STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL050017	A. BUILDING: _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERMITAGE	185 BRICKFARM ROAD DILLSBORO, NC 28725

(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 Home Licensure Section conducted an annual survey and a complaint investigation onsite from 03/24/22 - 03/25/22, 03/28/22 and an exit conference by phone on 03/29/22. The Jackson County Department of Social Services initiated the complaint investigation on 03/16/22.	D 000		
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: Based on observations, interviews, and record reviews, the facility failed to ensure toenail care was provided for 1 of 5 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 11/09/21 revealed: -Diagnoses included unspecified dementia without behavioral disturbance, spinal stenosis lumbar region, and hypothyroidism. -The resident was constantly disoriented. Review of Resident #1's Care Plan dated 05/12/21 revealed:	D 269		

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D 269	Continued From page 1 -The resident was always disoriented. -The resident had significant memory loss and must be directed. Observation of Resident #1 on 03/25/22 at 2:20pm revealed: -The resident was seated in a wheelchair and was wearing socks on her feet. -A personal care aide (PCA) removed the sock from Resident #1's right foot. -The skin on the resident's right foot was dry and flaky. -The resident's great right toenail was elevated from the nail bed by approximately 1/16th of an inch of thickened layers of yellow nail growth which lifted and pushed the entire toenail to the right side of the toe. -The other toenails on the right foot extended approximately 1/8th of an inch beyond the flesh of the toes and were rough and needed filing. -The PCA then removed the sock from Resident #1's left foot. -The skin on the resident's left foot was dry and flaky. -The resident's great left toenail was elevated from the nail bed by approximately 1/8th of an inch of thickened layers of yellow nail growth which lifted and pushed the entire toenail to the left side of the toe. -The left great toenail elevation protruded from the nail bed at approximately 1/2 inch. -The toenail on the third toe of the left foot was rough and protruded 1/4 inch from the flesh of the toe. -The toenail on the fifth toe of the left foot was rough and protruded 1/4 inch from the flesh of the toe. Interview with the PCA on 03/25/22 at 2:30pm and 4:50pm revealed:	D 269		

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D 269	Continued From page 2 -Resident #1's toenails had needed care for "quite a while." -She had let the Special Care Coordinator (SCC) and Resident Care Coordinator (RCC) know Resident #1's toenails were long and the resident needed to be seen by Podiatry. -The PCA's "usually" cut toenails once a month. -Resident #1 was not "cognitive enough" to cut her own toenails. Interview with a second PCA on 03/25/22 at 4:52pm revealed Resident #1 was not "with it enough" to be able to cut her own toenails without assistance from staff. Interview with a medication aide (MA) on 03/25/22 at 2:36pm revealed: -She had noticed Resident #1's toenails were "bad." -She had let the RCC know Resident #1 needed Podiatry care. Interview with the RCC on 03/25/22 at 2:44pm revealed: -Podiatry had recently been to the facility to provide toenail care for residents. -The PCAs had documented on the shower sheets Resident #1 needed toenail care, but the staff "didn't tell me" the toenails were "that bad." -Resident #1 already had a signed consent allowing for Podiatry care. -She or the SCC were responsible for getting Resident #1's name on the list to be seen by Podiatry for toenail care. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 269		

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D 273	Continued From page 3	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure appropriate and timely follow-up for acute shoulder, wrist, and hip injuries due to falls for 1 of 5 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 11/09/21 revealed: -Diagnoses included unspecified dementia without behavioral disturbance and spinal stenosis lumbar region. -The resident was constantly disoriented, ambulatory, and a wanderer. -The resident's level of care was special care unit (SCU). a. Interview with a medication aide (MA) on 03/24/22 at 12:50pm revealed: -She witnessed Resident #1's fall on 02/10/22, and she completed an Incident Report. -Resident #1 had been trying to get out the locked entrance doors of the special care unit (SCU). -Resident #1 accidentally hit her hand on the railing and it startled the resident. -Resident #1 fell back to the floor on her left side and complained of pain. -She took Resident #1's vital signs and looked at Resident #1's back, left side, and her left hand.	D 273		

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-Resident #1 was able to move the fingers on her left hand.
-At the time the MA obtained vitals for Resident #1, there was "bruising and swelling" on the resident's left wrist, but she did not think it was significant.
-Resident #1 complained of pain in her left wrist when touched.
-Resident #1 had an order for as needed acetaminophen (used to treat pain).

Interview with a personal care aide (PCA) on 03/24/22 at 3:55pm revealed:
-She witnessed Resident #1's fall on 02/10/22.
-Resident #1 was upset and wanted to go home.
-The resident was startled when she hit her right hand on the railing and fell onto the floor, landing on her left side.
-Resident #1 appeared to be in pain.
-Resident #1 was crying, but the PCA could not remember what the resident was saying.
-She and the MA obtained Resident #1's vital signs, checked her for any obvious injuries, and assisted her to get up off the floor.

Interview with a MA on 03/25/22 at 9:00am revealed:
-The MA worked 02/11/22 from 7:00am to 7:00pm.
-He found Resident #1 seated by the piano.
-He went to where Resident #1 was seated to administer her morning medications.
-Resident #1 could not lift her left arm to take her medications.
-Resident #1's left arm was very badly swollen.
-The night shift staff had not reported any issues with Resident #1's left upper extremity to him at shift change.
-Resident #1 appeared to be in pain.

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Telephone interview with Resident #1's Guardian on 03/25/22 at 9:32am revealed:
-He received a phone call on 02/10/22 around 5:00pm from facility staff.
-The staff told him Resident #1 had fallen but had not sustained any injuries.
-He went to visit Resident #1 on 02/11/22 around 10:00am.
-He found Resident #1 seated at the piano holding her left arm.
-There was a goose egg sized area of swelling on the resident's left arm.
-There was no splint on the resident's left arm.
-He informed the MA he was concerned Resident #1's arm might be broken.
-The MA told him they had contacted the primary care provider (PCP) and they had obtained an order for a mobile x-ray.

Review of Resident #1's FL2 dated 11/09/21 revealed an order for acetaminophen 500mg 1 tablet every 6 hours as needed for pain.

Review of Resident #1's February 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for acetaminophen 500mg 1 tablet every 6 hours as needed for minor discomfort.
-There was no documentation the acetaminophen 500mg was administered on 02/10/22.
-There was documentation acetaminophen 500mg was administered on 02/11/22 at 11:44pm.

Review of Resident #1's record revealed there were no other prescribed medications to treat pain ordered for Resident #1 and no documentation the PCP was notified of Resident #1's pain.

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D 273	Continued From page 6 Interview with the Special Care Coordinator (SCC) on 03/25/22 at 8:28am revealed: -On 02/11/22, she arrived to work between 7:45am and 8:00am. -The MA on duty reported to her bruises and swelling on Resident #1's left wrist. -That was when she contacted Resident #1's PCP and obtained an order for a mobile x-ray of left wrist and hand. -She went and talked to Resident #1 and Resident #1 said her arm was "hurting." Interview with the Resident Care Coordinator (RCC) on 03/25/22 at 11:02am revealed: -On 02/11/22, she arrived to work at 9:00am. -An MA informed her Resident #1's left wrist was "red and swollen." -Resident #1 also had a bluish-purple bruise on her left upper arm "about the size of half her upper arm." -Resident #1 complained of pain when her left hand was touched. -She called Resident #1's PCP to report the redness and swelling in the resident's wrist, the bruising on the resident's left upper arm, and the residents pain reaction when the left hand was touched. -The PCP ordered a mobile x-ray of the resident's left hand and wrist. -She "could tell" Resident #1 was in pain "throughout the day" and "before mobile x-ray got here." -She thought the PCP ordered a one-time dose of acetaminophen before or after the mobile x-ray was completed. -After the mobile x-ray results were received at 4:33pm, she contacted the PCP to let her know Resident #1 had a left wrist fracture and the PCP ordered a brace for Resident #1's "hand."	D 273		

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-A hand brace was purchased from a local discount store and the brace was applied to Resident #1's left wrist "around 5:00pm or so."
-Resident #1's Guardian arrived around 7:00pm and asked if they could take the resident to the hospital for evaluation.
-She assisted the Guardian to dress Resident #1 and the Guardian took Resident #1 to a local hospital for evaluation.
-Resident #1 returned from the hospital the same evening wearing a sling and a brace on her left arm.
-The brace had been wrapped to help to keep Resident #1 from removing it.

Review of Resident #1's PCP orders dated 02/11/22 revealed:
-An x-ray of the left hand and wrist was ordered due to swelling and pain.
-Apply brace to left hand due to fracture from fall until orthopedic appointment.

Review of Resident #1's PCP order dated 02/14/22 revealed acetaminophen 500mg 1 tablet every 6 hours for minor pain and discomfort.

Telephone interview with a representative from the mobile x-ray service on 03/25/22 at 10:40am revealed:
-They received an order for a mobile x-ray of the left hand and wrist for Resident #1 on 02/11/22 at 7:52am.
-The x-ray was completed on 02/11/22 at 12:29pm.

Review of Resident #1's left wrist mobile x-ray dated 02/11/22 at 4:33pm revealed there was an acute mildly displaced fracture of one of the two large bones in the forearm where growth occurs adjacent to the growth plate.

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D 273	Continued From page 8 Telephone interview with Resident #1's family member on 03/25/22 at 12:21pm revealed: -The Guardian visited Resident #1 on 02/11/22 at around 10:00am. -The Guardian found Resident #1 seated at the piano trying to play it. -The Guardian told her that Resident #1 was hurting. -The Guardian was concerned because Resident #1's arm appeared to be broken. -She was at work but called the facility and asked them to put a splint on the left wrist. -The RCC told her she could not apply a splint because they did not know if the arm was broken because the x-rays had not been completed and the results made available. -She then asked the RCC to put a "pillow splint" (a supportive device made from a bed pillow used to keep in place a suspected fracture) on the arm until Resident #1 could be gotten to a physician. -The RCC told her she could not put a pillow splint on the arm. -After 4:00pm, she still had not been notified of the mobile x-ray results and decided to drive to the facility. -When she arrived at the facility, Resident #1 told her she was hurting. -Resident #1 was wearing a brace on her left wrist. -She asked the MA if they had given Resident #1 anything for pain. -The MA said they were getting something for her pain. -Resident #1 appeared to have a shoulder injury because Resident #1 could not pick her arm up without pain. -The resident had a "huge" hematoma over the area of her left upper arm. -At approximately 7:00pm, she and the Guardian	D 273		

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took the resident to a local emergency room (ER) for evaluation.

Review of Resident #1's ER discharge summary dated 02/11/22 revealed:
-The resident arrived at the emergency department at 7:08pm.
-The chief complaint was left upper extremity injury secondary to fall.
-The left wrist "with obvious" deformity and swelling consistent with distal radius and or ulna fracture.
-The left elbow had normal passive range of motion (movement of a joint without participation of effort on the part of the subject).
-There was some tenderness to the left genohumeral joint (shoulder) to the area of the greater tuberosity of left humeral head (the prominent area on top of the shoulder).

Review of Resident #1's left humerous (the long bone that runs from the shoulder to the elbow) x-ray dated 02/11/22 revealed closed left greater tuberosity fracture of humeral head (the bone at the top of the long bone of the arm is broken with intact skin over the area).

Review of Resident #1's left forearm x-ray dated 02/11/22 revealed closed left distal radius comminuted fracture (one of the two long bones in the forearm is broken in at least two places close to the wrist with intact skin over the area).

Telephone interview with Resident #1's Orthopedic Physician's Assistant's Registered Nurse on 03/25/22 at 11:56am revealed:
-Resident #1 was seen in their practice on 02/15/22, 02/24/22, and 03/21/22.
-The injury to Resident #1's left shoulder would not have allowed the resident to lift her arm.

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D 273	Continued From page 10 -With the left shoulder injury and left wrist injuries found on the x-ray, Resident #1 would have been in "severe" pain. Telephone interview with Resident #1's PCP on 03/25/22 at 2:55pm revealed: -She could not remember if facility staff reported Resident #1's complaints of pain to her. -She could not remember when facility staff contacted her about Resident #1's fall that occurred on 02/10/22 at 5:00pm. -She could not remember if facility staff had reported bruising of Resident #1's left upper arm on the morning of 02/11/22. -She could not remember when facility staff had reported bruising and swelling in Resident #1's left wrist and hand. -She was aware Resident #1 "ended up having a fracture." -She saw Resident #1 on 02/15/22 for a follow-up to the fall with injury which occurred on 02/10/22. -She could not tell if the resident was in pain or not during her visit on 02/15/22. -Resident #1 was not using her left upper arm. -Resident #1 was capable of flexing and extending from the left elbow without "visible pain." -She did not have Resident #1 raise her left arm. Telephone interview with the Administrator on 03/29/22 at 8:39am revealed: -It was the facility's policy to check vital signs, range of motion, for bruising and swelling on residents every shift for 72 hours after a fall. -The staff who worked 7:00pm to 7:00am on 02/10/22 did not report increased pain, bruising, swelling of Resident #1's left arm to her. -The staff followed policy by reporting the increased bruising, swelling, and pain to the RCC and SCC on 02/11/22.	D 273		

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-The MA got orders for a mobile x-ray and then later received an order for a brace.
-Resident #1 received an immobilizer in the emergency room.
-They obtained an follow-up appointment with orthopedics on 02/15/22 and Resident #1 was taken to the appointment for continued evaluation and treatment.
-Facility staff contacted the PCP and followed the orders given by the PCP.

Review of Resident #1's Incident Report dated 02/11/22 revealed:
-The resident had a witnessed fall in the hallway with injury on 02/10/22 at 5:00pm.
-The resident "lost balance" and fell backwards onto the floor.
-The location of the injury was left wrist and hand.
-The type of injury was "bruising and swelling."
-An x-ray was obtained of Resident #1's left hand and left wrist.
-The x-rays were positive for a fracture of the left wrist.
-Resident #1's Primary Care Provider (PCP) was notified of the fall on 02/10/22 at 5:05pm.

Refer to the review of the facility's accident and falls policy dated September 2021.

Attempted interview with a night shift (7:00pm to 7:00am) PCA on 03/24/22 at 4:18pm was unsuccessful.

Attempted interview with a night shift (7:00pm to 7:00am) MA on 03/25/22 at 10:36am was unsuccessful.

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

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D 273	Continued From page 12 b. Interview with a personal care aide (PCA) on 03/25/22 at 2:20pm revealed: -Resident #1 went into another residents room on 03/25/22. -The other resident pushed Resident #1 causing Resident #1 to trip and fall. -After the fall, Resident #1 said her left leg hurt. Interview with a medication aide (MA) on 03/28/22 at 2:30pm revealed: -At 12:15pm on 03/25/22, he overheard a resident state "I push her". -He went down the hallway with a PCA and entered the resident's room and found Resident #1 sitting in the floor. -Resident #1 denied having any pain and was assisted to a standing position. -When attempting to walk after being assisted to a standing position, Resident #1 stated she had hip pain. -The MA retrieved a wheelchair and assisted Resident #1 into a seated position. -The Special Care Coordinator (SCC) called the Nurse Practitioner (NP) for a telephone order for mobile x-ray. -Once the telephone order was received, he called mobile x-ray. -He called Resident #1's Guardian to inform him of the incident. -Resident # 1's Guardian stated he had already planned on coming to the facility and would be there later. -He gave Resident #1 acetaminophen (used to treat minor discomfort) that afternoon for pain and the resident appeared to get some pain relief. Review of Resident #1's March 2022 electronic Medication Administration Record (eMAR) revealed Resident #1 received acetaminophen	D 273		

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	HAL050017	A. BUILDING: _____ B. WING _____	03/29/2022

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THE HERMITAGE	185 BRICKFARM ROAD DILLSBORO, NC 28725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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500mg at 5:48pm on 03/25/22.

Interview with the Special Care Coordinator (SCC) on 03/28/22 at 2:44pm revealed:
-Resident #1 went into another resident's room and was pushed down by that resident.
-The MA and PCA assisted Resident #1 to a standing position after "verifying" she was not in pain.
-When Resident #1 started to walk after being assisted to a standing position by staff, she complained of left hip pain.
-She called the NP to get an order for mobile x-ray.
-The MA called mobile x-ray.
-Resident #1's Guardian was present when the x-ray technician arrived around 3:00pm.
-The Guardian left and returned after dinner and was requesting x-ray results.
-The SCC called mobile x-ray 3 or 4 times and no results were available.
-The Guardian wanted Resident #1 transported to the hospital for evaluation since no x-ray results were available.
-Emergency Medical Services (EMS) was called around 7:45pm to transport Resident #1 to the hospital.

Telephone interview with Resident #1's Guardian on 03/29/22 at 9:09am revealed:
-Resident #1 was "pushed down" by another resident on 03/25/22.
-He went to the facility to see Resident #1 on 03/25/22.
-He and another family member sat with Resident #1 for "4 hours" to keep her "immobile" and awaiting the mobile x-ray results.
-Resident #1 would "cry out" in pain when her left thigh was touched.
-Resident #1 could not "tolerate standing up."

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D 273	Continued From page 14 -Resident #1 could "hardly" walk. -The Guardian found Resident #1 "limping around trying to find a chair." -He decided to call 911 and have Resident #1 taken to the hospital for evaluation after waiting with the resident for 4 hours to receive mobile x-ray results. -The resident was diagnosed with a fractured left hip at the hospital and was admitted for surgical intervention. Review of Resident #1's progress note entries for 03/25/22 revealed: -At 12:49pm, there was documentation a medication aide (MA) called and set-up a mobile x-ray appointment for the resident. -At 7:28pm, there was documentation the Resident Care Coordinator (RCC) entered an order for a mobile x-ray on left hip/pelvis to be completed on 03/25/22 at the facility. -At 7:29pm, there was documentation by the RCC the resident's family requested x-ray results on 03/25/22 at 6:00pm. -At 7:30pm, there was documentation the RCC spoke with a representative from the mobile x-ray office at 6:05pm to ask about the results of Resident #1's left hip/pelvis x-ray; the x-ray was still being reviewed by the radiologist and results would be back on 03/25/22. -At 7:32pm, there was documentation the resident's family again requested x-ray results, x-ray results were still not available at 6:45pm. -The Guardian said if they could not get results back immediately, they wanted to send the resident to the Emergency Department (ED). -At 7:37pm, there was documentation the RCC called to notify Resident #1's PCP the resident was being sent out to the hospital per family request due to a fall and because the x-ray report was not available yet.	D 273		

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D 273	Continued From page 15 -At 7:38pm, there was documentation the RCC called and gave report at 7:35pm to a nurse at the local ED nurse about Resident #1. Review of Resident #1's ED discharge summary dated 03/25/22 at 8:11pm revealed: -Resident #1 presented to the ER with a chief complaint of fall and left hip pain. -On examination, Resident #1 had "significant pain" with attempted movement of the left hip. -Resident #1's x-ray and examination were consistent with a hip fracture. Review of Resident #1's physician discharge summary from the other hospital dated 03/27/22 revealed: -Imaging performed in the ED on 03/25/22 revealed the resident had an acute left hip fracture. -The resident's medical history included advanced age, advanced Alzheimer's dementia, osteoporosis, and hypertension. -The family asked for the hip to be stabilized in order to reduce the pain and possibly allow for ambulation. -The resident underwent orthopedic surgical intervention to stabilize the left hip on 03/26/22. -In the immediate postoperative setting on 03/26/22, the resident appeared to be stable. -Over the course of the day on 03/27/22, the resident became increasingly drowsy and was observed to have apneic (temporary cessation of breathing) pauses in her breathing. -The family wished to transition her to hospice after discharge. -Resident #1 was discharged from the hospital to hospice care on 03/27/22. Review of Resident #1's mobile x-ray of the hip dated 03/25/22 revealed:	D 273		

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-The x-ray was electronically signed by the physician at 9:25pm.
-The x-ray was ordered due to fall with complaint of pain.
-The left hip demonstrated no fracture or dislocation.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 03/28/22 at 4:09pm revealed:
-She did not receive any calls from the facility after the initial call (12:26pm) requesting an order for an x-ray for Resident #1.
-The facility did not contact her if the x-ray results were negative.

Telephone interview with the Administrator on 03/29/22 at 2:44pm revealed:
-Resident #1 fell on 03/25/22 when she went into another resident's room and the resident pushed her.
-The staff contacted Resident #1's PCP and obtained an order for a mobile x-ray of the left hip.
-The PCP was notified of the fall immediately after the fall on 03/25/22 at 12:26pm.
-The staff informed her Resident #1 was showing signs of left hip pain after the fall.
-The mobile x-ray results of Resident #1's hip did not come back until 9:00pm on 03/25/22.
-The Guardian visited the resident on the afternoon of 03/25/22 and the resident was sent out to a local hospital for evaluation between 3:30pm-4:00pm.

Review of Resident #1's Incident Report dated 03/25/22 revealed:
-The resident had an unwitnessed fall in another resident's room with injury on 03/25/22 at 2:30pm.
-The resident was found on the floor of another

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resident's room.
-The resident complained of pain related to the incident in her left leg.
-The type of injury was pain in left leg.
-The Primary Care Provider (PCP) was notified of the fall on 03/25/22 at 2:45pm.
-The resident was transported to the emergency department (ED) for evaluation on 03/25/22 at 7:30pm by emergency medical services (EMS).

Refer to the review of the facility's accident and falls policy dated September 2021.

_____

Review of the facility's accident and falls policy dated September 2021 revealed:
-When an accident or an emergency situation occurs, evaluate the situation.
-Call 911, or have someone call 911, if necessary.
-Assess the resident.
-If injury is apparent or possible, do not move the resident.
-Administer first aide as appropriate.
-Continue emergency intervention until emergency medical services (EMS) arrives.
-Call or notify the resident's physician and responsible party.
-If injury, complete the Report of Accident and Incident form.

_____

The facility's failure to ensure appropriate and timely follow-up for fractures of the shoulder, wrist, and hip caused Resident #1 to endure severe pain, an inability to move her left arm and left hand from 02/10/22 at 5:00pm until 02/11/22 after 6:32pm when she was sent to a local hospital for evaluation, and an inability to bear weight and walk without significant hip pain from 03/25/22 at 12:26pm until 03/25/22 at 7:30pm when she was sent to a local hospital for evaluation which resulted in serious physical

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D 273	Continued From page 18 harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/25/22 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 28, 2022.	D 273		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure 1 of 7 sampled residents (#6) had orders to self-administer medication that was observed in resident's room. The findings are:	D 375		

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D 375	Continued From page 19 Review of Resident #6's current FL2 dated 03/14/22 revealed diagnoses included restrictive lung disease, COPD and history of noncompliance with treatment. Observation during the initial tour on 03/24/22 at 9:38am of Resident #6's room revealed an albuterol sulfate 90mcg inhaler sitting on resident's bedside table. Review of Resident #6's January 2022 and March 2022 electronic Medication Administration Record revealed: -Resident was on therapeutic leave from 01/27/22 through 03/07/22. -There was an order for albuterol sulfate 90mcg inhaler (used to treat shortness of breath), inhale 2 puffs every four hours as needed. -There was no documentation albuterol sulfate 90mcg every four hours as needed was administered for the months of January and March of 2022. Interview with Resident #6 on 03/24/22 at 9:38am revealed: -He used his albuterol sulfate 90mcg inhaler on a regular basis and whenever he needed it. -He wanted to be able to take all his medications himself. -The Administrator picked up his medications from the Pharmacy but did not give them to him. Review of Resident #6's there was not a physician's order to self-administer his albuterol sulfate 90mcg inhaler. Interview with Medication Aide (MA) on 03/24/22 at 12:00pm revealed:	D 375		

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D 375	Continued From page 20 -She did not know that Resident #6 had an albuterol sulfate 90mcg inhaler in his room. -She did not recall a time when Resident #6 asked for albuterol sulfate 90mcg inhaler every four hours as needed. Interview with the Resident Care Coordinator (RCC) on 03/25/22 at 3:50pm revealed: -She did not know that resident #6 had an albuterol sulfate 90mcg inhaler in his room. -She knew Resident #6 had been on therapeutic leave from 01/27/22 to 03/07/22. -The Administrator picked up Resident #6's medications from his pharmacy. -Per facility policy the physician wrote an order for self-administration including the specific medications to be self-administered. -The facility staff completed a self-administration assessment in order to assess a resident's ability to self-administer medications appropriately and safely. Interview with Administrator on 03/28/22 at 11:05am revealed: -She picked up Resident #6's medications from his pharmacy. -She did not know that he had albuterol sulfate 90mcg inhaler in his room. -She did not know how Resident #6 obtained the albuterol sulfate 90mcg inhaler. -Resident #6 did not tell her that he had obtained an albuterol sulfate 90mcg inhaler.	D 375		
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	D912		

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D912	Continued From page 21 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Baed on observations, interviews, and record reviews, the facility failed to ensure residents received care and services that were adequate, appropriate and in compliance with revelant federal and state laws and rules and regulations as related to health care referral and follow-up. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure appropriate and timely follow-up for acute shoulder, wrist, and hip injuries due to falls for 1 of 5 sampled residents (Resident #1). [Refer to Tag 0273, 10A NCAC 13F .0902 (b) Health Care (Type A1 Violation)].	D912		