22, Resident #2 was found on the floor by her bed.
-Resident #2's hospice nurse was called, and the MA was directed to give Resident #2 her 2:00pm prn Ativan and to administer prn (as needed) pain medication every 4 hours and to keep a close eye on Resident #2.
-The MA was keeping Resident #2 with her, because there was no one available to sit with the resident 24/7.
-On 01/03/22, Resident #2 was found on the floor in a vacant room.
-Every time the personal care aide (PCA) or the MA looked in on Resident #2, she was trying to get out of the bed.
-On 01/29/22, Resident #2 was found on the floor beside her bed.

Review of Resident #2's hospice care note dated 01/01/22 revealed:
-At 2:40pm, received a call from the MA that Resident #2 had a fall.
-The MA reported Resident #2 was trying to pull her pants up and fell.
-Resident #2 was lying on the floor beside her bed.
-The MA reported there were no bruises or skin tears noted and Resident #2 denied pain.
-The MA was advised to monitor Resident #2.

Review of Resident #2's hospice care note dated 01/02/22 at 10:17am revealed:
-The visit was a skilled nursing visit for falls and decline.
-Resident #2 was found to be lethargic.
-Resident #2 was able to answer simple

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questions but answers were one to two words and her voice was a whisper.
-Resident #2's respirations were irregular with 40 seconds of apnea (stopped breathing) noted.
-Resident #2's pulse was weak.
-Resident #2 had multiple bruises at various healing stages all over her trunk and extremities from multiple falls.
-Facility staff reported Resident #2 fell a total of 4 times in the last 24 hours.
-Resident #2 denied hitting her head and no knots or bruising were noted.
-Facility staff reported Resident #2 would not use her call bell when she needed to get up.
-Facility staff were unaware of why Resident #2 was trying to get up.
-Resident #2 had 2 falls within 30 minutes of each other on 01/01/22 per the MA.
-The hospice nurse educated staff on signs and symptoms of agitation and pain, comfort medications, disease progression, and fall safety precautions.

Review of Resident #2's hospice care note dated 01/02/22 revealed:
-At 10:40am, received a call from the MA that Resident #2 had another fall.
-When the MA went into Resident #2's room, the resident was sitting on the floor, and no bruises or skins tears were noted.
-Advised the MA to administer Ativan at 2:00pm.
-The hospice medical provider did not want to change Resident #2's medication at this time.
- At 2:10pm, received a second call from the MA, Resident #2 had a fall.
-The MA reported Resident #2 was found lying in front of her wheelchair.
-The MA reported there were no bruises or cuts.
-She spoke to the hospice medical provider who did not want to change Resident #2's

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medications.

Review of Resident #2's hospice care note dated 01/03/22 at 11:05am revealed:
-She received a telephone call from the MA to report Resident #2 had a fall while trying to get into another resident's bed.
-The nurse planned to make a skilled nurse visit to assess the decline.

Review of Resident #2's hospice care note dated 01/03/22 at 7:17pm revealed:
-Wound care was provided, removed old dressings, and replaced.
-Resident #2 had 6-centimeter (cm) skin tear on her left upper arm.
-Resident #2 had 4cm x 2cm wound to the left top inner foot.
-Resident #2 had a 3cm skin tear right of the foot.
-Resident #2 had 1.5cm skin tear to her right knee.
-Reiterated to Resident #2 to use the call bell and ask for assistance when she needed to get up.
-Reviewed the visit with the MA, updated on wound care and fall precautions.

Review of Resident #2's hospice care note dated 01/04/22 revealed:
-There was no time noted for the hospice visit.
-Resident #2's diagnoses included heart failure, dementia, anxiety, and recurrent falls with skin tears and bruises.
-Resident #2's hospice start of care was dated 12/31/21.
-In December 2021, Resident #2 was found to have mental status changes and hypoxia and was admitted to the local hospital.
-At the time of admission to hospice on 12/31/21, Resident #2 was bedbound, confused, having poor appetite and speech was garbled.

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-Since the 1st of January 2022, Resident #2 had had at least four falls.
-One of the falls occurred when the resident was trying to get out of her wheelchair, on another hall, trying to get into another resident's bed.
-Resident #2 had skin tears secondary to the fall.
-Staff reported Resident #2 did not remember to use her call bell because of the resident's dementia.
-Resident #2 was noted to have a bruise on the left side of her head.
-There was concern for Resident #2's safety because the resident had several falls, the resident could not reliably use her call bell, and the resident's room was at the end of the hall very far from the main nursing area.

Review of Resident #2's hospice care note dated 01/04/22 at 7:39pm revealed:
-Routine skilled nursing visit.
-Facility staff reported Resident #2 was mostly confused.
-Facility staff reported Resident #2 pulled her incontinence brief down and urinated in her wheelchair.

Review of Resident #2's hospice care note dated 01/05/22 at 3:45pm revealed the nurse had received a phone call from the facility staff to report Resident #2 had 2 falls today, 01/05/22, with no injuries.

Review of Resident #2's hospice care note dated 01/12/22 at 2:49pm revealed:
-Dressings were changed on three skin tears.
-Facility staff reported Resident #2 was more confused than normal and possibly had a urinary tract infection (UTI).
-She reviewed recent hospitalization notes, and Resident #2 had been administered Zosyn

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(antibiotic) during the hospitalization and the urinalysis was negative.
-The medical provider thought the increased confusion was related to Resident #2's poor heart function.
-She educated staff on Resident #2's hospitalization and medication course and that it was not likely Resident #2 had a UTI since it was negative a week ago.

Review of Resident #2's hospice care note dated 01/13/22 at 5:00pm revealed the facility staff called to notify the hospice nurse Resident #2 had a fall without injury.

Review of Resident #2's hospice care note dated 01/21/22 at 3:45pm revealed:
-Resident #2's roommate reported the resident fell around 3:00am.
-The roommate reported Resident #2 walked without complaint of pain after the fall.
-Staff was not aware of the fall, and no details were available.
-Resident #2 had a small bruise on the left side of her head that appeared to be in the healing stage.
-Resident #2's skin tear on her left foot was healed (scabbed).
-Resident 2's left arm and right leg dressings were changed.
-Resident #2 had a skin tear on her left upper arm, 4 centimeters (cm) by 5cm.
-Resident #2 had a skin tear on her right shin, 4cm by 5cm.
-Resident #2 had scattered scabs all over her legs which the resident picked at and caused to bleed.
-Resident #2 had multiple areas of dried blood on her legs.
-The plan for the next 2 weeks was to visit 1-2 times per week to focus on confusion, safety and

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wound care.
-She educated the staff on fall prevention and safety of Resident #2, and frequent rounding of Resident #2 was necessary.

Telephone interview with Resident #2's hospice nurse on 02/07/22 at 9:18am revealed:
-On 02/03/22 she discussed fall precautions with the PCA including keeping Resident #2's bed in the lowest position, eliminating clutter around the room, and keeping the resident's door open.
-She asked if Resident #2 could be moved to a more central location (the resident was at the end of the hall).
-She instructed the PCA to monitor Resident #2 "more often."
-Resident #2 should be checked on at least every hour if Resident #2's roommate was not in the room.
-Resident #2's roommate was attentive to calling for help for Resident #2.
-The more eyes on Resident #2, the better.

Telephone interview with another hospice nurse for Resident #2 on 02/07/22 at 9:18am revealed:
-She had been notified of Resident #2 having multiple falls.
-Ideally, staff should be checking on Resident #2 every 30 minutes.
-She thought the facility staff was already checking on Resident #2 every 30 minutes.

Interview with a MA on 02/01/22 at 10:15am revealed:
-Resident #2 was found "a while back" outside in the bushes with skin tears.
-There was a meeting with the MAs about the incident reports not being completed correctly.
-There were no instructions given about increased supervision.

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Telephone interview with a third shift PCA on 02/01/22 at 2:15pm revealed:
-Resident #2 got out of bed on her own.
-Resident #2 had been found in random rooms when she was doing her room checks.
-Resident #2 could answer questions but could not remember if she had eaten or not.
-Resident #2 was on 2-hour checks but she checked on her more often.
-No one told her to check on Resident #2 more often, she just did it.

Interview with Resident #2's roommate on 02/01/22 at 4:51pm revealed:
-Resident #2 was "here, there, and everywhere."
-She pushed her call bell when Resident #2 was trying to get out of the bed because she did not want the resident to get hurt.
-She had to wait as long as 30 minutes before someone came to answer the call bell.

Interview with Resident #2 on 02/01/22 at 5:11pm revealed:
-She had fallen at the facility.
-She did not know what caused her falls; "I just fall."

Interview with another MA on 02/02/22 at 7:42am revealed:
-When Resident #2 was found outside, the Administrator directed staff to check on Resident #2 every 15-minutes for 3 days.
-Resident #2 was observed using her trashcan as a toilet in the last 2 weeks.
-Resident #2 was reminded to use her call bell for assistance but the resident was not going to remember.
-She had not been told to do anything different for Resident #2 to reduce her falls or provide more

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supervision.
-The facility did not use chair/bed alarms.
-Physical therapy had not been ordered for Resident #2 because she was on hospice care.
-It was not out of the norm for Resident #2 to be confused.
-Resident #2 was on checks every 2 hours.
-Resident #2 had more falls on the 3rd shift.
-When she worked, if she noted Resident #2 was more confused, she would check on her more often.

Telephone interview with a MA on 02/02/22 at 1:10pm revealed:
-All residents were supposed to be checked every 2 hours.
-Resident #2 had a lot of falls.
-She thought Resident #2's falls were related to toileting because the resident always had her pants around her ankles when she found her.
-Resident #2's falls had "slacked up" in the last couple of weeks.
-No one told her to check on Resident #2 more often, she just did because she cared about her residents.
-She sometimes took Resident #2 with her on her rounds in the facility, because she was afraid if she left Resident #2, she would fall again.

Telephone interview with another MA on 02/02/22 at 10:41am revealed:
-Resident #2 had been on increased checks after a fall, but it had been a while since that happened.
-There was a printed paper they had to document the increased checks, but she did not recall how often the checks were.
-She thought the fall was in December 2021.
-Resident #2 seemed to be falling when going to the bathroom.

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Interview with the Resident Care Coordinator (RCC) on 02/03/22 at 2:48pm revealed:
-She was aware Resident #2 had multiple falls; the falls were "typically during the day" when the resident crawled off the bed onto the floor.
-A lot of Resident #2's falls were in September 2021, prior to being hospitalized for a UTI.
-Resident #2 did not fall that often.
-They did not do anything particularly different for Resident #2 related to multiple falls, but hospice increased their visits.
-The facility's fall policy was if a resident had a fall and hit their head, the staff would call the PCP to see if the resident should be sent out.
-They followed the recommendations from the hospital or the resident's PCP if a resident had multiple falls.
-If a resident was on hospice services, she would let the hospice nurse know so they could follow closer.
-If the resident was not on hospice, she would see about ordering therapy.
-Stand-up meetings were held every other week and falls were discussed.
-They discussed residents who had increased falls or were at risk for falls.

Interview with the RCC on 02/04/22 at 10:36am revealed:
-Resident #2 could be checked on more often because of the resident's history of falls.
-She had not directed the staff to check on Resident #2 more often; she had, "just mentioned it."
-She thought she sent out a group text message about checking on Resident #2 more often, "maybe 2-3 weeks ago."

Interview with Resident #2's PCP on 02/04/22 at

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2:49pm revealed:
-She was aware Resident #2 had falls, but she did not know if she had been notified of every fall.
-She thought Resident #2 had some type of device in place alerting staff to know when the resident was up and needed to be monitored.
-She thought part of the care for residents in facilities was alarms to know when Resident #2 was up.
-If the facility staff would have suggested a bed/chair alarm for Resident #2, she would have ordered it.
-It was an assumption on her part Resident #2 had a bed/chair alarm already in place.

Based on interviews and record reviews, there was no increased supervision or other interventions implemented for Resident #2 after 3 falls between 09/02/21-11/15/21 and 7 falls between 12/11/21-01/21/22, which resulted in multiple skin tears and bruising.

Interview with the Administrator on 02/04/22 at 11:56am revealed:
-She and the RCC did Quality Assurance meetings on falls.
-They looked at what they could do in the resident's room to decrease falls, such as moving the bed.
-If a resident had frequent falls, the PCP was notified to obtain an order for physical therapy.
-She could not prevent someone from falling.
-The PCP was notified of every fall.
-The PCP always asked what happened.
-"We tell the PCP what we did, and they may say, here is something else to try."
-They did not have the authority to make recommendations to a resident's PCP.
-She and the RCC always look at the situation to see what could be done to keep the residents

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D 270	Continued From page 79 safe. Attempted telephone interview with Resident #2's family member on 02/04/22 at 4:47pm was unsuccessful. The facility staff failed to provide supervision to residents who were known to have intermittent confusion, resulting in a resident exiting the facility without staff knowledge when the temperature was below freezing and was found deceased outside the next morning (Resident #1); and a second resident (Resident #2) exiting the facility without staff knowledge and was found on the ground outside the facility with a fractured wrist and had multiple falls without increased supervision, resulting in skin tears and bruising; and a third resident (Resident #4) who was identified as having wandering tendencies and opened the front door to visitors. The facility's failure to supervise residents resulted in a death and injuries to another resident and constitutes a Type A1 Violation. The facility provided a plan of protection (POP) in accordance with G.S. 131D-34 on 02/01/22 for this violation. A POP addendum was added on 02/04/22. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 6, 2022.	D 270		
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	D 392		

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D 392	Continued From page 80 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances was maintained for 6 of 6 sampled residents (#4, #6, #8, #9, #10 and #13) with physician orders for narcotic pain medication. The findings are: Review of the facility's policy for Controlled Substances revealed: -Documentation of controlled substances will be maintained by the facility and available for review. -All controlled substances shall be counted prior to a Medication Aide (MA) receiving keys to the medication cart. -MAs should review the count sheet and the card verifying accuracy of the number on the punch card and the count sheet. -The Resident Care Coordinator/ Administrator/ Designee will randomly monitor the count on all controlled substances within the community. 1. Review of Resident #2's current FL2 dated 02/01/21 revealed diagnoses included osteopenia, chronic back pain, and fibromyalgia. Review of Resident #2's signed physician's	D 392	Pharmacy RN/Administrator retrained Med Aides on Narcotic Policies to include signing the MAR and control sheets when administering narcotics. Administrator/RCC audited all narcotics in facility to ensure the pill count is correct by the narcotic count sheet and documentation matches the MAR and effectiveness documented for all PRN narcotics. RCC will audit all narcotic controls sheets, and MARS for complete documentation x5 days per week x3 weeks and then 1x weekly going forward 2/3/22	2/8/2022 3/24/2022 3/24/2022

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orders dated 10/08/21 revealed there was an order for oxycodone IR (immediate release) 10mg one tablet every 4 hours as needed (prn) for pain control. (Oxycodone is a schedule II narcotic used to treat moderate to severe pain.)

Review of Resident #2's hospice care note dated 01/01/22 revealed:
-At 2:40pm hospice received a call from the MA, Resident #2 had a fall.
-Resident #2 was trying to pull her pants up and fell.
-Resident #2 was lying beside her bed.
-There were no bruises or skin tears noted and Resident #2 denied pain.
-The MA was advised to monitor Resident #2.

Review of Resident #2's facility care notes dated 01/02/22 revealed:
-Resident #2 was found on the floor by her bed.
-Resident #2's hospice nurse was called, and the MA was directed to give Resident #2 her 2:00pm prn Ativan (used to treat anxiety) and to administer prn pain medication every 4 hours and to keep a close eye on Resident #2.

Telephone interview with a hospice nurse on 02/02/22 at 9:35am revealed Resident #2 was admitted to hospice services on 12/31/21.

Telephone interview with Resident #2's hospice nurse on 02/07/22 at 9:18am revealed:
-There was documentation Resident #2 was administered prn anxiety medication and prn oxycodone 10 mg for pain.
-There was no documentation in the hospice encounter note dated 01/02/22 regarding the hospice medical provider increasing Resident #2's pain medication to every 4 hours routinely.

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D 392	Continued From page 82 Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/22 at 11:30am revealed: -The pharmacy provided controlled substance count sheets (CSCS) with each dispensing of a controlled substance to be used along with the electronic medication administration (eMAR) for documenting administration of the medication. -Oxycodone 10mg was routinely dispensed for Resident #2 for 30 tablets on 11/04/21, 11/20/21, 12/14/21, 12/27/21, 01/14/21, and on 01/26/22. Review of Resident #2's November 2021 electronic medication administration (eMAR) revealed: -There was an entry for oxycodone 10mg one tablet every 4 hours prn for pain control. -There was no scheduled time for administration of oxycodone 10mg. -There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication. Review of Resident #2's November 2021 electronic medication administration (eMAR) compared to Resident #2's CSCS for 30 tablets of oxycodone 10mg dispensed on 11/04/21 revealed: -There were 30 tablets initialed as signed out on the CSCS from 11/09/21 at 11:21am to 11/21/21 at 7:30am. -There were 26 of 30 doses initialed as signed out by the same MA. -There were 15 doses on the eMAR documented as administered and effective. -There were 15 of 30 doses of oxycodone 10mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 11/09/21 at 11:21am to 11/21/21 at 7:30am.	D 392		

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Review of Resident #2's November 2021 eMAR and December 2021 compared to Resident #2's CSCS for 30 tablets of oxycodone 10mg dispensed on 11/20/21 revealed:
-There were 30 tablets initialed as signed out on the CSCS from 11/21/21 at 11:21am to 12/14/21 at 7:30pm.
-There were 27 of 30 doses initialed as signed out by the same MA.
-There were 14 doses on the eMAR documented as administered and effective.
-There were 16 oxycodone 10mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 11/21/21 at 11:21am to 12/14/21 at 7:30pm.

Review of Resident #2's December 2021 eMAR compared to Resident #2's CSCS for 30 tablets of oxycodone 10mg dispensed on 12/14/21 revealed:
-There were 30 tablets initialed as signed out on the CSCS from 12/15/21 at 7:27am to 12/31/21 at 7:30pm.
-There were 28 of 30 doses initialed as signed out by the same MA.
-There were 9 doses on the eMAR documented as administered and effective.
-There were 21 oxycodone 10mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 12/15/21 at 7:27am to 12/31/21 at 7:30pm.

Review of Resident #2's January 2022 eMAR compared to Resident #2's CSCS for 30 tablets of oxycodone 10mg dispensed on 12/27/21 revealed:
-There were 30 tablets initialed as signed out on the CSCS from 01/01/22 at 7:20am to 01/15/22 at 7:10pm.

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D 392	Continued From page 84 -There were 30 of 30 doses initialed as signed out by the MA. -There were 6 doses on the eMAR documented as administered and effective including oxycodone 10mg administered on 01/02/22 at 11:37am on the eMAR and doses signed out on the CSCS at 7:20am, 11:30am, 3:30pm and 7:30pm. -There were 24 oxycodone 10mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 01/01/22 at 7:20am to 01/15/22 at 7:10pm. Review of Resident #2's January 2022 eMAR compared to Resident #2's CSCS for 30 tablets of oxycodone 10mg dispensed on 01/14/22 revealed: -There were 5 doses on the eMAR documented as administered and effective by the same MA as follows: on 01/18/22 at 2:44pm, on 01/21/22 at 11:00am and 3:28pm, on 01/22/22 at 3:32pm and on 01/23/22 at 7:33pm. -There were 25 oxycodone 10mg tablets not documented as administered on the eMAR. -There was no CSCS available for review to determine the number of oxycodone 10mg tablets documented as signed out, or the return of the 30 oxycodone 20mg dispensed from the pharmacy. Review of Resident #2's January 2022 eMAR compared to Resident #2's CSCS for 30 tablets of oxycodone 10mg dispensed on 01/26/22 revealed: -There were 11 tablets initialed as signed out on the CSCS from 01/27/22 at 7:15am to 01/31/22 at 3:10pm. -There were 11 of 11 doses initialed as signed out by the same MA. -There were two tablets signed out on the CSCS on 01/28/22 at 7:28pm with one entry crossed out	D 392		

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but the count was not adjusted to add back one tablet, making the quantity on hand short one tablet for 01/28/22.
-There was no documentation for correcting the error.
-There was 1 dose on the eMAR documented as administered and effective on 01/31/22 at 3:10pm.
-There were 11 oxycodone 10mg tablets dispensed on 01/26/22 that were not documented on the eMAR as administered prn or the effectiveness documented from 01/27/22 at 7:15am to 01/31/22 at 3:10pm.

Observation of oxycodone 10mg tablets available for administration on 02/04/22 at 9:00am revealed there were 19 tablets remaining with 19 tablets showing on the remaining count (should have been 20) in a bubble card of 30 dispensed on 01/26/22.

Confidential interview with a staff revealed:
-MAs routinely count off the controlled drugs between shift changes.
-The MAs verified the number of tablets on the CSCS compared to the quantity of medication remaining on the medication cart before exchanging the medication cart keys.
-She was not responsible to audit the eMAR documentation of administration compared to the documentation signed out on the CSCS.
-She noticed that one MA had routinely signed on the CSCS for Resident #2's oxycodone 10mg ordered prn.
-Resident #2 had not requested prn oxycodone 10mg or complained pain on the days she had staffed the medication cart.

Interview with the Resident Care Coordinator (RCC) on 02/03/22 at 2:48pm revealed she did

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not believe Resident #2 was administered oxycodone 10mg because Resident #2 would have been in a more sedated state than she was in had she been administered the medication.

Telephone interview with Resident #2's primary care provider (PCP) on 02/04/22 at 2:49pm revealed:
-The PCP continued to provide care and monitor Resident #2 even though she had started hospice care.
-The PCP had provided care for Resident #2 for more than 20 years.
-Resident #2 had chronic pain for many years.
-She felt like Resident #2 would be able to ask for pain medication (oxycodone 10mg) when she needed it.
-Resident #2's level of pain should be consistent from day to day, meaning she expected the resident may ask for pain medication daily.
-She looked at Resident #2's CSCS only to see that the resident was receiving oxycodone 10mg, but not closely to see which staff was documenting administration or if the administration was daily.
-She expected Resident #2 would need oxycodone 10mg on more days than when one MA worked.
-She was not sure Resident #2 needed oxycodone 4 times a day.

Based on observation of medication on hand, and reviews of the eMARs, CSCS documentation, and dispensing records, and interviews with the pharmacy staff, Resident #2 had 87 oxycodone 10mg not accurately accounted for on the eMARs compared to the CSCS logs for 180 oxycodone 10 mg dispensed to the resident as follows:
-There were 15 oxycodone 10mg tablets dispensed on 11/04/21 not documented on the

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eMAR as administered prn or effectiveness documented from 11:21am on 11/09/21 to 7:30am on 11/21/21.
-There were 16 oxycodone 10mg tablets dispensed on 11/20/21 not documented on the eMAR as administered prn or effectiveness documented from 11:21am on 11/21/21 to 7:30pm on 12/14/21.
-There were 21 oxycodone 10mg tablets dispensed on 12/14/21 not documented on the eMAR as administered prn or effectiveness documented from 7:27am on 12/15/21 to 7:30pm on 12/31/21.
-There were 24 oxycodone 10mg tablets dispensed on 12/27/21 not documented on the eMAR as administered prn or effectiveness documented from 7:20am on 01/01/22 to 7:10pm on 01/15/22.
-There were 11 oxycodone 10mg tablets dispensed on 01/26/22 not documented on the eMAR as administered prn or effectiveness documented from 7:15am on 01/27/22 to 3:10pm on 01/31/22.
-There was no CSCS available for review to compare documentation of administration, document the return of, or accounting for the 30 oxycodone 10mg dispensed from the pharmacy on 01/14/22 dispensing of 30 tablets.

Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/22 at 2:55pm.

Refer to the interview with Staff B on 02/03/22 at 1:39pm:

Refer to the interview with the RCC on 02/03/22 at 2:48pm.

Refer to the telephone interview with the facility's primary care provider (PCP) on 02/04/21 at

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2:15pm.

Refer to the interview with the Administrator on 02/02/22 at 5:40pm.

2. Review of Resident #8's current FL2 dated 05/18/21 revealed:
-Diagnoses included cerebral infarction, congestive heart failure, and chronic obstructive pulmonary disease.
-There was an order for oxycodone IR 10mg one tablet 2 times a day. (Oxycodone is a schedule II narcotic used to treat moderate to severe pain.)

Review of Resident #8's physician's orders dated 11/22/21 revealed an order for oxycodone 10mg one every 4 hours as needed (prn) for pain, up to 4 tablet per day.

Telephone interview with a pharmacist at Resident #8's pharmacy on 02/02/22 at 1:50pm revealed:
-The pharmacy did not provide controlled substance count sheets (CSCS) with each dispensing of a controlled substance to be used for signing out narcotics because the facility had not requested a CSCS.
-Resident #8's had 120 tablets of oxycodone 10mg dispensed each time on 10/25/21, 11/22/21, and on 01/20/22.

Review of Resident #8's October 2021 electronic medication administration records (eMAR) revealed:
-There was an entry for oxycodone 10mg one tablet every 6 hours prn for pain.
-There was no scheduled time for administration of oxycodone 10mg.
-There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn

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D 392	Continued From page 89 medication. Review of Resident #8's October 2021 eMAR compared to Resident #8's CSCS for 120 tablets of oxycodone 10mg dispensed on 10/26/21 revealed: -There were 12 tablets initialed as signed out on the CSCS from 10/27/21 at 7:30am to 10/31/21 at 7:00pm. -There were 6 doses on the eMAR documented as administered and effective. -There were 6 oxycodone 10mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 10/27/21 at 7:30am to 10/31/21 at 7:00pm. -There were 9 of 12 doses initialed as signed out on the CSCS by the same MA. Review of Resident #8's November 2021 eMAR revealed: -There was an entry for oxycodone 10mg one tablet every 6 hours prn for pain discontinued on 11/23/21. -There was no scheduled time for administration of oxycodone 10mg. -There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication. -There was an entry dated 11/22/21 for oxycodone 10mg one every 4 hours prn for pain up to 4 tablets daily. Review of Resident #8's November 2021 eMAR compared to Resident #8's CSCS for 120 tablets of oxycodone 10mg dispensed on 10/26/21 revealed: -There were 80 tablets initialed as signed out on the CSCS from 8:00am on 11/01/21 to 9:31pm on 11/30/21. -There were 51 of 80 doses on the eMAR	D 392		

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documented as administered and effective.
-There were 29 oxycodone 10mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 11/01/21 at 8:00am to 11/30/21 at 9:31pm
-There were 37 of 80 doses initialed as signed out on the CSCS by the same MA.

Review of Resident #8's December 2021 eMAR revealed:
-There was an entry dated 11/22/21 for oxycodone 10mg one every 4 hours prn for pain up to 4 tablets daily.
-There was no scheduled time for administration of oxycodone 10mg.
-There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication.

Review of Resident #8's December 2021 eMAR compared to Resident #8's CSCS for 120 tablets of oxycodone 10mg dispensed on 10/26/21 revealed:
-There were 28 tablets initialed as signed out on the CSCS from 12/01/21 at 10:30am to 12/12/21 at 7:55am.
-There were 22 of 28 doses documented on the EMAR as administered and effective.
-There were 6 oxycodone 10mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 12/01/21 at 10:30am to 12/12/21 at 7:55am.

Review of Resident #8's December 2021 eMAR compared to Resident #8's CSCS for 120 tablets of oxycodone 10mg dispensed on 11/22/21 revealed:
-There was one oxycodone 10mg initialed as signed out on the CSCS for 11/26/21 at 2:33am.
-There were 59 tablets initialed as signed out on

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the CSCS from 12/12/21 at 12:00pm to 12/31/21 at 7:30pm.
-There were 31 of 59 doses documented on the eMAR as administered and effective.
-There were 25 oxycodone 10mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 12/12/21 at 12:00pm to 12/31/21 at 7:30pm.

Review of Resident #8's January 2022 eMAR revealed:
-There was an entry for oxycodone 10mg one every 4 hours prn for pain up to 4 tablets daily.
-There was no scheduled time for administration of oxycodone 10mg.
-There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication.

Review of Resident #8's January 2022 eMAR compared to Resident #8's CSCS for 120 tablets of oxycodone 10mg dispensed on 11/22/21 revealed:
-There were 60 oxycodone 10mg initialed as signed out on the CSCS from 01/01/22 at 7:35pm to 01/21/22 at 5:41pm.
-There were 31 of 60 doses documented on the eMAR for administered and effective.
-There were 29 oxycodone 10mg tablets not documented on the eMAR administered prn or the effectiveness documented from 01/01/22 at 7:35pm to 01/21/22 at 5:41pm.
-There were 36 of 60 doses initialed as signed out on the CSCS by the same MA.

Review of Resident #8's January 2022 eMAR compared to Resident #8's CSCS for 120 tablets of oxycodone 10mg dispensed on 01/20/21 revealed:
-There were 35 oxycodone 10mg initialed as

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D 392	Continued From page 92 signed out on the CSCS from 01/21/22 at 3:25pm to 01/31/22 at 5:41pm. -There were 11 of 35 doses documented on the eMAR as administered and effective. -There were 24 oxycodone 10mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 01/21/22 at 3:25pm to 01/31/22 at 5:41pm. Observation of Resident #8's medication on hand on 02/04/22 at 9:10am revealed Resident #8 had 19 oxycodone 10mg in a bubble card dispensed on 01/20/22 which matched the quantity remaining on the CSCS. There were 2 complete bubble cards of 30 each remaining for dispensing date of 01/20/22. Based on observation of medication on hand, and reviews of the eMARs, CSCS documentation, and dispensing records, and interviews with the pharmacy staff, Resident #8's oxycodone 10mg was not accurately accounted for 115 tablets out of 243 tablets dispensed as follows: -Resident #8 had 34 oxycodone 10mg tablets not accurately accounted for on the eMARs compared to the CSCS for 108 oxycodone 10 mg tablets dispensed to the resident on 10/25/21. -Resident #8 had 57 oxycodone 10mg tablets not accurately accounted for on the eMARs compared to the CSCS for 120 oxycodone 10 mg tablets dispensed to the resident on 11/22/21. -Resident #8 had 24 oxycodone 10mg tablets not accurately accounted for on the eMARs compared to the CSCS for 35 of 120 oxycodone 10 mg tablets dispensed to the resident on 01/20/22. Confidential interview with a staff revealed: -The MAs routinely counted off the controlled drugs between shift changes.	D 392		

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-The MAs verified the number of tablets on the CSCS compared to the quantity of medication remaining on the medication cart before exchanging the medication cart keys.
-She was not responsible to audit the eMAR documentation compared to the documentation of administration on the CSCS.
-She noticed that only one MA had signed for administering Resident #8's oxycodone 10mg ordered prn most of the time.
-Resident #8's requested prn oxycodone 10mg in the morning and evening on the days she had staffed the medication cart.
-Some MAs were not documenting administration of prn pain medications on the residents eMARs which made it difficult to tell if a resident could receive the pain medication when they requested the medication without checking the CSCS instead of the eMAR.

Interview with a MA on 02/03/22 at 1:39pm revealed:
-Another MA told her that Resident #8 did not ask for oxycodone when they worked.
-She did not understand why Resident #8 did not ask the other MAs for her oxycodone.

Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/22 at 2:55pm.

Refer to the interview with Staff B on 02/03/22 at 1:39pm:

Refer to the interview with the RCC on 02/03/22 at 2:48pm.

Refer to the telephone interview with the facility's primary care provider (PCP) on 02/04/21 at 2:15pm.

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D 392	Continued From page 94 Refer to the interview with the Administrator on 02/02/22 at 5:40pm. 3. Review of Resident #9's current FL2 dated 08/05/21 revealed: -Diagnoses included diabetes mellitus, chronic obstructive pulmonary disease, and chronic pain -There was an order for oxycodone 20mg one tablet every 6 hours as needed (prn) for severe pain. (Oxycodone is a schedule II narcotic used to treat moderate to severe pain.) Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/22 at 11:30am revealed: -The pharmacy provided controlled substance count sheets (CSCS) with each dispensing of a controlled substance for documenting administration of the medication. -Resident #9 had 30 tablets of oxycodone 20mg was dispensed on 11/06/21, 12/06/21, 12/19/21, 12/21/21, 01/07/22, 01/14/22, 01/19/22, and 02/01/22 for a total of 240 oxycodone 20mg tablets. -On 12/20/21, oxycodone 10mg was dispensed from an order on a hospital discharge summary. a. Review of Resident #9's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for oxycodone 20mg one tablet every 6 hours as needed for severe pain. -There was no scheduled time for administration of oxycodone 10mg. -There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication. Review of Resident #9's November 2021 eMAR compared to Resident #9's CSCS for 30 tablets	D 392		

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of oxycodone 20mg dispensed on 11/06/21 revealed:
-There were 30 tablets initialed as signed out on the CSCS from 11/09/21 at 8:00pm to 12/06/21 at 6:45am.
-Resident #9 was in the hospital from 11/11/21 to 11/30/21 and no oxycodone 20mg was documented as administered.
-There were 23 of 30 doses documented on the eMAR as administered and effective.
-There were 7 oxycodone 20mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 11/09/21 at 8:00pm to 12/06/21 at 6:45am.

Review of Resident #9's December 2021 eMAR and January 2022 eMAR revealed:
-There was an entry for oxycodone 20mg one tablet every 6 hours as needed for severe pain.
-There was no scheduled time for administration of oxycodone 10mg.
-There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication.

Review of Resident #9's December 2021 eMAR compared to Resident #9's CSCS for 30 tablets of oxycodone 20mg dispensed on 12/06/21 revealed:
-There were 30 tablets initialed as signed out on the CSCS from 12/06/21 at 10:17pm to 12/23/21 at 12:12pm.
-Resident #9 was documented in the hospital from 12/12/21 to 12/20/21.
-There were 19 of 30 doses documented on the eMAR as administered and effective.
-There were 11 oxycodone 20mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 12/06/21 at 10:17pm to 12/23/21 at 12:12pm.

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Continued review of Resident #9's December 2021 eMAR compared to Resident #9's CSCS for 30 tablets of oxycodone 20mg dispensed on 12/09/21 revealed:
-There were 30 tablets initialed as signed out on the CSCS from 12/23/21 at 6:21pm to 12/31/21 at 7:00am.
-There were 16 of 30 doses documented on the eMAR as administered and effective.
-There were 14 oxycodone 20mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 12/23/21 at 6:21pm to 12/31/21 at 7:00am.

Review of Resident #9's December 2021 and January 2022 eMAR compared to Resident #9's CSCS for 30 tablets of oxycodone 20mg dispensed on 12/21/21 revealed:
-There were 30 tablets initialed as signed out on the CSCS from 12/31/21 at 1:00pm to 01/08/22 at 5:48am.
-There were 17 of 30 doses documented on the eMAR as administered and effective.
-There were 13 oxycodone 20mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 12/31/21 at 1:00pm to 01/08/22 at 5:48am.

Review of Resident #9's January 2022 eMAR compared to Resident #9's CSCS for 30 tablets of oxycodone 20mg dispensed on 01/07/22 revealed:
-There were 30 tablets initialed as signed out on the CSCS from 01/08/22 at 11:51am to 01/16/22 at 12:51am.
-There were 19 of 30 doses documented the eMAR as administered and effective.
-There were 11 oxycodone 20mg tablets not documented on the eMAR as administered prn or

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the effectiveness documented from 01/08/22 at 11:51am to 01/16/22 at 12:51am.

Review of Resident #9's January 2022 eMAR compared to Resident #9's CSCS for 30 tablets of oxycodone 20mg dispensed on 01/19/22 revealed:
-There were 29 tablets initialed as signed out on the CSCS from 01/24/22 at 7:50am to 01/31/22 at 11:57am.
-There were 18 of 29 doses documented on the eMAR as administered and effective.
-There were 11 oxycodone 20mg tablets not documented on the eMAR as administered prn or the effectiveness documented from 01/24/22 at 7:50am to 01/31/22 at 11:57am.

Observation of Resident #9 oxycodone 20mg tablets on hand for administration on 02/04/22 at 9:00am revealed there were 20 tablets on hand matching the CSCS for 30 oxycodone 20mg tablets dispensed on 02/01/22.

Observation of medication on hand, and reviews of the eMARs, CSCS documentation, and dispensing records, and interviews with the pharmacy staff for Resident #9 revealed:
-Resident #9 had 67 oxycodone 20mg tablets not accurately accounted for on the eMARs compared to the CSCS for 180 oxycodone 20 mg tablets dispensed for the resident from 11/06/21 to 01/19/22 and 30 oxycodone 10mg dispensed on 01/14/22 with no corresponding CSCS available for accurately accounting for administration.

Interview with Resident #9 on 02/01/22 at 5:27pm revealed:
-He had an order for oxycodone as needed (PRN) for lower back and stomach pain.

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-He needed the oxycodone when he first woke up in the mornings; some mornings the pain would wake him up.

Confidential interview with a staff revealed:
-The medication aides (MAs) routinely count off the controlled drugs between shift changes.
-The MAs verify the number of tablets on the CSCS compared to the quantity of medication remaining on the medication cart before exchanging the medication cart keys.
-She was not responsible to audit the eMAR documentation compared to the documentation of administration on the CSCS.
-She signed the CSCS for the medication when she prepared the medication for administration and documented the administration on the resident's eMAR. About one hour later she documented the effectiveness of the medication on the eMAR.
-Some MAs were not documented administration of prn pain medications on the residents eMARs which made it difficult to tell if a resident could receive the pain medication when they requested the medication without checking the CSCS instead of the eMAR.
-Resident #9's requested prn oxycodone 20mg every 6 hours most of the time.

Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/22 at 2:55pm.

Refer to the interview with Staff B on 02/03/22 at 1:39pm:

Refer to the interview with the RCC on 02/03/22 at 2:48pm.

Refer to the telephone interview with the facility's primary care provider (PCP) on 02/04/21 at

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2:15pm.

Refer to the interview with the Administrator on 02/02/22 at 5:40pm.

b. Review of Resident #9's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry dated 12/20/21 for oxycodone 10mg one tablet every 4 hours as needed.
-There was documentation oxycodone 10mg was administered on 12/20/21 at 11:59pm.
-There was documentation oxycodone 10mg was administered on 12/21/21 at 4:00pm and was effective.
-There was documentation oxycodone 10mg was administered on 12/21/21 at 8:01am and was effective.

Review of Resident #9's CSCS available for review revealed there was no CSCS for oxycodone 10mg dispensed on 12/20/21 for 30 tablets available for review to compare documentation of the administration, or the return of the 30 oxycodone 10mg dispensed from the pharmacy on 12/20/21 for Resident #9.

Interview with the Resident Care Coordinator (RCC) on 02/04/22 at 2:00pm revealed:
-Resident #9 was discharged from the hospital on 12/20/21 with an order for oxycodone 10mg take one tablet every 4 hours as needed.
-She recalled clarifying the order for Resident #9 to remain on oxycodone 20mg every 6 hours as needed with the primary care provider and a new order was sent to the pharmacy.
-She could not locate the order for Resident #9 to discontinue oxycodone 10mg.
-She remembered preparing the remaining

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oxycodone 10mg tablets for return to the contracted pharmacy and believed she sent the CSCS back with the medication without keeping a copy.
-She was not able to provide documentation for returning a partial medication card of oxycodone 10mg for the remaining tablets of 30 tablets dispensed on 12/20/21.

Review of Resident #9's January 2022 eMAR revealed:
-There was an entry dated 12/06/21 for oxycodone 20mg every 6 hours prn for pain.
-There were 17 doses documented on the eMAR as administered and effective from 01/16/22 to 01/22/22.

Review of Resident #9's CSCS available for review revealed:
-There was no CSCS for oxycodone 20mg dispensed on 01/14/22 for 30 tablets available for review to compare documentation of the administration, or the return of the 30 oxycodone 20mg dispensed from the pharmacy on 01/14/22 for Resident #9.
-There was no CSCS available for review to correspond with oxycodone 20mg prn administration from 01/17/22 to 01/23/22 documented as administered on Resident #9's January 2022 eMAR.

Interview with the RCC on 02/04/22 at 2:00pm revealed:
-She could not locate the CSCS for Resident #9 for Resident #9's oxycodone 20mg dispensed on 01/14/22..
-She thought the CSCS was located in paperwork that had been misfiled.
-There was documentation on the eMAR for Resident #9 being administered the medication

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D 392	Continued From page 101 from 01/17/22 to 01/22/22. -She was responsible to ensure the controlled substances were account for. Based on observation of medication on hand, and reviews of the eMARs, CSCS documentation, and dispensing records, and interviews with the pharmacy staff for Resident #9 revealed: -There were 30 oxycodone 10mg dispensed on 12/20/21 with no corresponding CSCS available and not accounted for. -There were 30 oxycodone 20mg dispensed on 01/14/22 with no corresponding CSCS available and not accounted for. Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/22 at 2:55pm. Refer to the interview with Staff B on 02/03/22 at 1:39pm: Refer to the interview with the RCC on 02/03/22 at 2:48pm. Refer to the telephone interview with the facility's primary care provider (PCP) on 02/04/21 at 2:15pm. Refer to the interview with the Administrator on 02/02/22 at 5:40pm. 4. Review of Resident #10's current FL2 dated 06/08/21 revealed diagnoses included generalized weakness, gait difficulty, atrial fibrillation, and chest pain. Review of Resident #10's local hospital emergency department (ED) report dated 12/01/21 revealed: -Resident #10 visited the ED on 12/01/21	D 392		

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subsequent to a fall in the bathroom and complaint of right shoulder pain.
-Resident #10 was ordered Lortab 5/325 one tablet every 6 hours as needed (prn). (Lortab 5/325 is a schedule II narcotic used to treat moderate to severe pain).

Review of Resident #10's physician orders dated 12/17/21 revealed an order for Lortab 5/325 one tablet every 6 hours prn for pain.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/22 at 11:30am revealed:
-The pharmacy provided controlled substance count sheets (CSCS) with each dispensing of a controlled substance to be used along with the electronic medication administration (eMAR) for documenting administration of the medication.
-The pharmacy dispensed Lortab 5/325 mg for Resident #10 on 12/01/21 for 12 tablets and on 12/17/22 for 30 tablets.

Review of Resident #10's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry Lortab 5/325 one tablet every 6 hours prn for pain.
-There was no scheduled time for administration of Lortab 5/325.
-There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication.

Review of Resident #10's December 2021 eMAR compared to Resident #10's CSCS for 12 tablets of Lortab 5/325 dispensed on 12/01/21 revealed:
-There were 12 tablets initialed as signed out on the CSCS from 12/02/21 at 2:00am to 12/12/31 at 7:05pm.

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D 392	Continued From page 103 -There were 10 of 12 doses documented on the eMAR as administered and effective. -There were 2 Lortab 5/325 not documented on the eMAR as administered prn or the effectiveness documented for one tablet on 12/02/21 at 2:00am and one tablet on 12/12/21 at 7:04pm. Review of Resident #10's December 2021 eMAR compared to Resident #10's CSCS for 30 tablets of Lortab 5/325 dispensed on 12/17/21 revealed: -There were 2 tablets signed out on the CSCS for administration with one tablet at 8:10am on 12/22/21 and one tablet at 5:42pm on 12/31/21. -The eMAR had 2 of 2 doses documented as administered and effective. Review of Resident #10's January 2022 eMAR revealed: -There was an entry for Lortab 5/325 one tablet every 6 hours prn for pain. -There was no scheduled time for administration of Lortab 5/325. -There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication. Review of Resident #10's January 2022 eMAR compared to Resident #10's CSCS for 30 tablets of Lortab 5/325 dispensed on 12/17/22 revealed: -There were 27 tablets initialed as signed out on the CSCS from 01/02/22 at 10:22am to 01/31/22 at 2:30pm. -There were 9 of 27 doses documented on the eMAR as administered and effective. -There were 18 Lortab 5/325 not documented on the eMAR as administered prn or the effectiveness documented from 01/02/22 at 10:22am to 01/31/22 at 2:30pm. -There were 30 of 30 doses initialed as signed	D 392		

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D 392	Continued From page 104 out on the CSCS by the same medication aide (MA). Based on observations, interviews, and record review Resident #10 had 18 Lortab 5/325 tablets not accurately accounted for on the eMARs compared to the CSCS for 42 Lortab 5/325 tablets dispensed for the resident on 12/01/21 and 12/17/21. Confidential interview with a staff revealed: -She noticed that only one MA had signed for administering Resident #10's Lortab 5/325 ordered prn most of the time (30 of 30 opportunities in December 2021 and January 2022). -Resident #10 did not request prn Lortab 5/325 when she worked on the medication cart. Interview with Resident #10 on 02/03/22 at 12:10pm revealed: -She did not take many medications. -She had a fall in the bathroom and hurt her shoulder a while back and had a lot of pain at first. -The shoulder pain was pretty much gone now. -She asked for a pain pill a few times when she first hurt her shoulder. -She did not think she requested the pain medication from the same medication aide each time. -She could not recall the exact date of the last time she asked for a pain pill. Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/22 at 2:55pm. Refer to the interview with Staff B on 02/03/22 at 1:39pm:	D 392		

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D 392	Continued From page 105 Refer to the interview with the RCC on 02/03/22 at 2:48pm. Refer to the telephone interview with the facility's primary care provider (PCP) on 02/04/21 at 2:15pm. Refer to the interview with the Administrator on 02/02/22 at 5:40pm. 5. Review of Resident #6's current FL2 dated 08/26/21 revealed diagnoses included major depressive disorder, chronic atrial fibrillation, and insomnia. Review of Resident #6's signed physician's orders dated 08/26/21 revealed an order for hydrocodone/acetaminophen 5/325mg (a schedule II narcotic used to treat moderate to severe pain) one tablet every day as needed (prn) for pain. Telephone interview a pharmacist at the facility's contracted pharmacy on 02/02/22 at 11:30am revealed: -The pharmacy provided controlled substance count sheets (CSCS) with each dispensing of a controlled substance to be used for documenting administration of the medication. -The pharmacy dispensed hydrocodone/acetaminophen 5/325mg for Resident #6 on 05/13/21 and on 06/13/21 for 30 tablets each time. Review of Resident #6's November 2021 and December 2021 electronic medication administration records (eMAR) revealed: -There was an entry for hydrocodone/acetaminophen 5/325mg with directions for one tablet every day prn for pain.	D 392		

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-There was no scheduled time for administration of hydrocodone/ acetaminophen 5/325mg.
-There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication.

Review of Resident #6's November 2021 and December 2021 eMARs compared to Resident #6's CSCS for 30 tablets of hydrocodone/acetaminophen 5/325mg dispensed on 05/13/21 revealed:
-There were 4 tablets initialed as signed out on the CSCS for administration from 11/02/21 at 4:25pm to 12/09/21 at 6:30am.
-There were 4 of 4 doses of hydrocodone/acetaminophen 5/325mg documented on the eMAR as administered and effective.
-There were 4 of 4 doses initialed as signed out on the CSCS by the same MA.

Review of Resident #6's January 2022 eMAR revealed:
-There was an entry for hydrocodone/acetaminophen 5/325mg with directions for one tablet every day prn for pain.
-There was no scheduled time for administration of hydrocodone/ acetaminophen 5/325mg.
-There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication.

Review of Resident #6's January 2022 eMARs compared to Resident #6's CSCS for 30 tablets of hydrocodone/acetaminophen 5/325mg dispensed on 05/13/21 revealed:
-There were 10 tablets initialed as signed out on the CSCS for administration from 12/09/21 at 3:00pm to 01/31/22 at 1:59pm.
-There were 8 of 10 doses of

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hydrocodone/acetaminophen 5/325mg documented on the eMAR as administered and effective.
-There were 2 hydrocodone/acetaminophen 5/325mg not documented on the eMAR as administered prn or the effectiveness documented for one tablet on 01/10/22 at 3:00pm and one tablet on 01/28/22 at 3:30pm.
-There were 8 of 10 doses initialed as signed out on the CSCS by the same MA.

Observation of medication on hand for administration for Resident #6 on 02/03/22 revealed:
-Resident #6 had 3 tablets of hydrocodone/acetaminophen 5/325mg remaining for 30 tablets dispensed on 05/13/21; the count on the CSCS matched the number of tablets remaining in the bubble card.
-Resident #6 had 30 tablets of hydrocodone/acetaminophen 5/325mg remaining for 30 tablets dispensed on 06/07/21, matching the count remaining on the corresponding CSCS.

Based on observations, interviews, and record review Resident #6 had 2 hydrocodone/acetaminophen 5/325mg not accurately accounted for on the eMARs compared to the CSCS for 30 hydrocodone/acetaminophen 5/325mg tablets dispensed for the resident on 05/13/21 from 11/02/21 at 4:25pm to 01/21/22 at 1:55pm.

Confidential interview with a staff revealed:
-She noticed that only one MA had signed for administering Resident #6's hydrocodone/acetaminophen 5/325mg ordered prn most of the time (12 of 14 opportunities in November 2021, December 2021 and January 2022).

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D 392	Continued From page 108 -Resident #6 did not request prn hydrocodone/acetaminophen 5/325mg when she worked on the medication cart and did not appear to be in any pain. Interview with Resident #6 on 02/04/22 at 12:40pm revealed: -She knew she had a strong pain medication for pain that she could request if her legs were hurting a lot. -She asked the MA for the pain medication occasionally, but not very much. -She did not think the MAs were giving her pain medication daily. Telephone interview with the facility's primary care provider (PCP)on 02/04/21 at 2:15pm revealed: -Resident #6 was routinely seen by the PCP. -Resident #6 should be able to identify if she was requesting a pain medication. -Resident #6 had not indicated she was having additional pain when she saw her on last visit (12/28/21 per encounter notes). Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/22 at 2:55pm. Refer to the interview with Staff B on 02/03/22 at 1:39pm: Refer to the interview with the RCC on 02/03/22 at 2:48pm. Refer to the telephone interview with the facility's primary care provider (PCP) on 02/04/21 at 2:15pm. Refer to the interview with the Administrator on 02/02/22 at 5:40pm.	D 392		

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6. Review of Resident #13's current FL2 dated 01/25/22 revealed:
-Diagnoses included heart failure, and pain in the right hip.
-There was an order for hydrocodone/acetaminophen 5/325mg (a schedule II narcotic used to treat moderate to severe pain) one tablet every 6 hours as needed (prn).

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/22 at 11:30am revealed:
-The pharmacy provided controlled substance count sheets (CSCS) with each dispensing of a controlled substance to be used for documenting administration of the medication.
-The pharmacy dispensed hydrocodone/acetaminophen 5/325mg for Resident #13 on 01/18/22 with directions for one tablet every day prn for pain for a quantity of 30 tablets.

Review of Resident #13's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for hydrocodone/acetaminophen 5/325mg with directions for one tablet every 6 hours prn for pain.
-There was no scheduled time for administration of hydrocodone/ acetaminophen 5/325mg.
-There was space on the eMAR for documenting date, time, quantity and effectiveness of the prn medication.

Review of Resident #13's January 2022 eMARs compared to Resident #13's CSCS for 30 tablets of hydrocodone/acetaminophen 5/325mg dispensed on 01/18/22 revealed:

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D 392	Continued From page 110 -There were 14 tablets signed out on the CSCS for administration from 01/20/22 at 10:50am to 01/31/22 at 2:13pm. -There were 8 of 14 doses of hydrocodone/acetaminophen 5/325mg documented on the eMAR as administered and effective. -There were 6 hydrocodone/acetaminophen 5/325mg not documented on the eMAR as administered prn or the effectiveness from 01/20/22 at 10:50am to 01/31/22 at 2:13pm. -There were 13 of 14 doses initialed as signed out on the CSCS by the same MA. Observation of medication on hand for administration for Resident #13 on 02/04/22 at 9:00am revealed Resident #13 had 16 tablets of hydrocodone/acetaminophen 5/325mg remaining for 30 tablets dispensed on 01/18/22; the count on the CSCS matched the number of tablets remaining in the bubble card. Based on observations, interviews, and record review Resident #13 had 6 hydrocodone/acetaminophen 5/325mg not accurately accounted for on the eMARs compared to the CSCS logs for 30 hydrocodone/acetaminophen 5/325mg tablets dispensed for the resident on 01/18/22. Confidential interview with a staff revealed: -She noticed that one MA had signed for administering Resident #6's hydrocodone/acetaminophen 5/325mg ordered prn most of the time (13 of 14 opportunities in January 2022). -Resident #13 did not request prn hydrocodone/acetaminophen 5/325mg when she worked on the medication cart and did not appear to be in any pain.	D 392		

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D 392	Continued From page 111 Interview with Resident #13 on 02/04/22 at 12:30 revealed: -She did not ask for her pain medication every day. -She could not recall the last day she requested pain medication. -Due to her poor vision, she could not see all the medications brought to her by the MAs. Telephone interview with the facility's primary care provider (PCP) on 02/04/21 at 2:15pm revealed: -Resident #13 was routinely seen by the provider. -Resident #13 was a good historian, able to describe how she felt, when she saw her at visits. -Resident #13 should be able to identify if she was requesting a pain medication. -She was alarmed that Resident #13 was documented for receiving 2 hydrocodone/acetaminophen 5/325mg tablets on the days a certain medication aide worked. Refer to interview with the Resident Care Coordinator (RCC) on 02/02/22 at 2:55pm. Refer to interview with Staff B on 02/03/22 at 1:39pm: Refer to interview with the RCC on 02/03/22 at 2:48pm. Refer to telephone interview with the facility's primary care provider (PCP) on 02/04/21 at 2:15pm. Refer to interview with the Administrator on 02/02/22 at 5:40pm. Interview with the RCC on 02/02/22 at 2:55pm revealed:	D 392		

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-She was responsible for ensuring accurate accounting for controlled substances.
-When she audited CSCS, she routinely looked for the inventory count on the CSCS to match the quantity remaining on hand for the medication.
-She had not done routine audits on control substances due to staffing issues and assisting with Business Office Manager's duties.
-She did not know there was such a large number of controlled medications that were not matching for the number of tablets signed out on the CSCS and not matching the eMAR documentation.

Interview with Staff B on 02/03/22 at 1:39pm revealed:
-The CSCS were sent back to the pharmacy after a medication has been discontinued.
-The completed CSCS were placed in the RCC's office.
-The RCC filed them in the residents' records.
-She was told about the control substance inventory concerns the night before, 02/02/22.
-She was told on 02/02/22 to document administration of all controlled medication on the electronic medication administration record (eMAR) as well as the CSCS going forward.
-She only administered controlled medications when a resident would ask for them.
-She did not know why the residents only asked her for controlled medications and did not ask other MAs.
-If a resident asked for a pain pill she gave them a pain pill and if a resident asked for acetaminophen, she gave them acetaminophen.
-She did not always document the administration of prn medications on the eMAR because she got get busy and forgot.
-She did not want to document the administration of prn medications late because then the resident would not be able to get the medication again at

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the allotted length of time.
-She understood it made it hard for other MAs to know when to administer a prn medication if the eMAR did not reflect a correct administration time.
-It looked bad when she was the only MA signing the control logs.
-Another MA told her that a resident did not ask for prn oxycodone when they worked.
-She did not understand why the resident did not ask the other MAs for her prn oxycodone.
-Neither the RCC nor corporate staff had done a cart audit or a controlled tablet count with her.
-The CSCS would all be accurate because she made sure she documented and signed on them.

Interview with the RCC on 02/03/22 at 2:48pm revealed:
-She and the Administrator audited the controlled substances on 02/02/22 after 7:00pm.
-They counted all the narcotics, matched to the control sheets, and matched the eMARs to the control sheets.
-She was aware there were "quite a few" narcotics that were administered as prn and not documented on the eMAR.
-The audit information results were given to the corporate office on 02/02/22 in the evening.
-The Administrator discussed the prn documentation with a medication aide (MA), as well as if a resident needed prn medication routinely, it needed to be discussed with the primary care provider PCP.

Telephone interview with the facility's PCP on 02/04/21 at 2:15pm revealed:
-Only one of the residents she was currently caring for at the facility would require administering pain medication routinely.
-All her other residents should be managed on

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D 392	Continued From page 114 prn pain medications not requiring more than one to two tablets a day. -All the residents should be able to identify if they needed to request a pain medication. -She requested the residents' eMARs when she saw a resident. -She had not compared eMARs to the CSCS for documentation of prn pain medications. -If the eMAR was not accurate for administration of medications, even prn medications, it would interfere with her ability to correctly treat a resident. -The level of pain should be pretty consistent for her residents currently at the facility and only one resident routinely requested his prn pain medication. Interview with the Administrator on 02/02/22 at 5:40pm revealed: -The facility was responsible to report controlled substance discrepancies to the corporate office for further follow-up. -The RCC was responsible to ensure controlled medication accounting was accurate and complete. -She did not know there was a very large number of controlled medications documented as administered prn and not properly accounted for on the eMAR and CSCS. -She was not able to account for any missing CSCS unless they were just misfiled.. The facility failed to ensure a readily retrievable record of controlled substances for 6 of 6 residents by documenting the administration and disposition of 87 of 180 oxycodone 10 mg not accurately accounted for on the eMARs compared to the CSCS and 30 oxycodone 10mg not accounted for due to missing CSCS (#2); for 120 tablets out of 275 tablets of oxycodone 10mg	D 392		

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D 392	Continued From page 115 not accurately accounted for on the eMARs compared to the CSCS for Resident #8's; for 67 of 180 oxycodone 20mg not accurately accounted for on the eMARs compared to the CSCS, and 30 oxycodone 10mg plus 30 oxycodone 20mg not accounted for due to missing CSCS (#9); for 18 of 42 Lortab 5/325 tablets not accurately accounted for on the eMARs compared to the CSCS (#10); for 2 of 30 hydrocodone/acetaminophen 5/325mg tablets not accurately accounted for on the eMARs compared to the CSCS(#6) and 6 of 30 hydrocodone/acetaminophen 5/325mg tablets not accurately accounted for on the eMARs compared to the CSCS (#13) which resulted in inaccurate accounting for CSCS compared to the eMARS which could interfere with the PCP ability to monitor residents' pain medication effectiveness. This failure was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on February 2, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 24, 2022.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the	D 399		

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D 399	Continued From page 116 pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to report suspected drug diversions by Staff B (medication aide) of controlled substances to the pharmacy, the local law enforcement and the North Carolina Health Care Personnel Registry (HCPR) for 5 of 5 residents sampled (#4, #6, #8, #10 and #13) who were prescribed oxycontin and hydrocodone/acetaminophen for moderate to severe pain. The findings are: Review the facility's Controlled Substance Count Sheets (CSCS) for 5 of 5 sampled residents receiving narcotic pain medications revealed Staff B initialed residents' CSCS for documented administration of a disproportionate quantity of oxycodone 10mg and hydrocodone 5/325mg compared to other medication aides during the same time frame as follows: -One resident (#2) had 128 doses of as needed (prn) oxycodone 10 mg out of 139 opportunities initialed on the CSCS for documented as administered from 11/09/21 to 01/31/22. -One resident (#8) had 145 doses of prn oxycodone 10 mg out of 263 opportunities initialed on the CSCS for documented as administered from 11/01/21 to 01/31/22.	D 399	Pharmacy RN/Administrator retrained Med Aides on Narcotic Policies to include signing the MAR and control sheets when administering narcotics. Administrator/RCC audited all narcotics in facility to ensure the pill count is correct by the narcotic count sheet and documentation matches the MAR and effectiveness documented for all PRN narcotics. Facility/Administrator will assure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. Documentation of the action taken will be made. RCC audited all narcotic controls sheets, and MARS for complete documentation x5 days per week x3 weeks and then 1x weekly going forward 2/3/22	2/8/2022 2/8/2022 3/24/2022 3/24/2022

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D 399	Continued From page 117 -One resident (#10) had 34 doses of prn hydrocodone/acetaminophen 5/325mg out of 42 opportunities initialed on the CSCS for documented as administered from 12/02/21 to 01/31/22. -One resident (#6) had 11 doses of prn hydrocodone/acetaminophen 5/325mg out of 14 opportunities initialed on the CSCS for documented as administered from 11/02/21 to 01/31/22. -One resident (#13) had 13 doses of prn hydrocodone/acetaminophen 5/325mg out of 14 opportunities initialed on the CSCS for documented as administered from 01/20/22 to 01/31/22. Telephone interview with a Corporate Representative on 02/02/22 at 10:00am revealed: -The facility had reported one staff to the Health Care Personnel Registry (HCPR) related to a controlled substance variation on 01/28/22 not properly reported by a staff member. -The facility did an audit of a controlled substance related to an occurrence for one missing dose of a narcotic. -The facility reported the missing controlled medication to the local law enforcement, the pharmacy and did an initial allegation report to the Health Care Personnel Registry on 02/02/22. -The staff who was reported on 02/02/21 was not the same staff identified for having several medications for different residents (Staff B) not properly accounted for. Telephone interview with a Second Corporate Representative on 02/02/22 at 5:30pm revealed: -There had been an audit of some controlled substances related to variance in the controlled substance count sheet for a medication discovered during controlled substance shift	D 399		

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count off prior to 02/02/22.
-The facility Resident Care Coordinator (RCC) and the Administrator were responsible to monitor controlled substances and notify the corporate staff for an discrepancy discovered in audits.
-She did not know the facility was missing CSCS documentation for medications or the numerous medications not accounted for on the eMARs compared to the CSCS for residents and reported to the facility on 02/02/22.

Interview with the Administrator on 02/02/22 at 5:40pm revealed the Administrator and the RCC would be doing an audit of the residents with narcotic pain relievers this evening (02/02/22) for compliance with accounting for controlled substances.

Interview with Staff B on 02/03/22 at 1:39pm revealed:
-The CSCS were sent back to the pharmacy after a medication had been discontinued.
-The completed CSCS were placed in the RCC's office.
-The RCC filed them in the residents' records.
-She was told about the control substance inventory concerns the night before, 02/02/22.
-She was told on 02/02/22 to document administration of all controlled medication on the electronic medication administration record (eMAR) as well as the CSCS going forward.
-She only administered controlled medications when a resident would ask for them.
-She did not know why the residents only asked her for controlled medications and did not ask other MAs.
-If a resident asked for a pain pill she gave them a pain pill and if a resident asked for acetaminophen, she gave them acetaminophen.
-She did not always document the administration

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of prn medications on the eMAR because she got get busy and forgot.
-She did not want to document the administration of prn medications late because then the resident would not be able to get the medication again at the prescribed length of time.
-She understood it made it hard for other MAs to know when to administer a prn medication if the eMAR did not reflect a correct administration time.
-It looked bad when she was the only MA signing the control logs.
-Another MA told her that a resident did not ask for prn oxycodone when they worked.
-She did not understand why the resident did not ask the other MAs for her prn oxycodone.
-She said, "I know it looks like I am taking their meds, but I don't do that".
-Neither the RCC nor corporate staff had done a cart audit or a controlled tablet count with her.
-The CSCS would all be accurate because she made sure she documented and signed on them.
-She had "picked" up another job somewhere else; she was not working double shifts at the facility.
-She did not drink [alcohol] and she was not a morning person.
-She took a medication to help her sleep at night.
-Sometimes if she took her sleeping medication late at night she would be sleepy in the morning; it took awhile for the sleep medication to wear off.

Interview with the RCC on 02/03/22 at 2:48pm revealed:
-She and the Administrator audited the controls on 02/02/22 after 7:00pm.
-They counted all the narcotics, matched to the control sheets, and matched the eMARs to the control sheets.
-She was aware there were "quite a few"

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narcotics that were initialed on the CSCS for residents that documented administered as prn not documented on the eMAR.
-The audit information results were given to the corporate office on 02/02/22 after 8:00pm.
-The Administrator discussed the documentation of prn narcotic medications with Staff B, as well as if a resident needed prn medication routinely, it needed to be discussed with the PCP.
-The MA was called to the facility by the Administrator and RCC on 02/02/22 in the evening to sign a paper related to documenting prn pain medications on the eMAR to correspond to the CSCS.
-She did not notify the HCPR for any suspected drug diversion due to the large disproportionate quantity of oxycodone 10mg and hydrocodone 5/325mg signed out on the CSCS compared to other medication aides during the same time frame.
-The Corporate Representatives were responsible to complete any additional paperwork.

Telephone interview with the Director at the facility's contracted pharmacy on 02/04/22 at 9:20am revealed:
-There was documentation the pharmacy had not received a phone call from the Administrator until this morning, 02/04/22, regarding the possibility of missing controlled substances.
-There was no documentation for the quantity, medication, or circumstances related to the suspected missing controlled medications by the Administrator.
-The pharmacy was available to assist with information for dispensing or shipping if the facility requested the information.

Interview with the RCC on 02/04/22 at 9:50am

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D 399	Continued From page 121 revealed: -The facility's policy for administering prn controlled medications was as follows: -A resident was responsible to request a medication ordered prn. -MAs were supposed to consult the eMAR for the medication order. -The MA looked for the last time the medication was administered to ensure the proper time had elapsed. -The MAs were responsible to count the controlled medications with the oncoming MA between shifts. -Any CSCS not matching the medication on hand count was to be reported immediately to the RCC, and/or Administrator. -The RCC would report the non-matching results to the Administrator who in turn reported to the Corporate Office. Interview with the Administrator on 02/04/22 at 8:46am revealed: -She called the pharmacy regarding another suspected diversion of controlled medications this morning (02/04/22). -She called the pharmacy regarding possible drug diversion from a MA with disproportionate quantity of oxycodone 10mg and hydrocodone 5/325mg compared to other medication aides during the same time frame and documentation on the residents' eMARs not matching documentation on the corresponding CSCS for the medications. -She explained to the pharmacist at the contracted pharmacy that this was a second report, not the same as the one 2 days earlier. -She would provide the initial allegation report completed by the Corporate Representative and send to HCPR today for missing CSCS and possible diversion of controlled medications by a MA.	D 399		

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1. Review of Resident #2's current FL2 dated 02/01/21 revealed diagnoses included osteopenia, chronic back pain, and fibromyalgia.

Review of Resident #2's signed physician's orders dated 10/08/21 revealed there was an order for oxycodone IR (immediate release) 10mg one tablet every 4 hours as needed (prn) for pain control. (Oxycodone is a schedule II narcotic used to treat moderate to severe pain.)

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/22 at 11:30am revealed:
-The pharmacy provided controlled substance count sheets (CSCS) with each dispensing of a controlled substance to be used along with the electronic medication administration (eMAR) for documenting administration of the medication.
-Oxycodone 10mg was routinely dispensed for Resident #2 for 30 tablets on 11/04/21, 11/20/21, 12/14/21, 12/27/21, 01/14/21, and on 01/26/22.

Review of Resident #2's November 2021 electronic medication administration (eMAR) compared to Resident #2's CSCS for 30 tablets of oxycodone 10mg dispensed on 11/04/21 revealed there were 26 of 30 doses signed out by the same medication aide (MA).

Review of Resident #2's November 2021 eMAR and December 2021 eMAR compared to Resident #2's CSCS for 30 tablets of oxycodone 10mg dispensed on 11/20/21 revealed there were 27 of 30 doses initialed as signed out by the same MA.

Review of Resident #2's December 2021 eMAR compared to Resident #2's CSCS for 30 tablets

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of oxycodone 10mg dispensed on 12/14/21 revealed there were 28 of 30 doses initialed as signed out by the same MA.

Confidential interview with a staff member revealed:
-Resident #2 did not ask her for pain medication when she worked as the medication aide and Resident #2 did not appear to be in pain.
-She noticed that only one MA had signed for administering Resident #2's oxycodone 10mg ordered prn most of the time.
-Resident #2 had not requested prn oxycodone 10mg or seemed to be in pain on the days she had staffed the medication cart.

2. Review of Resident #8's current FL2 dated 05/18/21 revealed:
-Diagnoses included cerebral infarction, congestive heart failure, and chronic obstructive pulmonary disease.
-There was an order for oxycodone IR 10mg one tablet 2 times a day. (Oxycodone is a schedule II narcotic medication used to treat moderate to severe pain.)

Review of Resident #8's physician's orders dated 11/22/21 revealed an order for oxycodone 10mg one every 4 hours as needed for pain, up to 4 tablet per day.

Telephone interview with a pharmacist at the Resident #8's non-contracted pharmacy on 02/02/22 at 1:50pm revealed 120 tablets of oxycodone 10mg were dispensed on 10/25/21, 11/22/21, and on 01/20/22.

Review of Resident #8's October 2021 electronic medication administration record (eMAR), November 2021 eMAR and December 2021

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D 399	Continued From page 124 eMAR compared to Resident #8's CSCS for 120 tablets of oxycodone 10mg dispensed on 10/26/21 revealed: -There were 9 of 12 doses initialed as signed out by the same MA from 10/27/21 at 7:30am to 10/31/21 at 7:00pm. -There were 37 of 80 doses initialed as signed out by the same MA from 11/01/21 at 8:00am to 11/30/21 at 9:31pm. -There were 12 of 28 doses initialed as signed out by the same MA from 12/01/21 at 10:30am to 12/12/21 at 7:55am. Review of Resident #8's December 2021 eMAR and January 2022 eMAR compared to Resident #8's CSCS for 120 tablets of oxycodone 10mg dispensed on 11/22/21 revealed: -There were 35 of 57 doses initialed as signed out by the same MA from 12/12/21 at 12:00pm to 12/31/21 at 7:30pm. -There were 36 of 64 doses initialed as signed out by the same MA from 01/01/22 at 7:35pm to 01/21/22 at 5:41pm. . Review of Resident #8's January 2022 eMAR compared to Resident #8's CSCS for 120 tablets of oxycodone 10mg dispensed on 01/20/21 revealed there were 25 of 35 doses initialed as signed out by the same MA from 01/21/22 at 3:25pm to 01/31/22 at 5:41pm. Confidential interview with a staff member revealed: -The medication aides (MAs) routinely counted the controlled drugs between shift changes. -She noticed that only one MA had signed for administering Resident #8's oxycodone 10mg ordered prn most of the time. -Resident #8's requested pm oxycodone 10mg in the morning and evening on the days she had	D 399		

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staffed the medication cart.
-She initialed the CSCS for the medication when she prepared the medication for administration and documented the administration on the resident's eMAR. About one hour later she documented the effectiveness of the medication on the eMAR.

Interview with a Staff B (MA) on 02/03/22 at 1:39pm revealed:
-Another MA told her that Resident #8 did not ask for PRN oxycodone when they worked.
-She did not understand why Resident #8 did not ask the other MAs for her prn oxycodone.

3. Review of Resident #10's current FL2 dated 06/08/21 revealed diagnoses included generalized weakness, gait difficulty, atrial fibrillation, and chest pain.

Review of Resident #10's local hospital emergency department (ED) report dated 12/01/21 revealed there was an order for Lortab 5/325 (hydrocodone/acetaminophen 5/325) one every 6 hours as needed. (Lortab 5/325 is a schedule II narcotic pain reliever used to treat moderate to severe pain.)

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/22 at 11:30am regarding Lortab 5/325 dispensed for Resident #10 revealed:
-On 12/01/22, 12 tablets of Lortab 5/325 were dispensed.
-On 12/17/22, 30 tablets of Lortab 5/325 were dispensed.

Review of Resident #10's December 2021 and January 2022 eMARs compared to Resident #10's CSCS for Lortab 5/325 revealed there were

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D 399	Continued From page 126 33 of 42 doses signed out by the same MA from 12/02/21 at 2:00am to 01/31/22 at 2:30pm. Confidential interview with a staff revealed: -The medication aides (MAs) routinely counted the controlled drugs between shift changes. -The MAs verified the number of tablets on the CSCS compared to the quantity of medication remaining on the medication cart before exchanging the medication cart keys. -She was not responsible to audit the eMAR documentation compared to the documentation of administration on the CSCS. -She noticed that one MA had signed for administering Resident #10's Lortab 5/325 ordered prn most of the time (33 of 42 opportunities in December 2021 and January 2022). -Resident #10 did not request prn Lortab 5/325 when she worked on the medication cart. 4. Review of Resident #6's current FL2 dated 08/26/21 revealed diagnoses included major depressive disorder, chronic atrial fibrillation, and insomnia. Review of Resident #6's physician's orders revealed an order dated 05/13/21 for hydrocodone 5/325 (a schedule II narcotic pain reliever used to treat moderate to severe pain) one tablet every day as needed (prn) for pain. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/22 at 11:30am revealed: -The pharmacy provided controlled substance count sheets (CSCS) with each dispensing of a controlled substance to be used for documenting administration of the medication. -The pharmacy dispensed 30 tablets of	D 399		

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D 399	Continued From page 127 hydrocodone/acetaminophen 5/325mg for Resident #6 on 05/13/21 and 06/13/21. Review of Resident #6's November 2021, December 2021 and January 2022 electronic medication administration records (eMAR) compared to the CSCS logs for 30 hydrocodone/acetaminophen 5/325mg tablets dispensed for the resident on 05/13/21 revealed there were 11 of 14 doses signed out by the same MA from 11/02/21 at 4:25pm to 01/21/22 at 1:55pm. Confidential interview with a staff revealed: -She noticed that only one MA had signed for administering Resident #6's hydrocodone/acetaminophen 5/325mg ordered prn most of the time (11 of 14 opportunities in November 2021 and January 2022). -Resident #6 did not request prn hydrocodone/acetaminophen 5/325mg when she worked on the medication cart and did not appear to be in any pain.. Interview with Resident #6 on 02/04/22 at 12:40 revealed: -She knew she had a strong pain medication for pain that she could request if her legs were hurting a lot. -She asked the MA for the pain medication occasionally, but not very much. -She did not think the MAs were giving her pain medication daily. Telephone interview with Resident #6's primary care provider (PCP) on 02/04/21 at 2:15pm revealed: -Resident #6 was routinely seen by the provider. -Resident #6 should be able to identify if she was requesting a pain medication.	D 399		

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-Resident #6 had not indicated she was having additional pain when she saw her on last visit (12/28/21 per encounter notes).

5. Review of Resident #13's current FL2 dated 01/25/22 revealed:
-Diagnoses included heart failure, and pain in the right hip.
-There was an order for hydrocodone/acetaminophen 5/325mg (a schedule II narcotic pain medication used to treat moderate to severe pain) one tablet every 6 hours as needed (prn).

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/02/22 at 11:30am revealed:
-The pharmacy provided controlled substance count sheets (CSCS) with each dispensing of a controlled substance to be used for documenting administration of the medication.
-The pharmacy dispensed 30 tablets of hydrocodone/acetaminophen 5/325mg for Resident #13 on 01/18/22.

Review of Resident #13's January 2022 electronic medication administration record (eMAR) compared to the CSCS logs for 30 hydrocodone/acetaminophen 5/325mg tablets dispensed for the resident on 01/18/22 revealed there were 13 of 14 doses initialed as signed out by the same MA.

Confidential interview with a staff revealed:
-She noticed that only one MA had signed for administering Resident #6's hydrocodone/acetaminophen 5/325mg ordered prn most of the time (13 of 14 opportunities in January 2022).
-Resident #13 did not request prn

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D 399	Continued From page 129 hydrocodone/acetaminophen 5/325mg when she worked on the medication cart and did not appear to be in any pain. Interview with Resident #13 on 02/04/22 at 12:30 revealed: -She did not ask for her pain medication every day. -She could not recall the last day she requested pain medication. The facility failed to report instances of suspected drug diversion for 5 of 5 residents identified on 02/02/21 to the North Carolina Health Care Personnel Registry, local law enforcement and the pharmacy resulting in an increased risk of continued drug diversions and residents not receiving prn pain medication. This failure was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on February 3, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 24, 2022. [Refer to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].	D 399		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and	D 438		

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D 438	Continued From page 130 .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) initial allegation report within 24 hours of knowledge related to accounting for controlled medications and allegations a medication aide (Staff B) worked impaired. The findings are: Review of Staff B's (medication aide) personnel record revealed: -Staff B was hired as a medication aide on 01/19/21. -There was a check of the HCPR completed on 01/25/21. Confidential interview with a resident: -The resident had seen Staff B when she appeared to be real sleepy or groggy on a few mornings lately. -He had not seen the named medication aide asleep at the medication cart. Confidential interview with a staff revealed: -Staff B had been seen nodding off at the medication cart. -Staff B came to work sleepy, had dozed off in the middle of counting controlled substances at shift change, and sometimes had slurred speech. -Staff B had been seen "high" and could not carry on a conversation. -A named resident had reported Staff B had tried to administer her medications twice the same	D 438	Administrator will report allegation and/or irregularities/discrepancies in audits to Corporate Office as soon as possible. HCPR 24 hour report will be completed by corporate office or designee and ensure that the Department is notified of all allegations against health care personnel which appear to be related to any act listed in GS 131E-256 (a)(1). COO retrained Administrator and RCC on identifying potential issues when auditing records, observations and/or conversations. RCC conducted med pass observations x 3 weekly for 3 weeks, then randomly thereafter. RCC counted all narcotics daily to ensure there are not any missing x5 days per week x 4 weeks, weekly thereafter. RCC audited all controlled sheets and MARS for complete documentation x 5 days per week for 3 weeks, weekly thereafter.	3/24/2022 2/8/2022 3/242022 3/24/2022 3/24/2022

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morning.
-The RCC and Administrator were aware of the concern with Staff B and said, "we are watching her."

Confidential interview with a second staff revealed:
-Staff B went to lunch outside the building and came back to the facility in a sleepy state especially in the last 3 weeks.
-Staff B dozed off during shift changes and counts of narcotics.
-She was concerned for the residents getting correct medications when Staff B was often dozing, groggy, and speech was not clear.
-The staff had reported her concerns to the RCC and the Administrator in the past but did not provide an exact date.

Telephone interview with a Corporate Representative on 02/02/22 at 10:00am revealed:
-The facility had reported one staff (not Staff B) to the HCPR related to a controlled substance variation on 01/28/22 not properly reported by another staff.
-Staff B was not the staff reported in the previous incident.
-The facility did an audit of a controlled substance related to an occurrence for one missing dose of a narcotic.
-There had been no report related to Staff B and CSCS initialed as signed out for residents' controlled substances in disproportionate quantities compared to other MAs.

Telephone interview with a Second Corporate Representative on 02/02/22 at 5:30pm revealed:
-There had been an audit of some controlled substances related to variance in the controlled substance count sheet for a medication

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discovered during controlled substance shift count off prior to 02/02/22.
-The facility Resident Care Coordinator (RCC) and the Administrator were responsible to monitor controlled substances and notify the corporate staff for an discrepancy discovered in audits.
-The Corporate Representatives would be responsible to ensure the HCPR was notified for allegations of drug diversion or staff working while impaired.
-She did not know the facility was missing CSCS documentation for medications, the numerous medications not accounted for on the eMARs compared to the CSCS for residents and disproportionate amount of controlled substances initialed as signed out for residents by Staff B, until reported to the facility on 02/02/22 during the surveyor's review.

Interview with Staff B on 02/03/22 at 1:39pm revealed:
-The CSCS were sent back to the pharmacy after a medication has been discontinued.
-The completed CSCS were placed in the RCC's office.
-The RCC filed them in the residents' records.
-She was told about the control substance inventory concerns the night before, 02/02/22.
-She was told on 02/02/22 to document administration of all controlled medication on the electronic medication administration record (eMAR) as well as the CSCS going forward.
-She only administered controlled medications when a resident would ask for them.
-She did not know why the residents only asked her for controlled medications and did not ask other MAs.
-If a resident asked for a pain pill she gave them a pain pill and if a resident asked for acetaminophen, she gave them acetaminophen.

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D 438	Continued From page 133 -She did not always document the administration of prn medications on the eMAR because she got get busy and forgot. -She did not want to document the administration of prn medications late because then the resident would not be able to get the medication again at the allotted length of time. -She understood it made it hard for other MAs to know when to administer a prn medication if the eMAR did not reflect a correct administration time. -It looked bad when she was the only MA signing the control logs. -Another MA told her that a resident did not ask for prn oxycodone when they worked. -She did not understand why the resident did not ask the other MAs for her prn oxycodone. -She said, "I know it looks like I am taking their meds, but I don't do that". -Neither the RCC nor corporate staff had done a cart audit or a controlled tablet count with her. -The CSCS would all be accurate because she made sure she documented and signed on them. Interview with the RCC on 02/03/22 at 2:48pm revealed: -She and the Administrator audited the controls on 02/02/22 after 7:00pm. -They counted all the narcotics, matched to the control sheets, and matched the eMARs to the control sheets. -She was aware there were "quite a few" narcotics that were administered as prn (as needed) not documented on the eMAR. -The audit information results was given to the corporate office on 02/02/22 in the evening. -The Administrator discussed the prn documentation with Staff B in the evening on 02/02/22, as well as if a resident needed prn medication routinely, it needed to be discussed	D 438		

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with the PCP.
-On 01/26/22 or 01/27/22, staff reported to the RCC that Staff B was having trouble passing medications, almost gave a resident her oral medications twice but the resident reminded Staff B that she gave her the tablets already but not a nasal spray.
-On 01/31/22, the RCC observed Staff B having trouble staying awake and appearing very sleepy or sluggish.
-She reported the behavior to the Administrator who then went to do her own observation of Staff B.
-The Administrator did not confirm the RCC's observations.
-The Administrator said she would keep a check on Staff B.

Telephone interview with the Second Corporate Representative on 02/04/22 at 5:00pm revealed:
-She or the other Corporate Representative were responsible to report to the Health Care Personnel Registry (HCPR).
-The Administrator and RCC conducted an audit of controlled substances on the evening of 02/02/22.
-She had not been made aware there were so many controlled substances administered by Staff B that were not properly accounted for until reported by survey staff on 02/02/22.
-She had been informed that Staff B documented administration of prn medications to residents that did not receive prn medications except on days Staff B worked.
-She had not started the initial report to the HCPR because she was not sure there were missing medications, or just incomplete or missing documentation on paperwork.
-Staff B worked on 02/03/22 after signing the form related to documenting prn controlled

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D 438	Continued From page 135 medications on the eMAR as well as the CSCS for complete and accurate accounting of controlled substances. The facility failed to report to HCPR within 24 hours an allegation of Staff for inaccurate accounting for controlled substances and working while impaired which resulted in Staff B continuing to work in the facility with direct contact with all residents. This failure was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on February 3, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 24, 2022. [Refer to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)]. [Refer to Tag D0399, 10A NCAC 13F .1008(h) Controlled Substances (Type B Violation)].	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record	D912		

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D912	Continued From page 136	D912		

reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Controlled Substances and Health Care Personnel Registry.

The findings are:

1. Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances for 6 of 6 sampled residents (#4, #6, #8, #9, #10 and #13) with physician orders for narcotic pain medication. [Refer to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].

2. Based on observations, interviews and record reviews, the facility failed to report suspected drug diversions of controlled substances by Staff B (medication aide) to the pharmacy, the local law enforcement and the North Carolina Health Care Personnel Registry (HCPR) for 5 of 5 residents sampled (#4, #6, #8, #10 and #13) who were prescribed oxycontin and hydrocodone/acetaminophen for moderate to severe pain. [Refer to Tag 399, 10A NCAC 13F .1008(h) Controlled Substances (Type B Violation)].

3. Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) initial allegation report within 24 hours of knowledge related to accounting for controlled medications and allegations a medication aide (Staff B) worked impaired. [Refer to Tag D0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B

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D912	Continued From page 137 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record review, interviews and observations, the facility failed to ensure residents were free of neglect related to Personal Care and Supervision and Physical Environment. The findings are: 1. Based on record reviews, interviews, and observations, the facility failed to provide supervision to ensure exit door alarms were monitored when activated when there were residents known to be confused, who exhibited exit seeking behaviors and had wandering behaviors (#1, #2, #4) including two residents who eloped from the facility without staff's knowledge (#1, #2) and did not provide increased supervision to a resident (#2) with multiple falls. [Refer to Tag D 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled residents received personal care assistance from 3rd shift staff including a resident (#11) who had skin irritation on his scrotum	D914	Administrator/Ombudsman retrained staff on Resident rights. Director will assure that residents are treated in accordance with the provisions of residents bill of rights as outlined in GS 131D-21. Administrator/RCC/Designee will do random interviews with residents to ensure staff are addressing issues identified on the care plan; weekly x4 weeks, then monthly x4 months.	3/18/2022 3/18/2022 3/18/2022

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D914	Continued From page 138 secondary to being in a soiled incontinence brief and required total assistance with toileting and a resident who did not receive assistance when she was vomiting and had diarrhea and was not able to get out of her bed without assistance (#12). [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure two exit doors (the smoking area and the staff breakroom exit doors) accessible by residents known to be disoriented and/or wandered, were equipped with a sounding device that was activated when the door was opened. [Refer to tag 67, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)].	D914		