STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025023	A. BUILDING: _____ B. WING _____	R 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD HOME FOR THE AGED	603 WEST STREET NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey and complaint investigation on 11/13/19 through 11/15/19 with an exit conference via telephone on 11/19/19.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure proper repair, maintenance and cleaning of floors with depressed, soft, warped, loose and missing tile areas in three resident rooms and three shared resident bathrooms; walls with bubbled, cracked and peeling paint in 4 resident rooms and 2 shared resident bathrooms; multiple holes in 1 shared resident bathroom; heating units loose from the wall in the dining room and 1 resident room; loose door knobs on 1 resident room and 1 shared resident bathroom; ill fitting door to 1 resident room; broken and missing window blinds in 2 resident rooms; and walls and windows with stains in 1 resident room and 1 shared resident bathroom. The findings are:	D 074		

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D 074	Continued From page 1 Observations during the initial tour on 11/13/19 between 10:15am and 11:35am revealed: -There was a heating unit on the wall in the dining room that had become partially detached at the left side from the wall. -There were 3 large tiles missing from the floor of a resident's restroom on east hall in front of the toilet. Observations on 11/13/19 at 10:46am revealed: -Room #31's door knob was loose from the door; the blinds were missing from one of the windows and there were broken slats on the blinds in the remaining three windows. -There were brown stains on the wall around the second window from the left and the window pane. Interview with a housekeeper on 11/13/19 at 10:46am revealed: -The resident who occupied room #31 would get angry, slam her door and throw stuff around. -He did not know what happened to the blinds because he put up new blinds a week ago; he did not know where the missing blinds were. -The door knob was not loose on 11/12/19 and it looked like Resident #4 had thrown coffee on the wall and the window. Observation on 11/13/19 at 11:05am revealed: -The door to room #32 stuck to the frame on the side of the door knob and was difficult to open. -There were several broken slats in the window blinds above the resident bed. -There was a soft depression approximately the diameter of a basketball in front of the sink in room #32. -There was an opening of approximately one inch between the wall and the top of the air	D 074		

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D 074	Continued From page 2	D 074		

conditioning unit.

Interview with the resident of room #32 on 11/13/19 at 11:05am revealed:
-He had not noticed the soft, depression in front of the sink.
-He did not know of any water leaks that may have caused the soft depression in the floor in front of the sink.
-He had learned how to make the door work easily and had not noticed the blinds or opening above the air conditioning unit.

Interview with the maintenance person on 11/13/19 at 1:19pm revealed:
-The depression in the floor in room #32 was from a tile that was missing in that spot.
-The floor under the laminate was solid.
-The depression in the floor could be repaired, but he would have to take the floor up to make the repair.

Observations on 11/13/19 at 11:18am revealed:
-There was more than a one-half inch gap between the loose door knob and the door on the shared bathroom on the north hall across from the soiled linen room.
-The paint at the seam where the exterior and interior walls meet had bubbled, cracked and peeling from the floor to the ceiling.
-There were areas of tan discoloration on the wall near the floor.
-There were multiple dime sized holes in the wall next to the tub.
-There was a hole approximately the diameter of a tennis ball in the wall under the window.
-There was a hole approximately 3 inches in height and 5 inches in length near the baseboard on the wall between the tub and the sink.

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D 074	Continued From page 3	D 074		

Interview with a housekeeper on 11/13/19 at 11:24am revealed:
-There was a maintenance person who was working on making repairs including the walls.
-The maintenance person was at the facility daily during the week.

Interview with the maintenance person on 11/13/19 at 11:42am revealed:
-He was renovating the walk-in shower which was next to the bathroom on the north hall across from the soiled linen room.
-Installing the new shower made the holes in the wall; he was working on repairing the holes in the wall.

Observation on 11/13/19 at 11:24am revealed there was an area of cracked and peeling paint with a hole approximately 2 inches in height and greater than 10 inches in length in the wall underneath the air conditioning unit in room #27.

Interview with the resident of room #27 revealed she was not concerned about the hole in the wall.

Observations on 11/13/19 at 4:04pm revealed:
-There were seven cracked and loose tiles and with one missing tile in the tub and shower in the bathroom next to room #24.
-There was a hole the approximate diameter of a golf ball in the wall above the edge of the tub where the missing tile was.

Observations on 11/13/19 at 4:04pm revealed there was an area greater than two square feet of the floor in front of the toilet in the shared resident bathroom across from the soiled linen room that was spongy.

Observation of room #23 on 11/15/19 at 8:19am

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D 074	Continued From page 4	D 074		

revealed:
-There was a large area of the floor that was concave and caused the trim molding to separate from the baseboard approximately two feet in length.
-The paint on the wall above the concave area of the floor was bubbled, chipped and peeling.

Observation of the north hall on 11/14/19 between 9:20am and 9:40am revealed:
-There were several black areas on the wall, ceiling and floor in the soiled linen closet.
-There was an indention with flaking paint on the wall in the common shower room on the north hall that was approximately 3 inches in diameter.
-There was a hole at the base of the wall in the common shower room on the north hall approximately 5 inches in width.

Observations on 11/15/19 at 8:24am revealed the tile floor in the shared resident bathroom next to room #24 had a three foot square area from the door to the floor drain of loose tiles that rose and fell when stepped on.

Telephone interview with the maintenance person on 11/19/19 at 8:51am revealed:
-He had been doing a lot of work on the walls in resident rooms, going room by room.
-He was currently working on room #20.
-He knew about floors with loose tile and soft and concave areas; the floors were solid and were not going to give way.
-He had been all over the building checking the floors and there was no rotten wood under the floors.
-There were still tiles that were cracked underneath the flooring the made the soft and concave areas.

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D 074	Continued From page 5 Interview with the Manager on 11/15/19 at 12:10pm revealed: -She was not aware of the floors other than the bathroom on the back hall, far right. -DHSR Construction came out and said there was a bubble in the floor in front of the toilet. -The Maintenance Director who was responsible for the floors. -Maintenance was aware of the blinds, walls and doors because construction told them. -The Manager did walk throughs every day and sent a work order to the Vice President. Interview with the Administrator on 11/15/19 at 4:45pm revealed: -The floors had been repaired and maintenance was still working on the walls and the bathrooms. -There were new housekeepers to keep things clean. -The Manager was responsible for rounding in the facility daily and submitting all work orders to the Maintenance Director. -The maintenance person was in the facility daily and was expected to round in the facility weekly. _____ The facility failed to assure floors with depressed, soft, warped and loose tile areas were properly repaired and maintained in 4 resident rooms and 2 shared resident bathrooms which was detrimental to the safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 3, 2020.	D 074		

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D 077	Continued From page 6	D 077		
D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health sanitation score of 85.5 or above at all times. The findings are: Review of the environmental health inspection for the facility dated 01/25/19 revealed: -The facility score was 84.5 with 15.5 total demerits. -There were 2 demerits for the floors, walls and ceilings with a comment for repeat concern related to floors in hallways, several bedrooms and some restrooms; and ceilings and walls with peeling paint in rest rooms and some bedrooms. -There were 2 demerits for ambient air temperature 65 degrees to 85 degrees and equipment clean with a comment for repeat concern related to broken knobs on ventilation	D 077		

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equipment with many loose from the wall and having a build up of dust.
-There were 2.5 demerits for toilet, hand washing, laundry and bathing facilities with comment for repeat concerns related to cracked and missing tile and grout.
-There was one demerit for "miscellaneous" with a comment for repeat concern for personal care items including incontinence briefs stored in aid station.
-Under general comments there was documentation the hot water temperature was 120.5 degrees Fahrenheit (F) in room #10.

Observations on 11/13/19 at 10:00am upon entering the facility revealed:
-There was a sanitation grade of 84.5 dated 01/25/19 posted on the wall.
-There was a facility cleaning schedule posted on an office door.

Review of the facility cleaning schedule posted on the office door revealed:
-There were assigned duties for cleaning rooms 1, 2, 3, 4, and 8 on Mondays.
-There were assigned duties for cleaning rooms 5, 6, 7, 9, and 11 on Tuesdays.
-There were assigned duties for cleaning rooms 10, 27, 28, 29, and 30 on Wednesdays.
-The room cleaning duties included dusting furniture, cleaning and dusting blinds, clean baseboards, and windowsills, vacuuming, and pulling out the furniture and cleaning behind, around, over and under the furniture.
-There was an entry for cleaning of the window air conditioning units and filters.

Observations of the facility during the initial tour on 11/13/19 between 10:15am and 11:35am revealed:

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D 077	Continued From page 8 -In room #23 there was an area of a white sloughing substance detached from the wall next to the bedside table and to the left of an electrical outlet in room #23. -In room #5 the wall heating and air conditioning unit had a whitish-gray substance covering the heating element that had a wire see through cover over the heating unit. There were no knobs on the wall heating and air unit. -In the common bathroom next to room #24 there were areas of missing tile and a black color substance along the grout lines of the tiles surrounding the bathtub. -The window blind attached to the exit door close to room #24 had four broken slats. -There was a three-inch approximate sized piece of tape connected to two of the window blind slats in the middle of the window blind. -The aid station on the north hall had an unused medication cart with a large storage box on top, and piled blankets and packages of incontinence briefs on the counters. Interview with a housekeeper on 11/13/19 at 1:17pm revealed when he became aware of repair issues in the facility, he would verbally tell the Supervisors of the maintenance issues needing repair. Interview with the resident in room #23 on 11/13/19 at 10:55am revealed she was not happy at the facility because she had seen bugs in her room and there was "white stuff" coming off the wall. Interview with the resident in room #5 on 11/13/19 at 11:32am revealed the heating/air conditioning unit was not plugged in and he had never used the heater.	D 077		

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D 077	Continued From page 9 Observations of the facility on 11/15/19 between 8:15am and 8:40am revealed: -The first wall heating/air conditioning unit on the right side of the activity room did not have a grill covering. There was warm air blowing out of the unit. -In room #23, the bed had been repositioned off the wall in the middle of the room. There was an approximate sized five-inch area of a white loose wall covering detached from the wall. -There were bags of clothing on the floor in room #5. Interview with the Manager on 11/15/19 at 8:44am revealed the resident who was previously in room #5 was moved to another room on 11/13/19 because the heater was not working properly. Interview with the Manager on 11/19/19 at 9:20am revealed: -When staff told her there were maintenance needs, she would tell the maintenance person, Administrator, and send an email to the Vice President. -She had been notified of things like door knobs missing, light bulbs out, and heater not working. Telephone interview with the County Inspector on 11/14/19 at 1:46pm revealed: -She had completed the last inspection for the building on 01/25/19 and the score was 84.5. -She discussed all concerns during an inspection with the person in charge; she discussed the concerns on 01/25/19 with the Assistant Manager. -The facility was inspected twice per fiscal year. -If the facility had made improvements and wanted a reinspection the facility would have to contact the county environmental health and	D 077		

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request the reinspection.
-The facility had not requested reinspection.

Interview with the Assistant Manager on 11/15/19 at 11:07am revealed:
-She thought the building inspection was done in December 2018 when she was the Manager.
-The county inspector had told her she could call for reinspection after six months and repairs and improvements were done.
-There was a new Manager in June 2019 who would have been responsible for contacting the county inspector.
-She had told the new Manager of the need to follow up with the county inspector for reinspection.
-Everything in the facility was addressed from the 01/25/19 inspection.
-The floor had been replaced, three resident rooms "had been torn apart and redone," rooms #5 and #19 (she could not remember the third).
-The Maintenance Director was working on a floor that was soft and the peeling paint.

Interview with the Manager on 11/15/19 at 12:10pm revealed:
-She was not aware she needed to call regarding the building inspection.
-The Assistant Manager never told her to call about it.

Telephone interview with the maintenance person on 11/19/19 at 8:51am revealed:
-He did not know about the building inspection report dated 01/25/19.
-He had been doing a lot of work on the walls in resident rooms, going room by room.
-He was currently working on room #20.
-He knew about floors with loose tile and soft and concave areas; the floors were solid and were not

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going to give way.
-He had been all over the building checking the floors and there was no rotten wood under the floors.
-There were still tiles that were cracked underneath the flooring the made the soft and concave areas.

Interview with the Administrator on 11/15/19 at 4:31pm revealed:
-She had seen the sanitation grade posted on the wall in the facility.
-She was not aware of the sanitation report and did not see it unless she asked for it.
-The sanitation inspection report went to the Vice President.
-The Vice President went over the sanitation inspection report with the maintenance staff.
-She was told the environmental health inspector would come back for a re-inspection in six months.
-A call was made about the re-inspection and was told the health inspector was out of the office.
-She had a full-time maintenance person in the facility to get things done.
-The facility was still working on the walls, floors, filters, showers, and bathrooms.
-The Manager was responsible for completing work orders.
-The Manager should be making rounds in the facility every day and sending a report to the Vice President weekly.
-The maintenance person should be completing rounds in the facility weekly.

Attempted interview with the Maintenance Director on 11/19/19 at 10:47am was unsuccessful.

Attempted telephone interview with the Vice

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D 077	Continued From page 12 President on 11/19/19 at 9:49am was unsuccessful. [Refer to Tag 074 10A NCAC 13F 0306(a)(1) Housekeeping & Furnishings] [Refer to Tag 113 10A NCAC 13F 0311(d) Other Requirements] _____ The facility failed to assure the building environmental health score was a minimum of 85 following an inspection completed 01/25/19 with multiple violations resulting in a score of 84.5 which was detrimental to the safety and welfare of resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 3, 2020.	D 077		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.	D 113		

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D 113	Continued From page 13 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to assure that hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) for 19 fixtures in 6 shared resident bathrooms on the east hall, north hall and Sampson hall and 3 resident rooms (#16, #22 and #30), with temperatures of 78.9 degrees F to 121.4 degrees F. The findings are: Observation on 11/13/19 at 11:05am of resident room #16 revealed, the hot water temperature at sink A was 120 degrees Fahrenheit (F). Observation on 11/13/19 at 11:34am of resident room #22 revealed, the hot water temperature at the sink in was 119 degrees F. Observation on 11/13/19 at 11:18am revealed the hot water temperature from the tub in the common bathroom on the north hall across from the soiled linen room was 85.9 degrees Fahrenheit (F). Observation on 11/13/19 at 11:21am revealed the hot water temperature at the sink in common bathroom next to resident room #24 was 86.5 degrees F. Observation on 11/13/19 at 11:24am revealed the hot water temperature at the tub/shower combo in the common bathroom next to resident room #24 was 95.0 degrees F. Observation on 11/13/19 at 11:33am revealed the hot water temperatures in the common bathroom	D 113		

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on the north hall next to the soiled linen room were 96.4 degrees F from the sink and 91.0 degrees F from the tub.

Observation on 11/13/19 at 11:36am revealed the hot water temperature from the sink in resident room #30 was 78.9 degrees F.

Interview with a Personal Care Aide (PCA) on 11/13/19 at 11:22am revealed:
-She had just finished showering a resident in the common bathroom next to resident room #24.
-It usually did not happen that all the hot water was used unless more people were taking showers at the same time.
-Maintenance staff checked water temperatures "about one time a month".

Interview with a resident on 11/13/19 at 11:24am revealed:
-She used the common bathroom next to resident room #24.
-The hot water was hot enough to wash with.

Observation of the sink in common bathroom next to resident room #24 on 11/13/19 at 1:29pm revealed the water temperature was 90.5 degrees F.

Observation of the tub/shower combo in the common bathroom next to resident room #24 11/13/19 at 1:33pm revealed the water temperature was 87.4 degrees F.

Interview with the PCA on 11/13/19 at 1:30pm revealed:
-The hot water temperature got hotter than it felt presently.
-A resident had just finished showering and she had somebody in another shower at the same

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time.
-It took a little while for the hot water to build back up.

Observation on 11/13/19 at 4:04pm revealed the hot water temperature in the common bathroom on the north hall next to resident room #24 were 104.0 degrees F from the sink and 99.0 degrees F from the tub.

Observation on 11/13/19 at 4:12pm revealed the hot water temperatures in the common bathroom on the north hall across from the soiled linen room were 121.4 degrees F from the sink and 92.5 degrees F from the tub.

Observation on 11/13/19 at 4:16pm revealed the hot water temperatures in the common bathroom on the north hall next to the soiled linen room were 106.5 degrees F from the sink and 101.1 degrees F from the tub.

Observation on 11/13/19 at 4:18pm revealed the hot water temperature from the sink in resident room #30 was 109.0 degrees F.

Interview with the resident who occupied room #30 on 11/13/19 at 4:18pm revealed the hot water from the sink in his room was warmer than it usually was (109.0 degrees F).

Observations on 11/13/19 at 4:45pm and 4:48pm revealed:
-The hot water temperature at sink A in resident room #16 was 120 degrees Fahrenheit (F).
-The hot water temperature at sink B in resident room #16 was 120 degrees F.
-There was not a sign at sink A or sink B in resident room #16 warning residents of hot water.

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Observation on 11/13/19 at 4:55pm, in the men's common bathroom on the east hall revealed:
-The hot water temperature at the sink was 120 degrees F.
-There was a sign posted on the mirror warning of hot temperatures.

Interview with a resident on 11/13/19 at 11:10am revealed:
-The water in the men's tub in the common bathroom on the east hall was so hot that it burned his hand.
-This occurred a few weeks ago.
-He pulled his hand away from the hot water immediately.
-He increased the amount of cold water to decrease the heat.
-He did not report this to staff since he did not feel his hand was injured.
-He learned to test the water because the water temperatures tended to vary.

Interview with a resident on 11/13/19 at 4:15pm revealed that if the water felt too hot, he would ask staff to adjust it.

Interview with a second resident on 11/13/19 at 4:25pm revealed:
-She preferred to take a shower, but the water was usually too cold.
-When the water was not hot enough for her to take a shower, she would wash from the sink in her room.

Interview and observation with the Manager on 11/13/19 from 5:18pm-5:46pm revealed:
-Signs warning residents of temperature changes at sinks and bathtubs had been posted in all areas of concern.
-At 5:18pm the Manager was observed checking

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the temperature of the sink on north hall in the common bathroom.
-There was a sign posted warning residents of hot water.
-The temperature at the common bathroom sink was 120 degrees F.
-At 5:38pm the Manager was observed checking the temperature of both sinks in resident room #16.
-The temperature at both sinks in resident room #16 was 120 degrees F.
-There was no sign posted warning residents of hot water.
-She had forgotten to post a sign at both sinks warning residents of hot water temperatures.
-At 5:46pm the Manager was observed checking the temperature in the women's common bathroom sink.
-The temperature was 119 degrees F.
-There was a sign posted warning residents of hot water.

Observation of the north hall on 11/14/19 at 9:08am and 9:15am revealed:
-At 9:08am, the hot water temperature at the common bathtub was 79 degrees F.
-At 9:15am, the hot water temperature at the common bathtub was 95 degrees F.

Observation of the north hall on 11/14/19 between 9:30am and 9:40am revealed:
-The temperature for the common bathtub was 91 degrees F.
-The temperature for the common sink was 96 degrees F.

Observation of a common bathroom on Sampson hall on 11/14/19 at 9:45am revealed the temperature for the sink was 75 degrees F.

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Interview with a personal care aid (PCA) on 11/14/19 at 9:20am revealed:
-She would run the water in the bathtub on the north hall to ensure the water was warm enough for the residents to receive a bath.
-She would ask residents to test the water with their fingertips to assess if the water temperature was comfortable for them.

Interview with the maintenance person on 11/13/19 at 11:42am revealed:
-The Manager was responsible for checking hot water temperatures.
-There was a second hot water heater to back up the main hot water heater for the north hall.
-All the temperatures on the north hall should be the same.

Telephone interview with the Manager on 11/18/19 at 11:40am revealed:
-It was her responsibility to check water temperatures throughout the building two times a day.
-It was her responsibility to post warning signs if temperatures were too low or too high.
-If there was a problem with water temperatures, she would contact the Maintenance Director, Office Manager at Corporate Headquarters and the Administrator to notify them of the problem.
-If she was not at the facility for the day the lead medication aide (MA), Maintenance or Administrator would be responsible for checking the water temperatures in the building.
-It was her responsibility to maintain a daily log of water temperatures throughout the building.

Telephone interview with Administrator on 11/18/19 at 1:35pm revealed:
-She expected the water temperatures to be checked twice a day throughout the facility by the

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D 113	Continued From page 19 manager. -She expected the Manager to maintain a log book for recording water temperatures twice a day. -The log book for recording water temperatures was maintained by the Manager. -The Manager informed her on 11/13/19 that she was unable to locate the log book. -If water temperatures were too high or too low, it was the responsibility of the Manager to notify maintenance. -She expected the Manager to place warning signs at any locations where the water temperature was too high or too low. Telephone interview with the Administrator on 11/18/19 at 2:40pm revealed: -She expected water temperatures to be checked twice a day. -There was a book the water temperature checks were in but the book had been misplaced. _____ The facility failed to assure hot water temperatures were maintained between 100 - 116 degrees Fahrenheit (F) which resulted in hot water of 78.9 to 121.4 degrees F from 19 fixtures in 9 shared resident bathrooms and resident rooms which was detrimental to the safety of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/13/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 3, 2020.	D 113		

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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 B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 2 of 5 sampled residents (#1, #10) including failure to notify the primary care provider (PCP) of fingerstick blood sugars (FSBS) greater than 400 (#1), and failure to notify the PCP of a resident (#10) with a 17 pound weight loss over five months. The findings are: 1. Review of the current FL-2 for Resident #1 dated 08/15/19 revealed: -Diagnoses included diabetes, hypertension, depression, and chronic pain. -There was an order for Novolog flex pen100u/ml inject 5 units subcutaneously three times a day before meals. (Novolog is a rapid-acting insulin used to lower high blood sugar.) -There was an order for Levemir 100u/ml inject 30 units subcutaneously twice a day. (Levemir is a long-acting insulin used to lower high blood	D 273		

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sugar.)
-There was an order for Novolog flex pen 100u/ml sliding scale insulin (SSI) for blood sugars 151-200 give 2 units, for blood sugars 201-250 give 4 units, for blood sugars 251-300 give 6 units, for blood sugars 301-350 give 8 units, for blood sugars 351-400 give 10 units, and for blood sugars 400 and greater give 10 units and call the primary care provider (PCP).

Review of Resident #1's Resident Register revealed an admission date of 10/12/18.

Review of Resident #1's September 2019 medication administration record (MAR) revealed:
-There was an entry for Novolog flex pen 100u/ml SSI for blood sugars 151-200 give 2 units, for blood sugars 201-250 give 4 units, for blood sugars 251-300 give 6 units, for blood sugars 301-350 give 8 units, for blood sugars 351-400 give 10 units, and for blood sugars 400 and greater give 10 units and call the primary care provider (PCP).
-On 09/04/19 at 5:30pm, staff documented Resident #1's FSBS was 429 and 10 units of Novolog insulin administered; there was no documentation of PCP notification.
-On 09/05/19 at 7:30am, staff documented Resident #1's FSBS was 423, and there was no documentation of Novolog insulin administered or of PCP notification.
-On 09/06/19 at 7:30am, staff documented Resident #1's FSBS was 475, and there was no documentation of Novolog insulin administered or of PCP notification.
-On 09/07/19 at 7:30am, staff documented Resident #1's FSBS was 416, and there was no documentation of Novolog insulin administered or of PCP notification.
-On 09/28/19 at 7:30am, staff documented

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Resident #1's FSBS was 448, and there was no documentation of Novolog insulin administered or of PCP notification.

Review of Resident #1's October 2019 MAR revealed:
-There was an entry for Novolog flex pen 100u/ml SSI for blood sugars 151-200 give 2 units, for blood sugars 201-250 give 4 units, for blood sugars 251-300 give 6 units, for blood sugars 301-350 give 8 units, for blood sugars 351-400 give 10 units, and for blood sugars 400 and greater give 10 units and call the primary care provider (PCP).
-On 10/02/19 at 7:30am, staff documented Resident #1's FSBS was 477 and 10 units of Novolog insulin administered; there was no documentation of PCP notification.
-On 10/15/19 at 7:30am, staff documented Resident #1's FSBS was 458 and 10 units of Novolog insulin administered; there was no documentation of PCP notification.
-On 10/18/19 at 7:30am, staff documented Resident #1's FSBS was 527 and 10 units of Novolog insulin administered; there was no documentation of PCP notification.
-On 10/19/19 at 7:30am, staff documented Resident #1's FSBS was 401, and there was no documentation of Novolog insulin administered or of PCP notification.
-On 10/26/19 at 7:30am, staff documented Resident #1's FSBS was 518 and 10 units of Novolog insulin administered; there was no documentation of PCP notification.

Review of Resident #1's November 2019 MAR revealed:
-There was an entry for Novolog flex pen 100u/ml SSI for blood sugars 151-200 give 2 units, for blood sugars 201-250 give 4 units, for blood

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sugars 251-300 give 6 units, for blood sugars 301-350 give 8 units, for blood sugars 351-400 give 10 units, and for blood sugars 400 and greater give 10 units and call the primary care provider (PCP).
-On 11/11/19 at 7:30am, staff documented Resident #1's FSBS was 432 and 15 units of Novolog insulin administered; there was no documentation of PCP notification.

Review of Resident #1's Quarterly Pharmacy Review dated 09/09/19 revealed the pharmacist recommended to continue to notify Resident #1's PCP for his abnormal blood sugars per the sliding scale used.

Interview with Resident #1 on 11/15/19 at 10:10am revealed:
-He received one type of insulin three times a day before his meals and another type of insulin twice a day.
-He received additional insulin three times a day if his blood sugar was high.
-He had never refused his insulin, but many times the staff just did not bring it to him.
-Sometimes the 11:00pm-7:00am personal care aide (PCA) would check his FSBS in the morning and his blood sugar would be high, but the medication aide (MA) never brought him his insulin.
-He knew his blood sugar was high on those mornings because he woke up "ill tempered" with a dry mouth and felt like was going to urinate on himself.

Interview with a 7:00am-3:00pm shift medication aide (MA) on 11/14/19 at 10:30am revealed:
-She knew about Resident #1's SSI parameters but did not know where to document if she called the PCP.

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D 273	Continued From page 24 -She did not know if she called the PCP for Resident #1's blood sugar of 432 on 11/11/19, or if the 11:00pm-7:00am MA notified the PCP. Interview with the 11:00pm-7:00am shift MA on 11/14/19 at 11:15am revealed: -She did not know where to document if she had to call the PCP for a high blood sugar. -She did not know if she called the PCP for Resident #1's blood sugar of 432 on 11/11/19. Interview with the Manager and the Administrator on 11/15/19 at 11:45am revealed: -The Manager did not know Resident #1's PCP was not notified for 11 FSBS results of 400 and greater since 09/04/19. -The process for the MA documenting notification of the PCP for a FSBS result of 400 and greater, was to immediately document on the back of the MAR. -For any high FSBS that required notifying the PCP, the Manager should be notified immediately, or the Administrator if the Manager is not available. -It was the responsibility of the MA's, Manager and the regional Quality Assurance nurse to check the MARs twice a week for accuracy, which included checking for PCP notification per orders, for 100% of residents. Interview with Resident #1's PCP's office nurse on 11/19/19 at 2:35pm revealed: -Resident #1 had a history of high blood sugars. -The PCP had expected to be notified for any FSBS 400 and greater for Resident #1. -The PCP had not been notified by the facility for any high blood sugars for Resident #1. -The PCP did not provide any potential effects on Resident #1 having prolonged uncontrolled high blood sugars.	D 273		

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2. Review of the current FL-2 for Resident #10 dated 06/19/19 revealed:
-Diagnoses included diabetes, hypertension, schizophrenia and renal failure.
-There was no weight listed for Resident #10.

Review of Resident #10's physician orders on 11/15/19 at 11:00am for revealed:
-There was a physician's order for the month of September 2019, October 2019 and November 2019 for staff to check Resident #10's weights monthly to assess for a weight gain or weight loss of 10-pounds.
-The physician orders directed staff to contact the physician if Resident #10 had a 10-pound weight loss or 10-pound weight gain.

Review of Resident #10's Monthly Weights in the facility log book revealed:
-Resident #10 had a 17 pound weight loss in five months.
-Resident #10 weighed 195 pounds in June 2019, (specific date not documented).
-Resident #10 weighed 180 pounds on 07/10/19, 08/08/19 and 09/10/19.
-Resident #10 weighed 178 pounds on 10/04/19.
-Resident #10 weighed 178 pounds in November 2019, (specific date not documented).

Review of the facility's standing orders for weight change revealed that for a weight change of 10 pounds in one-month (gain or loss), the staff should contact the resident's primary care physician (PCP) so an appointment can be made to assess resident.

Telephone interview with Resident #10's PCP's nurse on 11/18/19 at 11:15am revealed:
-The PCP expected to be notified if Resident #10 had a weight loss or gain of 10 pounds or more in

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D 273	Continued From page 26 one month. -If a resident had a weight loss or gain of 10 pounds or more in one month, the PCP expected the facility to complete a new care plan and send it to the PCP's office to be signed. -Any weight loss of 10 pounds or more should be followed up with an appointment with resident's PCP. -The PCP was not aware that Resident #10 had a 17 pound weight loss in five months. Telephone interview with the Manager on 11/18/19 at 11:40am revealed: -Personal care aides (PCA'S) were expected to weigh residents as the PCP ordered. -When a resident had a 10 pound weight gain or loss, the PCA was expected to notify the manager so she could notify the physician. -She did not know that Resident #10 had a 17 pound weight loss. Telephone interview with the Administrator on 1/18/19 at 1:20pm revealed: -She was not aware that Resident #10 had a 17-pound weight loss in five months. -There was one PCA at the facility who was responsible for weighing residents monthly per physician orders. -The facility had a scale for residents that are in a wheelchair. -It was the Manager's responsibility to monitor the weights of residents. -The facility had just recently started entering weights into the facility monthly log book. _____ The facility failed to assure referral and follow up for Resident #1 who experienced symptoms of high blood sugar as a result of having 11 blood sugars greater than 400 in a 60-day period and	D 273		

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D 273	Continued From page 27 not receiving insulin for 5 of those blood sugars, and the facility failing to notify Resident #1's Primary Care Provider (PCP). The facility failed to notify Resident #10's PCP of a 17 pound weight loss over 5 months. The facility's failure was detrimental to the 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 11/14/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 3, 2020.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure foods being stored, prepared, and served to residents were protected from contamination related to several dead roaches in the kitchen, food storage areas and an area adjacent to the residents dining room, opened and undated food containers in the refrigerator and pantries and expired food items. The findings are:	D 283		

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D 283	Continued From page 28 Observation of the kitchen and storage areas on 11/14/19 from 11:23am-11:30am revealed: -There was one dead roach beside a large metal storage rack that contained gallon sized canned vegetables. -There was 1 large container in the kitchen pantry that was approximately 5 gallons that was labeled coffee, there was no coffee in the container and there were 2 dead roaches in the container. Observation of a locked food pantry on 11/14/19 at 12:26pm revealed: -There was 1 dead roach in the locked food pantry. -The locked food pantry was used for storage of non-perishable food items and water. Interview with the Manager on 11/14/19 at 12:26pm revealed: -The locked food pantry was designated as emergency preparedness storage of non-perishable food items and water. -She did not know there was a dead roach in the locked storage area. Observation of an open area adjacent to the residents' dining room on 11/14/19 at 11:52am revealed: -There was a community microwave on a small table. -There was a dead roach on the floor against the wall. -There were 5 bags of cereal that had been opened. -One bag of cereal was opened and was not secured. -There were 6 non-perishable pasta dinners that had expired, with "Enjoy by 4/16/19" imprinted on the box.	D 283		

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D 283	Continued From page 29 Observation of the refrigerator in the kitchen on 11/15/19 from 8:51am-8:53am revealed: -On the top shelf, there was a gallon container of mayonnaise that had expired, dated 10/25/19 and a gallon pitcher with an unknown red substance that was partially covered with plastic wrap and was not labeled or dated. -On the third shelf, there was a storage container labeled "dinner" with an unknown meat inside, with no date and not in the original container. -There was a storage container with an unsecured lid with uncooked chicken dated 11/14/19. -On the bottom shelf there was an unknown meat wrapped in plastic wrap with several areas of the meat exposed, with no date and not in the original package. Interview with a Cook on 11/15/19 at 9:40am revealed: -She knew that all food should be labeled with name and date when opened. -She did not know that all food was not labeled in the pantries, refrigerators and freezer. Interview with the Administrator on 11/15/19 at 12:45pm revealed: -A pest control company sprayed the facility approximately 2 weeks ago for roaches. -She was not aware that there were dead roaches in the kitchen, storage areas and dining room. -She expected the Manager to notify her if there was a problem with roaches. -She had not noticed any dead roaches in the kitchen, storage areas or dining room when she toured these areas weekly. -She expected the Manager to inspect the kitchen, storage areas and dining room for roaches at least weekly.	D 283		

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D 283	Continued From page 30 -It was her understanding that the Manager toured the kitchen and storage areas daily. -The Manager was responsible for overseeing the dietary department. -The Manager was responsible for ensuring that the dietary staff were trained on proper food storage. -She expected the food to be rotated on shelves weekly. -She expected all items in the pantry, refrigerator and freezer to be labeled with the name of the item and the date it was opened. -She expected expired items to be discarded. -She threw away the 6 non-perishable pasta dinners that were expired. Interview with the Manager on 11/18/19 at 11:40am revealed: -She was not aware that there were dead roaches in the kitchen, storage areas and dining room. -She expected all staff to inform her of any pest control issues. -She expected dietary staff to identify and discard any expired items. -The facility should not be serving any expired food items. -The dietary staff were expected to maintain food storage with labels and dates on all opened items.	D 283		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of	D 285		

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D 285	Continued From page 31	D 285		

non-perishable food in the facility based on the menus, for both regular and therapeutic diets.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to assure there was at least a three-day supply of perishable food and a five-day supply of non-perishable food on hand in the facility, based on the menus.

The findings are:

Interview with the Administrator on 11/13/19 at 10:00am revealed the facility census was 33 residents.

Observation of the milk inventory on 11/14/19 at 11:52am revealed:
-The facility had 7 gallons (896 ounces) of milk on hand.
-Per the facility menu, milk should be served at breakfast and dinner.
-There was not a sufficient supply of milk to serve 33 residents' milk at breakfast and dinner thru 11/15/19.
-There was a shortage of 160 ounces of milk.

Review of the dinner menu for regular diets dated 11/15/19 revealed the meal consisted of cream of potato soup, saltine crackers, tuna salad sandwich, relish plate, fruit parfait, beverage of choice and milk.

Observation of the food supply on 11/14/19 at 11:30am and 11/15/19 at 8:45am compared to the regular menu revealed:
-There was only one 8 ounce can of tuna fish.
-The can of tuna fish was located in the locked food pantry that was designated as emergency preparedness.

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D 285	Continued From page 32 Review of the dinner menu for regular diets dated 11/16/19 revealed the meal consisted of tossed salad with dressing, beef pot pie, biscuit, tropical fruit, assorted cookie, beverage of choice and milk. Observation of the food supply on 11/14/19 at 11:30am and 11/15/19 at 8:45am compared to the regular menu revealed that lettuce, tomatoes and assorted cookies were not available. Review of the dinner menu for regular diets dated 11/17/19 revealed the meal consisted of BBQ beef sandwich, potato chips, cole slaw, fruit mix, beverage of choice and milk. Observation of the food supply on 11/14/19 at 11:30am and 11/15/19 at 8:45am compared to the regular menu revealed BBQ beef, hamburger buns and potato chips were not available. Review of the dinner menu for regular diets dated 11/15/19 revealed the meal consisted of spaghetti with meat sauce, garden blend vegetables, garlic bread, pudding and beverage of choice. Observation of lunch meal on 11/15/19 at 12:15pm revealed a resident complained to other residents sitting at her table that she did not understand why the facility used ketchup instead of meat sauce for the spaghetti. Interview with a resident during the lunch meal on 11/15/19 at 12:20pm revealed: -She was upset and frustrated that ketchup had been used instead of meat sauce for her spaghetti. -She did not understand why the Manager had not ordered meat sauce for the spaghetti.	D 285		

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D 285	Continued From page 33	D 285		

-She did not understand why the meat sauce had not been delivered with the regular food delivery earlier today (11/15/19).

Observation of the Cook with the resident on 11/15/19 at 11:23am revealed:
-The Cook came to the residents' table and listened to her complaint.
-The Cook explained to the resident that dietary staff mixed ketchup with the meat sauce.
-The Cook later explained that dietary staff did not have meat sauce in their inventory, so they added ketchup to the spaghetti.
-The Cook offered to make the resident a sandwich as a substitution for the spaghetti.
-The resident accepted a sandwich as a replacement for the spaghetti.

Interview with a Cook on 11/15/19 at 8:58am revealed:
-She had been working as a personal care aide (PCA) but was told to work as cook in dietary yesterday.
-If there were a food on the menu that was not available, she would notify the Manager.
-The Manager would identify a substitution for the menu item.
-The Cook would then post the substitution meal item in the dining room where menus were posted.
-Goldfish were substituted for granola bars on 11/14/19 for the 10:00am snack, because granola bars were not available.
-Green beans were substituted for peas on 11/14/19 for the regular lunch menu because peas were not available.
-Biscuits were substituted for dinner rolls on 11/14/19 for the regular lunch menu because dinner rolls were not available.
-The food delivery truck usually came on Fridays.

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D 285	Continued From page 34 -The Manager was responsible for ordering food. Interview with the Manager on 11/15/19 at 11:40am revealed: -She would count inventory and place the food order based on the menu. -She placed her order with the corporate office. -The corporate office would make changes at times. -She or another staff member would go to the store to get items when needed. -The Cook would notify her of any substitution needs. -She was not aware that there was not enough food available to assure at least a three-day supply of perishable foods and a five-day supply of non-perishable foods were on hand based on the menus and census. -The food deliveries were every Friday. Interview with the Administrator on 11/18/19 at 1:20pm revealed: -The Manager was responsible for counting food inventory and placing food orders with the corporate office. -She was not aware there was not enough food available to ensure at least a three-day supply of perishable foods and a five-day supply of non-perishable foods on hand based on the menus. -She expected the Manager to ensure that the facility maintained enough food on hand to meet at least a three-day supply of perishable foods and a five-day supply of non-perishable food on hand based on the menus	D 285		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service	D 299		

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D 299	Continued From page 35 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to serve eight-ounce glasses of milk at least twice daily to residents. The findings are: Observation of the week #1 regular menu cycle for 11/14/19 and 11/15/19 revealed residents were to be served 8 ounces of milk at breakfast and dinner. Observation of the dinner meal on 11/14/19 from 6:00pm-6:20pm revealed no residents were served milk. Observation of the milk inventory on 11/14/19 at 11:52am revealed: -The facility had 7 gallons (896 ounces) of milk on hand. -Per the facility menu, milk should be served at breakfast and dinner. -There was not a sufficient supply of milk to serve 33 residents' milk at breakfast and dinner thru 11/15/19. -There was a shortage of 160 ounces of milk.	D 299		

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Interview with a resident on 11/15/19 at 8:40am revealed:
-He did not receive milk with his breakfast on 11/14/19 or 11/15/19.
-He received juice with his breakfast on 11/14/19 and 11/15/19.

Interview with the cook on 11/15/19 at 8:55am revealed:
-Eight ounces of milk should be served with breakfast and dinner meals.
-The menu posted listed milk as a beverage to be served with breakfast and dinner meals.
-The Personal Care Aides (PCA's) would provide residents with their beverages at breakfast, lunch and dinner.
-She was not aware the PCA's had not served milk to residents at breakfast on 11/14/19 and 11/15/19.
-She was not aware the PCA's had not served milk to residents at dinner on 11/14/19.

Interview with a second resident on 11/15/19 at 12:10pm revealed:
-He only received milk at his breakfast meal when he asked for it.
-He did not receive milk with his breakfast meal today (11/15/19).
-He did not usually receive milk with his dinner.

Interview with a third resident during lunch on 11/15/19 at 12:18pm revealed:
-He did not receive milk with his dinner meal on 11/14/19.
-He did not receive milk with his breakfast meal on 11/15/19.

Telephone interview with the Manager on 11/18/19 at 11:40am revealed:
-It was the expectation that residents be served 8

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D 299	Continued From page 37 ounces of milk twice a day. -She expected the dietary staff to serve milk with residents' meals at breakfast and dinner. -She monitored meals "often." -She would observe residents in the dining room at several meals during the week. -She was not aware that the PCA's were not serving milk to residents at breakfast and dinner. -She was responsible for ordering the milk. -There was an adequate supply of milk for residents for 3 days. -She was not aware there was a shortage of milk to provide residents with 8 ounces of milk with breakfast and dinner. Telephone Interview with the Administrator on 11/18/19 at 1:20pm revealed: -She observed meals several times a week but was not aware that PCA's were not providing residents with milk at breakfast and dinner. -She toured the kitchen a few times a week and did not realize there was a shortage of milk. -Residents should be served 8 ounces of milk at breakfast and dinner. -If a resident did not like milk, she expected staff to contact the resident's physician to obtain an order clarifying that they did not need to be served milk at breakfast and dinner. -The Manager was responsible for ensuring residents received 8 ounces of milk at breakfast and dinner. -The Manager was responsible for ordering milk. -It was the responsibility of the Manager to monitor the dietary department.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 310		

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D 310	Continued From page 38	D 310		

(e) Therapeutic Diets in Adult Care Homes:
(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to assure nutritional supplements were served as ordered for 1 of 2 sampled residents (#5).

The findings are:

Review of Resident #5's current FL-2 dated 10/24/19 revealed:
-Diagnoses included end stage chronic obstructive pulmonary disease, right leg injury and gait disturbance.
-There was no order for nutritional supplement.

Review of a physician order for Resident #5 dated 03/20/19 revealed an order for a nutritional supplement three times a day.

Review of the dietary nutritional supplement list provided by the Administrator on 11/13/19 at 11:52 revealed Resident #5 was on the dietary nutritional supplement list to receive nutritional supplements 3 times a day.

Review of the dietary nutritional supplement list in the kitchen on 11/14/19 at 11:11am revealed that Resident #5 was listed on the dietary nutritional supplement list to receive nutritional supplements 3 times a day.

Observation of the refrigerator in the kitchen on 11/15/19 from 8:51am-8:53am revealed that there was an adequate supply of nutritional

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D 310	Continued From page 39 supplements. Review of Resident #5's September 2019-November 2019 medication administration record (MAR) revealed there was no entry for a nutritional supplement and no documentation the resident received the nutritional supplement three times a day. Interview with Medication Aide (MA) on 11/15/19 at 11:05am revealed: -Resident #5 was listed on the dietary nutritional supplement list located in the kitchen. -It was the MA's responsibility to document in the MAR when a resident received their nutritional supplement. -If a resident refused their nutritional supplement, the MA documented in the MAR that the resident refused. -Resident #5 had been receiving the nutritional supplement 3 times a day. -She was not aware that there were not any entries on the MAR for nutritional supplements for Resident #5. -She was not aware there was a physician order for Resident #5 dated 03/20/19 for a nutritional supplement three times a day. -The nutritional supplement should have been listed 3 times a day on Resident #5's MAR. -After reviewing the physicians order for Resident #5, the MA acknowledged that there was a physician's order dated 03/20/19 for Resident #5 to receive a nutritional supplement 3 times a day -The facility failed to fax the physicians order dated 03/20/19 to the pharmacy. -After reviewing with her Administrator on 11/15/19, the MA faxed an order to the pharmacy on 11/15/19 for resident to receive a nutritional supplement 3 times a day.	D 310		

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Interview with Resident #5 on 11/14/19 at 11:54am revealed:
-He received a nutritional supplement with "most meals" from staff who passed out food or from a MA.
-Sometimes he received his nutritional supplement from a Personal Care Aide (PCA).
-He usually received 1-2 nutritional supplements at day.

Interview with the Manager on 11/15/19 at 4:16pm revealed:
-She was aware Resident #5 was listed on the nutritional supplement list in the kitchen.
-She was not aware the MA's had not documented in Resident #5's MAR that he had received the nutritional supplement as ordered.
-She expected the MA's to document in Resident #5's MAR each time they provided him a nutritional supplement.
-She was not aware there was a physician's order dated 3/20/19 for Resident #5 to receive nutritional supplements 3 times a day.
-She was aware Resident #5 had received nutritional supplements for several months.
-She was not aware that the nutritional supplement was not listed on the MAR.

Observation of the lunch meal on 11/14/19 from 12:00pm-12:28pm revealed Resident #5 was not served a nutritional supplement.

Observation of the dinner meal on 11/14/19 from 6:00pm-6:20pm revealed Resident #5 was not served a nutritional supplement.

Observation of the lunch meal on 11/15/19 from 11:54am-12:25pm revealed Resident #5 did receive a nutritional supplement.

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D 338	10A NCAC 13F .0909 Resident Rights	D 338		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure residents were free of mental and physical abuse and neglect related to residents being treated with respect and dignity and not experiencing serious neglect.

The findings are:

1. Based on observations, record reviews, and interviews, the facility failed to assure residents were treated with respect and dignity as related to not providing wheelchair accessible transportation for a resident who had bilateral below the knee amputations and was required to climb into the facility van to be transported to physician appointments (#1); and a resident (#10) being asked to assist staff with another resident's personal care just prior that resident's death which resulted in emotional distress for Resident #10 [Refer to Tag 911 G.S.131D-21(1) Residents' Rights (Type B Violation)].

2. Based on interviews and record reviews, the facility neglected Resident #3 by not administering as needed medication including inhalers, a nebulizer, Ativan and Morphine and continuous supplemental oxygen as ordered by Hospice for constant complaints of difficulty breathing, not notifying Hospice and/or the

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D 338	Continued From page 42 primary care provider about Resident #3's difficulty breathing, not calling emergency medical services immediately following an alleged witnessed head injury and not assuring staff, instead of other residents, provided personal care assistance [Refer to Tag 914 G.S.131D-21(4) Residents' Rights (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for housekeeping and furnishings, other requirements, health care, medication administration, controlled substances and residents' rights [Refer to Tag 980 G.S.131D-25 Implementation (Type A1 Violation)].	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with facility's policies and procedures for 3 of 5 residents (#7, #8, #9) observed during medication	D 358		

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passes including errors with a blood pressure and an oral diabetic medication (#7), insulin (#8), and medications for anxiety (#9); and record review for 1 of 5 sampled residents (#1) with 23 errors in sliding scale insulin administration during a three month period.

The findings are:

1. The medication error rate was 22% as evidenced by 6 errors out of 27 opportunities during the 5:00pm and 5:30pm medication passes on 11/13/19 and the 8:00am medication pass on 11/14/19.

A. Review of Resident #7's current FL-2 dated 09/24/19 revealed diagnoses included cerebral infarction, diabetes, hypertension, hyperlipidemia, vitamin D deficiency, and dementia.

a. Review of physician orders for Resident #7 revealed:
-There was an order for metformin (used to treat diabetes) 1000mg tablet twice a day with meal on the current FL-2 dated 09/24/19.
-There was a subsequent physician's order dated 10/02/19 for Metformin 1000mg take one tablet two times a day with meals for DM (diabetes mellitus).

Review of Resident #7's November 2019 medication administration record (MAR) revealed there was an entry for metformin HCL 1000mg take one tablet two times a day with meals for DM with scheduled administration times of 8:00am and 5:00pm printed to the MAR.

Observation of the 5:00pm medication pass on 11/13/19 revealed:
-The medication aide (MA) prepared 3 oral

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medications, including metformin 1000mg one tablet and a cup of water for administration to Resident #7 at 4:57pm.
-The MA began to leave the medication room with the cup of medications and water to administer the medications to Resident #7 who was seated outside the medication room.

Interview with the MA on 11/13/19 at 4:59pm revealed:
-Resident #7 would eat dinner at 6:00pm, so the resident would have food in his stomach.
-If the instructions for medication administration stated with food or meals, the medication should be scheduled at dinner time at 6:00pm.
-She administered medications to resident at the time the medication was scheduled for administration on the MAR.
-She had never asked anyone about how or when to administer medication with food or meals.
-She could administer medications one hour before or after the scheduled time for administration.
-It would "probably be fine" for her to administer Resident #7 his medication at dinner time.
-She had never administered Resident #7's medication with food.
-She "guess"[ed] the best option would be to get something for the resident to snack on before administering Resident #7 the medications.
-She would go to the kitchen and get Resident #7 a snack before administering the medications.

Interview with a Pharmacist from the facility contracted pharmacy on 11/15/19 at 8:51am revealed:
-There was a current order for Glucophage (brand name for metformin) 1000mg twice a day with meals.
-Resident meal times were around 8:00am and

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dinner at 5:00pm.
-Medication administration times were assigned by the provider pharmacy who printed the MARs for the facility.
-Medications scheduled to be administered with the meal should either be administered before a meal or right with the meal.
-An hour before or after the meal would be okay for administering the metformin to the resident.
-It would be ideal if the metformin was given closer to the meal which helps to eliminate side effects such as diarrhea and stomach irritation.

Interview with Resident #7 on 11/14/19 at 1:30pm revealed the resident denied stomach discomfort.

b. Review of physician orders for Resident #7 revealed:
-There was an order for carvedilol (used to treat high blood pressure) 3.125mg tablet twice a day with food on the current FL-2 dated 09/24/19.
-There was a subsequent physician's order dated 10/02/19 for carvedilol 3.125mg take one tablet two times a day with food for blood pressure.

Review of Resident #7's November 2019 medication administration record (MAR) revealed there was an entry for carvedilol 3.125mg take one tablet two times a day with food for blood pressure with scheduled administration times of 8:00am and 5:00pm.

Observation of the 5:00pm medication pass on 11/13/19 revealed:
-The medication aide (MA) prepared 3 oral medications, including carvedilol 3.125mg one tablet and a cup of water for administration to Resident #7 at 4:57pm.
-The MA began to leave the medication room with the cup of medications and water to administer

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the medications to Resident #7 who was seated outside the medication room.

Interview with the MA on 11/13/19 at 4:59pm revealed:
-Resident #7 would eat dinner at 6:00pm, so the resident would have food in his stomach.
-If the instructions for medication administration stated with food or meals, the medication should be scheduled at dinner time at 6:00pm.
-She administered medications to resident at the time the medication was scheduled for administration on the MAR.
-She had never asked anyone about how or when to administer medication with food or meals.
-She could administer medications one hour before or after the scheduled time for administration.
-It would "probably be fine" for her to administer Resident #7 his medication at dinner time.
-She had never administered Resident #7's medication with food.
-She "guess"[ed] the best option would be to get something for the resident to snack on before administering Resident #7 the medications.
-She would go to the kitchen and get Resident #7 a snack before administering the medications.

Observation of the Resident #7 on 11/13/19 at 5:07pm revealed the resident was eating a bowl of peaches prior to administration of medications at 5:09pm.

Interview with a Pharmacist from the facility contracted pharmacy on 11/15/19 at 8:51am revealed:
-Medication administration times were assigned by the provider pharmacy who printed the MARs for the facility.
-Resident meal times were around 8:00am and

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dinner at 5:00pm.
-Medications scheduled to be administered with the meal should be administered either before but right with the meal.
-It would be okay if the carvedilol was administered an hour before or after the meal.
-The thinking of some providers was giving carvedilol with food helped with absorption and could cause less of a drop in the resident's blood pressure if the absorption was not slowed.

Interview with the Manager on 11/15/19 at 11:04am revealed:
-Resident #7's carvedilol should have been administered at 6:00pm because that was the time the resident ate a meal.
-She expected the MAs to let her know when they saw something like a time of medication administration that was not correct so that she could correct it.
-She expected the MAs to administer medications with food that were ordered to be administered with food.
-The physician had ordered the medication to be administered with food for a reason.

Interview with the Administrator on 11/15/19 at 12:03pm revealed:
-If the physician ordered a medication to be administered with a meal, the medication should be administered at the mealtime.
-The MAs were instructed to take the medication cart in the dining room at mealtimes and administer medication.
-The times on Resident #7's MARs "probably" needed to be changed.
-The provider pharmacy assigned medication administration times and printed the resident MARs.
-The facility could change the times of

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administration of medications on the MARs.

Review of the facility medication policy revealed the policy included a medication error occurred if a medication was administered at the wrong time. Deviation from established medication hour routines shall be permitted in the community according to resident needs and requirements.

B. Review of Resident #8's current FL-2 dated 10/24/19 revealed:
-Diagnoses included cerebral infarction and diabetes mellitus type II.
-There was a physician's order for "diabetic testing" two times a day before breakfast and supper.
-There was a physician's order for Novolog Flexpen inject 5 units subcutaneously before supper for any blood sugar greater than 250. (Novolog insulin is a rapid-acting insulin used to lower blood sugars. According to the manufacturer, the Novolog Flexpen should be primed with a 2-unit dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)

Review of Resident #8's November 2019 medication administration record (MAR) revealed:
-There was an entry for finger stick blood sugar (FSBS) two times a day before breakfast and supper for monitoring with scheduled times of 7:00am and 5:30pm.
-There was an entry for Novolog Flex Pen inject 5 units subcutaneously before supper for any blood sugar greater than 250. *Refer to blood sugar check order and documentation*

Observation of the 5:00pm medication pass on 11/13/19 revealed the medication aide (MA) obtained a FSBS result of 291 at 5:13pm for

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D 358	Continued From page 49 Resident #8. a. Observations of the MA on 11/13/19 at 5:00pm revealed: -The MA removed a Novolog Flex Pen from the refrigerator in the medication room that was labeled with the resident's name. There was no open date documented or expiration date documented on the label attached to the Novolog Flex Pen for documenting the same. There were printed instructions on the label to "discard after 28 days -There was a pharmacy printed label on the vial with a dispense date of 06/10/19. Interview with the MA on 11/13/19 at 5:17pm revealed: -There was supposed to be an open date documented on the Novolog Flex Pen and there was no open date on the Novolog Flex Pen. -The Novolog Flex Pen she removed from the refrigerator was the pen the MA had been using. -She would still use the Novolog Flex Pen. -She had first used the Novolog Flex Pen when she first started working at the facility about one month ago. -She would check with the Manager and then the Administrator if she had questions. Interview with the Manager on 11/13/19 at 5:20pm revealed: -She did not think the Novolog Flex Pen had been used because no insulin had been administered from the vial because the plunger had not moved down. -The MA should not use the Novolog Flex Pen if she was not sure when the Novolog Flex Pen was opened. Interview with the Administrator on 11/15/19 at	D 358		

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D 358	Continued From page 50 12:07pm revealed: -The MAs were supposed to initial and date a new insulin pen when opened. -The insulin pen was supposed to be disposed of 30 days after opening. -If the MA did not know when the Novolog Flex pen had been opened for Resident #8, she would have expected the MA to open a new insulin pen, initial and date the pen. b. Observations of the MA on 11/13/19 at 5:00pm revealed: -The MA removed the cap from the Novolog Flex Pen and attached a disposable needle to the tip of the Novolog Flex Pen. -The MA dialed the Novolog Flex Pen to 5 units. -The MA did not prime the insulin pen with a 2-unit air shot. Interview with the MA on 11/13/19 at 5:25pm revealed she had never done an air shot before to prime the Novolog Flex Pen. Interview with the MA on 11/13/19 at 5:31pm revealed: -This was her second time administering Resident #8 insulin. -"Somebody" told her with the pens you did not have to prime, and she did not remember who had told her. Interview with the Pharmacist from the facility contract pharmacy on 11/15/19 at 9:40am revealed: -There would be no way to tell if the insulin pen was used unless the facility documented the open date on the insulin pen. -There should be a 2-unit air shot performed before each injection with the Novolog flex pen to bleed the air out of the needle.	D 358		

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-If the air was not removed from the needle, the resident would not get the full dose of insulin ordered and the resident's blood sugar would not go down appropriately. The physician may want to increase the dose to compensate for the air shot.

Interview with the Manager on 11/15/19 at 11:10am revealed:
-All MAs were taught that there was not supposed to be an air bubble in the insulin needle.
-The MAs were skill competency validated by the Licensed Health Professional Support (LHPS) nurse but she did not know what the LHPS nurse told the MAs because she did not watch them during their training.

Interview with the Administrator on 11/15/19 at 12:07pm revealed:
-She used to perform insulin training for staff and trained staff to always perform an air shot.
-She did not know how the LHPS nurse trained staff now.
-She did not know if the air shot was still a requirement anymore.

Review of the facility medication policy revealed the policy included multi-dose vials shall carry a label with the date opened and qualified persons name or initials. All multi-dose vials shall be considered out-of-date (expired) and should be removed from used and placed in a designated area for disposal after 30 days from the date opened or as specified in the community's policies or manufacturers recommendations.

C. Review of Resident #9's current FL-2 dated 07/01/19 revealed diagnoses included schizo-affective disorder bipolar, hypertension, and gastro-esophageal reflux disease.

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D 358	Continued From page 52 a. Review of physician orders for Resident #9 revealed: -There was an order for clonazepam (used to treat anxiety) 1mg tablet three times daily on the current FL-2 dated 07/01/19. -There was a subsequent physician's order dated 09/13/19 for clonazepam 0.5mg take 2 tablets (1mg) three times a day for anxiety *yellow tablet only*. Review of Resident #9's November 2019 medication administration record (MAR) revealed there was an entry for clonazepam 1mg tablet three times a day for anxiety - brand yellow tablets only with scheduled administration times of 8:00am, 2:00pm, and 8:00pm printed to the MAR. b. Review of physician orders for Resident #9 revealed: -There was an order for risperidone 1mg/ml liquid (used to treat behaviors) give 2mls every morning with breakfast and give 1ml twice a day with lunch and dinner on the current FL-2 dated 07/01/19. -There was a subsequent physician's order dated 09/13/19 for risperidone 1mg/ml liquid give 2mls every morning with breakfast for schizophrenia with aggressive behaviors. Review of Resident #9's November 2019 MARs revealed there was an entry for risperidone 1mg/ml take 2mls every day with breakfast for schizophrenia with aggressive behaviors with a scheduled administration time of 8:00am printed to the MAR. c. Review of physician orders for Resident #9 revealed: -There was an order for Haldol 2mg/ml liquid	D 358		

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(used to treat behavior) give 5mls (10mg) two times a day on the current FL-2 dated 07/01/19.
-There was a subsequent physician's order dated 09/13/19 for Haldol 2mg/ml liquid take 5mls (10mg) two times a day for mood/behavior place in food/drink.

Review of Resident #9's November 2019 MARs revealed there was an entry for haloperidol 2mg/ml take 5mls(10mg) two times a day for mood/behavior **place in food/drinks** with scheduled administration times of 8:00am and 8:00pm printed to the MAR.

Observation of the 8:00am medication pass on 11/14/19 revealed:
-Resident #9 approached the medication cart in the dining room while the MA was preparing medications to administer to another resident.
-The MA aide told Resident #9 it would be a few minutes.
-Resident #9 was observed to mumble words as he approached the medication cart and continued to mumble words in a low tone while he waited for the MA to prepare his medications.

Observation of the MA on 11/14/19 at 8:12am revealed she prepared and administered three medications(Docusate Sodium, Senna, and Lactulose) to Resident #9.

Interview with the medication aide (MA) on 11/14/19 at 8:14am revealed:
-Resident #9 was also supposed to get Haldol, Risperidal, and Klonopin.
-The MAs usually mixed those medications with Resident #9's food.

Observation of the MA on 11/14/19 between 8:14am and 8:22am revealed:

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D 358	Continued From page 54 -She prepared for administration the clonazepam 1mg tablet, the risperidone 2ml liquid, and haloperidol 5ml. -The MA went to the kitchen and asked the cook for Resident #9's breakfast meal. -The MA mixed the prepared clonazepam, risperidone, and haloperidol in the grits on the plate and served the plate to Resident #9. -The MA left Resident #9 seated at a dining room table alone. -The resident was positioned with his face to the wall. -The MA returned to the medication cart and initialed Resident #9's MAR documenting administration of the clonazepam, risperidone, and haloperidol. Interview with the MA at 8:21am revealed: -She would "eye ball" Resident #9 to see what he ate. Observation of the MA on 11/14/19 at 8:24am revealed: -The MA took a breakfast drink to another resident who was sitting at the opposite end of the dining room. The MA glanced at Resident #9 as she gave the other resident the breakfast drink. -The MA returned to the medication cart and began preparing medications for administration to another resident which she administered at 8:30am. Observation of Resident #9 on 11/14/19 at 8:31am revealed: -The resident got up from the dining room table and took his breakfast tray to the trashcan. -The resident dumped his food, including all the grits served, into the trashcan.	D 358		

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Interview with the MA on 11/14/19 at 8:34am revealed:
-She was not paying attention to Resident #9.
-She had already documented administration of medication for the clonazepam, risperidone, and haloperidol on Resident #9's MAR.
-She was not sure how she would document that Resident #9 did not take his medications since she did not see what he ate.

Second interview with the MA on 11/14/19 at 10:00am revealed:
-She had seen a medication policy but could not put her hands on it right now.
-When she did not know something, she would go to her supervisor.
-Staff would bring Resident #9's tray to her.
-Everyone knew medications were mixed in Resident #9's food.
-Resident #9 was the only resident with medications mixed in their food.

Interview with a provider pharmacist on 11/15/19 at 9:25am revealed:
-The pharmacy recommended putting medication in a small amount of food to make sure the resident got the medications.
-If the resident did not eat all the food, the resident would not get the proper dose of medications and symptoms of anxiety, behaviors, and psychoses would not be treated.
-One missed dose of the medications would not be detrimental, but it would also depend on the level of symptoms the medication is prescribed for.
-It would be ideal for the MA to observe the resident eat the food that the medications have been mixed in.

Interview with the primary care provider (PCP) on

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D 358	Continued From page 56 11/15/19 at 10:21am revealed: -Resident #9 had a history of medication refusals. -Resident #9 could get very aggressive and have increased hallucinations. -The resident normally talked to himself and saw things that were not there. -The resident's baseline behavior was him talking to self. -Resident #9's behavior was "pretty stable, no aggression". -She would expect to know if the resident was not getting his prescribed medications. -She would expect the MA to go back and check to make sure the resident ate the food. -The MA could mix the medications in a small amount of food. Interview with the Manager on 11/15/19 at 11:17am revealed: -She expected the MA to be positioned so the MA could watch Resident #9 and make sure the resident ate the food his medications were mixed in. -Resident #9 would not eat the food if he saw the color of the food was changed which is why the resident's clonazepam was switched to the "yellow" tablet. -Resident #9 did not like for anybody to stare or watch him. Interview with the Administrator on 11/15/19 at 12:18pm revealed: -The MA was not watching Resident #9 after she mixed the resident's medications in his food. -When the MA asked her for advice, the MA was told to always pull the medication cart so she was close enough to observe the resident. -Resident #9 did not like staff to stand over him. -Resident #9 had to be kept in "eye shot".	D 358		

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Review of the facility medication policy revealed the policy included no resident shall be left alone while taking medication. The community staff will ensure that medication is taken properly and, in the quantities, prescribed.

2. Review of the current FL-2 for Resident #1 dated 08/15/19 revealed:
-Diagnoses included diabetes, hypertension, depression, and chronic pain.
-There was an order for Novolog flex pen100u/ml inject 5 units subcutaneously three times a day before meals. (Novolog is a rapid-acting insulin used to lower high blood sugar.)
-There was an order for Levemir 100u/ml inject 30 units subcutaneously twice a day. (Levemir is a long-acting insulin used to lower high blood sugar.)
-There was an order for Novolog flex pen 100u/ml sliding scale insulin (SSI) for blood sugars 151-200 give 2 units, for blood sugars 201-250 give 4 units, for blood sugars 251-300 give 6 units, for blood sugars 301-350 give 8 units, for blood sugars 351-400 give 10 units, and for blood sugars 400 and greater give 10 units and call the primary care provider (PCP).

Review of Resident #1's Resident Register revealed an admission date of 10/12/18.

Review of Resident #1's September 2019 medication administration record (MAR) revealed:
-There was an entry for Novolog flex pen 100u/ml SSI for blood sugars 151-200 give 2 units, for blood sugars 201-250 give 4 units, for blood sugars 251-300 give 6 units, for blood sugars 301-350 give 8 units, for blood sugars 351-400 give 10 units, and for blood sugars 400 and greater give 10 units and call the primary care

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provider (PCP).
-On 09/01/19 at 7:30am, Resident #1's fingerstick blood sugar (FSBS) was documented as 253 which would have required 6 units of SSI; there was no documentation that Novolog SSI was given.
-On 09/02/19 at 7:30am, Resident #1's FSBS was documented as 283 which would have required 6 units of SSI; there was no documentation that Novolog SSI was given.
-On 09/05/19 at 7:30am, Resident #1's FSBS was documented as 423 which would have required 10 units of SSI and the PCP called; there was no documentation that Novolog SSI was given or the PCP called.
-On 09/06/19 at 7:30am, Resident #1's FSBS was documented as 475 which would have required 10 units of SSI and the PCP called; there was no documentation that Novolog SSI was given or the PCP called.
-On 09/07/19 at 7:30am, Resident #1's FSBS was documented as 416 which would have required 10 units of SSI and the PCP called; there was no documentation that Novolog SSI was given or the PCP called.
-On 09/15/19 at 7:30am, Resident #1's FSBS was documented as 200 which would have required 2 units of SSI; the quantity of Novolog SSI documented was 4 units.
-On 09/21/19 at 7:30am, Resident #1's FSBS was documented as 189 which would have required 2 units of SSI; the quantity of Novolog SSI documented was 4 units.
-On 09/23/19 at 7:30am, Resident #1's FSBS was documented as 231 which would have required 4 units of SSI; there was no documentation that Novolog SSI was given.
-On 09/28/19 at 7:30am, Resident #1's FSBS was documented as 448 which would have required 10 units of SSI and the PCP called; there

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was no documentation that Novolog SSI was given or the PCP called.

Review of Resident #1's October 2019 MAR revealed:
-There was an entry for Novolog flex pen 100u/ml SSI for blood sugars 151-200 give 2 units, for blood sugars 201-250 give 4 units, for blood sugars 251-300 give 6 units, for blood sugars 301-350 give 8 units, for blood sugars 351-400 give 10 units, and for blood sugars 400 and greater give 10 units and call the primary care provider (PCP).
-On 10/04/19 at 7:30am, Resident #1's FSBS was documented as 316 which would have required 8 units of SSI; the quantity of Novolog SSI documented was 6 units.
-On 10/05/19 at 7:30am, Resident #1's FSBS was documented as 392 which would have required 10 units of SSI; the quantity of Novolog SSI documented was 6 units.
-On 10/10/19 at 7:30am, Resident #1's FSBS was documented as 259 which would have required 6 units of SSI; there was no documentation that Novolog SSI was given.
-On 10/11/19 at 7:30am, Resident #1's FSBS was documented as 334 which would have required 8 units of SSI; there was no documentation that Novolog SSI was given.
-On 10/12/19 at 7:30am, Resident #1's FSBS was documented as 374 which would have required 10 units of SSI; there was no documentation that Novolog SSI was given.
-On 10/17/19 at 7:30am, Resident #1's FSBS was documented as 200 which would have required 2 units of SSI; there was no documentation that Novolog SSI was given.
-On 10/19/19 at 7:30am, Resident #1's FSBS was documented as 401 which would have required 10 units of SSI and the PCP called; there

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was no documentation that Novolog SSI was given or the PCP called.
-On 10/22/19 at 7:30am, Resident #1's FSBS was documented as 284 which would have required 6 units of SSI; the quantity of Novolog SSI documented was 10 units.

Review of Resident #1's November 2019 MAR revealed:
-There was an entry for Novolog flex pen 100u/ml SSI for blood sugars 151-200 give 2 units, for blood sugars 201-250 give 4 units, for blood sugars 251-300 give 6 units, for blood sugars 301-350 give 8 units, for blood sugars 351-400 give 10 units, and for blood sugars 400 and greater give 10 units and call the primary care provider (PCP).
-On 11/02/19 at 7:30am, Resident #1's FSBS was documented as 353 which would have required 10 units of SSI; the quantity of Novolog SSI documented was 8 units.
-On 11/05/19 at 7:30am, Resident #1's FSBS was documented as 292 which would have required 6 units of SSI; there was no documentation that Novolog SSI was given.
-On 11/06/19 at 7:30am, Resident #1's FSBS was documented as 252 which would have required 6 units of SSI; there was no documentation that Novolog SSI was given.
-On 11/08/19 at 7:30am, Resident #1's FSBS was documented as 208 which would have required 4 units of SSI; there was no documentation that Novolog SSI was given.
-On 11/15/19 at 7:30am, Resident #1's FSBS was documented as 317 which would have required 8 units of SSI; there was no documentation that Novolog SSI was given.
-On 10/11/19 at 7:30am, Resident #1's FSBS was documented as 432 which would have required 10 units of SSI and the PCP called; the quantity

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of Novolog SSI documented was 15 units and there was no documentation that the PCP was called.

Interview with Resident #1 on 11/15/19 at 10:10am revealed:
-He received one type of insulin three times a day before his meals and another type of insulin twice a day.
-He received additional insulin three times a day if his blood sugar was high.
-He had never refused his insulin, but many times the staff just did not bring it to him.
-Sometimes the 11:00pm-7:00am personal care aide (PCA) would check his FSBS in the morning and his blood sugar would be high, but the medication aide (MA) never brought him his insulin.
-He knew his blood sugar was high on those mornings because he woke up "ill tempered" with a dry mouth and felt like was going to urinate on himself.

Interview with a 7:00am-3:00pm shift medication aide (MA) on 11/14/19 at 10:30am revealed:
-She documented for the 11:00pm-7:00am MA for Resident #1's blood sugar 432 and 15 units of Novolog insulin given on 11/11/19 at 7:30am.
-She did not know if she called the PCP for Resident #1's blood sugar of 432 on 11/11/19, or if the 11:00pm-7:00am MA notified the PCP.

Interview with the Manager and the Administrator on 11/15/19 at 11:45am revealed:
-The Manager did not know about the 23 errors on Resident #1's SSI since 09/04/19.
-The MA's were responsible for documenting the FSBS and corresponding amount of insulin to give (if applicable) based on the SSI.
-It was the responsibility of the MA's, Manager

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D 358	Continued From page 62 and the regional quality assurance nurse to check the MARs twice a week for accuracy for 100% of residents. Interview with Resident #1's PCP's office nurse on 11/19/19 at 2:35pm revealed: -Resident #1 had a history of high blood sugars. -The PCP had expected the SSI for Resident #1 to be implemented as per the PCP order on the FL2 dated 08/15/19. -The PCP had expected to be notified for any FSBS 400 and greater for Resident #1. -The PCP had not been notified by the facility for any high blood sugars for Resident #1. -The PCP did not provide any potential effects on Resident #1 having prolonged uncontrolled high blood sugars. _____ The facility failed to administer a rapid-acting insulin as ordered to Resident #1 for 23 opportunities when the residents finger stick blood sugar results were within physician prescribed parameters. This failure placed the resident at risk for high blood sugars. The failure of the facility to administer insulin to Resident #1 as ordered was detrimental to the health and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 3, 2020.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

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D 366	Continued From page 63 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the Medication Administration Records (MARs) were accurate to include the initials of the 11:00pm-7:00am shift medication aide (MA) who administered the medications for 1 of 5 sampled residents (Resident #1) with orders for blood sugar checks three times a day with sliding scale insulin (SSI), but had the 7:00am-3:00pm shift MA document the administration. The findings are: The findings are: Review of Resident #1's current FL-2 dated 08/15/19 revealed: -Diagnoses included diabetes, hypertension, depression, and chronic pain. -There was an order for Novolog flex pen100u/ml inject 5units subcutaneously three times a day before meals. (Novolog is a rapid-acting insulin used to lower high blood sugar.) -There was an order for Novolog flex pen 100u/ml	D 366		

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D 366	Continued From page 64 sliding scale insulin (SSI) for blood sugars 151-200 give 2 units, for blood sugars 201-250 give 4 units, for blood sugars 251-300 give 6 units, for blood sugars 301-350 give 8 units, for blood sugars 351-400 give 10 units, and for blood sugars 400 and greater give 10 units and call the primary care provider (PCP). Review of Resident #1's November 2019 MAR revealed: -There was an entry for Novolog flex pen 100u/ml SSI for blood sugars 151-200 give 2 units, for blood sugars 201-250 give 4 units, for blood sugars 251-300 give 6 units, for blood sugars 301-350 give 8 units, for blood sugars 351-400 give 10 units, and for blood sugars 400 and greater give 10 units and call the PCP. -On 11/11/19 at 7:30am, the 7:00am-3:00pm shift MA documented Resident #1's finger stick blood sugar (FSBS) was 432 and 15 units of Novolog insulin administered; there was no documentation of PCP notification. Interview with Resident #1 on 11/15/19 at 10:10am revealed: -He received one type of insulin three times a day before his meals and another type of insulin twice a day. -He received additional insulin three times a day if his blood sugar was high. -He had never refused his insulin, but many times the staff just did not bring it to him. -Sometimes the 11:00pm-7:00am personal care aide (PCA) would check his FSBS in the morning and his blood sugar would be high, but the medication aide (MA) never brought him his insulin. -He knew his blood sugar was high on those mornings because he woke up "ill tempered" with a dry mouth and felt like was going to urinate on	D 366		

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himself.

Interview with a 7:00am-3:00pm shift MA on 11/14/19 at 10:30am revealed:
-Sometimes the 11:00pm-7:00am shift MA would give her a list of resident blood sugars and insulin she gave but did not have time to document.
-She would document the blood sugars and insulin given by the 11:00pm-7:00am MA if she was asked.
-She would sign her own initials on the MAR because she was the one signing it, not the 11:00pm-7:00am shift MA..
-She documented for the 11:00pm-7:00am MA for Resident #1's blood sugar 432 and 15 units of Novolog insulin given on 11/11/19 at 7:30am.

Interview with the 11:00pm-7:00am shift MA on 11/14/19 at 11:15am revealed:
-She did not remember if she documented Resident #1's high blood sugar or SSI insulin dose on 11/11/19 at 7:30am.
-Sometimes she would give the 7:00am-3:00pm MA a list of resident blood sugars and insulin she gave but did not have time to document.
-She tried to take the MAR with her to the resident's room when she gave the insulin but sometimes she did not and would just write it on a piece of paper.
-The 7:00am-3:00pm MA helped her out by documenting for her; "we work together".

Interview with the Manager and the Administrator on 11/15/19 at 11:45am revealed:
-The Manager did not know that the 7:00am-3:00pm MA was documenting on the MAR for the 11:00-pm-7:00am MA.
-The process for the MA documenting FSBS results and medications administered, was to immediately document after the medication was

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D 366	Continued From page 66 given and the FSBS was obtained. -The MA should never write it on a piece of paper and document it later, or have another staff document it for them. -If a MA performed false documentation, they would be removed from the medication cart immediately. -It was the responsibility of the MA's, Manager and the regional Quality Assurance nurse to check the MARs twice a week for accuracy for 100% of residents.	D 366		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure an accurate accounting of the receipt and disposition of controlled substances for 1 of 4 sampled residents (#3) which resulted in 6.25ml of morphine being unaccounted for. The findings are: Review of Resident #3's current FL-2 dated 07/01/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD) exacerbation, acute on chronic respiratory failure,	D 392		

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chronic chest pain, diabetes mellitus, peripheral neuropathy, leukocytosis, coronary artery disease and tobacco use.

Review of Hospice orders dated 06/26/19 for Resident #3 revealed there was an order for morphine20mg/ml - 0.25ml (5mg total dose) every 4 hours as needed (PRN) for pain.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/18/19 at 8:49am revealed:
-The pharmacy had an order for morphine 0.25ml every 4 hours PRN and 0.125ml every hour PRN dated 06/27/19 for Resident #3.
-The pharmacy dispensed a 30ml bottle of morphine on 06/27/19 for Resident #3.
-There was no other morphine dispensed from the pharmacy.

Review of Hospice orders dated 07/26/19 for Resident #3 revealed:
-There was an order for morphine 0.25ml (5mg) every 4 hours scheduled.
-There was an order for morphine 0.125ml (2.5mg) every hour PRN pain, shortness of breath, until comfortable or until symptoms subside.

Review of Resident #3's August 2019 medication administration record (MAR) revealed:
-There was an entry for morphine .0.25ml (5mg) every 4 hours PRN for pain.
-There were 31 doses (7.75ml) of morphine 0.25ml (5mg) documented as administered between 08/01/19 and 08/31/19 on the front and the back of the MAR.

Review of a controlled drug record (CDR) dated 07/27/19 through 08/19/19 for Resident #3

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revealed:
-The heading of the CDR indicated the form was for tablets, capsules, ampules and patches measured in a minimum of 1 unit.
-There were hand written instructions for morphine 0.25ml (5mg) every 4 hours PRN for pain.
-The count started at 60 doses (instead of 30ml) on 07/27/19 at 8:00pm; 20 doses of an undocumented amount (0.25ml verses 0.125ml) were initialed as administered leaving a remaining count of 40 doses (unknown quantity of ml) on 08/18/19 at 10:00am.
-20 doses of 0.25ml equals 5ml.
-There was no way to determine the quantity administered on the CDR.

Review of Resident #3's August 2019 MAR and the CDR dated 07/27/19 through 08/19/19 revealed:
-There was documentation on the CDR morphine 0.25ml was administered on 08/15/19 at 5:00pm which was not documented on the MAR.
-There was documentation on the MAR morphine 0.25ml was administered on 08/26/19 (no time) which was not documented on the CDR.
-There was documentation on the MAR morphine 0.25ml was administered on 08/28/19 at 8:00pm which was not documented on the CDR.
-There was documentation on the CDR morphine 0.25ml was administered on 08/31/19 at 9:36pm which was not documented on the MAR.

Review of a controlled substance record (CSR) dated 08/19/19 through 09/03/19 revealed:
-There was a preprinted pharmacy label with instructions for morphine 0.25ml (5mg) every 4 hours PRN for pain.
-The pharmacy label indicated 30ml (600mg) of morphine was dispensed on 06/27/19.

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D 392	Continued From page 69 -The beginning count was documented as 23ml on hand on 08/19/19 at 11:20am. -There was documentation 17 doses of 0.25ml (5mg) were administered with a remaining count of 19.25ml. -On 08/29/19, there was documentation 0.25ml (5mg) of morphine was administered at 4:00pm and 10:00pm with a remaining count of 20.5ml for each entry. -On 09/02/19, there was documentation 0.25ml (5mg) of morphine was administered with a remaining count of 19.25ml. -On 09/03/19, there was documentation 0.25ml (5mg) of morphine was administered, but there was no remaining amount documented. -23ml minus 17 doses of 0.25ml (4.25ml total) should have had a remaining balance of 18.75ml. Review of Resident #3's September 2019 MAR revealed: -There were two preprinted entries for morphine 0.25ml every 4 hours scheduled for pain and shortness of breath. -There was a handwritten entry "waiting for clarification" after one entry, a handwritten entry "duplicate order" after the second entry and no doses were documented as administered for both entries. -There was a handwritten entry for Morphine 0.25ml every 4 hours scheduled for pain and shortness of breath at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm and 10:00pm. - There was documentation one dose was administered on 09/02/19 at 10:00am. -There was documentation the dose was not administered on 09/01/19 at 10:00am, 09/01/19 at 2:00pm and 09/02/19 at 2:00pm. -The box for the following doses were blank: 09/01/19 at 2:00am, 09/01/19 at 6:00am, 09/01/19 at 6:00pm, 09/01/19 at 10:00pm,	D 392		

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09/02/19 at 2:00am, 09/02/19 at 6:00am, 09/02/19 at 6:00pm and 09/02/19 at 10:00pm.
-The boxes from 09/03/19 at 2:00am through 09/09/19 were blank.
-There was documentation on the back of the MAR the reason the dose on 09/02/19 at 2:00pm was not given was Resident #3 was "too sedated to take".
-There was no documentation for the reason doses were not given.
-There was a handwritten entry "waiting for clarification" after staff initials were documented.
-There was a total of 1 dose of morphine 0.25ml (5mg) documented as administered.

Review of Resident #3's September 2019 MAR and the CDR dated 08/19/19 through 09/03/19 revealed:
-There was documentation on the CDR morphine 0.25ml (5mg) was administered on 09/01/19 at 4:00pm which was not documented on the MAR.
-There was documentation on the CDR morphine 0.25ml (5mg) was administered on 09/03/19 at 4:00pm which was not documented on the MAR.

Interview with the Assistant Manager on 11/15/19 at 11:07am revealed:
-She had documented Resident #3 was too sedated to take morphine on 09/02/19.
-She could not remember why she had documented he was too sedated.
-Sometimes Resident #3 stayed up late at night and was drowsy in the morning.
-Resident #3 did not usually get up for the day until lunchtime.
-She had documented he was too sedated for a 2:00pm dose and she could not really say why.

Review of a prescription return to pharmacy form dated 09/09/19 revealed 13ml (260mg) of

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morphine for Resident #3 was returned to the pharmacy.

Second telephone interview with a pharmacy technician from the facility's contracted pharmacy on 11/18/19 at 9:47am revealed the pharmacy received a return of 13ml of morphine for Resident #3 on 09/09/19.

Review of Resident #3's CDR dated 08/19/19 through 09/03/19 and the prescription return to pharmacy form revealed there was a 6ml (120mg) discrepancy in the amount of morphine remaining and the amount returned to the pharmacy.

Interview with the Hospice Nurse (HN) on 11/15/19 at 9:45am revealed:
-Resident #3 was active with Hospice on 09/07/19; she had done teaching with staff on the use of morphine for shortness of breath.
-Morphine was ordered for Resident #3 on 06/27/19 for 0.25ml (5mg) every 4 hours PRN and 0.125ml (2.5mg) every hour PRN; the same order was clarified on 09/05/19.
-Hospice orders were written then faxed to the pharmacy and the facility; the facility should have copies of all Hospice orders.

Interview with a medication aide (MA) on 11/15/19 at 11:33am revealed:
-Controlled medications were poured according to the order on the MAR and administered to the resident.
-After she watched the resident take the controlled medication, she documented the dose administered on the MAR and CDR.
-If the controlled medication was a PRN medication, she documented the dose administered on the back of the MAR also.

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D 392	Continued From page 72 Second telephone interview with the MA on 11/19/19 at 9:50am revealed: -She drew up morphine in a syringe and measured the dose for Resident #3; the doses were not in prefilled syringes. -She documented the amount that was supposed to be in the bottle of morphine and then the amount she gave. -She verified the amount of morphine that was supposed to be in the bottle by setting the bottle on top of the medication cart and checking the level of the liquid by the marks on the side of the bottle. Telephone interview with the Manager on 11/19/19 at 9:58am revealed: -Resident #3's morphine was not in premeasured syringes. -She could not speak to the CSR that documented amounts by the number of doses. -She was only able to say she signed there was 23ml of morphine remaining in the bottle on 08/19/19 and she verified there was 23ml in the bottle before she signed. -She kept a book of all completed CSRs and CDRs; the MAs gave completed CSRs/CDRs to her when the count was at zero. -When she checked resident MARs, she checked to make sure controlled medications were signed on the MAR and the CSR/CDR. -She did not regularly check the amount on hand verses the documented amount on the CSR/CDR. -MAs were responsible for completing controlled drug counts each shift. -If there was a problem with the count, the oncoming MA was not to accept the keys and call her.	D 392		

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D 392	Continued From page 73 Interview with the Administrator on 11/15/19 at 4:31pm revealed if there were discrepancy on returns, the pharmacy would let the facility know. Based on interviews and record reviews, it was determined Resident #3 was not interviewable.	D 392		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to accurately account for and maintain a record of all residents' personal funds transactions with two witness signatures for 6 of 6 residents sampled (#1, #2, #3, #4, #5, #6). The findings are: 1. Review of the current FL-2 for Resident #1 dated 08/15/19 revealed: -Diagnoses included diabetes, hypertension, depression, and chronic pain. -There was no documented assessment of the resident's orientation status.	D 421		

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D 421	Continued From page 74 Review of the current care plan for Resident #1 dated 07/01/19 revealed the resident was assessed as oriented. Review of Resident #1's Resident Fund Sheet revealed: -There was no balance forward on the ledger. -The first entry was a transaction for "grant" dated 07/08/19 for a credit of $66.00. -There was a second entry dated 07/08/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 07/08/19 for a "payout" of $41.00 to Resident #1, with no balance documented. -On 08/06/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 08/06/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 08/06/19 for a "payout" of $15.00 to Resident #1, leaving a balance of $26.00. -On 08/15/19, there was an entry for "payment plan for back money owed" in the amount of a $26.00 credit. -On 09/10/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 09/10/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 09/10/19 for a "payout" of $21.00 to Resident #1, with no balance documented. -There was a fourth entry for "payment sent to [Vice President of the facility's name] in the amount of $20.00. -On 10/08/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 10/08/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 10/08/19 for	D 421		

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"payment plan" in the amount of $20.00.
-There was a fourth entry dated 10/08/19 for a "payout" of $21.00 to Resident #1, with no balance documented.
-On 11/06/19, there was an entry for "grant" for a credit of $66.00.
-There was a second entry dated 11/06/19 for a deduction of $25.00 to the pharmacy.
-There was a third entry dated 11/06/19 for a "payout" of $21.00 to Resident #1, with no balance documented.
-There a fourth entry dated 11/06/19 for "payment plan" in the amount of $20.00.
-There was no ending balance documented after each transaction.
-There was a resident signature but no witness signature for each transaction on 10/08/19 and 11/06/19.

Telephone interview with the provider pharmacy billing representative on 11/19/19 at 8:27am revealed:
-Resident #1 had a current pharmacy bill of $780.00.
-On 07/18/19, there was a payment of $25.00 posted to Resident #1's pharmacy bill.
-On 08/14/19, there was a payment of $25.00 posted to Resident #1's pharmacy bill.
-On 10/21/19, there was a payment of $25.00 posted to Resident #1's pharmacy bill.
-There were no payments posted to Resident #1's pharmacy bill for September 2019 or November 2019.

Interview with Resident #1 on 11/15/19 at 10:10am revealed:
-He was on a payment plan for money the facility told him he owed for room and board for October and November 2018.
-His social security check of $761.00 per month

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went directly to the facility, and the facility gave him $21.00 per month.
-He was told by management of the facility that he had to have his social security check sent directly to the facility or he "would be put on the streets".
-He was supposed to get $41.00 per month, but the facility kept $20.00 per month until he no longer owed the facility for room and board for October and November 2018.
-He signed a sheet when he was given money.
-The facility never gave him a receipt, "they don't believe in receipts".

Telephone interview with the Administrator on 11/18/19 at 2:40pm revealed:
-Resident #1 may have a payment plan agreement (she was not sure) because he owed money for room and board.
-Payment plan agreements should be in the resident record unless they were kept in a book somewhere.
-The Manager did not know about any payment plan agreements.
-The Manager only knew about the residents signing the resident fund sheet when the resident was taking out money.

Telephone interview with the Vice President on 11/18/19 at 9:05am revealed:
-Monies were deducted from Resident #1's personal funds because the resident owed money for room and board.
-Resident #1 owed the facility $4486.52, due to no social security or special assistance income for November 2018 and December 2018 and no special assistance income for January 2019 and February 2019.
-Additionally, Resident #1's income was short $10.00 every month for unknown reason.

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D 421	Continued From page 77 Records of monies received and paid for Resident #1 from 01/01/19 through 11/18/19 were requested on 11/18/19, but was not received prior to survey exit. Refer to interview with the Administrator on11/15/19 at 4:55pm. Refer to the telephone interview with the provider pharmacy billing representative on 11/19/19 at 8:25am. Refer to the second telephone interview with the provider pharmacy billing representative on 11/19/19 at 10:00am. Refer to interview with the Manager on 11/15/19 at 12:01pm. Refer to interview with the Vice President on 11/18/19 at 9:05am. 2. Review of the current FL-2 for Resident #2 dated 10/17/19 revealed: -Diagnoses included acute asthma, anxiety, ADHD (attention deficit hyperactive disorder), congestive heart failure, hypothyroid, PTSD (post-traumatic stress disorder), type 2 diabetes mellitus, and suicidal ideations. -There was no documented assessment of the resident's orientation status. -There were physician's orders for eight medications. Review of the current care plan for Resident #2 dated 10/17/19 revealed the resident was assessed as oriented. Review of the Resident Register for Resident #2	D 421		

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dated 10/17/19 revealed:
-The resident's date of admission was 10/17/19.
-The section titled "plans made for payment of personal needs" and "other" had no information documented.
-The section titled "request for assistance" included four areas requiring the resident's signature with three of those areas having a signature for Resident #2. The signature section for the area for "request that management of this home handle my personal funds" had an "x" marked and did not include a signature for Resident #2.

Review of Resident #2's Resident Fund Sheet revealed:
-The fund sheet available for Resident #2 had four transactions dated "11-6".
-On 11/06/19, a transaction of $66.00 for "grant" was posted on the ledger. There was no balance documented. There was a signature for Resident #2. There were no witness signatures for the transaction.
-On 11/06/19, a transaction of $25.00 for pharmacy (named) was posted on the ledger. There was no balance documented. There was a signature for Resident #2. There were no witness signatures for the transaction.
-On 11/06/19, a transaction of $21.00 for "payout" was posted on the ledger. There was no balance documented. There was a signature for Resident #2. There were no witness signatures for the transaction.
-On 11/06/19, a transaction of $20.00 for "payment plan payment" was posted on the ledger. There was no balance documented. There was a signature for Resident #2. There were no witness signatures for the transaction.

Telephone interview with the provider pharmacy

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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billing representative on 11/19/19 at 8:25am revealed:
-On 08/14/19, there was a payment of $25.00 posted to Resident #2's pharmacy bill.
-There were no payments posted to Resident #2's pharmacy bill since 08/14/19.
-There had been no payment of $20.00 or #25.00 for November 2019 posted.

Interview with Resident #2 on 11/13/19 at 10:55am revealed:
-She only got $10.00 this month because she owed a bill.
-She did not mind paying her bills if she had to.
-She signed a sheet when she was given money.
-She was administered medications at the facility.

Telephone interview with the Administrator on 11/18/19 at 2:40pm revealed:
-Resident #2 did not have a payment plan agreement.
-There should be a payment plan agreement.
-Payment plan agreements should be in the resident record unless they were kept in a book somewhere.
-The Manager did not know about any payment plan agreements.
-The Manager only knew about the residents signing the resident fund sheet when the resident was "taking out $20.00".

Telephone interview with the Vice President on 11/18/19 at 9:05am revealed:
-Monies were deducted from Resident #2's personal funds because the resident owed money for room and board.
-Resident #2 owed money due to not having social security income in August 2019 and missed a couple of months of special assistance.
-The facility did not receive anything in October

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2019 for Resident #2.

Records of monies received and paid for Resident #2 from 01/01/19 through 11/18/19 were requested on 11/18/19, but was not received prior to survey exit.

Refer to interview with the Administrator on11/15/19 at 4:55pm.

Refer to the telephone interview with the provider pharmacy billing representative on 11/19/19 at 8:25am.

Refer to the second telephone interview with the provider pharmacy billing representative on 11/19/19 at 10:00am.

Refer to interview with the Manager on 11/15/19 at 12:01pm.

Refer to interview with the Vice President on 11/18/19 at 9:05am.

3. Review of Resident #3's current FL-2 dated 07/01/19 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD) exacerbation, acute on chronic respiratory failure, chronic chest pain, diabetes mellitus, peripheral neuropathy, leukocytosis, coronary artery disease and tobacco use.
-There was no information on Resident #3's level of orientation.

Review of an "A/R Aging Detail Report dated 10/31/19 revealed:
-The form had columns titled date, name, class, aging and open balance.
-There were lines of documentation that were

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redacted leaving documentation related to Resident #3.
-The first line documented a date of 09/01/19, Resident #3's name, the name of the facility under class and the number 60 for aging with a balance of 236.00.
-There was a hand written entry in the left margin area "monies out, he owed the facility."
-There was no documentation of monies received or paid out.
-There was no documentation of Resident #3's signature or mark and no witness signature.

Review of Resident #3's Resident Fund Sheet revealed there was no ledger for Resident #3.

Interview with the Manager on 11/15/19 at 12:01pm revealed:
-Resident #3 did not have a personal funds ledger because the resident owed the facility money.
-The corporate office was not Resident #3's payee; his money went to his own bank account.
-The corporate office kept the record of monies received, paid and owed.

Records of monies received and paid for Resident #3 from 01/01/19 through 11/18/19 were requested on 11/18/19, but was not received prior to survey exit.

Refer to interview with the Administrator on 11/15/19 at 4:55pm.

Refer to the telephone interview with the provider pharmacy billing representative on 11/19/19 at 8:25am.

Refer to the second telephone interview with the provider pharmacy billing representative on

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D 421	Continued From page 82 11/19/19 at 10:00am. Refer to interview with the Manager on 11/15/19 at 12:01pm. Refer to interview with the Vice President on 11/18/19 at 9:05am. 4. Review of Resident #4's FL-2 dated 06/19/19 revealed: -Diagnoses included paranoid schizophrenia, anemia, pre-diabetes mellitus and delusional. -There was no documentation regarding Resident #4's orientation. Review of Resident #4's Resident Fund Sheet revealed: -There was no balance forward on the ledger. -The first entry was a transaction for "grant" dated 07/08/19 for a credit of $66.00. -There was a second entry dated 07/08/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 07/08/19 for a "payout" of $41.00 to Resident #4, with no balance documented. -On 08/06/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 08/06/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 08/06/19 for a "payout" of $41.00 to Resident #4, with no balance documented. -On 09/10/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 09/10/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 09/10/19 for a "payout" of $41.00 to Resident #4, with no balance documented. -On 10/08/19, there was an entry for "grant" for a	D 421		

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credit of $66.00.
-There was a second entry dated 10/08/19 for a deduction of $25.00 to the pharmacy.
-There was a third entry dated 10/08/19 for a "payout" of $41.00 to Resident #4, with no balance documented.
-On 11/06/19, there was an entry for "grant" for a credit of $66.00.
-There was a second entry dated 11/06/19 for a deduction of $25.00 to the pharmacy.
-There was a third entry dated 11/06/19 for a "payout" of $41.00 to Resident #4, with no balance documented.
-There was no ending balance documented after each transaction.
-There was a resident signature but no witness signature for each transaction on 11/06/19.

Telephone interview with the provider pharmacy billing representative on 11/19/19 at 8:44am revealed:
-Resident #4 had a current pharmacy bill of $802.86.
-On 07/18/19 there was a payment of $25.00 posted to Resident #4's pharmacy bill.
-On 08/14/19 there was a payment of $25.00 posted to Resident #4's pharmacy bill.
-On 10/21/19 there was a payment of $25.00 posted to Resident #4's pharmacy bill.
-There were no payments posted to Resident #4's pharmacy bill for September 2019 or November 2019.

Records of monies received and paid for Resident #4 from 01/01/19 through 11/18/19 were requested on 11/18/19, but was not received prior to survey exit.

Based on observations, interviews and record reviews, it was determined Resident #4 was not

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D 421	Continued From page 84 interviewable. Refer to interview with the Administrator on 11/15/19 at 4:55pm. Refer to the telephone interview with the provider pharmacy billing representative on 11/19/19 at 8:25am. Refer to the second telephone interview with the provider pharmacy billing representative on 11/19/19 at 10:00am. Refer to interview with the Manager on 11/15/19 at 12:01pm. Refer to interview with the Vice President on 11/18/19 at 9:05am. 5. Review of Resident #5's current FL-2 dated 10/24/19 revealed: -Diagnoses included end stage chronic obstructive pulmonary disease, right leg injury and gait disturbance. -Resident #5 was intermittently disoriented. Review of Resident #5's Resident Fund Sheet revealed: -There was no balance forward on the ledger. -The first entry was a transaction for "grant" dated 07/08/19 for a credit of $66.00. -There was a second entry undated for a deduction of $20.66 to the pharmacy. -There was a third entry dated 07/08/19 for a "payout" of $45.34 to Resident #5, with no balance documented. -On 08/06/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 08/06/19 for a deduction of $20.26 to the pharmacy.	D 421		

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D 421	Continued From page 85 -There was a third entry dated 08/06/19 for a "payout" of $45.74 to Resident #5, with no balance documented. -On 09/10/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 09/10/19 for a deduction of $35.00 to the pharmacy. -There was a third entry dated 09/10/19 for a "payout" of $31.00 to Resident #5, with no balance documented. -On 10/08/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 10/08/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 10/08/19 for a "payout" of $20.00 to Resident #5, with a balance of $21.00 documented. -On 11/06/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 11/06/19 for a deduction of $40.85 to the pharmacy. -There was a third entry dated 11/06/19 for a "payout" of $25.15 to Resident #5, with no balance documented. -There was no ending balance documented after each transaction. -There was no witness signature for each transaction on 11/06/19. -Resident #5's initials were documented on two lines below the last entry for 11/06/19 where there was no documentation of a transaction. Telephone interview with the provider pharmacy billing representative on 11/19/19 at 8:46am revealed: -Resident #5 had a current pharmacy bill of $40.85. -On 07/18/19 there was a payment of $20.26 posted to Resident #5's pharmacy bill. -On 08/14/19 there was a payment of $20.26	D 421		

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posted to Resident #5's pharmacy bill.
-There were no payments posted to Resident #5's pharmacy bill for September 2019, October 2019, or November 2019.

Interview with Resident #5 on 11/15/19 at 9:00am revealed:
-The facility had permission from him to manage his money.
-His social security check was deposited to the facility.
-His "rent" came out of his check every month.
-Sometimes he had a pharmaceutical bill.
-He received money every month; sometimes he would get $20.00, maybe more.
-He had to sign a paper every time he was given his money.

Records of monies received and paid for Resident #5 from 01/01/19 through 11/18/19 were requested on 11/18/19, but was not received prior to survey exit.

Refer to interview with the Administrator on 11/15/19 at 4:55pm.

Refer to the telephone interview with the provider pharmacy billing representative on 11/19/19 at 8:25am.

Refer to the second telephone interview with the provider pharmacy billing representative on 11/19/19 at 10:00am.

Refer to interview with the Manager on 11/15/19 at 12:01pm.

Refer to interview with the Vice President on 11/18/19 at 9:05am.

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D 421	Continued From page 87 6. Review of Resident #6's current FL-2 dated 09/09/19 revealed diagnoses included critical aortic valve stenosis with valve replacement on 09/05/18. Review of Resident #6's Resident Register revealed the resident was his own responsible party. Review of Resident #6's Resident Fund Sheet revealed: -There was no balance forward on the ledger. -The first entry was a transaction for "deposit" dated 06/27/19 for $20,000.00, with a remaining balance of $20,000.00 documented. -There was a second entry dated 06/27/19 for "withdrawal $5,000.00 to Resident #6's family member and $3,000.00 to self" with a remaining balance documented as $12,000.00. -On 07/03/19, there was an entry for "withdrawal" in the amount of $5,000.00, with a balance documented of $7,000.00 -On 07/08/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 07/08/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 07/08/19 for a "payout" of $41.00 to Resident #6, with no balance documented. -On 07/10/19, there was an entry for "withdrawal" in the amount of $5,000.00, with a balance documented of $2,000.00. On 07/15/19, there was an entry for "withdrawal" in the amount of $500.00, with a balance documented of $1,500.00. -On 07/26/19, there was an entry for "withdrawal" in the amount of $500.00, with a balance documented of $1,000.00. -On 08/06/19, there was an entry for "grant" for a credit of $66.00.	D 421		

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D 421	Continued From page 88 -There was a second entry dated 08/06/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 08/06/19 for a "payout" of $41.00 to Resident #6, with no balance documented. -On 09/10/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 09/10/19 for $25.00 to the pharmacy. -There was a third entry dated 09/10/19 for a "payout" of $41.00 to Resident #6, with no balance documented. -On 10/08/19, there was an entry for "grant" for a credit of $66.00. -There was a second entry dated 10/08/19 for a deduction of $25.00 to the pharmacy. -There was a third entry dated 10/08/19 for a "payout" of $41.00 to Resident #6, with no balance documented. -On 11/06/19, there was an entry for "rent" in the amount of $500.00, with a balance of $500.00 documented. -There was a second entry dated 11/06/19 for "grant" for a credit of $66.00. -There was a third entry dated 11/06/19 for a deduction of $25.00 to the pharmacy. -There was a fourth entry dated 11/06/19 for a "payout" of $41.00 to Resident #5, with no balance documented. -There was no ending balance documented after each transaction. -There was no witness signature for each transaction on 11/06/19. Interview with Resident #6 on 11/13/19 at 10:40am revealed: -He received $20,000 a few months ago for his disability. -He requested a receipt from the Manager, but still had not received it.	D 421		

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-He used some of his money to buy a scooter and gave some of his money to his mother.
-He had asked for a receipt of his balance from the Manager on several occasions.
-He had not received a receipt yet.
-A nurse at the facility provided him with his balance 3-4 months ago.
-He had not been able to get an update on his balance since then.
-He wrecked his moped a few months ago and told the Manager that he wanted to hire a lawyer for his case.
-The Manager told him that she would get him a lawyer.

Interview with Resident #6 on 11/15/19 at 8:53am revealed:
-His signature was on each line of the "payout" sheet.
-The Manager would give him his money and would sign, or he would sign and then get his money form the Manager; it happened both ways.
-He received $41.00 each month from his personal funds.
-The $8000 withdrawal on 06/27/19 and $5000 on 07/03/19 were accurate; he could not remember the second $5000 withdrawal on 07/10/19.
-He thought the two $500 withdrawals on 07/15/19 and 07/26/19 were accurate.
-He did not know why he was charged $500 for rent on 11/06/19; he had not given consent for the monies to be taken.
-No one had talked to him about the rent charge prior to taking the $500.
-One of the staff who used to handle the money was going to look into the $500 rent charge.

Interview with the Manager on 11/15/19 at 12:01pm revealed:
-She did not know the details of the $500 rent

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payment on 11/06/19 for Resident #6.
-The money was sent directly to the Vice President.
-Residents who received Medicaid paid $1182 per month for room and board.
-Resident #6 may have owed money because the money he received was close to $1182 each month, but not enough.
-She told Resident #6 he had to pay the $500 rent; that was why the resident signed.

Telephone interview with the Vice President on 11/18/19 at 9:05am revealed:
-Resident #6 received a large amount of money and asked for money from the balance all the time; Resident #6 also asked for a private room.
-Now that Resident #6's money has run out, he no longer wanted the private room.

Records of monies received and paid for Resident #6 from 01/01/19 through 11/18/19 were requested on 11/18/19, but was not received prior to survey exit.

Refer to interview with the Administrator on 11/15/19 at 4:55pm.

Refer to the telephone interview with the provider pharmacy billing representative on 11/19/19 at 8:25am.

Refer to the second telephone interview with the provider pharmacy billing representative on 11/19/19 at 10:00am.

Refer to interview with the Manager on 11/15/19 at 12:01pm.

Refer to interview with the Vice President on 11/18/19 at 9:05am.

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D 421	Continued From page 91 _____ Interview with the Administrator on 11/15/19 at 4:55pm revealed: -She did not get involved with funds anymore. -The Manager and Vice President dealt with resident funds. -She "guessed" the Vice President would be the person to set up a payment plan for residents. -Residents were supposed to sign for each transaction on their funds sheet. -The Manager was supposed to have initialed next to each resident fund transaction. Telephone interview with the provider pharmacy billing representative on 11/19/19 at 8:25am revealed: -She was not the person who received the monies or posted the payments to resident accounts. -She would have to contact the other person to determine if there were monies that had not been posted to the resident's account yet. Second telephone interview with the provider pharmacy billing representative on 11/19/19 at 10:00am revealed the pharmacy staff who received monies and posted payments to resident pharmacy bills was out of the office until 11/20/19. Interview with the Manager on 11/15/19 at 12:01pm revealed: -Some residents owed money because their direct deposit did not switch over when they were admitted to the facility. -Further, if the resident left and owed money then returned to the facility, the resident would still owe the prior balance. -She dispensed the monthly payments; she filled out the sheets before residents came to her office and signed when the resident was paid.	D 421		

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D 421	Continued From page 92 -She was the only witness and was responsible for signing for each transactions; may have overlooked signing some of the spaces. Telephone interview with the Vice President on 11/18/19 at 9:05am revealed: -He handled the finances for the facility. -There were some residents on payment plans because there were issues with money owed to the facility. -Some residents owed money because the residents would deny having a social security payment card or get a new one after setting up the facility as representative payee. -Some residents would continue to use the social security payment card instead of paying their rent. -He did not force residents to surrender the card; it was their choice. -Some residents get their own money and pay their rent and some residents have their money come to the facility. -There was a back payment from social security/special assistance for one month only for any resident admitted to the facility. -He kept a record of money received and paid out for the residents. -Residents made agreements to pay monies owed; signed agreements for payment plans were kept in the facility.	D 421		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to complete initial and 5 day reporting to the Health Care Personnel Registry (HCPR) for 1 of 1 residents (#3) for suspected neglect of the resident until six weeks after Resident #3's death.

The findings are:

Review of Resident #3's current FL-2 dated 07/01/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD) exacerbation, acute on chronic respiratory failure, chronic chest pain, diabetes mellitus, peripheral neuropathy, leukocytosis, coronary artery disease and tobacco use.

Review of a Hospice emergency plan dated 03/27/19 for Resident #3 revealed:
-Resident #3 had a Do Not Resuscitate (DNR) order in place.
-The Hospice Nurse (HN) should be contacted for breathing difficulty and falls.
-The contact number for Hospice was documented on the emergency plan.

Review a care note dated 09/08/19 for "6am" revealed:
-There was documentation by the medication aide (MA)/Staff A, Resident #3 was assisted to the shower by two other male residents.
-One of the male residents tried to stand Resident #3 up which resulted in Resident #3 laying down in the tub.
-Resident #3 slid from his wheelchair as Staff A

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and one of the other residents were leaving the bathroom.
-They lowered Resident #3 to the floor because they could not get him up.
-The personal care aide (PCA)/Staff B called emergency medical services (EMS) because they could not get Resident #3 up from the floor.
-By the time EMS arrived, Resident #3 "had passed".

Telephone interview with Staff A on 11/14/19 at 9:42am revealed:
-She was working as a MA/Supervisor for third shift on 09/07/19.
-The night of 09/07/19, Resident #3 called all night saying he was not getting oxygen; she offered to send him to the hospital, but the resident refused.
-She gave Resident #3 his inhaler around 4:30am which helped for about 45 minutes.
-She did not document administering the inhaler and thought it was an albuterol inhaler.
-Resident #3 had been incontinent of stool and told her he would allow a shower if she got help; she paid another resident $4.00 to help.
-Resident #3 said he needed to sit down while in the tub so he sat down inside the tub while holding onto the grab bar.
-She was taking Resident #3 back to his room when it "looked like he leaped out of the wheelchair onto his knees."
-She and a second male resident tried to get Resident #3 up from the floor but could not.
-Staff B called EMS to help get Resident #3 up.
-She did not call Hospice the night of 09/07/19 because she did not know Resident #3 was on Hospice.
-Resident #3 was not in any distress when EMS was called; EMS was called to help get Resident #3 up.

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-Resident #3 was not using his supplemental oxygen when he left his room and went to the shower because she did not know where the portable oxygen tanks tanks were kept.
-Resident #3 did not fall or hit his head; she was not sure if he slid or leaped out of the chair because "it happened so fast."
-The only time Staff B said Resident #3 did not "look right" was when Staff B returned after calling EMS which was when she picked up Resident #3's arm and it "flopped down."

Review of a care note dated "08/08 11-7" for Resident #3 revealed:
-There was documentation by the PCA/Staff B, she went to assist Staff A and Resident #3 and found the resident lying in the tub and Staff A was trying to get him out of the tub.
-Resident #3's "color didn't look so good, she (Staff A) let him lie on the floor."
-She asked Staff A if she should call 911 because Resident #3's "color was bad and she could not feel a pulse."

Telephone interview with Staff B on 11/14/19 at 12:08pm revealed:
-Resident #3 was at high risk for falling with a shower because he was not able to assist.
-Resident #3 "wore oxygen 24/7;" there was no portable oxygen tank for Resident #3 when he was taken to the shower the morning of 09/08/19.
-Resident #3 started yelling around 12:00am on 09/08/19 that he could not breathe.
-Resident #3 always yelled at night, but that night was different because he yelled "constantly."
-After she helped the resident, she saw Staff A in the bathroom with Resident #3, so she went down to the bathroom.
-When she got to the bathroom, Resident #3 was lying in the tub and "did not look so good," he was

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not responding, naked and his "color was fading."
-She checked Resident #3's pulse at his wrist and neck and there was no pulse, but his lip twitched.
-She asked Staff A if she should call EMS because of how Resident #3 looked.
-Staff A was trying to get Resident #3 up out of the tub with two male residents when she had to leave to help another resident.
-She returned and Resident #3 was in the wheel chair with his legs in the tub and was still not responsive.
-She told Staff A she needed to do something because she was the MA/Supervisor.
-Staff A said she (Staff A) was not going to give him mouth to mouth.
-Resident #3 was wet and heavy so she asked Staff A if she should call EMS to help get the resident off the floor.
-Staff A did not ask her for assistance with cleaning Resident #3.
-She documented the events prior to Resident #3's death in her statement which she gave to the Administrator the next morning (09/09/19).

Review of an incident/accident report dated 09/08/19 at 6:55am for Resident #3 revealed:
-The Manager documented arriving to find Resident #3 lying on the floor unresponsive.
-The MA, the PCA and EMS were present.
-Resident #3 became unresponsive during transfer from bath to chair, was assisted to floor and 911 was called.
-Resident #3 was pronounced dead at 6:55am by EMS.
-The Administrator, Hospice and primary care provider (PCP) were notified.

Telephone interview on 11/15/19 at 10:15am with the HN who responded to facility on 09/08/19 revealed:

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-Resident #3 was on the floor partially out of the bathroom doorway when she arrived between 8:00am to 8:30am; EMS, police officers and the Manager were present.
-Hospice had not been called overnight 09/07/19 into 09/08/19.

Interview with the Hospice Director on 11/15/19 at 9:45am revealed:
-Resident #3 was admitted to Hospice on 03/27/19 and his service end date was 09/08/19.
-A lack of oxygen presents an opportunity for hypoxia (oxygen deficiency to body organs and tissues) which can lead to weakness and, depending how severe, lack of consciousness.

Telephone interview with Resident #3's primary care provider's (PCP's) Registered Nurse (RN) on 11/19/19 at 9:43am revealed there was no documentation of any contact by staff on 09/07/19 or 09/08/19.

Telephone interview with the responding emergency medical technician (EMT) on 11/20/19 at 1:33pm (interview requested 11/15/19 at 8:43am) revealed:
-EMS received a call on 09/08/19 at for a man who fell and was shaking.
-Upon arrival to the facility; he could see from approximately 15 feet away that Resident #3 was blue and was not breathing; the resident was laying completely naked on the floor of the bathroom.
-There was one staff standing in the bathroom next to Resident #3's arm.
-Staff reported Resident #3 was incontinent of stool, they took the resident to the bathroom for a shower and the resident fell out of the wheelchair.
-Staff said she thought Resident #3 was on Hospice but did not know the resident's DNR

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D 438	Continued From page 98 status. -Staff reported prior to the EMS arrival Resident #3 was talking and moving his arms. -A second staff walked down the hall with the a DNR order for Resident #3 so CPR he initiated was stopped. -Staff did not report contacting Hospice or a PCP; Hospice was contacted after EMS arrival. -He had concern for how Resident #3 was laying on the floor; there was a shower chair inside the tub and Resident #3 was laying on his right side on the floor with his back against the tub so not completely on his side. -He did not see a wheelchair; he did not see any obvious trauma to Resident #3. -He had concern that the staff with Resident #3 in the bathroom did not notice the resident's chest was not rising and falling. -He covered Resident #3 with a sheet from the EMS stretcher to block the view since other residents were passing by the bathroom. Review of a HCPR initial allegation report dated 10/24/19 revealed: -There was documentation of resident abuse, neglect and injury of unknown source which occurred on 09/08/19 at 6:55am. -There was documentation the Administrator became aware of "further extenuating circumstances after speaking with (Staff A) on 10/24/19 about the incident that preceded a resident's death." -Staff A had asked two residents to assist with taking Resident #3 to the shower, Resident #3 slid to floor and passed away. -"There was question of (Resident #3) hitting his head on the tub when being lifted out of the tub." -"One of the residents who assisted said (Resident #3) tapped his head lightly when his head was turned."	D 438		

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D 438	Continued From page 99 Review of a HCPR 5 day report dated 11/01/19 revealed: -There was documentation Staff A asked two residents to assist with showering Resident #3 due to bowel incontinence. -Resident #3 was in the late stages of cancer, had a DNR order, slid to floor and passed away. -Another resident who assisted with getting Resident #3 to the shower, suffered "emotional behavior" which reoccurred when the resident was questioned again by the social worker. -There was no documentation Staff A neglected to administer as needed (PRN) medications for difficulty breathing. -There was no documentation Staff A neglected to contact Hospice for constant complaints of difficulty breathing. -There was no documentation Staff A neglected to provide Resident #3 with ordered supplemental oxygen when he was taken to the shower. -There was no documentation Staff A neglected to call EMS immediately after Resident #3 allegedly fell in the tub. Interview with the Administrator on 11/14/19 at 5:15pm revealed: -When the incident first happened (09/08/19) she did not know all the details until that Monday (09/09/19). -Since the police did not investigate, she "just put it all away." -She terminated Staff A because she did not follow the facility's protocol by asking residents to assist with the personal care of another resident. -She was not told Resident #3 refused to go to the hospital. -There was a complaint to the county Department of Social Services (DSS) in October 2019 that Resident #3 hit his head, so she decided to	D 438		

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conduct her own investigation.
-The result of the investigation she completed in October 2019 was "pretty much the same" as the original statements given by Staff A and Staff B.
-The second male resident who assisted Resident #3 in the tub told her Resident #3 "tapped" his head on the side of the tub.
-She talked to Staff A in October 2019 and Staff A said Resident #3 did not hit his head during the transfer.
-Following her second investigation in October 2019, she decided she needed to complete the HCPR reports.
-She did not report to the HCPR prior to 10/24/19 because she did not know Resident #3 hit his head and was in respiratory distress.
-On 11/12/19, she received a call from an anonymous source who offered more information about the incidents leading up to Resident #3's death on 09/08/19.
-She was told Resident #3 was smacked on the hand and yelled at by Staff A because of bowel incontinence.
-The second male resident had reported this to her also when she had completed the second investigation in October 2019.
-The anonymous source also reported Staff A saying she was going to give Resident #3 something to make sure he slept.
-Resident #3 "should not have died with someone yelling and screaming at him."
-Staff A had a harsh tone of voice but she was not aware of any prior issues involving Staff A and the care of residents.
-She had not yet completed an undated report to the HCPR.

Second interview with the Administrator on 11/15/19 at 4:31pm revealed:
-First time hearing about Resident #3

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D 438	Continued From page 101 experiencing shortness of breath was on 11/14/19. -No staff never reported concerns about Staff A yelling at residents until she got that call on 11/12/19 (she would not identify who the call came from). -She was going to give the caller a chance to come forward; the staff did not want her to give her name. -Staff should not have gotten Resident #3 up that night; he went into distress that night because of what they did - took him out of bed without oxygen. -The Administrator talked to Staff A in October - she had his inhaler in her pocket. -She did an investigation after she read the written statements that morning (09/09/19). -There was a delay in report to HCPR because did not think of abuse - never heard resident hit his head. -"Felt the resident was passing away".	D 438		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure residents were treated with respect and dignity as related to not providing wheelchair accessible transportation for a resident who had bilateral	D911		

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below the knee amputations and was required to climb into the facility van to be transported to physician appointments (#1); and a resident (#10) being asked to assist staff with another resident's personal care just prior that resident's death which resulted in emotional distress for Resident #10.

The findings are:
1. Review of the current FL-2 for Resident #1 dated 08/15/19 revealed diagnoses included diabetes, hypertension, depression, and chronic pain.

Observation of Resident #1 on 11/13/19 at 11:32am revealed:
-The resident was sitting in his room in a wheelchair.
-The resident had bilateral below the knee amputations.
-The resident had a one-inch diameter area of a scar on his right knee that was lighter in color than his skin.

Interview with Resident #1 on 11/13/19 at 11:32am revealed:
-There was not enough room in the facility van for everyone to go on an outing.
-He did not want to go out anyway, because he had to crawl into the van.
-The van was not wheelchair accessible.
-He still had to ride in the facility van to go to physician appointments.

Interview with a personal care aide (PCA) on 11/14/19 at 11:15am revealed:
-She worked as a PCA and also as an Activity Director.
-She transported residents to outings in the van.
-The facility van had never been wheelchair

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accessible.
-Resident #1 had not gone on any outings that much, but when he did, he would climb in the van on the floor from his wheelchair, and other residents would lift him up on the van seat.
-The transportation staff that took Resident #1 to his physician appointments would help Resident #1 in the van.

Interview with Resident #1 on 11/15/19 at 10:10am revealed:
-He had been living in the facility since 10/12/18.
-He had been a bilateral below the knee amputee since 2011.
-The facility transporter took him to doctors' appointments in the facility van about three times per month.
-He had to pull himself up in the van from his wheelchair, onto the van floor and then pull himself up into the van seat.
-A blanket was on the van floor that the transporter put there for him.
-He was strong and did not want anyone to help him because he didn't want them to pull on his armpits.
-Sometimes he would let another male resident help him, but most of the time it was just him in the van.
-His knees stayed scarred when he first was admitted to the facility and they wouldn't heal.
-The scarring on his knees came from climbing and sliding into the van.
-He had told the previous Administrator and the corporate owner that he needed a wheelchair accessible bus to go to his appointments, but never received a response.
-The transporter told him she had reported her concerns to management that they needed a wheelchair accessible van.

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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
D911	Continued From page 104 Interview with the Transporter on 11/15/19 at 11:20am revealed: -She had been working at the facility for 20 years. -She took Resident #1 to his physician appointments. -Resident #1 was the only resident that had to climb into the van by himself. -She would hold the wheelchair while Resident #1 climbed into the van. -She kept a blanket on the floor of the van so he wouldn't get any skin tears. -Once they had a pillow that slid in the van, but it was not safe, so she got the blanket. -She had told management several times in the past that they needed to get a wheelchair accessible van. Observation of the van on 11/15/19 at 11:40am revealed: -The van had two rows of seats, and including the front passenger seat, it would transport seven individuals including the driver. -There was one sliding door on the right side, for the passengers to enter in the back. -There were two side doors; one for the driver and one for the front seat passenger. -There was a blanket sitting on the floor just inside the sliding door. -The van did not have any wheelchair accessibility. Interview with the Manager and the Administrator on 11/15/19 at 11:45am revealed: -The Manager and the Administrator were not aware that the lack of wheelchair accessibility in the facility van was a problem. -It was their understanding that Resident #1 wanted to get into the facility van by himself, with no assistance. -The Manager and the Administrator had no	D911		

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knowledge that Resident #1 had sustained scrapes on his knees from trying to enter the van.
-The Manager and the Administrator did not know of any complaints from any resident or staff regarding the lack of wheelchair accessibility.

2. Review of Resident's #10's current FL-2 dated 06/19/19 revealed:
-Diagnoses included diabetes, hypertension, schizophrenia, and renal failure.
-Resident #10 was constantly disoriented.

Review a care note dated 09/08/19 for "6am" revealed:
-There was documentation by the medication aide (MA)/Staff A, another resident was being dressed when it was discovered the resident had been incontinent of stool.
-The other resident was "so covered in it that she asked (Resident #10) to help get the other resident in the shower."
-She put the other resident in the shower and began cleaning the resident.
-The other resident was "still very soiled so she asked Resident #10 to help stand the other resident up so she could clean his behind."
-When Resident #10 tried to stand the other resident up, the other resident "went to his knees and laid down in the tub."
-She got a second resident to assist her and Resident #10 with the resident lying in the tub.
-Staff A, Resident #10 and a second resident pulled the resident from the tub onto the wheelchair.
-They began to leave the bathroom when the other resident slid out of the chair to his knees.
-They lowered Resident #3 to the floor because they could not get him up.

Telephone interview with Staff A on 11/14/19 at

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D911	Continued From page 106 9:42am revealed: -She was working as a medication aide (MA) for third shift on 09/07/19. -The other resident told her he would allow a shower if she got help; she paid Resident #10 $4.00 to help. -She and Resident #10 got the other resident into his wheelchair and took him to the bathroom on the north hall. -She and Resident #10 transferred the other resident to a shower chair and she started to undress and wash Resident #3. -The other resident said he needed to sit down so he sat down inside the tub while holding onto the grab bar. -By that time, the personal care aide (PCA)/Staff B and Resident #10 were in the bathroom. -Resident #10 was holding the wheelchair so she had a second male resident help her to get the other resident out of the tub. -The other resident was sitting in the wheelchair and she was getting his legs out of the tub and at the same time Resident #10 was pulling the wheelchair back towards the bathroom door. -She was going to take the other resident back to his room when it "looked like he leaped out of the wheelchair onto his knees." -She and the second resident tried to get the other resident up from the floor but could not. -Staff B called emergency medical services (EMS) to help get the other resident up from the floor. -Resident #10 and the second resident left the bathroom. -Resident #10 was the only one to help stand the other resident in the shower. Interview with Resident #10 on 11/14/19 at 9:30am revealed: -He and another resident helped get the other	D911		

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D911	Continued From page 107	D911		

resident into the tub; the other resident was awake and talking when they got him in the tub.
-The other resident slipped and fell when they were helping into the tub; the other resident "seemed alright."
-He had to help the other resident to stand while he was in the tub then he "left out of there."
-The second male resident helped him get out of the tub.

Interview with the second resident on 11/13/19 at 5:17pm revealed:
-He did not help the other resident get into the tub; he helped to get him out of the tub around 6:00am.
-He did not know who helped get the other resident into the tub.
-One of the staff asked him and another resident to help; the other resident was "too heavy for the two of them."
-The other resident "was out of it" when he went to help get him out of the tub.
-The other resident was not speaking and "was not fully there."
-Staff had asked him regularly to help with residents' care; he helped on average every other day.
-The Manager put a stop to residents helping with other residents after the other resident died.

Review of a visit note from the mental health provider (MHP) for Resident #10 dated 10/04/19 revealed:
-Resident #10 was seen for a routine follow-up.
-Staff reported no hallucinations and Resident #10 was at his baseline.
-Resident #10 was positive for emotional outbursts, agitation, irritability, and poor concentration.

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D911	Continued From page 108	D911		

Review of a Nurse's Note for Resident #10 dated 10/25/19 revealed the Manager documented calling the MHP to "make sure" Resident #10 was on their list to be seen.

Attempted telephone interview with the MHP on 11/19/19 at 8:34am was unsuccessful.

Telephone interview with Resident #10's family member on 11/19/19 at 10:06am revealed:
-Resident #10 was not in the condition to help with another resident.
-He was a resident and under a physician's care.
-If Resident #10 was asked to do something by staff, that was not right.
-She told him not to answer any questions about the incident unless she was there, because he got scared and may not say the right things.
-He did not want to talk to Staff A anymore.
-The family member did not want Resident #10 to feel like he would get kicked out of the facility for helping Staff A.
-It was not his fault; Resident #10 was not employed by the facility.
-If staff told the residents to do something, the residents felt like they were supposed to do what was asked.
-It was the residents' rights.
-He would not harm anyone, neither of them would.

Interview with the Manager on 11/15/19 at 12:10pm revealed:
-This incident in September 2019 was the first time she had ever heard of residents helping staff with other residents.
-She did not know why Staff A asked other residents to assist her with another resident.
-Residents did not assist other residents with personal care because it was against the

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D911	Continued From page 109 residents' rights. -If staff needed assistance, they were to ask another staff. -Resident #10, who assisted Staff A, walked around saying, "I did not kill that man." -Those two residents should never have been put in that situation. -A couple of days after the incident, Resident #10's family member came to her and said he had called her and told her what happened. -Resident #10's family member was upset and told the Manager that Staff A got Resident #10 to help her with another resident. -That was how the Manager found out. Interview with the Administrator on 11/14/19 at 5:15pm revealed: -Resident #10 just kept saying he did not kill the other resident. -She had to have the mental health group come in a second time to talk to Resident #10 because he was "having a hard time." _____ The facility failed to treat Resident #1 with respect and dignity by failing to assure the resident, who had bilateral below the knee amputations, had wheelchair accessible transportation, and was required to climb into the facility van to be transported to doctor appointments and acquired knee injuries as a result; and Resident #10, who was asked by staff to assist with the care of another resident, resulting in Resident #10 feeling afraid. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/19. CORRECTION DATE FOR THE TYPE B	D911		

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D911	Continued From page 110 VIOLATION SHALL NOT EXCEED JANUARY 3, 2020.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings, other requirements, health care and medication administration. The findings are: 1. Based on observations and interviews, the facility failed to assure proper repair, maintenance and cleaning of floors with depressed, soft, warped, loose and missing tile areas in three resident rooms and three shared resident bathrooms; walls with bubbled, cracked and peeling paint in 4 resident rooms and 2 shared resident bathrooms; multiple holes in 1 shared resident bathroom; heating units loose from the wall in the dining room and 1 resident	D912		

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D912	Continued From page 111 room; loose door knobs on 1 resident room and 1 shared resident bathroom; ill fitting door to 1 resident room; broken and missing window blinds in 2 resident rooms; and walls and windows with stains in 1 resident room and 1 shared resident bathroom [Refer to Tag 074 10A NCAC 13F .0306(a)(1) Housekeeping & Furnishings (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health sanitation score of 85.5 or above at all times [Refer to Tag 077 10A NCAC 13F .0306(a)(4) Housekeeping & Furnishings (Type B Violation)]. 3. Based on observations, interviews, and record reviews the facility failed to assure that hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) for 19 fixtures in 6 shared resident bathrooms on the east hall, north hall and Sampson hall and 3 resident rooms (#16, #22 and #30), with temperatures of 78.9 degrees F to 121.4 degrees F [Refer to Tag 113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)]. 4. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 2 of 5 sampled residents (#1, #10) including failure to notify the primary care provider (PCP) of fingerstick blood sugars (FSBS) greater than 400 (#1), and failure to notify the PCP of a resident (#10) with a 17 pound weight loss over five months [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to administer	D912		

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D912	Continued From page 112 medications as ordered and in accordance with facility's policies and procedures for 3 of 5 residents (#7, #8, #9) observed during medication passes including errors with a blood pressure and an oral diabetic medication (#7), insulin (#8), and medications for anxiety (#9); and record review for 1 of 5 sampled residents (#1) with 23 errors in sliding scale insulin administration during a three month period [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B 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: TYPE A1 VIOLATION Based on interviews and record reviews, the facility neglected Resident #3 by not administering as needed medication including inhalers, a nebulizer, Ativan and Morphine and continuous supplemental oxygen as ordered by Hospice for constant complaints of difficulty breathing, not notifying Hospice and/or the primary care provider about Resident #3's difficulty breathing, not calling emergency medical services immediately following an alleged witnessed head injury and not assuring staff, instead of other residents, provided personal care assistance. The findings are:	D914		

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D914	Continued From page 113 Review of Resident #3's current FL-2 dated 07/01/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD) exacerbation, acute on chronic respiratory failure, chronic chest pain, diabetes mellitus, peripheral neuropathy, leukocytosis, coronary artery disease and tobacco use. Review of a Hospice emergency plan dated 03/27/19 for Resident #3 revealed: -Resident #3 had a Do Not Resuscitate (DNR) order in place. -The Hospice Nurse (HN) should be contacted for breathing difficulty and falls. -The contact number for Hospice was documented on the emergency plan. a. Review of Resident #3's current FL-2 dated 07/01/19 revealed medication orders included Albuterol HFA 90mcg 2 puffs every 6 hours as needed for wheezing (used to treat COPD), Ativan 1mg every 4 hours as needed (used to treat anxiety), Spiriva 18mcg inhalation daily as needed (used to treat COPD), Advair 250/50mg 1 puff twice daily as needed (used to treat COPD) and Duoneb via nebulizer every 2 hours as needed for wheezing (used to treat COPD). Review of Hospice orders dated 06/26/19 for Resident #3 revealed there was an order for morphine 0.25ml every 4 hours as needed (PRN) for pain. Review of Hospice orders dated 07/26/19 for Resident #3 revealed: -There was an order for morphine 0.25ml every 4 hours scheduled. -There was an order for morphine 0.125ml every 1 hour PRN pain, shortness of breath, until	D914		

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D914	Continued From page 114	D914		

comfortable or until symptoms subside.

Telephone interview with Staff A/medication aide (MA) on 11/14/19 at 9:42am revealed:
-She was working as the MA/Supervisor for third shift on 09/07/19; she only worked third shift every Friday, Saturday and Sunday.
-Resident #3 used oxygen sometimes; the night of 09/07/19, Resident #3 called all the time for his oxygen even though he was wearing it.
-When she started the shift on 09/07/19, the personal care aide (PCA)/Staff B told her Resident #3 was not getting any oxygen.
-She went down at 11:00pm on 09/07/19, put Resident #3's nasal canula in a cup of water and it bubbled showing it was working.
-Resident #3 called all night saying he was not getting oxygen; she offered to send him to the hospital, but the resident said no.
-She gave Resident #3 his inhaler around 4:30am which helped for about 45 minutes.
-She did not document administering the inhaler and thought it was an albuterol inhaler.
-She had checked Resident #3's oxygen all night; at one point Resident #3 was laying on top of the oxygen tubing.
-Resident #3 was not confused; he was awake all night.
-If he laid down it was from about 4:00am to 5:30am because that's when staff started getting residents up and dressed.
-Resident #3 did not want to leave his roommate and go to the hospital.
-Resident #3 did not have problem taking his medications.
-She did not give Resident #3 Morphine; she gave him Tylenol whenever he asked for something for pain and he did not have any pain issues for the last few months.
-Resident #3 did not have anxiety so she did not

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give him Ativan.
-Resident #3 was "not struggling to breath" and was not on Hospice that she knew of.
-Hospice had given him a 30 day notice for not paying his bill for two months.
-She worked third shift, so she did not know who Resident #3's primary care provider was.
-If there was a concern, she would have sent Resident #3 to the hospital if he agreed and then contacted the Manager and the resident's family member.

Review of Resident #3's September 2019 medication administration record (MAR) revealed:
-There were two preprinted entries for Morphine 0.25ml every 4 hours scheduled for pain and shortness of breath.
-There was a hand written entry "waiting for clarification" after one entry, a hand written entry "duplicate order" after the second entry and no doses were documented as administered for both entries.
-There was a hand written entry for Morphine 0.25ml every 4 hours scheduled for pain and shortness of breath.
-There was a hand written entry "waiting for clarification" and no doses were documented as administered on 09/07/19 or 09/08/19.
-There was a preprinted entry for Duoneb 0.5mg nebulizer every 2 hours as needed (PRN) for wheezing or shortness of breath (SOB); there were no doses documented as administered.
-There was a preprinted entry for Advair 250/50mg I puff twice daily PRN for SOB or wheezing; there were no doses documented as administered.
-There was a preprinted entry for Ventolin 90mcg 2 puffs every 6 hours PRN for wheezing or SOB; there were no doses documented as administered.

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-There was a preprinted entry for Ativan 1mg every 4 hours PRN for anxiety; there were no doses documented as administered on 09/07/19 or 09/08/19.
-There was a preprinted entry for Morphine 0.125ml every 1 one hour PRN for pain, SOB, until comfortable and/or symptoms subside; there were no doses documented as administered.

Telephone interview with Staff B/PCA on 11/14/19 at 12:08pm revealed:
-Resident #3 "wore oxygen 24/7;" he started yelling around 12:00am on 09/08/19 that he could not breath; he yelled all the time.
-Staff A, the MA, went to Resident #3 several times to check on him and she (Staff B) went a couple times.
-Resident #3 always yelled at night, but that night was different because he yelled "constantly."

Interview with the Hospice Nurse (HN) on 11/15/19 at 9:45am revealed:
-Resident #3 was active with Hospice on 09/07/19; she had done teaching with staff on the use of Ativan and morphine for shortness of breath and anxiety.
-Hospice was not contacted about Resident #3's constant shortness of breath over third shift 09/07/19 into 09/08/19.
-Resident #3's was ordered for continuous supplemental oxygen at 3 liters via nasal canula and he wore the oxygen continuously.

Interview with the Hospice Director on 11/15/19 at 9:45am revealed:
-Resident #3 was admitted to Hospice on 03/27/19 and his service end date was 09/08/19.
-Hospice issuing a 30 day notice for lack of payment was an inaccurate statement.

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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
D914	Continued From page 117 Interview with a MA/Assistant Manager on 11/14/19 at 11:48am revealed: -Resident #3 used oxygen most of the time. -Resident #3 was on Hospice because of COPD; if the resident moved around he would get short of breath and turn purple. -She was working as a MA on first shift on 09/07/19 and Resident #3 was his usual self with no change in condition. -She went to administer Resident #3's medications on 09/07/19, the resident said leave me alone which was something he usually said. -Resident #3 would get anxious and then get short of breath; administering Ativan and sitting down talking with him helped calm Resident #3. Telephone interview with Resident #3's primary care provider's (PCP's) Registered Nurse (RN) on 11/19/19 at 9:43am revealed there was no documentation of any contact by staff on 09/07/19 or 09/08/19. Interview with the Manager on 11/15/19 at 12:10pm revealed: -She did not receive a call from staff on 09/07/19 regarding Resident #3 being short of breath. -He took his medications earlier that night because she gave him his medications. -Staff knew and were expected to administer as needed medications to Resident #3 if he needed something. -If he was complaining of pain or short of breath, staff were supposed to look to see if he had a PRN medication ordered, give him the medication and let her know. -If the PRN medication did not help, staff were to call the physician or for Resident #3, call the hospice agency. -The hospice agency would direct staff to send him to the hospital or call the physician.	D914		

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	HAL025023	A. BUILDING: _____ B. WING _____	R 11/19/2019

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D914	Continued From page 118 Interview with the Administrator on 11/14/19 at 5:15pm revealed: -Staff A should have called EMS when Resident #3 continued to complain of not being able to breath; Staff B should have called the Manager. -She was not told Resident #3 refused to go to the hospital. Interview with the Administrator on 11/15/19 at 4:31pm revealed: -Her first time hearing about Resident #3 experiencing shortness of breath was on 11/14/19. -She asked all the MAs how they knew a resident was on Hospice on 11/11/19. The MAs said it was on the MAR and there was supposed to be a sign posted in the room. (The Administrator looked at Resident #3's MAR and stated she did not see it on the MAR). -The MAs do not know to look in the resident record to check for Hospice services. -Staff were supposed to call the Manager, who would direct them in what they needed to do. -The Administrator talked to Staff A in October; Staff A had his inhaler in her pocket. -Staff A did not call the Manager; she said she did not feel like she could call the Manager. b. Review of a Hospice Comprehensive Assessment and Care Plan dated 07/19/19 for Resident #3 revealed Resident #3 had SOB while at rest and was on continuous oxygen at 3 liters via nasal canula (NC). Review of Resident #3's care plan dated 07/01/19 revealed Resident #3 used oxygen continuously. Review of Resident #3's care plan dated 07/01/19 revealed Resident #3 used oxygen continuously.	D914		

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D914	Continued From page 119 Review a care note dated 09/08/19 for "6am" revealed: -There was documentation by Staff A/medication aide (MA), Resident #3 was being dressed when it was discovered he had been incontinent of stool. -She put Resident #3 in the shower and began cleaning the resident. -They were "backing him (Resident #3) out" and she pulled Resident #3's legs from the tub. -They began to leave the bathroom when Resident #3 slid out of the chair to his knees, "he was still with us." -They lowered Resident #3 to the floor because they could not get him up. -The personal care aide (PCA)/Staff B called emergency medical services (EMS) because they could not get Resident #3 up. -Staff B told EMS Resident #3 was still breathing and conscious; she did not know if Resident #3 was cold and clammy because they had just gotten him out of the shower. -Resident #3 was turning blue. -EMS was called to assist with getting Resident #3 off the floor and back to bed. -By the time EMS arrived, Resident #3 "had passed". Telephone interview with Staff A on 11/14/19 at 9:42am revealed: -Resident #3 could be "contrary" so she started with other residents the morning of 09/08/19. -It had to be 6:10am when she smelled feces upon entering Resident #3's room; the feces was all over the resident and the sheets. -She told Resident #3 she was going to have to give him a shower, he agreed and then said no because he was afraid staff would drop him. -Resident #3 told her he would allow a shower if she got help.	D914		

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D914	Continued From page 120 -She was going to take Resident #3 back to his room to finish cleaning him and dress him when it "looked like he leaped out of the wheelchair onto his knees." -Resident #3 did not have any oxygen when he left his room and went to the shower because she did not know where the portable tanks were kept. -Resident #3 only had the concentrator in his room. Review of a care note dated "08/08 11-7" for Resident #3 revealed: -There was documentation by Staff B, she was doing rounds on the east hall until 7:00am. -She had finished helping residents and was taking trash out when she saw Staff A with Resident #3 down the hall. -She went to assist Staff A and Resident #3 and found the resident lying in the tub and Staff was trying to get him out of the tub. -Resident #3's "color didn't look so good, she (Staff A) let him lie on the floor." Telephone interview with Staff B on 11/14/19 at 12:08pm revealed: -At 6:30am, she saw Staff A in the hall with Resident #3 in his wheelchair going to the bathroom; she went to help another resident. -Resident #3 "wore oxygen 24/7;" there was no portable oxygen tank for Resident #3 when he was taken to the shower the morning of 09/08/19. Interview with a MA/Assistant Manager on 11/14/19 at 11:48am revealed: -Resident #3 used oxygen most of the time; she did not know where the portable oxygen was stored. -Resident #3 was on Hospice because of COPD; if the resident moved around he would get short of breath and turn purple.	D914		

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D914	Continued From page 121 Interview with the Hospice Nurse (HN) on 11/15/19 at 9:45am revealed: -Resident #3's was ordered for continuous supplemental oxygen at 3 liters via nasal canula and he wore the oxygen continuously. -Resident #3 always had shortness of breath so it would be concerning for him not have the ordered supplemental oxygen. -Resident #3's COPD and not wearing the supplemental oxygen would have caused increased shortness of breath. Interview with the Hospice Director on 11/15/19 at 9:45am revealed a lack of oxygen presents an opportunity for hypoxia (oxygen deficiency to body organs and tissues) which can lead to weakness and, depending how severe, lack of consciousness. Interview with the Manager on 11/15/19 at 12:10pm revealed: -On the night of 09/07/19, Staff A should never have moved Resident #3 to the shower if he was in distress; she should have cleaned him up and changed his sheets on the bed. -Resident #3 also had oxygen; she had the key to the oxygen closet. -Staff A could have called her because she lived right next door to the facility. Interview with the Administrator on 11/15/19 at 4:31pm revealed: -Staff should not have gotten Resident #3 up that night; he went into distress that night because of what they did - took him out of bed without oxygen. -Staff A did not call the Manager; she said she did not feel like she could call the Manager. -MAs have access to the oxygen; key to oxygen	D914		

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D914	Continued From page 122	D914		

door on MAs key ring.

c. Review of Resident #3's care plan dated 07/01/19 revealed Resident #3 was totally dependent on staff for assistance with eating, toileting, ambulation, transfers, bathing and dressing.

Review of Resident #3's personal care record dated September 2019 revealed:
-Resident #3 was totally dependent on staff for bathing and received bed baths on first shift every Monday, Wednesday and Friday.
-Resident #3 was totally dependent on staff for incontinence care, dressing, undressing and transfers.
-There was no documentation of personal care provided for Resident #3 for third shift on 09/07/19.

Review a care note dated 09/08/19 for "16am" revealed:
-Staff A/medication aide (MA) documented Resident #3 was "so covered in it (feces) that she asked a male resident to help get him (Resident #3) the shower."
-She put Resident #3 in the shower and began cleaning the resident.
-Resident #3 was "still very soiled so she asked the (male) resident to help stand (Resident #3) up so she could clean his behind."
-When the (male) resident tried to stand (Resident #3) up, Resident #3 "went to his knees and laid down in the tub."
-She needed two male residents.
-She and the two male residents pulled the wheelchair up to the side of the tub, "he (Resident #3) was still with us," and they pulled Resident #3 onto the wheelchair.
-They were "backing him (Resident #3) out" and

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D914	Continued From page 123	D914		

she pulled Resident #3's legs from the tub.

Telephone interview with Staff A on 11/14/19 at 9:42am revealed:
-Resident #3 could stand with assistance.
-She was not able to do heavy lifting and had told the Manager before Resident #3 was moved to her assignment in June or July 2019.
-Resident #3 could be "contrary" so she started with other residents the morning of 09/08/19.
-It had to be 6:10am when she smelt feces upon entering Resident #3's room; the feces was all over the resident and the sheets.
-She told Resident #3 she was going to have to give him a shower, he agreed and then said no because he was afraid staff would drop him.
-Resident #3 told her he would allow a shower if she got help; she paid a resident $4.00 to help.
-She and a resident got Resident #3 into his wheelchair and took him to the bathroom on the north hall.
-She and a resident transferred Resident #3 to a shower chair and she started to undress and wash Resident #3.
-Resident #3 used a grab bar inside the shower and stood up.
-Resident #3 was still moving his bowels; she used a cup to try and rinse the backside of the resident.
-Resident #3 stood again and she removed his incontinence brief and "splashed water" on the back of the resident.
-With Resident #3 standing, she removed the shower chair from the tub so she could thoroughly clean the back of the resident.
-Resident #3 said he needed to sit down so he sat down inside the tub while holding onto the grab bar.
-By that time, Staff B/personal care aide (PCA) and a resident were in the bathroom.

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D914	Continued From page 124 -A resident was holding the wheelchair so she had a second male resident help her to get Resident #3 out of the tub. -Resident #3 was sitting in the wheelchair and she was getting his legs out of the tub and at the same time a resident was pulling the wheelchair back towards the bathroom door. -Residents "offered to help because they were always looking for money." -Resident #3 was not always a bed bath, she had seen first shift staff take Resident #3 for a shower. -Resident #3 could be wet with urine and would refuse to be changed, she would report it to the first shift when that happened. -There was only one resident who helped stand Resident #3 in the shower. -She chose to shower Resident #3 because if she had left him soiled in feces she "would have never heard the end of it." Telephone interview with Staff B on 11/14/19 at 12:08pm revealed: -Resident #3 was total care; he was not able to get up out of the bed on his own. -Resident #3 could not stand for long periods of time and could not assist with getting in and out of the shower and bathing himself. -She was trained to give bed baths for residents who were not able to assist with getting in and out of the shower and with bathing. -Resident #3 was at high risk for falling with a shower because he was not able to assist. -At 6:30am, she saw Staff A in the hall with Resident #3 in his wheelchair going to the bathroom; she went to help another resident. -Staff A asked the two male residents for help with Resident #3 because "if you're dying and deprived of oxygen you can't stand." -Resident #3 should not have been moved from	D914		

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D914	Continued From page 125	D914		

his bed; she had never seen Staff A take Resident #3 to the shower before.
-Staff A did not ask her for assistance with cleaning Resident #3.

Interview with the male resident on 11/14/19 at 9:30am revealed:
-He and another resident helped get Resident #3 into the tub; Resident #3 was awake and talking when they got him in the tub.
-He had to help Resident #3 to stand while he was in the tub then he "left out of there."
-The second male resident helped him get out of the tub.

Interview with the second male resident on 11/13/19 at 5:17pm revealed:
-He did not help Resident #3 get into the tub; he helped to get him out of the tub around 6:00am.
-He did not know who helped get Resident #3 into the tub.
-One of the staff asked him and another resident to help; Resident #3 was "too heavy for the two of them."
-Staff had asked him regularly to help with residents' care; he helped on average every other day.
-The Manager put a stop to residents helping with other residents after Resident #3 died.

Interview with a MA/Assistant Manager on 11/14/19 at 11:48am revealed:
-Resident #3 had a wheelchair and was able to wheel himself but not too far and needed assistance of one staff with transfers.
-She did not have anything to do with bathing Resident #3 so she did not know if he received a bed bath or a shower.

Review of a Hospice Comprehensive

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D914	Continued From page 126 Assessment and Care Plan dated 07/19/19 for Resident #3 revealed: -Resident #3 was easily agitated and "often" refused personal care. -Resident #3 needed assistance with bathing, dressing and toileting. -Resident #3 was self-propelled his wheelchair, was easily fatigued with poor endurance and stayed in bed "most" of the time. Interview with the Hospice Nurse (HN) on 11/15/19 at 9:45am revealed Resident #3 was always in his bed when she saw him; staff reported the resident was unsteady on his feet and needed one person assistance with transfers. Interview with a personal care aide (PCA) on 11/14/19 at 5:00pm revealed: -Resident #3 was able to get up on his own; he would get in his wheelchair and go outside to smoke. -Resident #3 wore oxygen; if he had the oxygen off and could not reach it he would call for help. -Staff had told the other resident not to help with residents; staff were responsible for residents' needs. Interview with the Manager on 11/15/19 at 12:10pm revealed: -Resident #3 could stand, but staff would provide stand-by assistance. -Sometimes, Resident #3 would get bed baths, because he did not want to go to the shower. -Two staff were required to assist him with a shower; staff would put him in the wheelchair to shower. -When Resident #3 had a bowel movement, staff were trained to give him a bath. -On the night of 09/07/19, Staff A should never have moved Resident #3 to the shower if he was	D914		

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in distress; she should have cleaned him up and changed his sheets on the bed.
-This incident was the first time she had ever heard of residents helping staff with other residents.
-She did not know why Staff A asked other residents to assist her with Resident #3.
-Residents do not assist other residents with personal care because it was against the residents' rights.
-If staff needed assistance, they were to ask another staff.
-Those two residents should never have been put in that situation.
-Resident #3 had the right to refuse care; if he would not do something for one staff, they should ask another staff or call her.

Interview with the Administrator on 11/14/19 at 5:15pm revealed:
-Staff A should never have asked residents to assist with other residents' personal care.
-She had to have the mental health group come in twice to talk to the two male residents because they were "having a hard time."

Interview with the Administrator on 11/15/19 at 4:31pm revealed:
-Resident #3 showered when he was healthier.
-No expectation for Staff A to take Resident #3 to shower that night.

d. Interview with a male resident on 11/14/19 at 9:30am revealed:
-Resident #3 slipped and fell when they were helping into the tub; Resident #3 "seemed alright."
-He had to help Resident #3 to stand while he was in the tub then he "left out of there."

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D914	Continued From page 128 Interview with a second male resident on 11/13/19 at 5:17pm revealed: -Resident #3 "was out of it" when he went to help get him out of the tub. -Resident #3 was not speaking and "was not fully there." Review a care note dated 09/08/19 for "6am" revealed: -Staff A/medication aide (MA) and a resident began to leave the bathroom with Resident #3 when Resident #3 slid out of the chair to his knees, "he was still with us." -They lowered Resident #3 to the floor because they could not get him up. -Staff B/personal care aide (PCA) called emergency medical services (EMS) because they could not get Resident #3 up. -Staff B told EMS Resident #3 was still breathing and conscious; she did not know if Resident #3 was cold and clammy because they had just gotten him out of the shower. -Resident #3 was turning blue. -EMS was called to assist with getting Resident #3 off the floor and back to bed. -By the time EMS arrived, Resident #3 "had passed". Telephone interview with Staff A on 11/14/19 at 9:42am revealed: -With Resident #3 standing in the tub, she removed the shower chair from the tub so she could thoroughly clean the back of the resident. -Resident #3 said he needed to sit down so he sat down inside the tub while holding onto the grab bar. -By that time, the Staff B and a resident were in the bathroom. -A resident was holding the wheelchair so she had a second male resident help her to get	D914		

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D914	Continued From page 129	D914		

Resident #3 out of the tub.
-Resident #3 was sitting in the wheelchair and she was getting his legs out of the tub and at the same time one male resident was pulling the wheelchair back towards the bathroom door.
-She was going to take Resident #3 back to his room to finish cleaning him and dress him when it "looked like he leaped out of the wheelchair onto his knees."
-She and the second male resident tried to get Resident #3 up from the floor but could not.
-Staff B called EMS to help get Resident #3 up.
-The two male residents left the bathroom and she was holding Resident #3 by his arms.
-Staff B spoke to EMS "for a long time" during which Resident #3 was "looking around, wiggling his fingers and chewing like he had gum."
-Resident #3 was conscious and breathing; it took EMS a long time to get to the facility.
-Staff B called the Manager; the Manager and EMS came through the doors at the same time.
-Resident #3 had passed away about the time EMS arrived; the emergency medical technician (EMT) said his body was still hot so the EMT started cardio-pulmonary resuscitation (CPR).
-The Manager went to get Resident #3's chart and his do not resuscitate (DNR) order.
-Resident #3 was not in any distress when EMS was called; EMS was called to help get Resident #3 up.
-Resident #3 did not fall or hit his head; she was not sure if he slid or leaped out of the chair because "it happened so fast."
-Resident #3 stood then went to his knees and laid in the tub after she took the chair out and told the resident not to sit down.
-She had a blanket and covered him up while he was on the floor.
-The only time Staff B said Resident #3 did not "look right" was when Staff B returned after

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calling EMS which was when she picked up Resident #3's arm and it "flopped down."

Review of a care note dated "08/08 11-7" for Resident #3 revealed:
-There was documentation by Staff B, she had finished helping residents around 7:00am and was taking trash out when she saw Staff A with Resident #3 down the hall.
-She went to assist Staff A and Resident #3 and found the resident lying in the tub and Staff was trying to get him out of the tub.
-Resident #3's "color didn't look so good, she (Staff A) let him lie on the floor."
-She asked Staff A if she should call 911 because Resident #3's" color was bad and she could not feel a pulse."
-Resident #3's mouth moved twice, and Staff A said he was still incontinent.
-She called 911; she did not know Resident #3 was on Hospice.
-She called the Manager.
-She left to finish taking care of Staff A's other residents.

Telephone interview with Staff B on 11/14/19 at 12:08pm revealed:
-Resident #3 was at high risk for falling with a shower because he was not able to assist.
-At 6:30am, she saw Staff A in the hall with Resident #3 in his wheelchair; she went to help another resident.
-After she helped the resident, she saw Staff A in the bathroom with Resident #3, so she went down to the bathroom.
-When she got to the bathroom, Resident #3 was lying in the tub and "did not look so good," he was not responding, naked and his "color was fading."
-She checked Resident #3's pulse at his wrist and neck and there was no pulse, but his lip twitched.

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-She asked Staff A if she should call EMS because of how Resident #3 looked.
-Staff A was trying to get Resident #3 up out of the tub with two male residents when she had to leave to help another resident.
-She returned and Resident #3 was in the wheel chair with his legs in the tub and was still not responsive.
-She told Staff A she needed to do something because she was the MA/Supervisor.
-She heard Staff A say she was not going to give him mouth to mouth.
-Resident #3 was wet and heavy so she asked Staff A if she should call EMS to help get the resident off the floor.
-Staff A asked the two male residents for help with Resident #3 because "if you're dying and deprived of oxygen you can't stand."
-She called EMS and the Manager.
-"That morning was just wrong all the way around because he (Resident #3) died a horrible, lonely death lying on the floor naked; he was vulnerable and deserved to die with dignity."

Review of EMS report revealed for Resident #3 dated 09/08/19 revealed:
-EMS received a call at 6:37am for an elderly male who was shaking, laying down in the shower and would not get up.
-EMS arrived on the scene at 6:47am and were with the patient at 6:49am.
-EMS remained at the scene until 7:51am.

Telephone interview with the responding emergency medical technician (EMT) on 11/20/19 at 1:33pm (interview requested 11/15/19 at 8:43am) revealed:
-EMS received a call for a man who fell and was shaking.
-Upon arrival to the facility; walking down the hall

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he could see from approximately 15 feet away Resident #3 was blue and was not breathing; the resident was laying completely naked on the floor of the bathroom.
-There was one staff standing in the bathroom next to Resident #3's arm.
-Staff reported Resident #3 was incontinent of stool, they took the resident to the bathroom for a shower and the resident fell out of the wheelchair.
-Staff said she thought Resident #3 was on Hospice but did not know the resident's DNR status.
-He started CPR on Resident #3.
-Staff reported prior to EMS arrival Resident #3 was talking and moving his arms.
-A second staff walked down the hall with the a DNR order for Resident #3 so CPR was stopped.
-He called the local police because that was routine when EMS responded to a death.
-Staff did not report contacting Hospice or a PCP; Hospice was contacted after EMS arrival.
-He had concern for how Resident #3 was laying on the floor based on staff report of the resident sliding out of the chair.
-There was a shower chair inside the tub and Resident #3 was laying on his right side on the floor with his back against the tub so not completely on his side as if he fell out of the shower chair and not a wheelchair.
-He did not see a wheelchair; he did not see any obvious trauma to Resident #3.
-He had concern that the staff with Resident #3 in the bathroom did not notice the resident's chest was not rising and falling.
-The report of Resident #3 talking and moving his arms sounded more like agonal breathing (Agonal breathing is a distinct abnormal pattern of breathing and brainstem reflex characterized by gasping, labored breathing and accompanied by strange vocalizations.)

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D914	Continued From page 133 -He covered Resident #3 with a sheet from the EMS stretcher to block the view since other residents were passing by the bathroom. Interview with the Hospice Nurse (HN) on 11/15/19 at 9:45am revealed Hospice was not notified by staff of any concerns/incidents until Resident #3's death. Telephone interview on 11/15/19 at 10:15am with HN who responded to facility on 09/08/19 revealed: -Resident #3 was on the floor partially out of the bathroom doorway when she arrived at 8:00am to 8:30am; EMS, police officers and the Manager were present. -Hospice had not been called overnight 09/07/19 into 09/08/19. Interview with the Manager on 11/15/19 at 12:10pm revealed: -The whole situation could have been avoided. -In a normal situation, the PCA would go to the MA and the MA would call the Manager. -On 09/08/19, she came up the ramp through the side door off the smoking porch. -She saw Staff A and Staff B standing against the wall by the bathroom. -She met the EMT coming in from the front door. -Resident #3 was on the floor covered with a sheet. -EMT went to Resident #3 and started CPR. -She went in the office and obtained Resident #3's DNR and yelled to the EMT that Resident #3 had a DNR. -EMT stopped CPR and pronounced Resident #3 deceased at 6:55am. -All staff knew Resident #3 was a DNR. -Staff A knew Resident #3 was on hospice and she should have told the EMT that.	D914		

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-Resident #3 had been on hospice since June 2019.
-The MAs were responsible for knowing who was receiving hospice services and who was a DNR.
-The EMT called the police because they did not think Staff A or Staff B were doing anything.
-The Manager contacted the funeral home.
-She did not see any injuries, but Resident #3 was lying on his back.
-She reported the incident to the Administrator, and the Administrator talked to the staff.

Interview with the Administrator on 11/14/19 at 5:15pm revealed:
-On 11/12/19, she received a call from an anonymous source who offered more information about the incidents leading up to Resident #3's death on 09/08/19.
-She was told Resident #3 was smacked on the hand and yelled at by Staff A because of bowel incontinence.
-The second male resident had reported this to her also.
-The anonymous source also reported Staff A saying she was going to give Resident #3 something to make sure he slept.
-Resident #3 "should not have died with someone yelling and screaming at him."
-Staff A had a harsh tone of vice but she was aware of any prior issues involving Staff A and the care of residents.
-When the incident first happened (09/08/19) she did not know all the details until that Monday (09/09/19).
-Resident #10 just kept saying he did not kill Resident #3 and second male resident just did not want to talk.
-Since the police did not investigate, she "just put it all away."
-She did terminate Staff A.

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D914	Continued From page 135 -There was a complaint to the county Department of Social Services (DSS) in October 2019 that Resident #3 hit his head, so she decided to conduct her own investigation. -The result of the investigation she completed in October 2019 was "pretty much the same" as the original statements given by Staff A and Staff B. -The second male resident who assisted Resident #3 in the tub told her Resident #3 "tapped" his head on the side of the tub. -She talked to Staff A in October 2019 and that was when she decided she needed to complete the HCPR reports. Interview with the Administrator on 11/15/19 at 4:31pm revealed: -The Manager called Hospice. -She guessed the Staff B called EMS. -Staff A seemed knowledgeable like she knew what she was doing. -Staff were supposed to call the Manager, who would direct them in what they needed to do. -Staff should not have gotten Resident #3 up that night; he went into distress that night because of what they did - took him out of bed without oxygen. Attempted interview with Resident #3's primary care provider (PCP) on 11/15/19 at 9:36am was unsuccessful. _____ The facility seriously neglected Resident #3 who had continuous complaints of difficulty breathing for 7.5 hours from 11:00pm until 6:30am and was not administered any as needed medication including inhalers, nebulizer, Ativan or Morphine per Hospice orders, staff did not contact Hospice and/or the primary care provider for Resident #3's difficulty breathing, staff did not provide ordered oxygen when Resident #3 was showered by two	D914		

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D914	Continued From page 136 male residents, staff did not respond immediately when Resident #3 allegedly sustained a witnessed head injury and staff did not call emergency medical services until 6:37am which was just prior to Resident #3 dying on the bathroom floor in the facility at 6:55am. The facility's failure to respond and provide care, services and ordered medications and treatments demonstrates serious neglect of Resident #3 and constitutes a Type A1 Violation._____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/19/19 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 19, 2019.	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the management and operations of the facility and the facility policies were implemented and rules were maintained for housekeeping and	D980		

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furnishings, other requirements, health care, medication administration, controlled substances and residents' rights.

The findings are:

Noncompliance was identified in the following rule areas at violation level:

1. Based on observations and interviews, the facility failed to assure proper repair, maintenance and cleaning of floors with depressed, soft, warped, loose and missing tile areas in three resident rooms and three shared resident bathrooms; walls with bubbled, cracked and peeling paint in 4 resident rooms and 2 shared resident bathrooms; multiple holes in 1 shared resident bathroom; heating units loose from the wall in the dining room and 1 resident room; loose door knobs on 1 resident room and 1 shared resident bathroom; ill fitting door to 1 resident room; broken and missing window blinds in 2 resident rooms; and walls and windows with stains in 1 resident room and 1 shared resident bathroom [Refer to Tag 074 10A NCAC 13F .0306(a)(1) Housekeeping & Furnishings (Type B Violation)].

2. Based on observations, interviews and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health sanitation score of 85.5 or above at all times [Refer to Tag 077 10A NCAC 13F .0306(a)(4) Housekeeping & Furnishings (Type B Violation)].

3. Based on observations, interviews, and record reviews the facility failed to assure that hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) for 19 fixtures in 6 shared resident bathrooms on the east hall, north

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hall and Sampson hall and 3 resident rooms (#16, #22 and #30), with temperatures of 78.9 degrees F to 121.4 degrees F [Refer to Tag 113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)].

4. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 2 of 5 sampled residents (#1, #10) including failure to notify the primary care provider (PCP) of fingerstick blood sugars (FSBS) greater than 400 (#1), and failure to notify the PCP of a resident (#10) with a 17 pound weight loss over five months. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].

5. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with facility's policies and procedures for 3 of 5 residents (#7, #8, #9) observed during medication passes including errors with a blood pressure and an oral diabetic medication (#7), insulin (#8), and medications for anxiety (#9); and record review for 1 of 5 sampled residents (#1) with 23 errors in sliding scale insulin administration during a three month period. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

6. Based on observations, record reviews, and interviews, the facility failed to assure residents were treated with respect and dignity as related to not providing wheelchair accessible transportation for a resident who had bilateral below the knee amputations and was required to climb into the facility van to be transported to physician appointments (#1); and a resident (#10) being asked to assist staff with another resident's

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personal care just prior that resident's death which resulted in emotional distress for Resident #10 [Refer to Tag 911 G.S.131D-21(1) Residents' Rights (Type B Violation)].

7. Based on interviews and record reviews, the facility neglected Resident #3 by not administering as needed medication including inhalers, a nebulizer, Ativan and Morphine and continuous supplemental oxygen as ordered by Hospice for constant complaints of difficulty breathing, not notifying Hospice and/or the primary care provider about Resident #3's difficulty breathing, not calling emergency medical services immediately following an alleged witnessed head injury and not assuring staff, instead of other residents, provided personal care assistance [Refer to Tag 914 G.S.131D-21(4) Residents' Rights (Type A1 Violation)].

_____

The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing residents' rights, health care and medication administration. The Administrator's failure to implement rules and regulations resulted in the neglect of Resident #3 who had complaints of difficulty breathing and Staff A did not administer any as needed medication including inhalers, nebulizer, Ativan or Morphine per Hospice orders, did not contact Hospice and/or the primary care provider and did not provide ordered oxygen when showering Resident #3 just prior to the resident dying on the bathroom floor in the facility. The Administrator's failure demonstrates serious neglect and harm which constitutes a Type A1 Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/19/19 for

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D980	Continued From page 140 this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 19, 2019.	D980		